AN EXPLORATION OF PSYCHOLOGICAL CHARACTERISTICS
OF PEOPLE SEEKING RELATIONSHIP COUNSELLING
IN AN AUSTRALIAN CLINICAL SETTING

A thesis submitted
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“Oh, the comfort - the inexpressible comfort of feeling safe with a person - having neither to weigh thoughts nor measure words, but pouring them all right out, just as they are, chaff and grain together; certain that a faithful hand will take and sift them, keep what is worth keeping, and then with the breath of kindness blow the rest away.”

Dinah Craik: *A Life for a Life*, 1859
ABSTRACT
Couple counselling has been offered in Australia for over 60 years and while professionalism and training standards have increased in that time very little research has been conducted that has investigated the reasons people seek relationship counselling and the benefits they receive from professional assistance. The current research aimed to narrow the gap between theory and practice in an Australian clinical setting. Empirical research conducted globally into relationship counselling shows that marital therapy is at least as efficacious as other forms of psychotherapy yet few evaluation studies have been conducted in clinical settings. Client satisfaction with the outcome of relationship counselling from the client’s perspective includes whether the goals of counselling were met, an increase in relationship satisfaction and a decrease in personal and/or relationship distress. Research has also shown that clients and counsellors often differ in their perceptions of what occurred in counselling. The current study explored pre and post counselling variables for couples attending for relationship counselling in a clinical setting and also explored counsellor perceptions of satisfaction with counselling outcome. Participants were clients who contacted a branch of a national provider of relationship services in Australia. Seventy six people completed pre counselling questionnaires and of these 20 people completed a post counselling questionnaire. Fifteen different counsellors also completed questionnaires about these participants. Results showed a significant gender difference with women overall being less satisfied with their relationship prior to counselling than men. Men and women were significantly more depressed, stressed and anxious and there was also a higher proportion of insecurely attached people than is found in the general population. While conducting research in real-life settings can be problematic due to the high levels of distress people are experiencing at the time such research is crucial in order to improve clinical practice. Recommendations for future research in clinical settings include further exploration of the relationship between insecure attachment, depression and relationship problems in adult life.
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Finally this research would not have been possible without the generosity of the participants who willingly participated in this study at a time when they were under enormous personal stress; to those people as well I say “thank you”.
DECLARATION OF ORIGINALITY

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University, except where due reference is made in the text of the thesis. To the best of my knowledge, this thesis contains no material previously published or written by another person except where due reference is made in the text of the thesis. I further declare that the ethical principles of the Australian Psychological Society in relation to research have been observed.

Adele Carmady

Date
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Chapter 1: Background to the Study and History of Marriage Counselling

1.1 Introduction to the Current Study

Relationship counselling has been available in Australia since 1948 and has developed from services provided by church affiliated volunteer counsellors to a contemporary model where professionally trained counsellors provide a range of therapeutic, educative and mediation interventions. While relationship counselling has existed for over 60 years in Australia there has been almost no research that has examined the reasons people seek relationship counselling and the benefits they might gain from having sought professional assistance. This thesis is comprised of two elements: an overview of the history of relationship counselling overseas and in Australia and an examination of a unique data set of couples attending relationship counselling together, as well as data from the counsellors they saw. As discussed in Chapters 2 and 3 most research that has been conducted into relationship counselling has been empirical research; the current study provides an unprecedented insight into real life relationship counselling conducted in an Australian clinical setting.

1.2 Background to the Current Study and Overview of Chapter

Relationships are an intrinsic part of human life. The quality of our relationships can affect our sense of well-being, our physical and emotional health and our sense of personal value and self worth. Healthy experiences of relationships in childhood increase the chances of having healthy adult relationships (Hazan, 2003; Schachner, Shaver & Mikulincer, 2003). However, when problems emerge in relationships, particularly couple relationships, how readily do people seek professional assistance and how willing are they to reveal the intimate and private details of their personal lives to a total stranger in a clinical setting? Based on contemporary figures of the number of people who seek relationship counselling and current divorce statistics it appears that many relationships end without partners seeking professional assistance.

Current separation and divorce statistics shows that one third of first marriages and 50% of second marriages will end in divorce (Australian Bureau of Statistics, 2002). However, despite the expanding range of relationship and family
counselling services it appears that only about 13% of couples experiencing relationship difficulties seek professional assistance (Lewis, Morgan & Clarke, 1992). Couple therapy is a vital component of mental health services not only for the emotional and physical well-being of adult partners but also for their children (Snyder, Castellani & Whisman, 2006). There is an increasing body of literature that supports the effectiveness of couple counselling in treating not only couple distress but also as an adjunct treatment for many individual emotional and physical health disorders (Snyder et al.).

The following chapter explores the development and history of marriage counselling both overseas and within Australia. The development of marriage counselling in Australia was preceded by developments overseas. Therefore, in order to understand the history of marriage counselling and its more contemporary evolution into relationship counselling, an overview of the historical development of services overseas is provided as an antecedent to the Australian situation.

While the provision of relationship counselling and education has existed for over 60 years research into the effectiveness of relationship counselling has only occurred over the past 20 to 30 years. Most of the research has been efficacy research conducted in the form of clinical trials; a definition of efficacy research can be found in Section 2.2. One criticism of this research is the limited generalisability to couple counselling that occurs in real life settings (Christensen, Russell, Miller & Peterson, 1998; Christensen, Baucom, Thuy-Anh & Stanton, 2005).

Section 1.3 reviews the development of marriage counselling from its early beginnings around the time of World War 1. Section 1.4 reviews the history of relationship counselling in the United Kingdom. Section 1.5 reviews the history of relationship counselling in the United States of America and contrasts the differences between the British and American models. Section 1.6 discusses the emergence of research and evaluation in the area of relationship counselling. Section 1.7 reviews the history of relationship counselling in Australia. Section 1.8 reviews contemporary changes in training and accreditation. Section 1.9 outlines the scientific paradigm distinguishing between efficacy and effectiveness research. Section 1.10 provides a summary of Chapter 1.
1.3 Development of Marriage Counselling

The development of marriage counselling has its origins around the time of the First World War (Broderick & Schrader, 1991) and yet research into the efficacy of relationship counselling is a more recent development over the past 20 to 30 years. Marriage counselling grew out of the attempts of various helping professions including medicine, psychology, the clergy, social work, education and law to address an increase in reported marital and sexual problems in the aftermath of World War 1 (Broderick & Schrader). However, in nearly every helping profession marriage counselling was an auxiliary activity to the mainstream services provided by each discipline.

The early social work movement in both Britain and America was inextricably linked with interventions in families and marriages. The social work discipline grew out of the charity movements in the late nineteenth century where the main focus was to minister to the needs of underprivileged members of society (Wetchler, 2003). The family system was seen to be a part of a larger societal system and problems within the family could not be addressed without considering the influence of societal pressures and later worldwide events such as the First and Second World Wars. Therefore, while interventions to help families in trouble have existed for over 100 years and relationship counselling as a profession and discipline has been in existence for approximately 50 years, a gap still exists between an increasing body of literature detailing research findings and their application to relationship counselling in real life settings (Christensen & Heavey, 1999).

1.4 History of Relationship Counselling in the United Kingdom

The Marriage Guidance Committee in Britain was established in 1938. Its mission was shaped by the social and political context at the time with a focus on stemming the perceived breakdown in family life (Lewis et al., 1992). These concerns about the breakdown in family life were forward thinking in 1938 given that the enormous dislocation of family life and social values caused by the Second World War was yet to be experienced. The early focus was on the moral and religious education of couples preparing for marriage. Differences on issues such as sex education and birth control divided the early proponents of marriage guidance.
with many church groups advocating a position of sexual abstinence and restraint for couples considering marriage and vehemently opposed groups with more liberal views on contraception and planned parenthood (Lewis et al.).

The Marriage Guidance Committee was effectively disbanded at the outbreak of the Second World War yet attempts to reform a group that focused on problems with re-establishing the family unit began to emerge during 1941-1943 (Lewis et al., 1992). The debate about marriage, the family, divorce and the role of women in the workforce postwar was conducted in the House of Lords following the Denning Report, which advocated a new type of social service including marriage preparation and encouraged couples to seek help early with the focus on reconciliation. The first government funding for marriage guidance occurred in 1949 but the debate about selection and training of suitable counsellors continued. Also, as an understanding of the complexity of marital problems increased, the need for more complex therapeutic interventions began to be understood more widely.

The early marriage guidance movement in Britain included both marriage education and marriage counselling. Counselling at this time was described as being more didactic than therapeutic and paralleled the training model provided to counsellors. Volunteers were used for many years as marriage counsellors. Marriage counselling offered educated women interesting voluntary work and was probably considered higher status than other forms of volunteerism as there was a period of training provided and an opportunity for personal growth (Lewis et al., 1992).

The British model of marriage intervention differed from the one that developed in America. The British model included a few professionals who trained lay people (paraprofessionals) to provide counselling and education services at a much reduced cost (Broderick & Schrader, 1991). Initially volunteers conducted assessment interviews and referred people with relationship problems onto consultants usually trained in the fields of medicine or religion. Throughout the 1950’s volunteers became less willing to refer clients onto specialized consultants and were eager to do the work themselves (Lewis et al., 1992). There was a move from counselling to therapy in the 1960’s influenced by psychodynamic approaches being developed at the Tavistock Institute and by ideas based on behavioural theories.
that were applicable to sexual difficulties experienced in marriage. These models influenced training programs that increasingly adopted eclectic approaches and provided trainees with a range of theoretical frameworks to tailor interventions to each particular couple or individual.

1.4.1 Evolution of Marriage Guidance to Counselling to Psychotherapy

In Britain initially marriage guidance was offered by members of the helping professions; “guidance” was didactic where an “expert” offered information, advice and recommendations to the person seeking assistance (Lewis et al., 1992). The influence of the work of Karl Rogers in the United States began to infiltrate into the marriage guidance field in the 1950’s. Instead of “guidance” there was an increasing emphasis on counselling as a process rather than a set of diagnostic and treatment techniques where insight and change could occur through some measure of self-understanding (Lewis et al.). The role of the counsellor was to engage in a process of positive unconditional regard where the client could openly explore unwanted feelings and negative behaviour.

Rogers influenced the British Marriage Guidance movement with his emphasis on counsellors developing listening skills and sensitivity to the client instead of the more traditional approach of “teaching” couples the ingredients of successful relationships. Counselling came to be seen as an interpersonal process between the client and the counsellor (Lewis et al., 1992). There was also a shift from thinking that the only successful outcome in marriage counselling was saving the marriage to one that considered a successful outcome for some couples was to help them separate and divorce amicably. However, one of the problems with Roger’s person-centered approach was its basis and foundations in individual theories of psychological development and not on issues relating to a couple relationship or couple interaction.

The British Marriage Guidance movement began to train counsellors in new techniques which emphasized thoughts and feelings in relationships in the late 1960’s. Lay counsellors were eager to work with clients themselves instead of referring on to the various trained professionals working the field of marriage guidance. About this time the Marriage Guidance movement was searching for
intellectual and theoretical validation of its work and joined with Institute of Marital Studies in Britain. This provided a highly developed framework for understanding the psychodynamic aspects of the couple relationship (Lewis et al., 1992). The influence of Rogers’ work in the United States and the Tavistock Institute in Britain combined to evolve the practice of counselling into a more therapeutic approach. However, “guidance”, “counselling” and “therapy” continued to exist in an overlapping relationship and is believed to have underpinned the eclectic approach in relationship counselling still seen today (Lewis et al.).

The word “psychodynamic” began to appear in the Marriage Guidance Bulletin by the mid 1950’s. The theoretical frameworks of psychology and psychoanalysis began to influence understanding of unconscious motivations that draw spouses into relationships with each other and unconscious conflicts that arise in intimate relationships (Lewis et al., 1992). Despite the increasing influence of psychodynamic approaches to relationship counselling by the mid 1980’s only 36% of counselling interviews in the field were conducted with both partners present (Lewis et al.).

1.4.2 The Development of Marital Sex Therapy

While a psychodynamic understanding of couple relationships began to influence the Marriage Guidance field in the 1980’s, it was not the only influence (Lewis et al., 1992). The development of marital sex therapy was based on the contrasting theoretical field of behaviourism. In 1970 Masters and Johnson’s influential work *Human Sexual Inadequacy* was published. The authors made some critical observations about existing marriage guidance practices including: Sex happens between two people and therefore it is preferable for them to be seen together in therapy; a male and female co-therapist team would maximise understanding of the male and female sexual experience; and since sexual arousal and response is a normal physiological response sexual dysfunction should be approached through education (Masters & Johnson, 1970). The British Department of Health and Social Security was approached to establish an experiential program of training and intervention to deal with sexual problems in couple relationships (Lewis et al.) but only married couples were seen. Masters and Johnson’s work influenced
training and skills development in couples’ therapists and maintained the inclusion of behaviourally based theoretical frameworks in relationship counselling.

1.5 History of Relationship Counselling in the United States of America

In the United States the first marriage counselling centres opened in 1930 (Wetchler, 2003) but considerable work occurred prior to this time that attempted to address problems within the family, including the couple relationship. As occurred in Britain, in the early years of marriage counselling and education the work was often performed by a professional as an auxiliary activity to their main occupation. For example; it was common for a college professor to provide marriage counselling to a couple in need of professional assistance (Broderick & Schrader, 1991). The development of marriage counselling in America was slow yet from its early beginnings the need for, and promotion of, professional associations to develop guidelines for training and research was recognised (Wetchler).

The family therapy movement provided the greatest influence on marriage and family counselling in the USA. The family therapy movement began with an emphasis on individual problems being seen as caused by relational problems with family members. This approach influenced marital therapy and gradually conjoint therapy replaced individual therapy as the approach seen to be the most effective way of addressing relationship issues.

Unlike the British model of training lay people to become marriage counsellors, in America the training of marriage counsellors and accreditation of training programs focused on academic training and qualifications from its inception (Broderick & Schrader, 1991). As early as 1949 the joint subcommittee on standards for marriage counsellors adopted by the National Council on Family Relations and the American Association for Marriage Counsellors stated that every marriage counsellor should have a graduate or professional degree. This accredited training should include various aspects of both individual personality development, sociology of marriage and counselling techniques and experience in marriage counselling conducted under approved supervision (Broderick & Schrader).

Paid professionals were the standard for provision of marriage counselling in
America from its inception whereas the model of paid professional staff providing marriage counselling in Britain only evolved during the 1970’s. In America clients paid for marriage counselling services provided by professionals from as early as 1930. A pioneer of one of the first marriage counselling centres on the west coast, Paul Popenoe, charged $3 per hour for a consultation and $100 for a workshop program (Broderick & Schrader, 1991). Given this was at the time of the Great Depression these fees would have been a considerable outlay for participants and probably only possible for the wealthy.

1.6 Emergence of Research and Evaluation

During the 1970’s there was an increasing focus on the importance of research and evaluation within all agencies involved in social welfare. As research into marriage counselling developed some of the methodological issues in measuring therapeutic outcomes in the counselling room began to emerge. For example, does evaluation of a successful outcome depend on whether it is the client or the counsellor’s point of view? Some of the early research focused on organizational issues and problems and less on what actually occurred in the counselling room (Lewis et al., 1992).

Traditionally questions about outcomes in couple counselling were posed to counsellors and not to clients. Contemporary research on agreement about outcomes in counselling between clients and counsellors has revealed that there is often little or no relationship between what counsellors and clients report as having been effective in the counselling process (Cummings, Hallberg, Slemon, & Martin, 1992; Manthei, 2005). This highlights the need for ongoing research in the area of couple counselling particularly as it occurs in real life settings.

From the 1980’s onwards many agencies began to consider counselling outcomes but it was usually the counsellors who were asked about improvement in couple relationships and generally only 30-40% of counsellors reported improvement in the relationships of couples they had seen (Lewis et al., 1992). Thus a problem with the client-centered approach was that there was virtually no existing research into the question of how effective this approach was (Lewis et al.). Such outcome research has historically been constrained by concerns regarding confidentiality,
methodological issues and lack of resources. Also there have been concerns that clients would be asked to respond to questions about their experience of therapy at a time when they may be experiencing considerable personal and relationship distress.

1.7 History of Relationship Counselling in Australia

Provision of relationship counselling and education services in Australia commenced nearly 60 years ago. Influenced by the work of the British Marriage Guidance movement and in response to disruptive family and marital changes following World War II, the first Marriage Guidance Council in Australia was established in Sydney in 1948 (Keane, 1997). By 1950 Melbourne, Sydney and Adelaide had established Marriage Guidance Councils (Miller, 2000). The National Marriage Guidance Council (NMGC) was established in 1953 and was modelled on the British marriage guidance movement (Simmons, 2006). Marriage and family support in Australia began in the 1950’s with a series of public lectures and talks. Early models of service provision were aimed at repairing marriages, clients were seen individually and it was usually only the wives who were seen. Interventions with both members of the couple were a later development. Clients were assessed for services via a case committee that performed an intake and assessment function (Simmons) and marriage guidance was offered mainly through advice and support. This model has since been superseded by a model whereby clients self-select into a variety of relationship support programs.

During the 1950’s a series of public talks and lectures with an educational and pre-marriage focus were offered together with some limited counselling services. Marriage guidance in Australia has had an educative and therapeutic approach to service provision from its inception. By the 1960’s marriage guidance services were provided mainly by volunteers who had been trained by the organisation they worked for; the use of volunteers was a matter of necessity as services were provided without cost to clients. Volunteers considered suitable were recruited and trained as educators and counsellors; attributes sought in volunteer counsellors included being married oneself, life experience and a personality that inspired confidence (Simmons, 2006).

Initially the main technique used in couple work was nondirective and was based on effective listening skills (Kelly, 2000). The emergence of conjoint couple
therapy in the 1960’s combined a more directive therapeutic style with skilled techniques that required additional training (Lewis et al., 1992; Wetchler, 2003). The need for skilled training and increasing accountability lead to volunteers initially being paid a nominal wage for their work, but then a movement towards paid staff with formal qualifications and training was adopted. Early training for professionals embraced new therapeutic ideas from the USA influenced by developments in the family therapy movement.

With the growth of the marriage guidance movement during the 1960’s and 1970’s and the increasing demand for accountability due to the input of government funding momentum increased to employ paid professional staff (Simmons, 2006). Client fees were introduced during the 1970’s and this opened the door for marriage counsellors to work in private practice. By the 1980’s most marriage guidance counsellors were trained professionals with tertiary degrees and the tradition of using volunteers as marriage counsellors was phased out. Challenges to the traditional morality of family life patterns and personal relationships also influenced the manner in which services were provided (Simmons). Marriage counselling and educational programs such as pre-marriage courses were separated and church organisations established their own pre-marriage and counselling courses. There was tension during this time between the groups who advocated more liberal approaches to family values including contraception and more traditional religious groups (Lewis et al., 1992). The government also intervened at this time and wanted the churches to separate marriage counselling from other denominational work.

During the 1990’s a trend emerged where the raising of children was separated from marriage in the provision of services. The range of programs offered broadened to include family counselling, specific child focused services and groups for parents to help them understand the impact of separation and divorce on children. The tendering out of services as defined by government policy during the late 1990’s - 2000 forced agencies to become more entrepreneurial and creative in order to secure funding. Service delivery has been redefined to comply with tender requirements and this has subsequently changed the context in which family and relationship counselling now occurs (Lewis et al., 1992; Simmons, 2006).
1.8 Contemporary Changes in Training and Accreditation

Professional accreditation for marriage and family counsellors initially was only available through the Australian Association of Marriage and Family Counsellors (AAMFC) which was formed in 1978. The name change from marriage counselling to the generic term of relationship counselling occurred early in the 1990’s, reflecting changing attitudes and acceptance of the diversity of relationships beyond that of heterosexual married couples. The changes in training and accreditation requirements have increased the necessity to evaluate the effectiveness of relationship counselling.

With changes to funding agreements and the development of Family Relationship Centres (FRC) in Australia there is increasing demand for agencies to demonstrate their effectiveness quantitatively. It is no longer sufficient to rely on anecdotal reports from clients that their experience of relationship counselling was worthwhile. Agencies are increasingly required to conduct research on outcomes for clients and report findings to the Federal Government. The development of FRC’s has also encouraged collaboration between agencies and has lead to partnership arrangements in order to fulfill tender requirements for particular geographical areas (Family Relationships Online, 2007).

Agencies increasingly have to demonstrate effectiveness in service provision, client outcomes and client satisfaction with the service they received. However, often the information required by government in the tendering and reporting process fails to capture the essence of what actually occurs in the consulting room (i.e., how satisfied are people with the relationships they are in; and how satisfied were clients with the counselling they received?). What is of interest for funding bodies (number of clients seen, number of sessions attended) may not be so clinically relevant (does therapy change the level of satisfaction with one’s relationship, have there been clinically significant changes in the problem areas of the relationship as a result of counselling?). Therapists are often too busy with clinical work to engage in research and researchers often miss the essence of what occurs in the consulting room (Johnson, 2003). These factors reduce the frequency of clinically relevant research.
1.9 The Scientific Paradigm

Much of the research that has been conducted over the past 20-30 years has focused on clinical outcomes in research settings (efficacy research) (Lambert & Young, 2001). One of the criticisms of this approach is the limitation of generalisability to clients in real life therapeutic settings (effectiveness research), (Lambert & Young). While findings from research settings may increase understanding of the effect of particular interventions on specified client groups, there has been little research on client outcomes in clinical settings where clients have self-referred to agencies that offer an eclectic therapeutic approach.

Efficacy research looks at the study of a treatment under controlled conditions; usually where participants are assigned to either a treatment group or a no treatment or wait list group and outcomes are compared between groups (Lambert & Young, 2001). Efficacy research may therefore have high internal validity but often lacks external validity. Effectiveness research assesses outcomes delivered in a naturalistic environment, such as clinical practice (Scott & Sensky, 2003). Effectiveness research is seen to be complementary to efficacy research because it explores the validity of experimental findings in naturalistic settings (Lambert & Young).

The current study aimed to explore some of the psychological characteristics of people who attended for relationship counselling in one of the Victorian branches of a national organisation within Australia. This organisation is a non religious, not-for profit agency that has a commitment to ongoing research and professional development. The agency developed its own internal process for client feedback prior to this becoming a requirement as mandated by the Australian Attorney General’s Department; the main source of funding for the agency. The focus in the current study was to explore the relationship between relationship satisfaction, attachment style and mood disorders in people seeking relationship counselling and to explore changes in the couple relationship as a result of counselling. Counsellors were also asked about changes in each couple’s relationship in order to provide a clinical perspective on the nature of change in a therapeutic setting.
1.10 Summary of the Chapter

This chapter has explored the history and development of relationship counselling both within Australia and overseas. While the provision of counselling services for couples and families experiencing problems in their relationships developed over 60 years ago research into the effectiveness and efficacy of couple counselling has only entered the field in the last 20-30 years. Over these years efficacy research has been the major contributor to the field of relationship counselling and there remains a considerable gap in the area of outcomes in clinical settings (effectiveness research) that informs practice. In the early stages of marriage guidance counselling people were seen individually, the practice of having both partners present in a counselling session was a later development. Therefore, in order to understand the development of relationship counselling where the counsellor works with a dyad it is necessary to first understand the theoretical and clinical implications of human psychology within individual counselling frameworks. The next chapter will explore research conducted in research settings in individual counselling in order to draw distinctions between effectiveness and efficacy research findings. Chapter 2 will focus on reviewing research conducted in areas of interest to the current study; depression, goals in therapy, attachment research and satisfaction with the outcome of counselling found in individual counselling.
Chapter 2: Empirical and Clinical Studies in Individual Counselling

2.1 Chapter Overview

The previous chapter reported on the history and development of couple counselling in the United Kingdom, the United States of America and in Australia. The current chapter will review findings from empirical and clinical studies in individual counselling to explore the relationship between research findings in individual counselling and the development of couple counselling. Section 2.2 provides an introduction to psychotherapy research distinguishing between efficacy and effectiveness research. Section 2.3 explores the development of theories of counselling. Section 2.4 is an overview of efficacy research findings in individual counselling. Section 2.5 reviews effectiveness research findings in individual counselling. Section 2.6 reviews clinical findings in individual counselling. Section 2.7 reviews the therapeutic alliance as a variable in satisfaction with the outcome of counselling. Section 2.8 explores other variables affecting client satisfaction found in individual counselling. Section 2.9 reviews qualities of the therapist that influence satisfactory outcomes in counselling. Section 2.10 provides a summary of Chapter 2.

2.2 Efficacy and Effectiveness Research

Psychotherapy studies usually take the form of either efficacy or effectiveness studies. Efficacy studies aim to test whether an intervention can give benefit under ideal conditions (Scott & Sensky, 2003). The use of randomised controlled trials (RCT) in efficacy studies aims to recruit homogenous samples and studies are designed to maximise differences between the intervention being tested (Scott & Sensky). In contrast effectiveness studies are designed to evaluate whether an intervention will work in a clinical setting. In effectiveness trials it is good practice to identify a priori an outcome measure. In a placebo-controlled drug trial it is easier to identify and measure outcomes dependent on treatment dose. In psychological treatments this is harder to measure. Outcomes are usually measured by symptom relief, for example a reduction in depressive illness symptoms evaluated by a valid and reliable research measure such as the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) or the Depression, Anxiety and Stress Scales (DASS 21; Lovibond & Lovibond, 1995).

There has been a plethora of research studies published on outcomes in
counselling. The most commonly researched theoretical framework is Cognitive Behavioural Therapy (CBT) because it is able to be administered within a short-term timeline, treatment can be administered in clearly defined steps, and outcomes or changes in the client are measured by changes in presenting symptoms by a reliable and valid measurement tool.

2.2.1 Empirical Validation of Psychotherapy

Little is known about the basic change processes in psychotherapy as there are few empirical studies about psychological changes that occur as a result of psychotherapy (Persons & Silberschatz, 1998). Seligman (1995) outlined five properties that characterise psychotherapy that are absent from controlled clinical trial studies; these are:

- psychotherapy as practiced in the field is not a fixed-term duration, therapy continues until the patient improves;
- in clinical practice therapy is self-cor recting, if a particular strategy or technique is not working the clinician adopts a different approach;
- psychotherapy patients in the field choose their own therapist usually by recommendation or by attending an agency or practice with a proven track record in the field of therapy the person is seeking treatment for;
- patients seen in therapists’ offices usually have multiple problems rather than a single diagnosis, and:
- psychotherapy aims to improve patients’ general level of functioning, not improvement in one particular domain of a person’s life.

The gap between efficacy research, in the form of randomised controlled trials, and effectiveness research, in the form of research conducted in actual clinical settings, continues to exist. However, both clinicians and researchers alike need to continue to collaborate to ensure the gap narrows. Both efficacy and effectiveness research should be informing the other to maximise positive outcomes for clients seeking psychotherapy. The next section will provide an overview of the history and development of the main theoretical approaches to individual counselling. It is important to review differing theoretical frameworks as they influence the type of research conducted and have also influenced the development of relationship or
couple counselling.

2.3 Development of Theories of Counselling and Psychotherapy

Prior to the late 19th century there was little understanding of emotional difficulties and mental disorders (Seligman, 2006). Many people with severe symptoms were confined to institutions and were often exposed to ineffective treatments while people with less severe problems often received no help at all. A brief overview of the development of influences on psychotherapeutic approaches will be made initially with a more detailed outline of each approach to follow.

2.3.1 Historical Influences on the Development of Psychotherapy

The work of Sigmund Freud provided the foundation for psychodynamic approaches to psychotherapy and this is often known as the first force of psychotherapy (Seligman, 2006). Psychodynamic and psychoanalytic approaches view past experiences as the source of people’s present emotional difficulties, emphasising unconscious processes and long term treatment.

The second force in approaches to psychotherapy was behavioural treatment developed in the 1970’s and the later development of cognitive and integrated behavioural approaches in the 1980’s (Seligman, 2006). Cognitive behavioural approaches focus on the present and seek to minimise dysfunctional cognitions and behaviours and replace them with more functional positive thoughts and actions.

Carl Rogers influenced the third force in the development of approaches dealing with psychological problems which is known as existential – humanistic psychotherapy (Rogers, 1951). Rogers believed that through a process of self-exploration the client learns new aspects of him/her self and also learns new ways of relating to others and new ways of behaving. Rogers’ client - centred approach influenced the work of American existentialists such as Fritz Perls and Gestalt therapy (1969), Irving Yalom (1980), and also influenced many European existentialists, for example, Rollo May (1961; 1983) and Viktor Frankl (1963). These approaches highlighted the importance of the therapeutic alliance and the importance of the therapist’s self knowledge in the practice of psychotherapy.

The beginning of the 21st century has heralded the fourth era of psychotherapy where elements of first, second and third force approaches are being
integrated into a comprehensive and holistic framework. In this framework clinicians are becoming more aware of the many influences on clients that contribute to their current situation and these influences become part of the treatment approach (Seligman, 2006). More than 75% of today’s clinicians describe themselves as eclectic (Walborn, 1996). Clinicians no longer seek one theory to inform their work; instead clinicians draw on a variety of concepts and skills in order to develop a strong therapeutic alliance with clients and treatment plans that aim to improve personal growth and development and ameliorate problems in the person’s life (Seligman). The next section will explore in more detail theories of counselling and psychotherapy.

2.3.1.1 Theory of Psychodynamic and Psychoanalytic Therapy.

Psychodynamic therapies including psychoanalysis are approaches to helping people that have developed from the ideas of Sigmund Freud (Freud, 1905; 1913; 1914; 1919; McWilliams, 1994). It was Freud’s pioneering work that provided the framework for all subsequent theories and therapeutic approaches; either in their difference, or similarity to, psychoanalysis. Clinical psychoanalysis as practiced in contemporary times has come to be defined as an open-ended effort to understand one’s unconscious thoughts, wishes, fears, conflicts and defenses. People usually seek psychoanalysis in order to pursue personal growth and develop in-depth understanding of universal issues they struggle with. Some clinicians believe psychoanalysis continues to be the most effective treatment for resolving problems embedded in the personality (McWilliams, 1999). Freud understood his patients’ symptoms as a conflict between unconscious wishes and an equally powerful unconscious intolerance of those wishes (Freud, 1913; 1919). Freud discovered that his patients began to relate to him as if he were a significant and problematic figure from their past and this transference relationship became a fundamental and crucial component of understanding the patient’s unconscious conflicts.

In contemporary analysis clients have to feel comfortable enough to allow themselves to feel intense emotions characteristic of childhood (McWilliams, 1994; 1999; 2004). Intense childhood feelings and identification with the therapist, as a reminder of a problematic relationship with a childhood carer, is known as the transference neurosis (McWilliams, 2004). In the context of the therapy hour several
times a week, often over many years, resolution of these intense emotions contributes to psychic and emotional healing.

Psychotherapy usually refers to therapeutic approaches that are not based solely on understanding the client’s transference of problematic earlier relationships onto the therapist. Psychotherapy has more modest goals than psychoanalysis such as reducing suffering, relieving specific disorders and building a stronger psychic structure (McWilliams, 1994). The therapeutic alliance is assumed to be internalised as a new model of relationship but not every aspect of the person’s internal emotional world is explored in psychotherapy (McWilliams, 2004; Symington, 1986). In psychotherapy usually one or two areas of psychic conflict or emotional themes are explored compared to the more in-depth treatment offered by psychoanalysis (McWilliams). However, not everyone is suited to, nor desires to have, an intensive experience of psychoanalysis. For some people a less intense therapy is the treatment of choice as psychoanalysis can be both expensive and impractical.

2.3.1.2 Object Relations Theory.

Freudian psychoanalysis has been revised by many subsequent theorists and has influenced the development of many theoretical and clinical frameworks. Psychoanalytic practitioners believe that the most significant thoughts, feelings and behaviours are not conscious and these unconscious influences impact on the decisions and actions made in everyday life, including partner choice (Clulow, 2001; McWilliams, 2004). Melanie Klein is considered to be the “mother” of object relations theory (Seligman, 2006). Klein (1948; 1957) further developed Freud’s ideas on human development and in particular paid attention to earlier infant states of mind than Freud had considered. Klein shifted the focus in psychoanalysis away from drive theory to the importance of early relationships (Klein; Seligman). One of the tenets of object relations theory is that features of early relationships are re-enacted in partner choice in adult relationships (Clulow).

Fisher and Crandell (2001) report a growing body of evidence that the quality of a person’s primary attachments is intimately linked with patterns of relating throughout the lifespan. There are two research areas that have contributed to this conclusion. The first of these is research based on observations of infants and
their primary caregivers with an aim of identifying social behavioural patterns in the infant that are taken to reflect an underlying attachment organisation that becomes part of the personality. Attachment organisation or attachment style, as it is also referred to, affects the later developmental sequence of behaviours relating to affectional bonds (Fisher & Crandell). The second research area involves a shift away from behavioural observations of infants and caregivers to adults’ mental representations of attachment relationships and how this influences the quality and nature of intimate relationships in adulthood (Ainsworth, 1985; Main, Kaplan & Cassidy, 1985). In order to understand adult attachment patterns in intimate relationships further discussion on attachment theory is warranted.

2.3.1.3 Attachment Theory.

John Bowlby is one of the most well known object relations theorists due to his contribution to understanding early attachment relationships, predominately between mother and child but also between the child and other significant caregivers. Bowlby hypothesised a universal human need to have close emotional bonds (Bowlby, 1969, 1988; Fonagy, 1999; Holmes, 1993). Attachment behaviour is defined as: “Any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual” (Holmes, pp. 68; 1993). Child and caregiver form a system in which the attachment behaviours of the infant, such as smiling and clinging, are reciprocated by attachment behaviours from the adult, such as feeding, touching and soothing (Seligman, 2006). This reciprocal pattern of behaviours develops closeness and intimacy between parent and child and provides security and emotional regulation (Bowlby, 1969). Bowlby believed that a strong causal relationship existed between children’s attachment to their parents and their later capacity to form affectional bonds and experience positive emotional experiences with others.

2.3.1.4 The Strange Situation Test.

Mary Ainsworth and colleagues (Ainsworth, Blehar, Waters & Walls, 1978) operationalised Bowlby’s concepts into a well known research experiment known as the Strange Situation Test (SST). In the strange situation infants are observed before, during and after a brief separation from their caregiver during which time they are left in a room with a complete stranger in an unfamiliar environment (Seligman,
Ainsworth classified infants’ responses into one of four categories (Ainsworth et al.). Although responses to separation by infants to the absence of the caregiver can range from seemingly not concerned to considerable distress, it is the infant’s response upon reuniting with the caregiver that is considered to indicate attachment style. There is one secure attachment style and three insecure styles; these are:

- **Secure attachment**– These children use the parent as a secure base. They demonstrated curiosity and comfort in the presence of their carer and often became distressed when left with the stranger. These children sought and accepted comfort when the caregiver returned and quickly settled back into exploratory play. These children prefer their caregiver to the stranger (Ainsworth et al.; Berk, 2006).

- **Anxious / Avoidant** – These children were less anxious with the stranger than children in the secure group and did not seek comfort from the caregiver and did not seem to prefer the caregiver over the stranger (Ainsworth et al.). It is believed these children had experiences where the caregiver did not help them regulate emotions and they would try to avoid situations that were emotionally troubling (Seligman, 2006).

- **Anxious / Resistant** – Children in this group engaged in little exploration in the presence of the caregiver, were highly distressed during separation, were reluctant to accept comfort when the caregiver returned and often continued to display anger or anxiety through hitting or pushing the caregiver when held (Ainsworth et al; Berk.).

- **Disorganised / Disoriented** – This pattern reflects the greatest level of insecurity. Children in this group displayed confusing and disorganised behaviour such as head banging and trying to escape even after the caregiver returned. Ainsworth suggested the caregivers of these children evoked both fear and comfort. A history of abuse or neglect is often associated with this pattern (Ainsworth et al.).

**2.3.1.5 Adult Attachment Patterns.**

Findings from the Strange Situation Test research (Ainsworth et al., 1978) have been expanded and developed into research that aims to determine adult
attachment patterns. Measures such as the Adult Attachment Interview (AAI) are designed to elicit narratives of childhood attachment patterns (George, Kaplan, & Main, 1985; Main et al., 1985; Seligman, 2006). Individuals classified as “Autonomous/secure” share common features in their thought processes regarding their early infant/parent relationships (Fisher & Crandell, 2001). They demonstrate a reflective and thoughtful manner in conversing about these relationships and are able to integrate both positive and negative aspects of their parents into a coherent narrative and acknowledge the influences of those experiences on their personality (Fisher & Crandell; Schachner, Shaver, & Mikulincer, 2003).

Individuals classified as “Dismissing/detached” have restricted affect and have difficulty recalling specific childhood memories. They devalue the importance of early childhood relationships and present an idealised or contradictory view of their early parent/child relationships (Fisher & Crandell). Individuals classified as “Preoccupied/entangled” have access to specific memories but are flooded by the negative emotional content of these memories. These people often show a preoccupied anger with their parents. The remaining group of adults known as the “Unresolved/disorganised” group are similar to the disorganised infants found in the Strange Situation Test where they demonstrate a disorganised, disoriented organisation of thought that is specifically related to thoughts of traumatic experiences or abuse (Fisher & Crandell; Schachner et al., 2003).

2.3.1.6 Attachment Pathways through Childhood.

Relationship patterns established in the first year of life affect children’s social adjustment, self-concept, their behaviour and auto-biographical capacity (Holmes, 1993). Briefly, studies show that mothers of secure one-year olds are responsive to their babies, mothers of insecure/avoidant infants are unresponsive, and mother of insecure/ambivalent infants are inconsistently responsive (Holmes). The key to secure attachment is reciprocal interaction and it seems that it is the quality of the interaction that is important rather than the quantity (Holmes, 1996). Studies have suggested that parents who physically abuse their children tend to have had neglectful or abusive childhood experiences themselves (Fraiberg, Adelson, & Shapiro, 1975; Lieberman, Padron, Van Horn, & Harris, 2005; Wolkind, Hall, & Pawlby, 1977). However, not all parents who have experienced childhood neglect or
abuse themselves go on to abuse their own children. The transmission of early nurturing experiences can also be passed on to the next generation and can be agents of positive change when worked through clinically with parents, where both negative and positive childhood experiences can be explored (Lieberman et al.).

The characteristic that mothers of insecurely attached infants have in common is best understood by the concept of maternal attunement (Johns, 2005; Stern, 1985). Maternal attunement refers to the sensitivity of the mother in recognising and responding to cues from her child and appropriate matching of her responses to the child’s needs (Holmes, 1993; 1996). Stern believes this attunement helps the infant develop an integrated sense of self. Mothers of insecurely attached infants show inconsistent or inappropriate patterns of attunement with their infants. For example, mothers of ambivalently attached infants can be observed forcing themselves on their infant when they are playing happily and ignoring the child’s cries of distress (Holmes, 1993).

2.3.1.7 Attachment Style and Adult Relationships.

Bowlby’s work has led to considerable research into the relationship between childhood attachment patterns and patterns of relationships through childhood into adulthood (Holmes, 1993). Several studies have shown consistency between the attachment status of infants on the SST and the classification of their mothers on the AAI (Fonagy, Steele, Steele, Moran, & Higgins, 1991; Main & Goldwyn, 1984). Main and Goldwyn found that 75% of secure infants had mothers who were rated as Secure/autonomous, while mothers of avoidant infants tended to be in the Dismissing/detached category and ambivalent infants had parents in the Preoccupied/entangled category.

Hazan & Shaver (1994b) have used the attachment typology of parent–infant attachment to explore intimate relationships between adults. Bowlby believed that the key elements of successful parenting are proximity and responsiveness; these elements are also necessary for successful adult relationships (Holmes, 1996). Further discussion of the relationship between attachment theory and intimate adult relationships will be explored in Chapter 3 which focuses on empirical and clinical findings in couple relationships.
2.3.2 Theory of Rogers Client Centered Approach

Carl Rogers’ person-centered theory has made an enormous contribution to both counselling and psychotherapy. Rogers’ vision of a collaborative therapeutic alliance with a supportive, empathic and accepting clinician provided an alternative framework to the anonymity of the Freudian analysts and the more directive approach of the early behaviourists (Seligman, 2006). Rogers emphasised the human qualities of clinicians and encouraged clinicians to be fully present in the moment with the client (Rogers, 1980). He provided considerable research to demonstrate that the therapeutic alliance is the most positive strategy for change in psychotherapy. Rogers was the first to record and publish transcripts of psychotherapy cases which provided a valuable teaching tool in the training of therapists (Rogers).

Rogers believed that psychological problems stemmed from destructive early interactions (Nichols & Schwartz, 2006). He believed that every person is born with an innate tendency towards self-actualisation and left unhindered each person will follow their own best interests (Rogers, 1961). However, this tendency towards following a path that is in one’s best interests is compromised by the need for approval. Rogers believed that the tension between the need for approval and self fulfillment leads to denial and distortion of one’s true inner feelings (Rogers, 1951).

The basic tenet of Rogers’ therapeutic approach included the client’s exploration of thoughts, feelings and attitudes related to problem areas in their life facilitated by a counsellor who displayed positive and unconditional regard for the client (Rogers, 1951). Through this process the client moves from a position of self-criticism to one of self-acceptance, insight and understanding of one’s behaviour. Criticisms of Rogers’ person-centred approach include its limited use with people with significant pathology, the approach is unfocused and a position of positive unconditional regard does not prepare the person for the real world where lack of acceptance and criticism abound (Seligman, 2006).

Despite the short comings of the client-centred approach Rogers’ emphasis on the importance of the therapeutic alliance being crucial to psychological change in the client, his stress on therapist qualities of warmth, empathy and compassion has had an impact on every therapeutic framework and counsellor training since that time (Holmes, 1993, 1996; McWilliams, 2004; Seligman, 2006).
2.3.3 Theory of Family and Systemic Therapy

During the 1920’s social scientists began studying small group dynamics and these ideas influenced the early family therapy movement. Similar parallel processes were observed between small groups and family groups (Lewin, 1951). The shift from an individual perspective in counselling to a systemic one was quite revolutionary in the 1950’s when family therapy first began to appear in practice and theory (Nichols & Schwartz, 2006). There were several contributors to the early development of family therapy including, Don Jackson, Nathan Ackerman, Jay Haley, John Bell and Murray Bowen. Family therapy has its origins with several psychiatrists who worked with families who had a family member suffering from schizophrenia. Hospital psychiatrists noticed that when the patient started to improve often another family member would deteriorate. It became clear to doctors treating in-patients that changing one person affected the whole system or family and that, in reverse, changing the family might be an effective way to change the individual (Nichols & Schwartz).

Historically many influential approaches to couples therapy preceded family therapy (Nichols & Schwartz, 2006). Couples therapy differs from family therapy (Gurman & Jacobson 2002). In couples therapy more time can be spent understanding the intimate dynamics between two people, in family therapy there is less focus on individuals’ thoughts and feelings and more time spent on the dynamic and patterns between family members.

While there are many different theoretical approaches under the umbrella of family therapy most of the techniques involve identifying, analysing and interpreting communication patterns between family members. Interactions between family members are manipulated through a variety of strategic maneuvers (Jackson & Weakland, 1961). Contemporary family therapists attempt to get all family members involved in discussing the presenting problem (as each person sees it) in the family (Nicholls & Schwartz, 2006). Bowenian therapists are concerned with systemic change in the family whereas strategic, solution-focused and behavioural family therapists are more concerned with changing the whole family system (Nicholls & Schwartz). However, one common goal found in both couple therapy and family therapy is strengthening the couple relationship. If the adult couple relationship is
functioning well often “problem” behaviours noticed in another family member dissipate (Holmes, 1993; Nicholls & Schwartz).

2.3.4 Theory of Cognitive Behavioural Therapy

The empirical foundations of Cognitive Behavioural Therapy (CBT) can be traced back to early in the 20th century where two principles from animal learning were applied to humans; these are classical conditioning and operant conditioning (Hawton, Salkovskis, Kirk, & Clark, 2004).

2.3.4.1 Classical Conditioning.

Classical conditioning is based on principles from early experiments performed by Pavlov and other Russian physiologists on dogs, for example, where the sound of a bell was followed by food. Researchers found that following a series of sequences of this pairing the dogs would begin to salivate at the sound of the bell before the food was given. The researchers found that emotional responses such as fear could also be conditioned (Hawton et al.).

2.3.4.2 Operant Conditioning.

Operant conditioning is based on the principle that if a particular behaviour is followed by a reward the behaviour is likely to be repeated. Skinner extended this principle by defining the reinforcers of behaviour in terms of the effect they have on people. Thus Skinner described positive and negative reinforcers of behaviour where if a particular behaviour is followed by a particular event and the behaviour increases, the behaviour is said to be reinforced (Hawton et al.). Positive reinforcement describes a situation where behaviour occurs more frequently because it is followed by positive consequences, for example praise, and negative reinforcement describes a situation where behaviour increases because of the omission of an aversive event, for example, anxiety (Hawton et al.).

2.3.5 Behavioural Therapy and Cognitive Behavioural Therapy

During the late 1950’s the applications of operant conditioning began to influence treatment in clinical settings with psychiatric patients (Hawton et al., 2004). In the 1970’s behaviour therapy evolved with new techniques being developed and experimentally validated. For several reasons behaviour therapy became the treatment of choice for many disorders including phobias, obsessions and sexual dysfunction (Hawton et al.). Behaviour therapy was experimentally validated
and provided a clear framework and instructions for implementation that could be easily taught. For example, sex therapy developed by Masters and Johnson (1970) focused on the physiology of sexual response instead of behavioural responses yet recommended treatments focused on cognitive and behavioural approaches. Their ground breaking work that focused on empirical evaluation and operational definition of treatment resulted in its inclusion in mainstream cognitive behavioural therapy.

A further development in the CBT model was proposed by Lang and others (Lang, 1970; Rachman, 1978) with a three-system approach for the conceptualisation of psychological problems; these were: behavioural, cognitive / affective and physiological. Lang’s three system approach laid the foundations for cognitive concepts to co-exist with behavioural concepts (Hawton et al., 2004). A more integrated cognitive therapy approach initially was applied to understanding depression with the view that depression originates in childhood in the formation of negative attitudes or assumptions (Beck, 1967). Beck’s cognitive model of depression suggests that people’s experiences generate assumptions about themselves and the world; these assumptions subsequently influence the way the world is perceived and how behaviour is evaluated (Beck). A cognitive behavioural approach to depression focuses on problem solving; it is a time limited, active and directive approach to therapy based on an underlying rationale that an individual’s affect and behaviour are largely determined by the way that person structures and perceives the world (Beck, Rush, Shaw & Emery, 1979).

### 2.4 Efficacy Research Findings in Individual Counselling

Efficacy research has been conducted into various individual counselling approaches (CBT, Emotion Focused and Psychodynamic) and various presenting symptoms or disorders including depression, anxiety, post traumatic stress, coping style and resilience and self esteem.

#### 2.4.1 Research on Treatment for Depression

One of the commonly used measures to determine client satisfaction with counselling is a decrease in reported symptoms of distress following counselling. People usually seek counselling because they are experiencing difficulty managing a problem or symptoms on their own; in other words people want to feel better. One
measure of mood disturbance is the presence of depression. It is estimated that at any
given point in time 15 – 20% of adults suffer significant depressive symptomatology
(Fennell, 2004). It seems that no single factor can explain depression but there are a
variety of biological, historical, environmental and psychosocial variables that
influence the development of a depressive illness. These variables include
disturbances in neurotransmitter functioning, a family history of depression or
alcoholism, early parental loss or neglect, recent negative life events, a critical or
hostile spouse, lack of a close and confiding relationship, low self esteem and lack of
social support (Fennell).

In Western countries CBT and antidepressant drugs dominate the treatment of
depression (Parker, Roy, & Eyers, 2003). A meta-analysis conducted by Parker et al.
challenged the often held view that CBT is as efficacious as is claimed by many
studies. Comparison between Randomised Controlled Trials (RCT) is problematic
because even CBT trials are not administered consistently and the intervention period
can vary from six weeks to several months. However, most findings support the view
that more is better; that is, severely depressed patients improved substantially more
after 16 rather than 8 sessions. Longer treatment plans are recommended for more
severely depressed patients (Parker et al.) These authors suggest that CBT is
efficacious because it is superior to control “no treatment” groups or wait list
controls but evidence suggests that CBT is not the only type of psychotherapy that is
effective in treating depression. In fact almost any treatment for depression is
superior to “no treatment” (McWilliams, 2004; Seligman, 2006).

One RCT involving 240 patients with mild to severe depression found that
medication and CBT were equally effective in alleviating symptoms but the
effectiveness of CBT was dependent on therapist experience (DeRubeis, Hollon,
Amsterdam, Shelton, Young, & Salomon, 2005). Skill of the therapist is one
contributing factor that is linked to successful outcomes generally in counselling or
psychotherapy.

The National Institute of Mental Health (United Kingdom) study of
depression is the largest of its kind in the world and results showed that CBT fared
less well than the other two main treatments, interpersonal therapy and clinical
management plus anti depressants (Holmes, 2000b). This is not to suggest that CBT
should be abandoned but rather that there should be a constant feedback between research findings and clinical practice, where both are continually informing the other. Collaboration between empirical research and clinical practice are crucial in the treatment of depression as it is a major mental health problem affecting not only individual functioning but relationship and family functioning as well.

2.5 Effectiveness Research in Individual Counselling

2.5.1 Overview of Client Satisfaction Variables in Individual Counselling

While there have been a number of studies in the area of depression and counselling other research variables found to be associated with client satisfaction in individual counselling include: client and therapist reports of improved ability to handle presenting problems (Deane, 1993; LaSala, 1997); attainment of goals for therapy (Deane); counsellor qualities (Hampson, Prince & Beavers, 1999; Helmke, Bischof & Ford Sori, 2002); and client expectations of counselling (Sanders, Trinh, Sherman, & Banks, 1998). Generally, clients who agree to participate in such studies report moderate to high levels of satisfaction and few differences in satisfaction have been found between male and female clients (Johnson & Lebow, 2000).

2.5.2 Social Desirability

The high levels of client satisfaction typically reported in research on client satisfaction with counselling have raised concerns about social desirability and acquiescence (Deane, 1993; Gaston & Sabourin, 1992). Gaston and Sabourin did not find a significant relationship between client satisfaction and social desirability but did find a low, but significant, relationship between treatment length and satisfaction. While the question of how much therapy is effective depends on many factors (Shadish, Ragsdale & Montgomery, 1995); this is an important issue in Australia where relationship counselling agencies are increasingly required to demonstrate effective client outcomes to secure ongoing financial support.

2.6 Clinical Findings on Client Satisfaction in Individual Therapy

A study by LaSala (1997) looked at the factors associated with client satisfaction in a small, private, not-for-profit counselling agency. These factors included: Reported improvement in coping with the presenting problem; therapist level of experience; length of treatment; attitudes about fees charged for counselling; and the extent to which counselling improved other areas of people’s lives. Clients
were either handed or mailed a client satisfaction survey at the end of counselling. A telephone survey was also conducted with all clients; the final group of participants who consented to participate in the study yielded 162 clients. This was an investigative study that aimed to clarify some of the conflicting results from previous research about influences on client satisfaction. It was hypothesised that client satisfaction would be related to a reduction in presenting symptoms and the therapist’s report of client progress.

Results from telephone interviews in the LaSala study (1997) yielded a higher response rate (53% of respondents) than the mail-out interviews (18% of respondents returned questionnaires). Telephone surveys revealed seven variables that were associated with client satisfaction. These were: client reports of their ability to manage target problems; whether the fee was assessed by clients as fair; whether or not clients would recommend the service to others; client assessment of the therapist as helpful; client reports of overall life improvement as a result of therapy, and whether or not the client would return to therapy if the need arose. These factors explained 76% of the variance in client satisfaction. Clients who presented with problems around children and adolescents were less satisfied than clients who presented with other problems (LaSala). While more females (66%) responded to the surveys than males (47%) no difference in satisfaction was found for male and female respondents. Length of treatment was not found to be associated with satisfaction and only a significant moderate relationship was found between client satisfaction and therapist rating of progress.

One of the methodological problems in evaluating client satisfaction with counselling is variability in the measurement instruments used and the tendency of clients to always report moderate to high levels of satisfaction (Lebow, 1983). Research findings may suggest that therapy works but client feedback may be influenced by other factors such as satisfied clients being more likely reply to surveys from the agency they attended than less satisfied clients (Lebow).

2.7 The Therapeutic Alliance

Client expectations of counselling and the quality of the client therapist relationship influence the level of satisfaction as perceived by the client (Sanders, Trinh, Sherman, & Banks, 1998). Client satisfaction studies are often specific to an
agency or client group and are usually designed to meet internal requirements of the agency. Generalisability of findings to other settings is often problematic due to small sample sizes and the fact that client outcomes have been linked to specific therapeutic approaches.

A study by Deane (1993) looked at client satisfaction with psychotherapy in outpatient clinics. The 21 therapists in this study used an eclectic approach. Client satisfaction was rated across four dimensions: characteristics of staff, treatment services, the physical environment, and activities that foster autonomy. Over 90% of clients \( (N = 93) \) gave a rating of 3 or more on all but 1 of 8 4-point items indicating high satisfaction levels with the service. The only item to which 32% of respondents gave a rating of 2 or less was the question: “To what extent has our program met your needs?” Despite this over 95% indicated they would come back again if needed and/or would recommend the service to friends who may need similar assistance. These results would suggest that recommendation of the service to others and willingness to use the service again appears to be reasonable indicators of level of satisfaction with a counselling service from the client’s perspective (Sanders, et al., 1998).

Deane (1993) also found that the number of visits to the psychologist was significantly correlated with satisfaction \( (r = .32, p < .01) \). The relationship between satisfaction and number of sessions attended increased when those still in therapy at the two-month follow up were included.

A positive therapeutic relationship correlates with a good outcome in psychotherapy but it is the client’s subjective evaluation of the relationship, rather than the therapist’s actual behaviour, that has the most impact on therapy outcome (Horvath, 2000). Some of the discoveries in research conducted by Carl Rogers and colleagues found that it was not the objectively measured presence of empathy, congruence or positive unconditional regard that had the most impact on the therapy outcome but the client’s perception of these qualities that had the most impact (Horvath; Rogers, 1961). Measurement of client satisfaction with counselling needs to consider a range of variables including reported satisfaction with counselling, assessment of the therapeutic relationship and reliable measures of positive inter or intrapersonal changes.
2.7.1 Client Satisfaction and Social Desirability

The generally high levels of reported client satisfaction have raised concerns about social desirability and acquiescence (Deane, 1993; Gaston, & Sabourin, 1992). One study that looked at the relationship between client satisfaction and social desirability did not find a significant relationship between the two dimensions (Gaston et al., 1992). They found a weak but significant relationship between treatment length and satisfaction ($r = .24$, $p < .01$). Participants in this study spent an average of 87 weeks in therapy, most attending once a week.

This raises the question of “how much therapy is effective?” The literature is divided on this point with confounding issues of presenting symptoms, therapeutic frameworks used and the fact that most studies have been conducted in research settings (Shadish et al., 1995; Shadish & Baldwin, 2003). Nevertheless, this is an important issue in an ever increasing climate of funding constraints where Australian counselling agencies are required to demonstrate effective client outcomes to secure ongoing financial support, usually sourced by government departments.

2.8 Other Variables Influencing Client Satisfaction

Measures of client satisfaction may be an indicator of a client’s level of satisfaction with the outcome of counselling, but other factors that influence how a client evaluates the experience of counselling apart from satisfaction have been reported. Ogles and Lunnen (1996) found that clients rate their level of satisfaction on “the basis of something other than their satisfaction with the symptom or presenting problem change” (p. 206). Satisfaction elements reported in the literature by Stacey et al. (2002) with community and mental health services included perceived therapist competence, therapist qualities of empathy, caring, understanding, therapist conduct, access to services, service procedures, information about the problem being experienced and therapy outcome.

In a child and adolescent mental health service a combination of grounded theory and quantitative methods were used to examine the relationship between changes in reported symptoms (in the child/adolescent) and levels of satisfaction with the service received (Stacey et al., 2002). Grounded theory is a qualitative research method that uses clinical observations in the field to generate hypotheses or theoretical frameworks. Parents/caregivers ($N = 94$) were interviewed on 3 different
occasions: prior to treatment commencing, 3 months after treatment had ceased and 12 months after treatment had ceased. The factors that emerged as influences on satisfaction were: Being treated with respect by the counsellor; Feeling supported and strengthened as parents; Developing new ways of understanding the situation and strategies for responding to issues; and, Managing as a parent regardless of whether the problem was easily resolved or not.

Stacey et al. (2002) noted that qualitative analysis of parents’ stories highlighted the importance of “conversations about expectations regarding both process and desired outcomes, a key factor in experiencing respect” (p. 87). This process requires ongoing dialogue with the client, a key factor in therapist accountability which creates an environment where clients are more confident their opinions will be heard. Clarity about clients’ expectations was a critical factor in understanding those clients who experienced improvement yet reported lower levels of satisfaction. Conversely, conversations between therapist and clients about what was realistically achievable and therapists providing clients with strategies to help them manage their situation made a valued difference for those clients who reported high levels of satisfaction. Clients reported high satisfaction levels even if their situation remained the same, or was even worse than it had been at the beginning of therapy (Stacey et al.); therefore it appears that clients in this study could distinguish between satisfaction with the process and outcome.

2.9 Therapist Qualities

Therapist qualities of empathy, non-possessive warmth, and positive regard as well as the patient perceiving the therapist as self-confident, skilful and active are all related to successful outcomes in integrative cognitive behaviour therapy (Parker et al., 2003). These qualities however, are not just related to successful outcomes in CBT. These results are consistent with the literature on the importance of counsellor qualities of warmth, empathy and impartiality, and the significance of a positive therapist/client alliance as essential components for therapeutic change (Christensen, Russell, Miller, & Peterson, 1998; Hampson et al., 1999; Helmke, Bischof, & Ford Sori, 2002). One of the most robust findings in the literature concerning psychotherapy is that a good therapeutic alliance is the best predictor of outcome in psychotherapy (Holmes, 2002b).
2.10 Summary of the Chapter

The previous chapter reported on efficacy and effectiveness research in individual counselling. Section 2.2 contrasted efficacy and effectiveness research and provided an overview of psychotherapy research and empirical validation of psychotherapy outcomes. Section 2.3 reported on the development of theories of counselling and psychotherapy from the 19th century to current times. Empirical research findings in individual counselling explored the evolution in most theoretical frameworks that early childhood experiences can influence resilience against, or the propensity to develop, mental health issues in later childhood and/or adult life. Sections 2.4, 2.5 and 2.6 reported on research findings from clinical or real life settings in individual counselling focusing on variables of interest in the current study including depression. There are considerable and consistent research findings that support the efficacy and effectiveness of individual psychotherapy for treatment of mental health issues such as a depressive illness. Section 2.7 reported on research findings on the therapeutic alliance in individual counselling. While a positive therapeutic alliance correlates with good outcomes in psychotherapy it is the individual’s subjective evaluation of the therapist qualities and their relationship with the counsellor that has the most impact on a positive outcome. Section 2.8 reported on other factors influencing client satisfaction in individual counselling including clients’ development of new strategies in response to issues that arise and being treated respectfully. Section 2.9 reported on research findings on therapist qualities that contribute to client satisfaction with counselling including empathy and competence. The following chapter explores efficacy and effectiveness research findings in couple counselling.
Chapter 3: Empirical and Clinical Findings in Couple Counselling

3.1 Chapter Overview

The previous two chapters focused on the history and development of couple counselling and empirical and clinical findings relating to individual counselling. Historically individual counselling preceded couple or relationship counselling, therefore a review of the individual counselling literature and theories of counselling provides a foundation for understanding couple counselling. The following chapter will review empirical and clinical studies in couple counselling. The majority of research in couple counselling has been conducted in research settings while the practice of couple counselling has occurred in real life or clinical settings. There is a constant tension between research findings and the relevance of these findings to the practising clinician; this chapter will explore some of these tensions.

Section 3.2 provides a definition of couple relationships from the earliest relationship between mother and infant to adult intimate relationships. Section 3.3 reviews some of the methodological issues involved in conducting research in couple counselling and explores the gap between the applicability of research findings and therapeutic interventions with couples in clinical settings. Section 3.4 reviews some of the empirical research findings in couple counselling. Section 3.5 reviews some of the meta-analytical findings in marriage and family counselling.

Research into the effectiveness of couple therapy and how outcomes are measured has predominately focused on studies conducted in research settings. These researchers have often aimed to eliminate the influence of extraneous variables on treatment outcome and have been interested in outcomes arising from a particular treatment approach where controlled conditions are constructed. Participants are often included or excluded for reasons relating to the researcher’s area of interest and the research aims and purpose.

Many of these research designs have resulted in a highly restricted sample of couples who may not reflect the nature of many couples who attend for couple counselling in the community. In contrast, service providers in the community accept almost any couple for relationship counselling as long as the couple are willing to engage in treatment and continue to attend for counselling. Consequently
this raises the issue of how applicable many research findings are to couple counselling as practised in the community. The next section will provide a definition of couple relationships.

3.2 Definition of Couple Relationships

The first couple relationship almost every person experiences is the one immediately following birth with their mother. John Bowlby’s (1969) seminal work on attachment theory and his emphasis on the importance of close emotional bonds between infants and their caregivers being crucial to healthy emotional development subsequently influenced most Western child rearing and child minding practices. Bowlby based his theory on the opposing themes of attachment and separation / loss (Holmes, 1993). Further discussion of Bowlby’s work will follow in Section 3.3, but the themes of attachment and level of comfort with closeness to another person and emotional responses to separation and/or loss from a significant other are features of all close relationships (Hazan, 2003).

Close relationships are typified by diverse and intense feelings such as acceptance, love, joy, security, gratitude and pride on the positive side and frustration, hatred, anger, jealousy, fear of rejection, grief and despair on the negative side (Mikulincer & Shaver, 2005). The practice of couple therapy encourages discussion and expression of the emotional experiences of both partners within the context of a safe environment. The therapeutic relationship is also identified by feelings of closeness and attachment over time towards the therapist and expression of a range of positive and negative emotional experiences by the client or couple.

3.3 Research Issues in Couple Counselling

The discrepancy between couples typically included in research trials and couples who self refer for counselling to a community based agency is one of the major problems facing both researchers and clinicians alike; how can research findings inform clinical practice and how can clinicians inform meaningful research that can be translated into improved treatments for couples?

Research findings are often not clinically accessible and clinicians often fail to see how research findings could aid their clinical practice (Johnson, 2003). Nevertheless, there is considerable literature devoted to the area of relationship satisfaction or dissatisfaction and to various treatment frameworks within
relationship counselling and therapy.

One of the problems in relating outcome research to clinical settings is that couples seen in real life settings often present with more complex relationship and personal problems than couples who are seen in research settings (Johnson, 2003). Christensen and Heavey (1999) have pointed out that effectiveness research often relies on retrospective data and select samples and that it may be preferable to conduct research in naturalistic settings using clinical efficacy trials. The next section will explore findings from the considerable body of empirical research conducted in the area of relationship counselling.

3.4. Outcome Measures in Relationship Counselling

One measure of change in relationship counselling for couples who remain together is increased satisfaction with their relationship and decreased levels of emotional distress (Lundblad & Hansson, 2006; Whisman & Bruce, 1999). Clients in couple therapy report these improvements to their counsellor and counsellors also note these indicators as evidence of change. This raises the question of the relationship between emotional distress and relationship dissatisfaction; which comes first and, if one area of a person’s life improves, for example their relationship, does their mood also improve?

3.5 Empirical Research in Couple Counselling

A telephone survey conducted in 1996 of approximately 800 people in the United States on the issues of communication, commitment and conflict found that negative interaction between partners was negatively associated with various measures of relationship quality and positively correlated with talking or thinking about divorce. They found that withdrawal during conflict by either partner was associated with negativity and less positive connection in the relationship (Stanley, Markman, & Whitton, 2002). These findings are consistent with the research of John Gottman (Gottman, 1979; Gottman & Gottman, 1999; Gottman & Levenson, 2002) where he has found that the presence of withdrawal or stonewalling is one of five factors found in the deterioration of a relationship that if left unaddressed can lead to increasing distress and eventual breakdown of the relationship. The other factors Gottman’s research has shown that contributes to relationship stress and possible breakdown of the relationship are: criticism, defensiveness, contempt and
belligerence (Gottman, 1979).

3.5.1 Steps in Seeking Couple Counselling

Measurement of relationship therapy’s effectiveness has been limited because of the small number of couples who seek help in clinical settings and the large time span that usually exists between problem recognition and help seeking (Doss, Atkins, & Christensen, 2003). Doss et al. found three relatively independent steps in seeking marital therapy: Problem recognition, treatment consideration and treatment seeking. They found that wives were significantly more involved in seeking marital therapy than were husbands and that seeking marital therapy was not generally a mutual process. Previous outcome studies have shown that the more distressed couples are prior to entering therapy the less likely they are to report moderate and above levels of relationship satisfaction at the end of treatment (Snyder, 1997; Snyder, Mangrum, & Wills, 1993). Therefore it appears that assessing the level of personal distress and relationship satisfaction or dissatisfaction experienced by partners who are seeking couple counselling early in treatment is warranted.

3.5.2 Reasons for Seeking Couple Therapy

A survey of 147 couples seeking marital therapy found that the most commonly reported reason for attending was problematic communication and lack of emotional affection (Doss, Simpson, & Christensen, 2004). The authors found that within couples, spouses showed little agreement on their reasons for seeking therapy. There were 19 broad and 84 specific categories given by participants as reasons for seeking counselling in this study. The authors found that when compared with their spouse husbands and wives only reported significant agreement on five broad categories and six specific categories of reasons for seeking counselling. Wives also reported more reasons for seeking counselling than did husbands, expressed more negative emotionality and less positive emotionality than did husbands.

The implications of these findings for clinical settings highlight the importance of addressing both individual and couple goals in therapy to ensure that both partners feel that their concerns are being addressed by the therapist. These findings regarding the reasons for seeking couple counselling provide insight into some of the reasons for seeking counselling but satisfaction with the outcome of couple counselling from the client’s perspective is usually measured by variables
such as: Whether the goals for counselling were met; Reports of increased relationship satisfaction and a decrease in personal and/or relationship distress; and Increased levels of communication including the development of problem solving skills (Doss et al., 2004; Gottman & Levenson, 2002).

3.5.2.1 Couple Counselling versus Couples’ Groups.

In an unpublished study (Carmady, 2005) comparing Australian couples who attended for relationship counselling \((N = 26)\) with couples who attended a 2 day relationship enrichment course \((N = 86)\) a significant difference was found between the 2 groups of couples on the length of time they had been in their current relationship and the level of problems reported in their relationship (as measured by the MSI-R; Snyder, 1997). Couples who attended for counselling reported significantly more problems in the following areas: Global Distress; Affective Communication; Time Together; Disagreement about Finances and Role Orientation than couples who attended the group program. Couples who attended for counselling had been together on average for 13 years whereas couples who attended the group program had been together on average for 7 years. Couples who attended for counselling were more distressed prior to attending, reported less affection and emotional sharing with their partner, said they spent less time together, argued more about financial matters and had more traditional roles in their relationship than couples who attended the group program. It appears that couples chose the type of service they required and when more entrenched problems were present couples selected counselling over a group program where other couples would be present.

3.5.3 Goals in Couple Counselling

A study by Werner-Wilson, Zimmerman, and Price (1999) examined the influence of gender on goals and topics raised in an initial marital and family therapy session. The authors acknowledged that identification of a common goal may be difficult in couple therapy because men and women may identify different goals due to differences in socialisation and different understanding of the problems present in their relationship. They proposed that the therapy process is influenced by an interaction between treatment modality and gender. Previous research suggests that goal attainment is linked to client satisfaction in individual therapy (Deane, 1993). Individuals in a relationship may have different reasons for attending counselling,
even when they attend together, and therefore may have different goals they want to achieve.

The study by Werner-Wilson et al. (1999) involved 103 couples or families who attended a non-profit university based marriage and family therapy clinic. The therapists were doctoral students on placement at the centre. Participants were asked to list three concerns they had and wanted addressed in therapy and to list the main goal they had (out of a list of three goals given) for therapy. Therapists were also asked to rate each client’s goals after the first session and these goals were matched with client reports of their goals for counselling to determine whether therapists could identify therapeutic goals that were consistent with the client’s main goal. The results showed that although 83% of couples agreed with at least 1 goal within the range of goals, 55% of couples identified different primary goals for therapy (Werner-Wilson et al., 1999). While this study was confined to an initial intake session they found that therapists were better able to match women’s goals in marital therapy (with just a couple present) but not in family therapy (with other family members other than the couple present). Therapists were not better at matching men’s goals in marital therapy. There were no significant results for the interaction between gender of the therapist and gender of the client. These researchers concluded that in order to address couple goals in therapy therapists must first address the primary goal of each participant.

3.6 Findings from Couple Counselling in Research Settings

While there is a limited amount of literature and research in the area of client outcomes for couples counselling in clinical settings, findings from research settings provide insight into some of the variables that affect client satisfaction. Hampson et al. (1999) found that couples without children fared best in therapy; couples living in a step-family made the least gains in therapy. Bray and Jouriles (1995) suggest some common ingredients for good therapy to be seen to happen from the client’s perspective. These include a context in which change is expected to occur; a decrease in negative affect and facilitation of positive interchanges; an understanding of family of origin issues and how the past impacts on the present; a positive therapeutic relationship and creation of an atmosphere that increases the likelihood of acceptance of characteristics in one’s partner that are different to oneself. Positive
outcomes in couple therapy as evidenced by interpersonal and intra-personal changes are preceded by changes in affect, cognition and behaviour.

3.7 Meta-Analyses on Marriage and Family Therapy

One criticism of many psychotherapy outcome studies has been that they emphasize statistical significance rather than clinical significance. A meta-analysis of previous research into the efficacy of marital therapy (Shadish et al., 1995) concluded that while marital therapy appeared to be at least as efficacious as other forms of psychotherapy, few such evaluation studies had been conducted in clinical settings. Shadish et al. also focused on clinical significance and found significant improvement in 41% of treatment conditions studied. Improvement in couples was deemed clinically significant if the couple was distressed when therapy commenced, but was no more distressed at the end of therapy than the average non-distressed (normal) couple. Analysis was limited to studies that used either the Marital Adjustment Scale or the Dyadic Adjustment Scale (Shadish et al.). When tested separately the effect size for marital therapy (MT; \(N=27\) studies, \(d=.60\)) and family therapy (FT; \(N=44\), \(d=.47\)) were both significant.

From the original database of 163 studies a smaller study was conducted comparing treated and untreated marital and family therapy clients in community settings. The original pool was reviewed for studies that used experienced counsellors; clients who were not recruited by the experimenter; counsellors who did not use specified training manuals or particular therapeutic approaches; and clients who attended non-university settings. Only 1 study was found to fit these criteria out of a total of 71 studies. The authors noted an absence in the literature of psychotherapy research in couples counselling that evaluated effectiveness of therapeutic outcomes in clinical settings as opposed to efficacy in research settings.

In a follow-up meta-analysis on treatment effectiveness in marital and family therapy (MFT) Shadish and Baldwin (2003) conducted a comprehensive meta-analysis of 20 different meta-analyses in the area of MFT. Results from 12 meta-analyses that compared marriage and family interventions to a ‘no treatment’ or control group showed an average effect size of \(d=.65\) at posttest and \(d=.52\) at follow-up. Four meta-analyses compared two or more different kinds of interventions and found small and non-significant differences between treatment approaches yet
provided substantial evidence for the relative effectiveness of those treatments (Shadish & Baldwin). In their 1993 study Shadish et al. found few differences between theoretical orientations of counsellors in marriage and family interventions. The results supported their previous findings that marriage and family therapies produce clinically significant improvements in distressed couples with 40 to 50% success rates compared to “no treatment” or waitlist control groups (Shadish & Baldwin).

Shadish and Baldwin (2003) also noted that most psychotherapy outcome research does not adequately represent the conditions of actual clinical practice. The authors found that none of the meta-analyses they investigated addressed the issue of clinical representativeness. However, they state that in the United States funding bodies have recently become more interested in research that has been conducted under clinically representative conditions rather than in research trials. These researchers suggest it is important to understand if therapy that is effective under ideal or highly controlled conditions is it also effective under conditions found in real life practice. These comprehensive meta-analyses highlight the gap between the amount of research conducted in laboratory settings and the lack of research conducted in actual clinical settings.

### 3.7.1 Applying Empirical Findings to Clinical Settings

Johnson (2003) suggests using therapists’ knowledge and expertise to examine changes that occur naturally in couple therapy and then applying a model of testing and refining these methods to increase the potential for change. Johnson believes that a central problem in the field of couple therapy is that most researchers commonly identify themselves as behaviourists whereas the majority of clinicians align themselves as eclectic, integrative or systemic. It appears that the issue of demonstrating applicability of research findings to the practicing clinician is warranted. While research studies that focus on statistical significance are valuable this does not necessarily translate into clinical significance or in fact to what may be of use to the practicing therapist.

Therapists need information presented in a clinically meaningful way. For example, it may not be enough to know from research trials that a certain percentage of people who present for relationship counselling are depressed. It may be more
useful clinically for the therapist to consider that when one partner in a relationship is depressed there is usually an impact on the non-depressed partner and a decrease in relationship satisfaction (Isakson et al., 2006; Lundblad & Hansson, 2005; Snyder & Whisman, 2004). In a retrospective study of 95 couples who had received couple therapy Isakson et al. found that when both partners started therapy with similar levels of emotional disturbance both responded well to treatment. However the authors also found that for females in the clinically distressed range prior to attending for couple therapy there was significantly less change in levels of emotional distress than for women who attended for individual therapy; this difference was not found for men. These findings highlight some of the complex clinical issues in the assessment and treatment of individuals within a couple relationship.

Therapists in clinical settings need to tailor interventions to assist each individual couple, unlike a research trial that may define the type of intervention to be administered or the relationship “problem” that will be targeted for the trial. The clinician is supported by research findings that treating depression in the context of the couple relationship will usually improve the level of relationship satisfaction reported by both partners and lead to reduced levels of depressive symptoms (Isakson et al., 2006; Lundblad & Hansson, 2005).

However, exploring the reasons for depressive symptoms in the context of the couple relationship may provide the therapist with considerably more insight into the functioning of the couple’s relationship than focusing on reducing depressive symptoms using cognitive or behavioural methods.

3.8 Empirically Supported Treatments

While meta-analytic studies support the effectiveness of marriage and family therapy further exploration of what works and for whom it works is required. In an attempt to determine any new developments in the field of couple therapy Johnson (2003) found that only two formally designated empirically supported treatments existed. These were behavioural approaches: Behavioural Marital Therapy (BMT: Dunn & Schwebel, 1995; Jacobson & Addis, 1993) and Emotionally Focused Couple Therapy (EFCT; Johnson, Hunsley, Greenberg, & Schindler, 1999). In addition to these two empirically supported treatments there has been one additional study using insight-oriented couples therapy (IOCT; Snyder & Wills, 1989) and one trial of
integrative behavioural couple therapy (IBCT; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000).

A meta-analysis of EFCT based on 4 of the most rigorous outcome studies found a 70% recovery rate for relationship distress and an effect size of 1.3. These findings are superior to the general effect size of 0.60 found by Shadish et al. (1995) and the 0.95 effect size found in a meta-analysis in BMT (Halweg & Markham, 1988). However, effect sizes are strongly influenced by a therapist’s skill and expertise; the choice of measures used and the theoretical background of the investigators (Johnson, 2003) and therefore caution should be exercised when comparing treatment types based on effect sizes from studies that are so disparate. However, Shadish et al. found no significant difference between treatment types when covariates such as: University versus non university settings and assignment of couples to treatment or wait list control groups were controlled for. If the majority of therapists claim they use an eclectic framework in couple therapy, and the research findings focus on defining specific theoretical frameworks used, this again highlights the discrepancy between research findings and clinical outcomes and the need for further research conducted in real-life clinical settings.

3.9 Research into Therapists’ Perspectives on Outcomes in Couple Counselling

A study by Whisman, Dixon, and Johnson (1997) looked at therapists’ perspectives on the therapeutic issues encountered in couple therapy. One hundred and twenty two couples’ therapists completed a survey asking them to rank the five problems they had most difficulty treating and the five problems they believed were most damaging to relationship functioning. The issues found to be the most important discussed in couple therapy were lack of loving feelings, power struggles, communication, extramarital affairs and unrealistic expectations. Therapists also rated the characteristics associated with negative outcomes for couples and found that the most common were a partner’s unwillingness or inability to change and lack of commitment to the relationship.

3.10 Clinical Studies in Couple Counselling

Vidler (2000) reviewed 30 evaluations of couple satisfaction with counselling dating from 1995-2000 and found that only 3 of these studies were conducted in clinical settings. One of these studies (Hampson, Prince, & Beavers, 1999) found that
92% of couples attending 3 or more counselling sessions experienced an improvement in their relationship. A German study which evaluated the effectiveness of marital counselling using pre and post measures found moderate improvement in marital satisfaction due to counselling, although the attrition rate was high with only 51% of the original group participating in post-treatment assessment (Hahlweg & Klann, 1997).

Vidler (2000) reviewed the research literature on couple counselling programs that focused on evaluation and outcomes globally between 1995-2000. The various research methods reported were observational, follow-up and outcome studies. Outcome studies include evaluation of client satisfaction from the client’s perspective. The author acknowledged the lack of research on couple therapy in clinical settings.

3.10.1 Effectiveness of Couple Therapy in a Clinical Setting in the United States

One of the three studies identified by Vidler (2000) evaluated the effectiveness of couple therapy in a clinical setting to determine the qualities and characteristics of couples who fare best in treatment (Hampson, Prince, & Beavers, 1999). Couples \( N = 139 \) participated in observational and self-report measures at the beginning and end of therapy. These couples attended a community based counselling centre. The study included both client self-report measures and observational measures by the therapist or an observer.

A direct relationship was found between the number of sessions attended and the degree of improvement. For couples attending 3 or more sessions, 92% experienced some, moderate, or significant gains. The study also found couples with no children, regardless of whether married for the first time or not, reported better outcomes in therapy than couples with children. It was suggested that couples with children present as a subset of a larger family system and the findings could reflect the absence of the family system being treated together as a totality (Hampson et al., 1999).

3.10.2 Clinical Study using Computer Assisted Technology in Israel

The second study reported by Vidler (2000) that occurred in a clinical setting detailed some of the difficulties encountered implementing a computerised integrated information system in a marriage counselling agency in Israel (Savaya, 1998). The
system was designed to track clients’ progress from initial assessment through to the end of treatment. The information system required therapists to structure interventions and predefine outcomes, a framework that was seen as incompatible with most therapeutic approaches that require sensitive attunement to the client within each therapy session and throughout the duration of the therapeutic relationship.

While this study provided some evaluation of client outcomes from the client’s perspective, the focus involved the therapist’s evaluation of client functioning using specific diagnostic tools (Savaya, 1998). This study raises the issue of how agencies implement monitoring and evaluation procedures that satisfy funding bodies yet also remain sensitive to the needs of clients and the therapeutic relationship. Issues around gathering reliable data on what makes a difference for clients from their perspective, without compromising the client’s access to the service or confidential nature of the work, are just a few of the reasons why there has been so little research in the area.

3.10.3 Evaluation of Effectiveness of Couple Counselling in Germany

The third study reported by Vidler (2000) reported similar difficulties to those experienced by Savaya (1998) in an evaluation of the effectiveness of marital counselling in a community setting in Germany (Hahlweg & Klann, 1997). Distressed couples were evaluated on measures of marital satisfaction, affective communication and problem solving. The differential effectiveness of counselling to other areas of the participants’ lives (e.g., sexual satisfaction) and the effectiveness of counselling in reducing individual distress (e.g., depression) were also investigated. Initially 234 couples and 27 individual clients were recruited. Pre and post assessment measures were recorded; however the attrition rate was high with only 51% of the original group participating in post-treatment assessment. The authors noted the high drop out rate and suggested this could have been due to client non-compliance or therapist non-compliance because of dissatisfaction with the therapy or the study (Hahlweg & Klann).

A battery of questionnaires given to both clients and therapists revealed an average post-assessment effect size of 0.28. This is considerably lower than the effect size of 0.60 found in marital therapy efficacy studies (Halweg & Klann, 1997).
Moderate effect sizes were found for global marital satisfaction (0.37) and marital problem solving (0.35). Small effect sizes were found for improvement in: The couple’s sexual relationship (0.21) and parent-child relationships (0.15). The effects of marital counselling were not considered to extend outside the marital dyad in this research. However, family therapists and relationship counsellors agree that a strong and healthy adult couple is the cornerstone to healthy family functioning and provides a model of intimate relating for children and a foundation for healthy partner selection in their adult life (Crowell & Treboux, 2001; Karen, 1998; Nicholls & Schwartz, 2006). Differences in effect sizes for the various domains covered in marital counselling highlights the diversity of skills required by therapists working in the field of relationships.

3.11 Australian Research in Relationship Counselling

While research conducted in clinical settings is limited compared to empirical research, interviews with clients after counselling has been completed can provide some insight into the factors that lead to satisfaction with the outcome of counselling. In 2000 telephone interviews were conducted nationally in Australia with 1,229 clients who had attended for relationship counselling at one of the 78 branches of a national provider of relationship counselling and support services. These interviews were conducted by an independent research company. Of the total sample of 1,229 participants, 324 people came to counselling with their partner for at least one session. For the total pool of 1,229 clients the mean number of sessions attended was 4 and 96% of participants attended for 10 sessions or less. Predictors of satisfaction with the outcome of counselling were: The number of sessions attended; positive perception of counsellor qualities including fairness and empathy of the counsellor; and if the client reported a willingness to recommend the service to others (Carmady, 2002).

Participants were asked about the range of strategies they had tried to improve the relationship before attending for counselling. Results showed that women tried significantly more strategies than men before attending for counselling including: reading books and literature, talking to family and friends, seeing a counsellor or psychologist or talking to their doctor (Carmady, Knowles, & Bickerdike, 2004). Participants were asked about their own goals for counselling and
what they thought their partner’s goals for counselling were. The most frequently reported goals reported were: To improve the relationship; To decide about the future of the relationship; To discuss personal issues; and To discuss parenting issues. Seventy seven per cent of participants thought they came to counselling with the same goal as their partner yet only 46% of participants actually came to counselling with the same goal as their partner (Carmady et al.). These findings highlight the importance of therapists working with couples to identify and work with the goals each partner brings to therapy.

Gender differences were found between reported levels of satisfaction with the outcome of counselling depending on whether or not the partner came with the same or a different goal for counselling. Males were less satisfied with the outcome of counselling if they had come to counselling with a different goal than their partner, this difference in satisfaction was not found for women (Carmady et al., 2004). Post hoc analyses revealed that couples who were no longer living together after counselling had been completed were significantly more likely to have attended counselling with a different goal than their partner.

This raises an important issue in clinical practice with couples who attend counselling together: The reasons partners in a relationship seek counselling may be very different for each individual. Unless each person’s reasons for attending couple counselling are clarified by the therapist one or both partners may feel unheard and dissatisfied with the process and outcome. Another area of clinical relevance regarding the reasons for seeking counselling is the possibility that these reasons change over time. For example, if partners attend for different reasons and this difference is revealed during counselling partners may change their minds on what is important in their counselling. Individuals in couple relationships may be influenced by their partner’s reasons for attending and in counselling may only hear for the first time the level of distress their partner has been experiencing in the relationship and this may change their mind about the importance of reasons for attending.

### 3.12 Therapeutic Alliance in Couple Counselling

The therapeutic relationship has been the focus of considerable research, however generally this relationship has been explored from the counsellor’s perspective (Manthei, 2005). Factors related to clients’ reported satisfaction with
their counselling has received less attention in the literature. Many experienced counsellors believe that evaluation of their effectiveness is a continuous activity embedded in the counselling process itself. Using grounded theory methodology Daniel and McLeod (2006) found that counsellors regarded four different types of information to be relevant to their understanding of success with clients. These were: Client satisfaction, evidence of change, the counselling relationship and personal satisfaction with their work. This research also indicated that counsellors are sensitive to the complexity of outcomes in counselling arising from moment-by-moment interactions in the therapeutic setting.

However, if counsellors consider changes in clients to be evidence of their effectiveness, is this assessment congruent with clients’ reported satisfaction with either the process or outcome of counselling and with their actual counsellor? Research has shown that clients’ and counsellors’ views on their counselling may differ (Manthei, 2005) and that even when the most important or critical events in counselling were identified clients and counsellors only agree about one third of the time (Cummings, Hallberg, Slemon, & Martin, 1992).

A qualitative study that evaluated client satisfaction and the process of therapy in a university based counselling centre (Sells, Smith, & Moon, 1996) revealed different perspectives for clients and therapists in defining effective moments in counselling. Therapists emphasised the importance of interventions such as reframing, giving equal speaking time to each partner and facilitating shared experience and understanding between the couple. Clients emphasised setting of goals, rapport between therapist and couple, and therapist qualities of warmth and caring (Sells et al.). The small sample size in this study \((N = 14)\) suggests these findings need replication. Nevertheless, these results are consistent with the literature on the importance of counsellor qualities of warmth, empathy and impartiality, and the significance of a positive therapist/client alliance as essential components for therapeutic change (Hampson, Prince, & Beavers, 1999; Helmke, Bischof, & Ford Sori, 2002).

### 3.13 Literature on Relationship Dissatisfaction and Depression and/or Mental Illness

Depressive disorders are the most prevalent of the Axis 1 mental disorders
and are likely to be encountered by a couple therapist in the clinical setting (Beach & Gupta, 2003). There is fairly consistent empirical support for an association between relationship discord and depression (Lemmens, Buysse, Heene, Eisler, & Demyttenaere, 2007; Whisman, 2001) and given conservative estimates that approximately one in four people will experience a depressive episode during their lifetime (Holmes, 2002) this is an area that warrants further attention in clinical settings where couples are treated for relationship problems.

Negativity and conflict often characterise the marriages of depressed persons and depression has been found to precipitate marital problems (Benazon & Coyne, 2000). The authors found that spouses living with a depressed partner reported significantly more depressed mood themselves than general population norms. Wives ranked their depressed husbands as more burdensome in terms of the physical and emotional strain on themselves than did husbands with a depressed wife (Benazon & Coyne). Both spouses and depressed partners had significantly more depressed mood when the depressed partner was male. The authors proposed that women may be more likely to recognise the needs of their depressed partner and are then more likely to develop a sense of responsibility in helping their partners than do male partners with depressed wives. When one or both partners experience a depressive illness there is considerable strain on the couple relationship (Benazon & Coyne; Lemmens et al. 2007) which raises the issue of where interventions should be targeted, at an individual level or towards the couple relationship?

Studies comparing individual versus couple therapy for psychological disorders have failed to demonstrate superior treatment outcomes for either treatment (Isakson et al., 2006). The degree of client disturbance has been shown to be a strong predictor of both the amount of psychological change clients experience and the number of sessions required (Anderson & Lambert, 2001; Isakson et al.); more disturbed patients usually require more sessions (Cobb & Bradbury, 2003). A retrospective study that compared the effects of individual versus couple therapy on clients attending a university counselling centre found that individual clients who presented with clinical levels of psychological disturbance were significantly less distressed following treatment (Isakson et al.). Several studies have shown that people who are unhappy in their current intimate relationship are not only more
likely to have physical or mental health problems but are also slower to respond to treatment (Snyder & Whisman, 2004). It appears that relationship functioning and mental health influence each other in diverse ways.

One study, the London Depression Intervention Trial, involved 77 participants and compared the use of antidepressant medication with couple therapy provided by experienced therapists. Participants were randomly assigned to either a group that received antidepressant medication or a group who received couple therapy with their partner (Leff et al., 2000). More than half the participants dropped out of the drug treatment compared to a drop-out of only 15% for participants receiving couple therapy. Results showed that couple therapy was at least as efficacious, if not superior, to drug treatment both in the treatment phase and the maintenance phase of the trial as measured by scores on the Beck Depression Inventory (BDI; Beck, 1967) and the Dyadic Adjustment Scale (DAS; Spanier, 1976), a measure of relationship satisfaction.

3.13.1 Relationship between Marital Distress, Depression and Attachment Style

There are conflicting findings in the literature on the relationship between marital conflict or distress and depression. Some authors suggest that the presence of marital distress leads to depression in one or both partners (Kendler, Karkowski, & Prescott, 1999; Whisman & Bruce, 1999) whereas other studies support the opposite view that depression precedes or precipitates marital conflict or divorce (Bruce, 1998; Kessler, Walters, & Forthofer, 1998). A meta-analysis across 10 studies involving 336 depressed individuals indicated that marital dissatisfaction accounted for approximately 44% of the variance between depressed and non-depressed individuals (Whisman, 2001). The relationship between marital distress and depression remains complex yet clinically relevant for those therapists working with couples in counselling settings.

A study by Lemmens et al. (2007) explored the relationship between depression, marital satisfaction, attachment style and psychological distress. Participants were 77 couples where 1 partner was a patient, either an in-patient or attended as a day clinic patient, at a Belgium hospital and a control group of 77 gender and age matched non-clinical couples. Patients and their partners were given a battery of questionnaires which aimed to measure the variables of interest; these
were level of depression, attachment style, marital satisfaction and psychological distress. In contrast to results found by Benazon and Coyne (2000) where higher levels of depressed mood were found in partners of depressed patients compared with population norms, Lemmens et al. found that the partners of depressed patients were not psychologically distressed. The authors hypothesised that an admission to a treatment program may relieve the partner of the burden of caring for a depressed spouse and furthermore, involvement in the program may have offered a sense of hope and expectation of change in the future which may have helped partners to feel less distressed (Lemmens et al.).

The depressed patients in the Lemmens et al. (2007) study reported less relationship satisfaction than their partners and couples in the non-clinical sample. The authors found a relationship between the two insecure attachment styles, avoidant and anxious styles, and depression (Lemmens et al.). A more detailed discussion of secure and insecure adult attachment styles can be found in Chapter 2 (see Section 2.3.1.5). A gender difference was found between attachment style and depression with female depressed patients more likely to be in the avoidant attachment category than males. However, both depressed males and females were equally in the anxious attached category yet partners of depressed patients did not show insecure attachment styles (Lemmens et al.). The authors noted that there may be a particular form of pairing found between a couple within a depressed relationship; an insecurely depressed partner with a securely attached partner.

In an earlier study that explored the relationship between depression and attachment in couples Whiffen, Kallos-Lilly and MacDonald (2001) compared a normative sample of couples ($N = 60$) with couples where the wife had met DSM-111 criteria for a depressive illness within the past year ($N = 52$). They found that husband’s insecure attachment patterns predicted maintenance of their wives’ depressive symptoms over a 6-month period and that husbands of women diagnosed with chronic depression reported less attachment security than husbands where the wife had experienced discrete episodes of depression. The authors found consistency with previous research where clinically depressed women report less attachment security and more fearful attachment than did women in a normative sample. The percentage of people in the secure and insecure attachment categories in Whiffen’s
study is consistent with Feeney’s findings (2002) where 57% of people in the normal population are securely attached and the remainder fall into one of the insecure attachment categories. However, in the clinically depressed sample Whiffen et al. found that only 26% of women were in the secure attachment group, whereas there was no difference for men in the secure attachment category whether their wives were depressed or not. The authors noted that depression is associated with negative working models of self and others and that depression is specifically associated with the belief that one is unlovable and that attachment figures will be rejecting.

These findings raise some complex issues for therapists working with couples in clinical settings. Internal working models of self and other exert a powerful influence on how an individual interprets relationship problems and the potential for change (Bartholomew, Henderson & Dutton, 2001; Fisher & Crandell, 2001). Further exploration of attachment theory in couple relationships, and in particular the dynamic between different attachment styles within a dyad will follow in the next section.

3.14 Attachment Theory and Couple Relationships

There is an increasing body of literature that supports the view that a person’s primary attachments in childhood are intimately linked with interpersonal patterns of relating throughout one’s life (Fisher & Crandell, 2001). Based on the pioneering work of John Bowlby (1969) attachment refers to the state and quality of one’s attachments to others (Holmes, 1993); both maintenance of close proximity to, and felt security with, the attachment figure (Feeney & Noller, 1996). The attachment literature describes typically one secure attachment style and three insecure attachment styles described (see Chapter 2: Section 2.3.1.4). The study of adult romantic attachment styles is based on similar premises to those in infant-caregiver attachment where emotional and relational patterns of behaviour are guided by internal working models of the self and on experience with prior relationship partners (Mickelson, Kessler, & Shaver, 1997). Hazan and Shaver (1987) based their measure of adult romantic attachment on three patterns or styles of behaviour. These are secure, avoidant and anxious (or anxiously ambivalent). A number of empirical studies have found the distribution of adult attachment styles is similar to those found in infants: 55% of individuals are classified as secure, 25% as avoidant and 20% as
anxious (Feeney, 2002; Shaver & Clarke, 1994; Shaver & Hazan, 1993).

Adults with a secure attachment style find it relatively easy to trust others, open up emotionally and commit themselves to a long term intimate relationship (Holmes, 1996; Schachner et al., 2003). Those with an anxious attachment style are often uncertain they are loved or worthy of being loved. These individuals are usually excessively vigilant and seek constant reassurance from their partner, frequently displaying angry protests and jealousy (Holmes; Schachner et al.). Adults with an avoidant attachment style have learned that in order to feel relatively secure they need to rely on themselves and not to rely on their partner (Holmes; Schachner et al.).

3.14.1 Measures of Adult Attachment

A variety of measures have been developed to assess patterns of adult attachment including the Adult Attachment Interview (AAI) developed by George, Kaplan, and Main (1985); the Current Relationship Interview (CRI) developed by Crowell and Owens (1996) and The Secure Base Scoring System for Adults (SBSS) also developed by Crowell (1998). In the Adult Attachment Interview (George et al.) adults are asked to describe their relationships with their parents in childhood. Adults are also asked to describe incidents of being hurt, ill or separated from parents during childhood and how these incidents may have influenced their personality and their understanding of why their parents behaved as they did (Fisher & Crandell, 2001). Interviews are audiotaped and transcribed verbatim, then rated for coherence on the manner in which the stories are told and how this relates to the content and quality of the story told. Four categories of adult attachment style have been identified that parallel infant classifications as found in the Strange Situation Test (Ainsworth et al., 1978). These adult attachment styles are outlined in Chapter 2; Section 2.3.1.5. An alternative approach in measurement of adult attachment is the use of a questionnaire measure for adults currently in a romantic relationship. A questionnaire developed by Griffin and Bartholomew (1994) was used in the current study and is described in Section 4.3.3.2.

3.14.2. The Role of Attachment in Adult Relationships

The major difference between attachment in parent-infant relationships and adult-adult relationships is that the attachment system between adults is reciprocal;
adults experience both being both depended on and being dependent on their partner (Fisher & Crandell, 2001). The adult attachment relationship includes elements of caregiving, nurturing, demonstration of love and affection just as the parent-infant relationship does; however, the adult relationship also includes physical intimacy and a sexual relationship necessary for bonding, enjoyment of pleasure and the creation of children (Hazan, 2003).

There are strong parallels between parent-infant attachment and adult romantic attachment. In both attachment relationships the individual feels secure if the attachment figure is close and insecure if the attachment figure is unavailable (Feeney & Noller, 1996). Individuals will attempt to move closer to the attachment figure to restore feelings of security if the attachment figure is distant. Hazan and Shaver propose that romantic love involves a combination of the three behavioural systems of attachment, caregiving and sexuality that promote closeness, intimacy and procreation between adults and ensure the survival of the species (Hazan & Shaver, 1988).

3.14.2.1 *Attachment Pairings in Adult Relationships.*

In secure couple attachment both partners are able to experience and shift freely between both the being depended upon and being dependent on their partner. There is an empathic feeling for the partner’s thoughts and feelings in both these positions (Fisher & Crandell, 2001). In insecure couple attachment there is a lack of mutuality and reciprocity in the relationship with one partner typically in each position (either the dependent or being depended on position) with little movement between positions (Fisher & Crandell). The dismissing/preoccupied couple attachment pairing is considered by some authors to be the one most commonly seen in couple therapy (Fisher & Crandell). The typical pattern seen is that the preoccupied partner expresses most of the dissatisfaction in the relationship and the dismissing partner believes that the only problems in the relationship are the preoccupied partner’s complaints and discontent (Fisher & Crandell; Hazan, 2003).

3.14.3 *Stability of Attachment Style from Infancy to Adulthood*

Bowlby (1973) proposed that internal working models or attachment styles would be well developed by early adulthood and therefore stability in attachment style could be presumed once a young person became an adult (Scharfe, 2003).
Bowlby (1982) later proposed changes in attachment models and behaviours in response to significant changes in the infant’s life suggesting the capacity for change in attachment style. For example, researchers have found that children who received inadequate care became avoidantly attached but these children tended to become secure when their caregiving experience changed to a more consistent and supportive adult, such as a grandmother (Egeland & Sroufe, 1984). Research exploring mother–infant attachment has found that approximately 65% of infants are classified in the same category when assessed at 2 different time points within the first year of life (Egeland & Sroufe). Increased quality of care is associated with changes from insecure to secure attachment (Egeland & Farber, 1984; Vondra, Hommerding, & Shaw, 1991) and correspondingly decreased quality of care is associated with changes from secure to insecure attachment (Egeland & Sroufe; Vondra et al.).

Given that changes in attachment can be found in infancy depending on circumstances in the child’s life, it is therefore reasonable to presume that changes in an adult’s life might also lead to changes in attachment style. Research examining the stability of adult attachment using categorical measures has found that 70% of participants report the same attachment category over time periods ranging from 2 to 12 months (Scharfe & Bartholomew, 1994). In a study that measured newlyweds on attachment style every 6 months for 2 and a half years high levels of stability were found over time; correlations for women ranged between $r = .62$ to .80 and for men ranged between $r = 50$ to .81 (Davila, Karney, & Bradbury, 1999). The researchers found that changes towards insecure attachment patterns were found in participants with reported vulnerabilities such as personality disturbance, past or family history of psychopathology and non-intact family of origin (Davila et al.).

Changes towards more insecure attachment patterns in adulthood are also associated with attachment related negative life events, for example divorce, illness and maternal depression (Hamilton, 2000; Lewis et al., 2000). Changes towards more secure attachment patterns are related to better family functioning (Scharfe, 2003). The relevance of these findings has implications in clinical settings. The therapeutic relationship can be seen as providing a “holding environment” where attachment patterns and dynamics can be used as a basis for understanding current relationship difficulties and an environment to facilitate working through dysfunctional patterns.
of relating (Johnson & Whiffen, 2003; Karen, 1994). Research suggests that adult attachment patterns can change from insecure to more secure with more positive relationship experiences (Feeney & Noller, 1996).

3.15 Summary of the Chapter

This chapter explored some of the empirical and clinical findings in couple counselling both in Australia and overseas. Some of the research issues found in both empirical and clinical settings were explored. Outcome measures in couple counselling were defined and findings from meta-analytic studies in couple counselling that demonstrate the overall effectiveness of couple counselling were reviewed. There have only been limited studies in couple counselling conducted in real life settings; some previous research has been conducted with Australian couples and this research was reported. The importance of the therapeutic alliance was explored with confirmation that counsellors and clients often report different factors as important in the therapeutic process. The relationship between distress, depression and attachment style was discussed within the context of couple counselling. Study findings highlight the need for further research in this area. The next chapter will describe the current study which explored relationship satisfaction for couples attending for counselling in clinical settings in Australia.
Chapter 4: The Current Research

4.1 Chapter Overview

Previous chapters have explored the history and development of couple counselling both within Australia and overseas. Couple counselling has its origins in individual counselling and therefore the historical and theoretical development of individual counselling was discussed prior to discussion of the development of couple counselling. Influences on couple counselling have included individual psychoanalytic theories, systemic and family therapy and cognitive-behavioural approaches. Contemporary approaches to clinical couple work draw on a range of theoretical frameworks and techniques with most couples therapists nowadays considering themselves to be eclectic in their approach (Walborn, 1996).

While couple therapy and counselling has existed for over 60 years, research into the efficacy and effectiveness of couple counselling only began to appear in the literature approximately 20 - 30 years ago. The majority of research that has been conducted has been empirical research while most couple counselling occurs in community or real-life settings. There is a considerable gap in the literature on effectiveness research in the area of couple counselling conducted in clinical or real-life settings.

This chapter integrates the literature reviewed in the previous chapters, thereby providing a context for the current study. The background and rationale for this study is discussed in Section 4.2. The theoretical frameworks relevant to this study are outlined in Section 4.3 including the relationship between relationship satisfaction, depression and attachment style in adult romantic relationships. In section 4.4 the current study is introduced including a presentation of the aim and the research questions. Section 4.5 outlines the design of the current study including methodological constraints (Section 4.5.1) and the measures used (Section 4.5.2). Section 4.6 provides a summary of the current study.

4.2 Background and Rationale

As was discussed in Chapter 1 the development of marriage counselling had its origins around the time of the First World War (Broderick & Schrader, 1991) yet research in the area of relationship counselling has only developed in the past 20 to 30 years. The development of marriage guidance, educational and counselling
services in Australia in the 1950s paralleled the development of the British model where initially lay volunteer counsellors were used and services were provided free of charge to the clients. The use of paid professionals as counsellors emerged during the late 1960s and 1970s; this occurred at the same time as research and evaluation of couple counselling began to appear in the literature (Lewis et al., 1992; Simmons, 2006) and when clients were charged a fee for the services they received. The development of marriage and relationship counselling in the United States of America differed from the British and Australian models. In the United States paid professionals were used from the early inception of relationship counselling and fee for services provided was the standard from the early 1930s.

As was discussed in Chapter 2 individual theories of counselling and psychotherapy preceded couple counselling. From the development of psychoanalytic theories (Freud, 1905; 1913; 1914) that attempted to understand the human psyche through to humanistic (Perls, 1969; Rogers, 1951), cognitive behavioural (Hawton et al., 2004; Lang, 1970) and family systems approaches (Nicholls & Schwartz, 2006), a variety of frameworks have influenced the development of theories and counselling approaches in clinical work with couples. Some of the variables found to influence client satisfaction in individual counselling include: Counsellor qualities of warmth, empathy and fairness (Christensen et al., 1998); attainment of goals in counselling (Deane, 1993); client and counsellor reports of improved ability to handle the presenting problem (Sanders et al., 1998); and, a decrease in reported symptoms of emotional distress or depression (Holmes, 2000b; McWilliams, 2004; Parker et al., 2003).

As described in Chapter 3, the majority of research in couple counselling has been efficacy research which involves conducting the research under controlled conditions where participants are usually assigned to one of three groups; a treatment, no treatment or waitlist control group (Shadish et al., 1993). One of the criticisms of efficacy research has been that while it possesses high internal reliability this research does not have good external validity. Therefore, findings from efficacy studies are limited in their capacity to be generalised to real life settings. While efficacy research helps to inform both researchers and clinicians about the changes which occur under controlled conditions there still remains an
absence in the literature of effectiveness research in couple counselling conducted in real-life settings (Johnson, 2003). The current study aims to narrow that gap.

Couples who attend for counselling in real life settings often present with more complex relationship and personal problems than couples seen in research settings (Christensen & Heavey, 1999). The most commonly reported reasons for seeking couple counselling include problems with communication and ineffective problem solving strategies (Doss et al., 2004). For couples attending relationship counselling clarification of each partner’s goals for attending counselling is crucial to a satisfactory process and outcome as partners may attend for different reasons (Werner-Wilson et al., 1999) and unless the therapeutic work is tailored towards both partners one or both may experience frustration and dissatisfaction with counselling. Therapists in real life settings need to tailor their interventions to each individual or couple and therefore, often require a greater repertoire of techniques and interventions than the more proscribed interventions that have been used to date in empirical research.

4.2.1 Prior Australian Research in Couple Counselling

The current research expanded on an earlier study which conducted a preliminary examination of factors that contribute to satisfaction with relationship counselling for couples attending a branch of a national provider of relationship counselling services in Australia (Carmady et al., 2004). Results of this study were presented in Chapter 3 (see Section 3.11). While this research provided a unique opportunity to explore some of the factors that contribute to client reports of satisfaction with couple counselling, the study was retrospective and therefore did not provide a profile of participants’ relationships prior to counselling.

Findings from this previous study showed the variables that contributed to client satisfaction with the outcome of relationship counselling were: The number of sessions attended, positive perceptions of counsellor qualities including fairness and empathy, and whether the client reported a willingness to recommend the service to others (Carmady, 2002). There are few clinical studies in the area of client satisfaction in couple counselling either within Australia or overseas. The current study has expanded on the earlier research (Carmady, 2002; Carmady et al., 2004) and was conducted through the Victorian branches of a national provider of
Research has shown that clients and therapists frequently differ in their perceptions of what occurred in counselling sessions and in one study even when the most important or critical events in counselling were identified clients and therapists only agreed about one third of the time (Cummings et al., 1992). The current research explored both pre and post counselling variables with couples attending for relationship counselling and also explored counsellors’ perceptions of the factors they believed contributed to a satisfactory outcome in each couple’s counselling.

4.2.2 Methodological Issues in Development of the Current Study

Participants in the current study were recruited from clients who contacted a Victorian branch of the agency for relationship counselling and who intended to come to counselling with their partner. Some individuals also contact relationship counselling services because they want help with relationship issues but are seeking individual counselling; these individuals were not given information about the study by administration staff.

The agency where clients were recruited played an active role in the design of the study as their concerns that client interests and access to the service were not compromised were paramount. All questionnaires used in this study were reviewed by the agency’s Ethics Committee and senior staff at one of the centres. A time limit of no more than 15 minutes for clients to complete either pre or post counselling questionnaires was required by the agency; this limited the overall length of the study instruments and influenced the research design. Participation by both clients and counsellors was voluntary and clients were informed that their participation would not compromise their access to the service nor would their counsellor be informed of their participation unless the clients chose to inform their counsellor themselves.

As access to the service for clients seeking relationship counselling occurred through an administration officer considerable discussion with administration staff was necessary in order to clarify the purpose of the study, to engage their cooperation in discussing the project with callers and to screen out those clients considered unsuitable for inclusion in the research. The agency undertakes routine screening of clients accessing services where issues of domestic violence are present; these clients are then seen by more experienced staff members. The agency
required that these clients be excluded from receiving information about the research as it was considered that their relationships were under enough stress without also asking them to consider completing questionnaires for a research project. No data were recorded on the number of callers who were considered unsuitable and screened out from receiving information about the research project by administration staff.

As questionnaires were mailed out to prospective clients prior to their first appointment those clients who were offered an appointment within a very short time frame from when they contacted the agency (i.e., a few days) could not be recruited. No data were recorded by the agency on these clients. The agency’s Ethics Committee stipulated that the information sheet about the project that was sent to clients should be no more than one page in length.

4.3 Variables of Interest in the Current Study

Based on previous literature, there were several areas of interest in the current study. These areas included changes in relationship satisfaction as a result of attending couple counselling, determining the level of psychological distress and depression in people experiencing relationship dissatisfaction and exploring the relationship between attachment style and relationship satisfaction in couples presenting for counselling. The selection of measures used will be outlined prior to definition of the research aims and hypotheses.

4.3.1 Relationship Satisfaction

A measure of relationship satisfaction prior to and after counselling is crucial to both understanding how partners rate their relationship satisfaction and how this changes over time, particularly after the counselling intervention. There have been several valid and reliable measures of relationship satisfaction developed, however most of these measures are lengthy and therefore time consuming to complete. For example, the Marital Satisfaction Inventory (MSI; Snyder, 1997) has 150 items and the Dyadic Adjustment Scale (DAS; Spanier, 1976) has 32 items. As relationship satisfaction was only 1 of several variables included in the current research and because the time required to complete all questionnaires could not exceed 15 minutes it was decided to use the 7-item generic measure of relationship satisfaction, the Relationship Assessment Scale (RAS; Hendrick, 1988). The Relationship Assessment Scale (RAS) is designed to measure relationship
satisfaction in couples who are in a romantic relationship.

A study that compared the Dyadic Adjustment Scale (DAS) and the RAS with 57 dating couples \((N = 114)\) found a high correlation between the 2 scales, \(r = .80, p < .05\) (Hendrick, 1988). A subsample of 30 couples were contacted 6 months after the initial study to determine how many couples were still together and how many couples had separated. Couples were administered both the DAS and the RAS. The RAS is a 5 point Likert-type scale with scores ranging from 1 – 5. Results showed the mean score for people in continuing relationships was 4.34 and for people no longer in relationships the mean score was 3.33. The RAS correctly predicted 91% of “together” couples and 86% of the “apart” couples while the DAS predicted 91% of “together” couples and 57% of the “apart” couples (Hendrick) showing the RAS to be a reliable and yet brief measure of relationship satisfaction and suitable for the current study.

4.3.2 Depression

There has been considerable literature devoted to understanding the complex relationship between relationship dissatisfaction and depressive illness (Anderson & Lambert, 2001; Isakson et al., 2006). Snyder and Whisman (2004) found that people who are unhappy in their current intimate relationship are more likely to have mental or physical health problems and be slower to respond to treatment than people who are happy in their intimate relationship. Awareness of depression as a major mental health problem in Australia has prompted programs such as Beyond Blue, a national initiative that has increased awareness in the community about symptoms of depression and how to access a range of services available for people experiencing a depressive illness (Beyond Blue, 2000). Since 2001 there have been approximately 5 million visitors to the Beyond Blue website and their information line receives nearly 5,000 calls per month (Beyond Blue, 2007), showing substantial public interest from people seeking information about depression and related disorders.

There are several well researched scales that measure levels of depression including the Beck Depression Inventory (BDI; Beck, 1967). For the purposes of the current research it was decided to use the DASS 21, the 21 – item Depression, Anxiety and Stress Scales developed in Australia by Lovibond and Lovibond (1995).
The DASS 21 has been developed and refined from the longer 42-item version of the DASS. Confirmatory factor analyses conducted on findings from a large overseas psychiatric sample referred to a mood disorders clinic \((N = 439)\) indicated support for a 3-factor model of the DASS 21 and the shorter version of the DASS showed improved fit over the 42-item version (Clara, Cox, & Enns, 2001).

The DASS 21 distinguishes between the three states of depression, anxiety and stress and has been developed using non-clinical Australian populations (Henry & Crawford, 2005; Lovibond & Lovibond, 1995; Ng et al., 2007) whereas the BDI has been validated on clinical populations in America. An Australian study tested the validity of the DASS 21 on 786 in-patients receiving treatment at a private psychiatric setting. Patients were administered four different routine measures at admission and discharge. The four measures were the DASS 21, the Health of the Nation Outcome Scales (HoNOS), the Mental Health Questionnaire (MHQ-14) and the Clinical Global Impressions (CGI) scale.

The authors tested the validity of the DASS 21 for use as a routine clinical outcome measure in a private in-patient setting and results showed significant reductions in DASS 21 scores between admission and discharge (Ng et al., 2007). The reduction in DASS 21 scores was mirrored by corresponding significant improvements on the HoNOS scales, the MHQ-14 and the CGI scale (Ng et al.). While the current study involved a non-clinical population, results from the study by Ng et al. support the use of the DASS 21 as a reliable measure to determine changes in reported levels of depression, anxiety and stress following counselling. Therefore the DASS 21 was the measure selected for the current study to determine levels of depression, anxiety and stress in people both prior to and following relationship counselling.

### 4.3.3 Attachment

Attachment theory may help to explain why some individuals experience anxiety in close relationships (Fisher & Crandell, 2001) but how might an understanding of attachment behaviours help clinicians and researchers to understand why problems emerge in couple relationships? At the broadest level attachment theory is based on the premise that a primary goal in close relationships is felt security (Davila, 2003). Therefore, relationship distress may be a symptom of
attachment insecurity or may indicate that the person’s attachment needs are not being met at that time. A large body of literature suggests that when security in people’s relationships is compromised they behave in a variety of relationship damaging ways and they view their relationship more negatively (Cobb, Davila, & Bradbury, 2001; Davila; Feeney, 1990). Some researchers believe that those couples most at risk for relationship problems are those with insecure attachment styles and that attachment insecurity binds couples together in a chronically unhappy relationship (Davila & Bradbury).

Bowlby claimed that the attachment system is most critical in the early years of life but is active throughout the entire lifespan (Bowlby, 1988) and that it is related to proximity seeking of the attachment figure in times of need (Schachner, Shaver, & Mikulincer, 2003). There has been considerable discussion in the literature regarding whether attachment measures capture an enduring characteristic of individuals or their functioning in the current relationship (Feeney & Noller, 1996). Findings on the stability of the forced choice method for determining attachment style with college students over a 4 year time period showed an overall stability rate of approximately 67% (Baldwin & Fehr, 1995).

4.3.3.1 Attachment as a Categorical or Dimensional Construct.

The measurement of attachment varies between categorical measures using forced choice statements (Hazan & Shaver, 1987; Main, Kaplan, & Cassidy, 1985), dimensional measures (Collins & Read, 1990) or the prototype approach (Griffin & Bartholomew 1994a). In categorical measures the individual chooses one statement they believe is most like them. For example, forced choice statements include: “I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me” (secure) or, “I am somewhat uncomfortable being close to others; I find it difficult to trust them completely” (avoidant) or, “I find that others are reluctant to get as close as I would like; I worry that my partner doesn’t really love me” (anxious/ambivalent) (Hazan & Shaver, 1987, p. 515). The respondent chooses the one category that best describes how they see themselves in relation to others.

In an attempt to address concerns about a model that only allows the respondent to choose one category some researchers have proposed a model that uses
the same statements but where the individual can rate the applicability of each one for himself or herself on a Likert-type scale (Feeney & Noller, 1996). This revision of the forced choice model allowed for more complete descriptions of individuals’ attachment style and makes it possible for individuals to be given a scale score for each of the three attachment styles: Secure, Anxious and Ambivalent (Feeney & Noller).

4.3.3.2 Attachment as a Dimensional Construct

A four-category two-dimensional model of attachment styles was developed by Bartholomew (1990) and can be used to assign people to an attachment category. This measure is based on Bowlby’s premise that attachment patterns reflect working models of the relationship with the self and with the attachment figure (Bartholomew & Horowitz, 1991); this measure is described in detail in Section 5.3.1.3. Bartholomew proposed that a working model of the self (positive or negative) interacts with a working model of the other (positive or negative) to produce one of four adult attachment styles. The model of the “self” reflects the amount of dependence or acceptance by others in close relationships. The model of the “other” reflects the degree of avoidance of others in close relationships (Bartholomew, Henderson, & Dutton, 2001; Feeney & Noller, 1996).

The prototype approach recognises and measures variations within a category and according to Griffin and Bartholomew (1994) is particularly appropriate for attachment research. These authors propose that individuals can show varying degrees of attachment patterns across time and situations and that most adults would be expected to show varying degrees of two or more attachment patterns. For example, the positivity of the self model is derived by adding together ratings of the patterns hypothesised to reflect positive self models (the Secure and Dismissing patterns) and subtracting the ratings of patterns hypothesised to reflect negative self models (the Fearful and Preoccupied patterns). The positivity of the other model is derived by adding together ratings hypothesised to reflect positive views of the other (the Secure and Preoccupied patterns) and subtracting scores on patterns hypothesised to reflect negative views of the other (the Dismissing and Fearful patterns), (Griffin & Bartholomew). See Figure 1 for further details on this model.
4.3.3.3 Attachment as a Categorical Construct.

The other method used to determine attachment style is a measure constructed by adding total scores on each of the four attachment subscales (continuous variables) within the RSQ. Items in the RSQ relate to four attachment styles, Secure, Preoccupied, Fearful and Dismissing (Griffin & Bartholomew, 1994).

While there has been considerable literature devoted to understanding the nature of attachment behaviours and patterns in adult romantic relationships it remains an area that warrants further research. Given the complex relationship between relationship distress, depression and attachment style identified in the empirical literature there remains little or no known published studies that have explored the relationship between these variables in clinical settings. The current research aimed to narrow the gap between research findings in empirical and clinical settings in relationship counselling.
4.3.4 Development of Other Study Variables

4.3.4.1 Emotional Distance Scale (EDS).

There are several published relationship satisfaction measures that capture both the degree of closeness and intimacy in the relationship as well as the degree of relationship distress (Marital Satisfaction Inventory - Revised; Snyder 1997; Dyadic Adjustment Scale, Spanier, 1976). As outlined previously these measures are lengthy and time consuming to complete and consequently could not be used in the current study. In the absence of a brief published measure to determine the level of emotional distance in the couple relationship a 5-item scale, the Emotional Distance Scale (EDS) was created by the principal researcher. Further description of the items used in the Emotional Distance Scale can be found in Section 5.3.1.4.

4.3.4.2 Attraction Scale (AS).

In the absence of a published brief questionnaire that measures the degree of physical attraction between partners two categorical items from the sexual Scale of the Marital Satisfaction Inventory - Revised (MSI-R- Snyder, 1997) and three items from the Locke - Wallace scale (1959) were expanded by the principal researcher to create a continuous scale to measure physical and sexual attraction. Further description of the items used in the Attraction Scale can be found in Section 5.3.1.5.

4.4 The Current Study

4.4.1 The Aim of the Current Study

The aim of the current study was to explore some of the psychological characteristics of couples attending together for relationship counselling in a real-life clinical setting in Australia. The current research explored the status of participants’ relationships with their partner both prior to, and after attending for counselling, with a focus on the impact of counselling on reported levels of mood disturbance (i.e., depression, anxiety and stress) relationship satisfaction, emotional closeness or distance and attraction to one’s partner. Previous research has found that women are more likely to become actively involved in seeking treatment for relationship problems than men (Doss, Atkins, & Christensen, 2003) and that women are often the “emotional managers” of the relationship (Gottman, 1999) and take on the role of ensuring emotional regulation within the relationship; identifying problems first and
talking to their partner about ways of addressing problems in the relationship (Carmady et al., 2004).

4.4.2 Research Hypothesis and Questions

Given the exploratory nature of the current research and the unique profile of having couples who attended counselling together both responding to questionnaires about their experience one hypothesis and five research questions were posed based on previous findings and areas of interest.

4.4.2.1 Research Hypothesis 1.

The first hypothesis related to the initiation of counselling, relationship satisfaction and emotional distance and attraction to one’s partner prior to attending for counselling. Previous American research has found that women are more actively involved in the steps taken towards seeking professional assistance when there are relationship difficulties than are their male partners (Doss et al., 2003). In addition to these findings, previous Australian research has found that women report higher levels of relationship dissatisfaction prior to seeking counselling than their male partners (Carmady et al., 2004). Therefore, it was argued that similar results would be found with this Australian sample of participants seeking relationship counselling. Apart from the measure of relationship satisfaction (RAS; Hendrick, 1988) measures for emotional closeness and attraction towards one’s partner were developed for use in the current study. These additional measures provided a more comprehensive picture of the interpersonal dynamics operating in couple relationships than only relying on a measure of relationship satisfaction.

Hypothesis 1: Women would initiate relationship counselling more often than men and would report significantly lower levels of relationship satisfaction, higher levels of emotional distance from their partner and lower levels of attraction prior to attending counselling than men.

4.4.2.2 Research Question 1.

The first research question was based on previous findings where the presence of depression in either one or both partners in a relationship has a negative
impact on relationship satisfaction (Lemmens et al., 2007). There are conflicting findings on whether the presence of depression in one or both partners precipitates marital conflict (Bruce, 1998; Kessler et al., 1998) or if the presence of marital conflict leads to depression in one or both partners (Karkowski & Prescott, 1999).

People attend for relationship counselling because their relationships are in difficulty and they have been unable to resolve problems satisfactorily themselves. Therefore, it was decided to explore whether the levels of depression in people attending for relationship counselling were the same as or higher than those found in the general population.

Research Question 1: Do people who attend for relationship counselling have higher levels of depression than is found in the general population?

4.4.2.3 Research Question 2.

The first second question related to attachment style in couples attending for counselling. Previous research has suggested that the presence of at least one securely attached partner in the couple dyad may result in the couple being more able to relate positively to each other, and therefore experience fewer relationship difficulties than couples where both partners are insecurely attached (Cowan & Cowan, 2001). Feeney (2002) carried out a large-scale study of attachment patterns and relationship satisfaction in 193 non-clinical married Australian couples. Non-clinical couples were defined as couples in the community who were in an intact relationship and not receiving therapy. In this sample, 54% of men and women were classified as having a secure attachment style, 17% were dismissive, 15% were fearful and 14% were preoccupied. The second research question explored whether attachment patterns in the current clinical sample of couples attending for relationship counselling was similar to, or different from, Feeney’s findings.

Research Question 2: Do people who attend for relationship counselling have higher levels of insecure attachment than is found in the general population?
4.2.2.4 Research Question 3.

The third research question explored the relationship between insecure attachment style, relationship dissatisfaction and mood disturbance (Lemmens et al., 2007; Whisman, 2001). Lemmens et al. found that depressed patients reported less relationship satisfaction than non-depressed people and also found a link between insecure attachment styles and depression. Therefore, the third research question explored the relationship between insecure attachment, relationship satisfaction and mood disturbance in these Australian couples seeking counseling.

Research Question 3: Do people attending for relationship counselling and classified as insecurely attached (i.e., classified as dismissing, fearful or preoccupied) report higher levels of relationship dissatisfaction and higher levels of mood disturbance than people who are securely attached?

4.4.2.5 Research Question 4.

The fourth research question was based on a provisional model of the predictors of relationship satisfaction. Based on previous overseas research on the relationship between high levels of emotional distress and relationship dissatisfaction (Isakson et al., 2006; Lundblad & Hansson, 2005; Snyder & Whisman, 2004) and between insecure attachment style, depression and relationship dissatisfaction (Lemmens et al., 2007) it was decided to explore whether a similar pattern would be found with these Australian couples seeking relationship counseling.

Research Question 4: Are high levels of emotional distress, depression and insecure attachment related to relationship dissatisfaction in Australian couples seeking relationship counseling?

4.4.2.6. Research Question 5.

The fifth research question related to the nature of the therapeutic relationship from client and counselor perspectives. Previous research has suggested
that consensus between clients and counsellors on outcomes in counselling may only occur about 30% of the time (Doss & Atkins, 2003), therefore further exploration of what occurs in the context of couple counselling was considered relevant in the current study. This research question explored whether a similar pattern to that found by Doss and Atkins (2003) would be found in the current sample of clients. The other variable of interest was the degree of consensus between partners in couple relationships on the factors that contributed to satisfaction with the outcome of counselling.

Research Question 5: Do clients individually, and as a couple, agree with their counsellors on the factors that contributed to satisfaction with the outcome of counselling in relationship counselling?

4.4.3 Longitudinal Research Questions.

The current study included a longitudinal component with pre and post-counselling data for some couples as well as their therapist’s evaluation of their counselling outcomes; these were explored to determine where there was consensus or disagreement on outcomes from client or counsellor perspectives. Where pre and post-counselling data were available these data were examined on a case by case basis in order to investigate individual differences in couple therapy. Individual differences were examined because group data could obscure patterns of progress in therapy and might also overlook differences between individuals in couple relationships.

4.4.3.1 Research Question 6.

The sixth research question explored changes following counselling for the six couples who attended counselling together and who both completed pre and post counselling questionnaires.

Research Question 6: To explore, using case studies, changes following counselling.
4.5 Summary of the Chapter

The present study was designed to explore some of the psychological variables present for couples attending for relationship counselling including the impact of relationship distress and an exploration of the process and outcomes of counselling from both client and counsellor perspectives.
Chapter 5: Method

5.1 Chapter Overview

This chapter has three main sections. Section 5.2 describes the participants and method used for recruiting participants, both clients and counsellors. Section 5.3 describes the method used to collect data for the study including description of the questionnaires used. Section 5.4 describes the procedure used for administering the questionnaires. Section 5.5 provides a summary of Chapter 5.

5.2 Participants

5.2.1 Clients

Participants were 76 individuals who contacted one of the 9 Victorian branches of a national provider of relationship counselling services and who intended to come to counselling with their partner. Callers who contacted the agency for relationship counselling were informed about the research project being conducted jointly between the agency and a Melbourne university and asked if they would be interested in receiving an information package in the mail about the project. Callers were informed their participation (or otherwise) in the project would not affect their access to the service. The information package included a brief description of the study, two pre-counselling questionnaires and two return paid envelopes for questionnaires to be returned to the researcher at the university. A copy of the information sheet given to clients can be found in Appendix A.

The mean age for males (n = 32) was 34.06 years (range 20 to 64, SD = 9.44) and the mean age for females (n = 44) was 29.98 years (range 19 to 44, SD = 5.75). Of the 76 participants who completed the pre-counselling questionnaire, 60 people came to counselling with their partner (i.e., 30 couples). Sixteen individuals responded to the questionnaire but their partner did not; of these 14 were female and 2 were male. The data file of 1 male participant was deleted from the final data set as 40% of questions were blank. This participant reported he could not complete the questionnaire as he found the questions distressing.

The marital status in the overall group (N = 76) of participants was 74% married or de facto, 5.3% separated or divorced and 20% reported they had never been married. Of the couples (N = 60) who both completed a questionnaire 44% were married, 52% were in a de facto relationship and 4% were separated or divorced.
Thirty three per cent of participants were living as a couple in a family with dependent children, 1% were living in a couple family with dependent and independent children, 4% were living in a couple family with only independent children, 9% were living an a step-family household, 31% were living in a couple relationship without children and 15% were living in the community with other non-family members. In total 44% of participants lived in a household with children.

5.2.1.1 Return Rate for Pre-Counselling Questionnaire.

One hundred information packages were prepared and mailed out to interested participants over a six-month period. Each participant was informed if he/she returned a completed questionnaire two movie vouchers would be posted to them. From these 100 packages (i.e., 200 individuals) 50 responses were received, providing a 25% response rate. Given the low return rate a further 25 packages (to 50 individuals) were prepared and mailed out. These packages informed participants that they would receive a $25 department store voucher and two movie vouchers if they completed and returned the questionnaire. A further 27 questionnaires were received providing overall a 62% response rate ($N = 77$). Participants were asked to write their name on the questionnaire so that vouchers and post counselling questionnaires could be mailed to them once counselling had been completed. Client details such as home address and the name of the counsellor they saw were obtained from the agency’s data base by the main researcher with the client’s permission. This enabled the researcher to identify the counsellor seeing each couple participating in the research project.

5.2.1.2 Return Rate for Post-Counselling Questionnaire.

Sixty two post-counselling questionnaires were mailed out to individuals who had completed pre-counselling questionnaires and who had completed counselling. Some participants who had completed pre-counselling questionnaires either did not attend the agency for counselling (i.e., did not attend for the first session) or did not write their names on the questionnaire. These participants could not be identified within the agency’s data base and therefore were not able to be contacted for post counselling questionnaires. Twenty participants completed the post counselling questionnaire. Of these 20 participants there were 8 males and 12 females and for 12 of these participants (6 couples) both partners in the relationship completed the post
counselling questionnaire. Twenty post-counselling questionnaires were received indicating a 35% response rate.

5.2.2 Counsellors

Counsellors were staff members at the counselling service clients attended. All Victorian branches of the agency were visited by the principle researcher during the client recruitment phase and staff attended an information session about the research project. Staff were informed that their participation in the research project was voluntary. Four of the 15 counsellors were male and 11 were female. The mean length of time counsellors had worked at the counselling service was 8.32 years (range 1 to 29, \(SD = 9.50\)), and 9 counsellors had less than 3 years experience working at the service. Seven counsellors had worked at the agency for 12 months or less. These counsellors were completing an internship at the agency as part of post graduate counselling, psychology or social work studies. Of the 15 counsellors, 5 reported their educational qualifications as “counsellor”, 9 as “psychologist” and 1 as “social worker”. All 15 counsellors had completed additional training and qualifications in relationship counselling either through attending the couple therapy course run by the agency and/or by completing an internship at the agency as part of post graduate studies. Four counsellors completed a questionnaire on 2 different clients providing a total of 19 counsellor responses to clients who had attended for relationship counselling.

5.2.2.1 Return Rate for Counsellor Questionnaire.

Sixty-six questionnaires were distributed to the counsellors of those clients who had completed pre-counselling questionnaires and who attended for counselling. Some counsellors completed more than one questionnaire because they had more than one client participating in the study. Fifteen different counsellors completed 19 questionnaires indicating a 29% response rate. One counsellor questionnaire was omitted from the final data set as there were 35% missing values in the counsellor’s responses.

5.3 Materials

Data were collected through written questionnaires. Questionnaires for both clients and counsellors were developed in consultation with senior agency staff and within the requirement of the agency’s Ethics Committee that completion time would
not exceed 15 minutes. Selection of published measures and style of wording and purpose of open-ended questions used in the client questionnaires were also made in consultation with senior managerial and clinical agency staff. The counsellor questionnaire was piloted on three senior clinical staff and feedback was incorporated into the final version used. Senior agency staff were enormously generous in both their time and clinical expertise in the development of all questionnaires.

5.3.1 Pre Counselling Questionnaire

The client pre-counselling questionnaire contained demographic questions such as age, gender, marital status and household makeup. Clients were asked who initiated counselling, how long problems had been present in their relationship and how long they had been thinking about seeking counselling. They were asked for their main reason for attending counselling. Participants were asked how helpful they thought counselling would be and how motivated they were and how motivated they thought their partner was to attend counselling. The 5-point Likert-type rating scale for these items ranged from 1 = “Not at all important” to 5 = “Extremely important”. A copy of the pre counselling questionnaire can be found in Appendix B

5.3.1.1 Relationship Satisfaction.

The 7-item generic measure of relationship satisfaction, the Relationship Assessment Scale (RAS; Hendrick, 1988) was used to measure relationship satisfaction pre and post counselling. Responses ranged from 1 = “Never” or “Not at all” to 5 = “Totally” or “Extremely satisfied”. Two of the items, “How often do you wish you hadn’t entered into this relationship?” and “How many problems are there in your relationship?” were reverse scored. With American couples the RAS obtained a Cronbach’s alpha of .86 (Hendrick). The RAS for this Australian sample was also $\alpha = .86$, supporting the use of the measure.

5.3.1.2 Mental Health.

The DASS 21 (Lovibond & Lovibond, 1995) is a 21 item self-report measure of depression (7 items), anxiety (7 items) and stress (7 items) that has been derived from the longer 42-item DASS. The internal consistencies for each scale of the 42-item DASS normative sample are: Depression 0.91; Anxiety 0.84; Stress 0.90 and
0.93 for the total scale (Lovibond & Lovibond, 1995). Several studies have shown the 21-item version of the DASS demonstrates adequate construct validity. In a large non-clinical sample \( N = 1,794 \) Henry and Crawford (2005) found that using the DASS 21 and doubling the scores produced very similar results to the full version of the DASS. Internal reliabilities for the DASS 21 in this study were 0.88 for Depression; 0.82 for Anxiety; 0.90 for Stress and 0.93 for the total scale (Henry & Crawford).

In a study that tested the validity of the DASS 21 as a routine clinical outcome measure Ng et al. (2007) found that the DASS 21 successfully measured the clinical status of depression, anxiety and stress states across treatment in a clinical population \( N = 786 \). Given the strength of the DASS 21 in successfully discriminating between the three states of depression, anxiety and stress both in clinical and non-clinical populations it was considered to be an acceptable measure for the current study. The DASS 21 was used to determine levels of psychological distress in people experiencing relationship difficulties prior to seeking counselling and to determine the presence of clinical changes in psychological distress following counselling.

5.3.1.3 Attachment Style.

The Relationship Styles Questionnaire (RSQ) (Griffin, & Bartholomew, 1994) was used to assess participants’ attachment styles. The RSQ contains 17 items that assess attachment to romantic partners using 4 continuously measured prototypes of attachment called Secure, Fearful-Avoidant, Dismissive-Avoidant and Preoccupied. The four category model is theoretically based on the intersection between two underlying dimensions; positivity of self and positivity of other. The Secure prototype assesses the degree to which participants have a sense of self worth and a belief that others are generally accepting and responsive to one’s needs. The Preoccupied subtype assesses the extent to which participants have a sense that the self is unworthy of care combined with a view that others are generally trustworthy and will fulfill one’s needs. The Fearful-Avoidant prototype assesses the self as unworthy of care and the other as untrustworthy and unreliable in responding to one’s needs. The Dismissive-Avoidant prototype assesses the self as worthy of care and comfort combined with a view that others are untrustworthy and unreliable.
Fraley and Shaver (1997) found the prototypes had good internal consistencies and test-retest reliabilities of .65 and above over a three week period.

The RSQ prototypes are valid measures of attachment style with moderate associations found with interview ratings of attachment (Griffin & Bartholomew, 1994). Satisfactory convergent and discriminant validity has been found. Griffin and Bartholomew (1994) found that the RSQ prototypes were not fully accounted for by the NEO Big Five factor model of personality. The authors found that none of the Big Five Scales captured the element of comfort with intimacy that relates to positive model of the other. The attachment prototypes were used to predict relationship satisfaction, emotional experience and relationship dynamics. Responses range from 1 = “Not at all like me” to 5 = “Very much like me”.

5.3.1.4 Emotional Distance Scale (EDS).

The Emotional Distance Scale (EDS) was created by the researcher from three items from the Affective Communication Scale of the MSI-R (Snyder) and two items from the Locke - Wallace Marital Adjustment Scale (1959) were expanded into a continuous scale to measure perceived levels of emotional distance from one’s partner. Responses ranged from 1 = “Strongly disagree” to 5 = “Agree strongly”. Items included “It is sometimes easier to confide in a friend than in my partner”; “My partner keeps most of his/her feelings to him/herself”; “I have important needs in our relationship that are not being met”; My partner and I need to improve the way we settle our differences”; and “There are some things my partner and I just can’t talk about”. Cronbach’s Alpha for the EDS was .76.

5.3.1.5 Attraction Scale (AS).

The Attraction Scale (AS) was created by the researcher to measure the degree of physical attraction between partners. Two categorical items from the Sexual Scale of the Marital Satisfaction Inventory - Revised (MSI-R- Snyder, 1997) and three items from the Locke - Wallace scale (1959) were expanded by the principal researcher to create a continuous scale to measure physical and sexual attraction. These items included questions such as; “Sexual intimacy is an important part of our relationship” and “My partner fits my ideal standards of physical beauty / handsomeness”. Responses ranged from 1 = “Strongly disagree” to 5 = “Agree
strongly”. Cronbach’s Alpha for the AS was .74.

5.3.2 Post Counselling Questionnaire

The post counselling client questionnaire asked participants the number of counselling sessions they attended, importance of the reasons for attending counselling, the Relationship Styles Questionnaire (RSQ), the Emotional Distance Scale (EDS), areas of counselling the participant would have liked more emphasis given to in counselling and the DASS 21. Based on results from previous research on post counselling outcomes in relationship counselling with Australian couples (Carmady et al., 2004) scales were created to measure outcomes in the current study. These scales were the Counsellor Qualities Scale (CQS), Satisfaction with the Outcome of Counselling Scale (SWOS) and Perceived Changes due to Counselling Scale (PCC). The post counselling questionnaire also included questions on the current living arrangements with their partner and qualitative questions on what was most and least helpful in counselling. A copy of the post counselling questionnaire can be found in Appendix C.

5.3.2.1 Counsellor Qualities Scale (CQS).

The CQS was a 5-item scale and included the following questions: “My counsellor handled sessions in a skilled manner”; “I felt the counsellor was helpful”; “Putting likeability and skill aside, my / our problem was handled in an effective manner”; “I felt the counsellor was fair and impartial when dealing with us”; and “I felt the counsellor was warm and empathic when dealing with us”. Cronbach’s alpha for the CQS was \( \alpha = .78 \).

5.3.2.2 Satisfaction with the Outcome of Counselling Scale (SWOS).

The SWOS was a 4–item scale that included the following questions: “Overall, how satisfied were you with the outcome of counselling?”; “Overall, how satisfied were you with the process of counselling?”; “If the need arose I would use the service again” and “I would recommend the service to others in a similar situation”. Cronbach’s alpha for the SWOS was \( \alpha = .95 \).

5.3.2.3 Perceived Changes due to Counselling Scale (PCC).

The PCC was a 4-item scale that included the following questions: “My life has improved as a result of counselling”; “My experience of counselling has
improved my ability to manage other relationship issues”; “I have personally changed as a result of counselling”; and “I learnt a lot about myself as a result of counselling”. Higher scores on the PCC indicate less perceived change. Cronbach’s alpha for the PCC was $\alpha = .91$.

### 5.3.3 Counsellor Questionnaire

Prior to the counsellor questionnaire being distributed to counsellors the couple or individual ID code used by the agency was recorded on the questionnaire. This step was taken to ensure no identifying client information was left on counsellor questionnaires. The counsellor questionnaire was piloted on five senior clinicians or management staff.

The counsellor questionnaire consisted of 14 questions including how long the counsellor had worked with the agency, educational qualifications and training in relationship counselling, theoretical frameworks used in couple work and the main theoretical framework used in couple work. Questions related to specific areas for each individual attending for counselling were asked including the importance of reasons for attending counselling, factors that contributed to the development of the therapeutic relationship, outcomes for each partner and for the couple in counselling. A copy of the counsellor questionnaire can be found in Appendix D.

### 5.4 Procedure

#### 5.4.1 Client Contact about the Research Project

People who contacted a branch of the agency for relationship counselling between 2003 and 2005 were asked if they wished to participate in a joint research project between a local university and the counselling agency. If the caller expressed an interest in the project an information package explaining the research was mailed to the caller. The information sheet enclosed in the package explained that the purpose of the study was to explore factors that contribute to clients’ experience of satisfaction with couples’ counselling and their satisfaction with the outcome of counselling. Information packages contained two copies, one for each partner, of an information sheet describing the research project, consent forms and the pre counselling questionnaire with two return paid envelopes for each partner to return his/her individual questionnaire to the researcher.
Participants were informed that their questionnaire responses would be confidential and anonymous. Individuals were asked to complete the questionnaire and not to discuss it with their partner until after the questionnaires were returned. Clients were informed that their counsellor would not know they were part of the research project unless the clients chose to disclose this in counselling themselves. Clients were informed that a second questionnaire would be sent to them after their counselling had been completed and that they may be sent a third questionnaire 12 months after counselling had finished. Clients were informed that each questionnaire would take around 10-15 minutes to complete (Appendix A). Counsellors were given questionnaires to be completed once counselling with each couple had finished. Further details about this can be found in Section 5.4.3.

5.4.2 Administration Staff Contact about the Research Project

The administration staff at each branch of the agency were visited and briefed on the research project. Administration staff are the initial point of contact for individuals ringing to enquire about services provided or who wish to make an appointment. Administration staff used their professional judgment in determining any callers where it may not have been appropriate to discuss the research project at that time. These callers included very distressed people and relationships where the presence of family violence was identified during the call. This screening out of potential participants in the project was required by the organisation as issues of family violence are prioritized and these couples are seen by more experienced clinicians. The organisation did not want any further stress placed on these couples. Given the time lag between posting the questionnaires and the time taken to complete the pre counselling questionnaire prior to the first appointment, those clients who were offered an appointment within a couple of days from the initial call were not able to be included in the project. No data were recorded by the administration staff on the number of callers who were screened out from receiving information about the research. A copy of the administration staff guidelines for the study can be found in Appendix E.

5.4.3 Counselling Staff Contact about the Research Project

The author visited the nine Victorian branches of the agency to discuss the research project with both administration and counselling staff. There are four urban
and five rural branches of the agency in Victoria. In all but one urban centre
administration staff remain the first point of contact for callers wishing to access
relationship counselling services. At the one urban centre that is the exception to this
system counselling staff manage an intake system for dealing with calls about
counselling.

Administration staff were informed about the project only if they played a
role in talking to callers about relationship counselling services. Counselling staff
were informed about the project both because they may have had clients potentially
involved in the project who may have wished to discuss the project with them and
also because counsellors were asked to complete a questionnaire about the
counselling clients had received. It was important to arouse counsellors’ interest in
the project as a condition of the agency’s participation was that counsellor
involvement was voluntary. Counsellors also were informed that while the researcher
could identify the counsellor assigned to each individual or couple that any
identifying information about counsellors would not be reported; only group data
would be reported.

Initially the principal researcher had to wait until a client case was closed
by the counsellor, sent to the administration staff and closed on the central database
before post counselling and counsellor questionnaires could be mailed out. This was
the only means of knowing that counselling had been completed. The process of
closing cases was often delayed because this was a task completed by administration
staff and was completed when there was available time. This time lag often meant a
considerable time delay (sometimes up to eight weeks) between clients finishing
counselling and receipt of the post-counselling questionnaire.

A change in the way counsellor questionnaires were administered had to be
implemented as a result of the time lag in closing cases because some counselling
staff (i.e., Interns) had left the agency and could not be contacted to complete a
counsellor questionnaire. The change that was then implemented, in consultation
with agency management, was that counsellors were given their questionnaire with
the client ID code inserted as soon as the pre-counselling questionnaire had been
received by the researcher. Counsellors were asked to complete the questionnaire
once counselling had been completed. In this way clients could be sent the post-
counselling questionnaire once the counsellor questionnaire had been completed and
returned to the researcher.

The researcher was still required to check the data base for closed cases in
order to send out post-counselling questionnaires as not all counsellors completed
and returned their questionnaires. Counsellors had to access the agency’s internal
database to match the client ID code on the questionnaire and then request retrieval
of the case file from the agency’s secure filing system where client files were stored.
Administration staff had to collect closed files from the secure filing system in order
for the counselling staff to complete their questionnaires.

5.5 Flow Chart for Participants in the Research Project

A flow chart outlining the number of participants involved in the research
project can be found in Figure 2.
Figure 2: Flow chart for participant response to research project
5.6 Summary of the Chapter

This chapter outlined the method used in recruiting both clients and counsellors for the current study as well as the method used to collect data including a description of the questionnaires used. The procedure used for administering the questionnaires was also described. The next chapter provides quantitative analyses of results from client questionnaires.
Chapter 6 Results: Quantitative Data

6.1 Chapter Overview

The following chapter describes the quantitative results from questionnaires received from clients. Seventy-six participants (30 couples and 16 individuals) completed pre counselling questionnaire and 20 clients (6 couples and 8 individuals) completed a post counselling questionnaire. In order to account for lack of independence between partners in a couple relationship the couple sample will first be analysed as a separate group ($N = 60$) followed by analyses for all participants ($N = 76$) where issues of non independence are less relevant. Sections 6.2 – 6.8 presents the preliminary data including presentation of quantitative pre-counselling data and the consideration of missing data. Section 6.9 describes how data from the post- counselling questionnaires will be analysed. Finally section 6.10 provides a summary of the quantitative findings.

6.2 Preliminary Analyses: Couple Data

6.2.1 Missing Values

Inspection of the data set showed that were no variables with greater than 5% missing values. Mean substitution of missing data was deemed appropriate for all analyses (Hair, Anderson, Tatham & Black, 1995; Tabachnick & Fidell, 2001).

6.2.2 Pre Counselling Questionnaire Responses

6.2.2.1 Responses to the Question: “In your opinion, how long have there been problems present in your relationship?”

Couples were asked how long there had been problems in their relationship; they were given a choice ranging between less than six months to more than five years. Results of frequencies of responses are presented in Table 6.1.
Table 6.1

*Frequencies for “How long have there been problems in your relationship?”*

<table>
<thead>
<tr>
<th>Response</th>
<th>Male ((n = 30))</th>
<th>Female ((n = 30))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>%</td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Less than 12 months</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>1 -2 years</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>2 -5 years</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

\(N = 60\)

Approximately one third of both men and women reported problems had been present in their relationship for two years or longer prior to seeking counselling. Twenty seven per cent of women and 20% of men reported problems had been present in their relationship for less than 12 months.

6.2.3 Reasons for Attending Counselling

In order to compare differences between men and women on the reasons couples gave for attending counselling Paired samples t-tests were performed on couple’s responses. Participants were asked to rate the importance of each 1 of 10 possible reasons for attending counselling on a 5 - point Likert type scale. Responses ranged from 1 = “Not at all important” to 5 = “Very Important”. Results are presented in Table 6.2.
Table 6.2
Descriptive Statistics and Paired Samples T-test Results for the Importance of Reasons for Attending Counselling

<table>
<thead>
<tr>
<th>Reason</th>
<th>Male</th>
<th>Female</th>
<th>df (29)</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve relationship</td>
<td>4.80 0.61</td>
<td>4.80 0.48</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Improve communication</td>
<td>4.67 0.55</td>
<td>4.70 0.53</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Resolve conflict</td>
<td>4.57 0.68</td>
<td>4.67 0.84</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Decide future of relationship</td>
<td>4.24 1.16</td>
<td>4.00 1.26</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Balance between work/family</td>
<td>3.47 1.48</td>
<td>3.53 1.38</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Discuss intimacy/sexuality</td>
<td>3.40 1.16</td>
<td>3.30 1.29</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Parenting/step parenting issues</td>
<td>2.49 1.61</td>
<td>2.83 1.39</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Influence of family background</td>
<td>2.37 1.61</td>
<td>3.10 1.40</td>
<td>2.71**</td>
<td></td>
</tr>
<tr>
<td>Discuss impact of affair</td>
<td>1.83 1.46</td>
<td>2.20 1.63</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Discuss how to separate</td>
<td>1.40 0.86</td>
<td>2.00 1.17</td>
<td>2.38*</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05; ** p < .01, N = 30 Couples

Results showed that there was a significant difference between men and women on 2 of the 10 reasons “To discuss how to separate” and “To discuss the influence of family background on my relationship”, with women reporting these issues were more important for them to discuss in counselling significantly more than their male partners.

For 4 of the 10 possible reasons for attending counselling the mean response for men and women was over 4, indicating that these reasons were very important.
issues to be discussed in counselling. They were: “To improve the relationship”; “To decide about the future of the relationship”; “How to communicate more effectively with your partner”; and “How to resolve conflict”.

6.2.4 Attachment Style Analyses

There were two methods used in analyses for attachment style, these were a categorical method where total scores for each of the four attachment items, Secure, Fearful, Dismissive and Preoccupied were calculated, as well as the Dimensional Model which calculated a score for positive view of the self and positive view of the other for each person. Scores on the Dimensional Model ranged between -2.70 – 4.15 for the Positive Self Model; and between -3.35 – 4 for the Positive Other Model. A more detailed description of calculation of these two methods can be found in Sections 4.3.3.1 to 4.3.3.3 in Chapter 4.

To examine multicollinearity between the study variables Pearson product moment correlations were calculated with scale scores for the four attachment categories for male and female partners separately in each couple. Correlations were calculated for each gender to account for lack of independence between partners in a relationship. These results are presented in Tables 6.3 and 6.4. A third and fourth correlation table was then calculated using the Positive Self and Positive Other attachment models (Griffin & Bartholomew, 1994) for male and female partners. The results are presented in Tables 6.5 and 6.6.
Table 6.3
Correlations between DASS 21 Subscales, RAS, EDS, AS & RSQ Scores Prior to Counselling for Male Partners

<table>
<thead>
<tr>
<th>Subscale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td></td>
<td>.67**</td>
<td>.70**</td>
<td>.91**</td>
<td>-.41*</td>
<td>.52**</td>
<td>-.24</td>
<td>-.56**</td>
<td>.38*</td>
<td>.33</td>
<td>.28</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td></td>
<td></td>
<td>.68**</td>
<td>.86**</td>
<td>-.25</td>
<td>.25</td>
<td>-.02</td>
<td>-.63**</td>
<td>.51**</td>
<td>.28</td>
<td>.06</td>
</tr>
<tr>
<td>3. Stress</td>
<td></td>
<td></td>
<td></td>
<td>.89**</td>
<td>-.15</td>
<td>.28</td>
<td>-.00</td>
<td>-.55**</td>
<td>.39*</td>
<td>.22</td>
<td>.34</td>
</tr>
<tr>
<td>4. Total DASS 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.32</td>
<td>.41*</td>
<td>-.11</td>
<td>-.65**</td>
<td>.48**</td>
<td>.32</td>
<td>.26</td>
</tr>
<tr>
<td>5. RAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.64**</td>
<td>.61**</td>
<td>.45*</td>
<td>-.26</td>
<td>-.33</td>
<td>-.06</td>
</tr>
<tr>
<td>6. EDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.44*</td>
<td>-.40*</td>
<td>.19</td>
<td>.32</td>
<td>-.01</td>
</tr>
<tr>
<td>7. AS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.22</td>
<td>-.23</td>
<td>.26</td>
<td>-.18</td>
</tr>
<tr>
<td>8. RSQ – Secure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.52**</td>
<td>-.12</td>
<td>-.01</td>
</tr>
<tr>
<td>9. RSQ - Fearful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.63**</td>
<td>.25</td>
</tr>
<tr>
<td>10. RSQ - Dismissive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.11</td>
</tr>
<tr>
<td>11. RSQ - Preoccupied</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01; n = 30
Table 6.4

Correlations between DASS 21 Subscales, RAS, EDS, AS & RSQ Scores Prior to Counselling for Female Partners

<table>
<thead>
<tr>
<th>Subscale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td></td>
<td>.80**</td>
<td>.76**</td>
<td>.95**</td>
<td>-.27</td>
<td>.16</td>
<td>-.24</td>
<td>-.20</td>
<td>.19</td>
<td>.37*</td>
<td>.37*</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td></td>
<td>.58**</td>
<td>.90**</td>
<td>-.11</td>
<td>.15</td>
<td>-.16</td>
<td>-.26</td>
<td>.08</td>
<td>.25</td>
<td>.50**</td>
<td></td>
</tr>
<tr>
<td>3. Stress</td>
<td></td>
<td>.90**</td>
<td>-.11</td>
<td>.05</td>
<td>-.03</td>
<td>-.02</td>
<td>.22</td>
<td>.37*</td>
<td>.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total DASS 21</td>
<td></td>
<td>-.19</td>
<td>.08</td>
<td>-.15</td>
<td>-.14</td>
<td>.19</td>
<td>.37*</td>
<td>.36*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. RAS</td>
<td></td>
<td>-.71**</td>
<td>.80**</td>
<td>.01</td>
<td>-.07</td>
<td>-.01</td>
<td>-.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. EDS</td>
<td></td>
<td>-.59**</td>
<td>-.07</td>
<td>.03</td>
<td>.03</td>
<td>.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. AS</td>
<td></td>
<td>.06</td>
<td>-.06</td>
<td>.09</td>
<td>.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. RSQ – Secure</td>
<td></td>
<td>.05</td>
<td>-.11</td>
<td>-.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. RSQ - Fearful</td>
<td></td>
<td></td>
<td>.57**</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. RSQ - Dismissive</td>
<td></td>
<td></td>
<td></td>
<td>-.11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. RSQ - Preoccupied</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01; n = 30
6.2.4.1 Correlations between Relationship Satisfaction and Other Study Variables for Male Partners.

Results from the Pearson product moment correlations in Table 6.3 for male partners showed moderate to high correlations ranging from $r = .38$ to $r = .91$ between the variables. There was a low but significant correlation between the Relationship Satisfaction Scale (RAS) and the depression subscale of the DASS 21 ($r = -.41, p < .05$) indicating that higher levels of mood disturbance were related to lower levels of relationship satisfaction. There was a moderate correlation between reported levels of relationship satisfaction and emotional distance prior to counselling ($r = -.64, p < .01$) indicating that the less satisfied men were with their relationship the more emotional distance they reported from their partner. There was a moderate correlation between the RAS and the Secure attachment style scale score ($r = .45, p < .05$) indicating that higher levels of relationship satisfaction were correlated with higher scores on the Secure attachment style. There was a moderate correlation between the RAS and the Attraction Scale ($r = .61, p < .01$) indicating the more satisfied male participants were with their relationship the more likely they were to report being physically attracted to their partner.

6.2.4.2 Correlations between Subscales of the DASS 21 for Male Partners.

As expected correlations between the 3 subscales of the DASS 21 were moderate to high ranging from $r = .68$ (Anxiety – Stress); $r = .67$ (Depression – Anxiety); and $r = .70$ (Depression – Stress) and all 3 subscales correlated highly with the overall DASS 21 ($r = .86 - .95$). Given that 30% of clients in the current study came to counselling with clinically severe levels of depression, anxiety and stress it was decided to proceed with the analyses, with appropriate caution, despite the fact that high means on all three subscales reduced the spread of scores.

6.2.4.3 Correlations between Attachment Subscales for Male Partners.

The Secure attachment scale of the RSQ showed a moderate significant negative correlation with the Fearful subscale; $r = -.52, p < .01$. There was a moderate positive correlation between the Fearful and Dismissive subscales; $r = .63, p < .01$. 
6.2.4.4 Correlations between the DASS 21 and Attachment (RSQ) for Male Partners.

There was a moderate significant negative correlation between the DASS 21 and the Secure attachment style scale scores ($r = -.65$, $p < .01$) and low to moderate significant correlations with the Fearful insecure attachment styles, ($r = .48$, $p < .01$). These results appear to support a link between positive levels of relationship satisfaction, secure attachment and greater levels of emotional well-being.

6.2.4.5 Correlations between Relationship Satisfaction and Other Study Variables for Female Partners.

Results from the Pearson product moment correlations in Table 6.4 for female partners showed moderate to high correlations ranging from $r = .37$ to $r = .95$ between the variables. There was a moderate correlation between the Relationship Satisfaction Scale (RAS) and the Emotional Distance Scale ($r = -.71$, $p < .01$) and the Attraction Scale ($r = .80$, $p < .01$) indicating that lower levels of emotional distance and higher levels of attraction were related to higher levels of relationship satisfaction.

6.2.4.6 Correlations between Subscales of the DASS 21 for Female Partners.

As expected correlations between the three subscales of the DASS 21 were moderate to high ranging from $r = .58$ (Anxiety – Stress); $r = .80$ (Depression – Anxiety); and $r = .76$ (Depression – Stress). Given that 30% of clients in the current study came to counselling with clinically severe levels of depression, anxiety and stress it was decided to proceed with the analyses, with appropriate caution, as the high means on all three subscales reduced the spread of scores.

Previous research has found positive correlations between the subscales ranging from $r = .60$ (Depression – Stress); $r = .50$ (Depression – Anxiety); and $r = .75$ (Stress – Anxiety); with a psychiatric sample ($N = 439$) from a mood disorders program (Clara et al., 2001). In a large non-clinical sample ($N = 717$) the correlations between the subscales ranged from $r = .42$, (Depression – Anxiety); $r = .46$, (Anxiety – Stress); and $r = .39$, (Depression – Stress); (Lovibond & Lovibond, 1995). Results from the current study for both male and female partners show correlations between the subscales are more similar to those from clinical studies (Clara et al.) than non-clinical studies (Lovibond & Lovibond) indicating high levels of distress on all three...
subcales and moderate to high correlations between subscales of the DASS 21.

6.2.4.7 Correlations between Attachment Subscales and Depression for Female Partners.

The Dismissive scale of the RSQ showed a low to moderate correlation with the Depression, $r = -0.37, p < .05$; Stress, $r = 0.37, p < .05$; and the Fearful scale $r = 0.57, p < .01$. The Preoccupied scale of the RSQ showed a low to moderate correlation with Depression, $r = 0.37, p < .05$; Anxiety, $r = 0.50, p < .01$; and the total DASS 21, $r = 0.36, p < .05$.

6.2.4.8 Comparison between Male and Female Correlations for Attachment Subscales (RSQ) and Other Study Variables.

There was a significant moderate correlation between depression and relationship satisfaction for men but not for women. There was also a significant correlation between depression and emotional distance for men but not for women. For men, the secure subscale of the RSQ was significantly correlated with all subscales of the DASS 21 and the total DASS 21 and with relationship satisfaction and emotional distance; this was not found for women. There was also a significant correlation between the anxiety subscale of the DASS 21 and the Fearful attachment style for men but not for women. For women there was a significant correlation between the Preoccupied attachment style and the depression and anxiety subscales and the total DASS 21; this correlation was not significant for men.

6.2.4.9 Correlations between “Positive Self” and “Positive Other” Dimensional Attachment Categories with Other Study Variables for Male Partners.

The results are for men are presented in Table 6.5 and for women in Table 6.6.
Table 6.5

**Correlations between DASS 21 Subscales, RAS, EDS, AS and the Positive Self/Positive Other Model for Attachment Prior to Counselling for Male Partners**

<table>
<thead>
<tr>
<th>Subscale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td></td>
<td></td>
<td>.67**</td>
<td>.70**</td>
<td>.89**</td>
<td>-.41**</td>
<td>-.52**</td>
<td>-.24</td>
<td>-.40**</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td></td>
<td></td>
<td></td>
<td>.68**</td>
<td>.87**</td>
<td>-.25</td>
<td>.25</td>
<td>-.02</td>
<td>-.46**</td>
</tr>
<tr>
<td>3. Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.89**</td>
<td>-.15</td>
<td>.28</td>
<td>-.00</td>
<td>-.49**</td>
</tr>
<tr>
<td>4. Total DASS 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.32</td>
<td>.41*</td>
<td>-.11</td>
<td>-.50**</td>
</tr>
<tr>
<td>5. RAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.64**</td>
</tr>
<tr>
<td>6. EDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.44**</td>
</tr>
<tr>
<td>7. AS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Positive Self Model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Positive Other Model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01; n = 30
Table 6.6

*Correlations between DASS 21 Subscales, RAS, EDS, AS and the Positive Self/Positive Other Model for Attachment Prior to Counselling for Female Partners*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Depression</td>
<td></td>
<td>.80**</td>
<td>.76**</td>
<td>.95**</td>
<td>-.27</td>
<td>.16</td>
<td>-.24</td>
<td>-.24</td>
<td>-.10</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td></td>
<td></td>
<td>.58**</td>
<td>.86**</td>
<td>-.11</td>
<td>.15</td>
<td>-.16</td>
<td>-.35</td>
<td>.05</td>
</tr>
<tr>
<td>3. Stress</td>
<td></td>
<td></td>
<td></td>
<td>.90**</td>
<td>-.11</td>
<td>.05</td>
<td>-.03</td>
<td>-.04</td>
<td>-.17</td>
</tr>
<tr>
<td>4. Total DASS 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.19</td>
<td>.08</td>
<td>-.15</td>
<td>-.21</td>
<td>-.10</td>
</tr>
<tr>
<td>5. RAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.71**</td>
<td>.80**</td>
<td>-.02</td>
<td>.08</td>
</tr>
<tr>
<td>6. EDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.59**</td>
<td>-.20</td>
<td>.08</td>
</tr>
<tr>
<td>7. AS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.04</td>
<td>-.01</td>
</tr>
<tr>
<td>8. Positive Self Model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.31</td>
</tr>
<tr>
<td>9. Positive Other Model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05, **p < .01; n = 30
Results presented in Table 6.5 showed there were moderate correlations between the *positive self* model of attachment with all 3 subscales of the DASS 21; depression ($r = -.40, p < .01$); anxiety ($r = -.46, p < .01$) and stress ($r = -.49, p < .01$) and with the total DASS 21 ($r = -.50, p < .01$). There were moderate correlations between the *positive other* model of attachment with all three subscales of the DASS 21; depression ($r = -.45, p < .01$); anxiety ($r = -.57, p < .01$) and stress ($r = -.38, p < .05$) and with the total DASS 21 ($r = -.52, p < .01$). No other significant differences were found between the dimensional attachment categories and the other study variables.

### 6.2.4.10 Correlations between “Positive Self” and “Positive Other” Dimensional Attachment Categories with Other Study Variables for Female Partners.

As shown in Table 6.6 there were no significant correlations on the *positive self* or *positive other* models of attachment for female partners.

### 6.2.4.11 Comparison Between Male and Female Correlations for “Positive Self” and “Positive Other” Model and Other Study Variables.

For men, there were significant correlations between the *positive self* model with all three subscales and the total DASS 21; these correlations were not significant for women. For men, there were significant negative correlations between the *positive other* model with all three subscales and the total DASS 21 and with the Emotional Distance scale; these correlations were not significant for women.

### 6.3 Research Hypothesis and Questions

#### 6.3.1 Hypothesis 1

**6.3.1.1 Gender Differences in the Initiation of Counselling**

In order to test the first part of Research Question 1 that women would be more likely to initiate counselling than men, Chi Square analyses were performed. Scores ranged from 1 = “I did”; 2 = “Mostly me”; 3 = “Mutual decision; 4 = Mostly my partner” to 5 = “My Partner”. Preliminary analyses showed that no female participant reported that her partner initiated counselling. Therefore in order to ensure no violation of the assumptions of Chi-square tests the categories “Mostly my partner” and “My partner” were collapsed into one category. Results are shown in Table 6.6.
Table 6.7

Chi-Square Analyses Examining Gender Differences on the Item: “Who first initiated counselling?”

<table>
<thead>
<tr>
<th>Response</th>
<th>Male (n = 30)</th>
<th>Female (n = 30)</th>
<th>$\chi^2$ (df = 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>“I did”</td>
<td>2</td>
<td>7%</td>
<td>13</td>
</tr>
<tr>
<td>“Mostly Me”</td>
<td>3</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>“Mutual Decision”</td>
<td>5</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>“Mostly My Partner/My Partner”</td>
<td>20</td>
<td>66</td>
<td>1</td>
</tr>
</tbody>
</table>

***p<.001; N = 60

Significant gender differences were found for initiation of counselling with both men and women stating that women initiated counselling more frequently than men. Only one female respondent stated that her male partner initiated counselling; however 7% of men stated that they believed they had initiated counselling. Inspection of the couple data showed that of the 30 couples who intended coming to counselling together there was agreement between partners on who initiated counselling in 22 couples and disagreement between 8 couples.

6.3.1.2 Relationship Satisfaction and Emotional Distance Prior to Counselling.

In order to test the second part of Hypothesis 1 that women would report significantly lower levels of relationship satisfaction and attraction towards their partner and higher levels of emotional distance from their partner prior to attending for counselling descriptive statistics and Paired samples t-tests for the Relationship
Satisfaction Scale (RAS: Hendrick, 1984); the Emotional Distance Scale (EDS); the Attraction Scale variables were performed. Results are presented in Table 6.8.

Table 6.8

*Descriptive Statistics and Paired Samples T-tests for the RAS, AS and EDS Pre-Counselling Study Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Relationship Assessment Scale</td>
<td>3.49</td>
<td>0.60</td>
</tr>
<tr>
<td>Emotional Distance Scale</td>
<td>3.44</td>
<td>0.89</td>
</tr>
<tr>
<td>Attraction Scale</td>
<td>4.09</td>
<td>0.65</td>
</tr>
</tbody>
</table>

*df(29) t

* p < .05, ** p < .01, *** p < .001; N = 30 couples

Results showed a significant difference between partners on their scores for relationship satisfaction, emotional distance and attraction prior to attending for counselling with female partners reporting lower levels of relationship satisfaction, more emotional distance and lower levels of attraction towards their partner than did their male partners. These results support the second part of Hypothesis 1.

Higher scores on the RAS indicate higher levels of relationship satisfaction. Hendrick (1986) found that the mean score on the RAS for “together” couples (i.e., couples still together in their relationship) was 4.34 and for “apart” couples (i.e., couples who had separated) was 3.33 on a 5 point Likert scale. The combined mean scores for men and women on the RAS was 3.21; more similar to Hendrick’s reported mean score for “apart” couples than to her reported mean score for “together” couples. Thus the current study participants came to counselling with mean levels of relationship distress similar to Hendrick’s mean score for “apart” (or separated) couples.

These results suggest a trend for this sample where women were less satisfied with their relationship and reported significantly higher levels of emotional distance from their partners than men reported prior to attending for counselling.
Women also report lower levels of physical and sexual attraction towards their partner than do men and indicate they want to discuss separation in counselling significantly more than men.

6.4 Research Question 1

6.4.1 Levels of Depression in People Attending for Relationship Counselling

In order to explore the first research question “Do people who attend for relationship counselling have higher levels of depression than is found in the general population?” participants’ scores were coded into five categories of normal, mild, moderate, severe and extremely severe for each of the three subscales. The DASS 21 provides a template for plotting percentiles and Z scores to define the clinical relevance of the subscale scores (Lovibond & Lovibond, 1995) in the therapeutic setting. All 76 participants in the current study were used for these analyses as the clinical relevance applies to all participants. Results are shown in Table 6.9.

Table 6.9
Percentages of the Total Sample in Five Clinical Categories on the DASS 21 Subscales

<table>
<thead>
<tr>
<th>DASS Subscale</th>
<th>Normal</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extremely Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>32 (42)</td>
<td>10 (13)</td>
<td>12 (16)</td>
<td>4 (5)</td>
<td>18 (24)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>50 (66)</td>
<td>5 (6)</td>
<td>7 (9)</td>
<td>3 (4)</td>
<td>11 (15)</td>
</tr>
<tr>
<td>Stress</td>
<td>26 (34)</td>
<td>7 (9)</td>
<td>21 (27)</td>
<td>11 (15)</td>
<td>11 (15)</td>
</tr>
</tbody>
</table>

| N = 76 |

Table 6.9 shows that 45% of the total group of participants reported clinically significant levels of depression in the moderate to extremely severe range, 26% reported clinically significant levels for anxiety and 57% reported clinically significant levels for stress prior to their first session. Thus almost half of the participants had clinically significant levels of mood disturbance for depression and more than half of the participants had clinically significant levels of mood.
disturbance for stress prior to attending for relationship counselling. These results show higher levels of depression in these people attending for relationship counselling than is found in the general population.

In order to determine gender differences between the depression, anxiety and stress subscales and the total DASS 21 paired samples t-tests were performed. Results are presented in Table 6.10.

Table 6.10
*Descriptive Statistics and Paired Samples T-tests for the DASS 21 subscales and Total DASS 21 Pre-Counselling Study Variables*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>DASS 21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>7.30</td>
<td>5.46</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3.37</td>
<td>4.13</td>
</tr>
<tr>
<td>Stress</td>
<td>9.23</td>
<td>4.21</td>
</tr>
<tr>
<td>Total DASS 21</td>
<td>19.90</td>
<td>12.27</td>
</tr>
</tbody>
</table>

*N = 30 couples*

Paired sample t-test analyses showed that men and women did not differ significantly on any of the three subscales of Depression, Anxiety, and Stress or on the total DASS 21 prior to attending for counselling.

6.5 Attachment Style Analyses

6.5.1 Cluster Analysis of Attachment Scale Scores

Cluster analysis is a classification analysis which groups cases together according to proximities and differences in scores across multiple variables (Hair, Anderson, Tatham, & Black, 1998). Resulting clusters should therefore exhibit high internal (within – cluster) homogeneity and high external (between – clusters) heterogeneity. The non-hierarchical method was utilised for the current data as this method specifies the numbers of clusters in order to find the best fit for the data (Hair
et al.). It is argued that four attachment patterns best describes adult attachment patterns (Griffin & Bartholomew, 1994; Feeney, 1996). Four clusters were selected for the current analyses as four attachment categories are expected theoretically and reported empirically in previous research. After six iterations no further combination of groupings were achieved. All 76 participants’ scores were used to calculate the cluster groupings. Results should be interpreted with caution due to the small sample size. The four final cluster centres produced four clear groupings; results are presented in Table 6.11.

Table 6.11  
Descriptive Statistics on Cluster Analysis of Attachment Scale Scores

<table>
<thead>
<tr>
<th>Cluster Group</th>
<th>Male (n = 32)</th>
<th>Female (n = 44)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (%)</td>
<td>M (%)</td>
</tr>
<tr>
<td>Dismissing</td>
<td>2.52 (31)</td>
<td>2.42 (25)</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>2.79 (9)</td>
<td>2.54 (30)</td>
</tr>
<tr>
<td>Secure</td>
<td>3.40 (41)</td>
<td>3.27 (27)</td>
</tr>
<tr>
<td>Fearful</td>
<td>1.68 (19)</td>
<td>1.96 (18)</td>
</tr>
</tbody>
</table>

N = 76

Descriptive statistics from the cluster analysis showed that 41% of men and 27% of women were in the Secure group. The percentages for men and women were similar for both the Dismissing and Fearful groups but 30% of women and only 9% of men were in the Preoccupied group. Post hoc chi – square analyses did not show any significant gender differences within attachment styles; \( \chi^2 (3) = 4.85, p = .18 \).

6.6 Research Question 2

In order to explore the second research question “Do people who attend for relationship counselling have higher levels of insecure attachment than is found in the general population?” descriptive analyses were performed on the cluster groupings for couples who completed pre counselling questionnaires (N = 60). Insecure attachment categories are the Dismissive, Preoccupied and Fearful groups. These results are presented in Table 6.12 and are compared with the results from
Feeney’s 2002 study on 193 non–clinical married Australian couples.

Table 6.12

*Descriptive Analyses on Attachment Categories Comparing Clinical and Non–Clinical Australian Couples*

<table>
<thead>
<tr>
<th>Attachment</th>
<th>Non-Clinical Couples (Feeney, ( N = 386 ))</th>
<th>Current Study Couples (( N = 60 ))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>54</td>
<td>30</td>
</tr>
<tr>
<td>Dismissive</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>Fearful</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>14</td>
<td>15</td>
</tr>
</tbody>
</table>

Results show there were less securely attached couples in the current study than found in Feeney’s non–clinical sample. In the current clinical study 67% of the entire sample and 70% of couples in this clinical population were insecurely attached.

6.6.1 *Attachment Pairings between Partners*

Inspection of the data on was conducted in order to determine the different types of attachment pairings between partners in these couple relationships. Results are presented in Table 6.13.
Table 6.13

Frequencies for Attachment Pairings between Partners in Couple Relationships Attending for Counselling

<table>
<thead>
<tr>
<th>Attachment Type</th>
<th>Total (N = 30 couples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure/Secure</td>
<td>4</td>
</tr>
<tr>
<td>Secure/Dismissing</td>
<td>6</td>
</tr>
<tr>
<td>Secure/Preoccupied</td>
<td>3</td>
</tr>
<tr>
<td>Secure/Fearful</td>
<td>1</td>
</tr>
<tr>
<td>Dismissing/Dismissing</td>
<td>3</td>
</tr>
<tr>
<td>Dismissing/Preoccupied</td>
<td>5</td>
</tr>
<tr>
<td>Dismissing/Fearful</td>
<td>2</td>
</tr>
<tr>
<td>Preoccupied/Preoccupied</td>
<td>2</td>
</tr>
<tr>
<td>Preoccupied/Fearful</td>
<td>2</td>
</tr>
<tr>
<td>Fearful/Fearful</td>
<td>2</td>
</tr>
</tbody>
</table>

As shown in Table 6.13, of the Secure/Insecure attachment pairings the most frequently reported pairing was the Secure/Dismissing type and the most frequently reported Insecure/Insecure pairing was the Dismissing/Preoccupied type.

6.6.2 Four Category – Two Dimensional Model of Attachment

Following Griffin and Bartholomew’s model (1994) for measuring attachment as a dimensional construct that gives each person a score on the dimensions: positive or negative view of the self and positive and negative view of the other; two variables were created reflecting these constructs. The positive view of the self model includes: (secure plus dismissing scores) minus (fearful plus preoccupied scores). The positive view of the other model includes: (secure plus preoccupied scores) minus (dismissing plus fearful scores).

In order to examine gender differences on these variables in the couples who came to counselling together paired samples t-tests were performed. Results are presented in Table 6.14.
Table 6.14

Descriptive Statistics and Paired T-test Results on the Positive Self – Positive Other Model for Attachment Prior to Counselling for Couples

<table>
<thead>
<tr>
<th>Scale</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Self Model</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Positive Other Model</td>
<td>M</td>
<td>SD</td>
</tr>
</tbody>
</table>

Results from paired sample t-tests showed a significant gender difference between men and women on the positive self model with men viewing themselves more positively than women prior to attending for counselling. No significant gender difference was found for the positive other model.

6.7 Research Question 3

6.7.1 Relationship between Attachment Style and Mood Disorders

In order to explore the third research question: “Do people attending for relationship counselling and classified as insecurely attached (i.e., classified as dismissing, fearful or preoccupied) report higher levels of relationship dissatisfaction and higher levels of mood disturbance than people who are securely attached?” a multivariate analysis of variance (MANOVA) was performed to determine whether scores on the DASS 21 subscales of depression, anxiety and stress differed according to attachment style categories as defined by cluster analysis. All 76 participants’ scores were used to calculate attachment style as defined by cluster analysis and these scores were used in this analysis. Results from a multivariate analysis of variance (MANOVA) comparing attachment style with the DASS 21 subscales and the total DASS 21 including post hoc Bonferroni tests are presented in...
Table 6.15.

Results shown in Table 6.15 indicated a significant main effect between attachment style and the subscales of the DASS 21. However, Levene’s test of equality of variances was significant for the DASS 21 anxiety subscale indicating a violation of the assumption of equality of variances. Levene’s test of equality of variances for the other DASS 21 subscales, and the total DASS 21, were not significant. Therefore, it was decided to proceed with the analyses but they should be interpreted with caution. Results showed a significant main group effect on all three subscales and the total DASS 21. Post hoc Bonferroni tests showed significant differences on the following subscales: for Depression, between the Fearful group and the Secure and Dismissing groups; for Anxiety, between the Fearful group and the Secure and Dismissing groups; for Stress, between the Fearful and Secure group; and for the total DASS 21, between the Fearful group and the Secure and Dismissing groups. There was a significant difference in mean scores between each of the three subscales and the total DASS 21 and the Fearful attachment category.
Table 6.15
*Multivariate Analysis of Variance for Attachment and Mood Disorder*

<table>
<thead>
<tr>
<th>DASS 21</th>
<th>Secure (n = 25)</th>
<th>Fearful (n = 14)</th>
<th>Dismissive (n = 21)</th>
<th>Preoccupied (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Between and Within Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>4.72a</td>
<td>4.11</td>
<td>12.21ab</td>
<td>5.56</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.80a</td>
<td>2.63</td>
<td>8.07ab</td>
<td>5.53</td>
</tr>
<tr>
<td>Stress</td>
<td>7.80a</td>
<td>3.62</td>
<td>12.93b</td>
<td>4.87</td>
</tr>
<tr>
<td>Total DASS 21</td>
<td>14.32a</td>
<td>8.98</td>
<td>33.21ab</td>
<td>13.67</td>
</tr>
</tbody>
</table>

*N = 76; Means in any row with different superscript are significantly different, p < .05 (Bonferroni post hoc tests)*
6.8 Research Question 4

In order to address the fourth research question that aimed to develop an illustrative model of the predictors of relationship satisfaction multiple hierarchical regression analyses were performed separately for men and women based on significant correlations between the variables as shown in Tables 6.3 to 6.6. Separate analyses were performed because male and female scores were not independent. Given this was an exploratory study with a small sample the model is considered to be illustrative only and would need to be tested on a larger sample. Variables were ordered in the regression analyses dependent on their level of significance to relationship satisfaction (as measured by the RAS). Results are presented in Table 6.16 – Table 6.20.

Table 6.16

Summary of the Hierarchical Multiple Regression Analyses on Emotional Distance and Attraction Scale Variables Predicting Relationship Satisfaction (RAS) for Male Partners (n = 30)

<table>
<thead>
<tr>
<th></th>
<th>RAS</th>
<th>β</th>
<th>SE β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDS</td>
<td></td>
<td>-0.43</td>
<td>-0.64</td>
<td>4.37</td>
<td>.000</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td>0.38</td>
<td>0.41</td>
<td>2.79</td>
<td>.01</td>
</tr>
</tbody>
</table>

Note: $R^2 = .41$; $\Delta R^2 = .38$, for Step 1; $R^2 = .54$; $\Delta R^2 = .50$, for Step 2

EDS = Emotional Distance Scale
AS = Attraction Scale

Results from Table 6.16 show that the significant predictors of relationship satisfaction for men were emotional distance and attraction towards one’s partner. Table 6.17 shows results from hierarchical multiple regression analyses for men to determine if depression and the Secure attachment style were predictors of relationship satisfaction.
Table 6.17

Summary of the Hierarchical Multiple Regression Analyses for Secure Attachment and Depression Variables Predicting Relationship Satisfaction (RAS) for Male Partners (n = 30)

<table>
<thead>
<tr>
<th>RAS</th>
<th>β</th>
<th>SE β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure Attachment</td>
<td>0.41</td>
<td>0.45</td>
<td>2.64</td>
<td>.01</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>-0.03</td>
<td>-0.23</td>
<td>1.13</td>
<td>ns</td>
</tr>
</tbody>
</table>

Note: $R^2 = .20; \Delta R^2 = .17$, for Step 1; $R^2 = .24; \Delta R^2 = .18$, for Step 2

As shown in Table 6.17 the only significant predictor of relationship satisfaction for men was the Secure attachment style. Depression was significantly correlated with relationship satisfaction suggesting that this variable was related to relationship satisfaction.

Another hierarchical regression analyses was performed for men to determine the predictors of depression. Results are presented in Table 6.18.

Table 6.18

Summary of the Hierarchical Multiple Regression Analyses for Emotional Distance and Attachment Variables Predicting Level of Depression for Male Partners (n = 30)

<table>
<thead>
<tr>
<th>Depression</th>
<th>β</th>
<th>SE β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDS (Emotional Distance)</td>
<td>2.18</td>
<td>0.35</td>
<td>3.21</td>
<td>.003</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure</td>
<td>-2.93</td>
<td>-0.35</td>
<td>1.89</td>
<td>.07</td>
</tr>
<tr>
<td>Fearful</td>
<td>0.85</td>
<td>0.13</td>
<td>0.19</td>
<td>ns</td>
</tr>
</tbody>
</table>

Note: $R^2 = .27; \Delta R^2 = -.24$, for Step 1; $R^2 = .43; \Delta R^2 = .36$, for Step 2
The only significant predictor of depression for men was emotional distance. Secure attachment failed to reach significance at the .05 level as a predictor of depression. The Fearful attachment style was not a significant predictor but was a mediating factor in depression.

6.8.1 Predictors of Relationship Satisfaction for Women

A series of hierarchical multiple regression analyses was performed for women to determine if the Emotional Distance Scale, the Attraction Scale and the depression and stress subscales were predictors of relationship satisfaction and to determine if the Dismissive and Preoccupied attachment styles were predictors of depression for women. Results for the predictors of relationship satisfaction are presented in Table 6.19. Results for the predictors of depression are presented in Table 6.20.

Table 6.19

Summary of the Hierarchical Multiple Regression Analyses on Emotional Distance, Attraction Scale and DASS 21 Variables Predicting Relationship Satisfaction (RAS) for Female Partners (n = 30)

<table>
<thead>
<tr>
<th>RAS</th>
<th>β</th>
<th>SE β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDS</td>
<td>-0.61</td>
<td>-0.71</td>
<td>5.32</td>
<td>.000</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AS</td>
<td>0.45</td>
<td>0.58</td>
<td>4.67</td>
<td>.000</td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>0.01</td>
<td>0.04</td>
<td>0.25</td>
<td>ns</td>
</tr>
<tr>
<td>Stress</td>
<td>-0.12</td>
<td>-0.15</td>
<td>0.92</td>
<td>ns</td>
</tr>
</tbody>
</table>

Note: R² = .50; ΔR² = .49, for Step 1; R² = .73, ΔR² = .70, for Step 2, R² = .74; ΔR² = .70 for Step 3.

EDS = Emotional Distance Scale
AS = Attraction Scale
Results from Table 6.19 showed that the significant predictors of relationship satisfaction for women were emotional distance and the level of attraction felt towards her partner. The DASS 21 subscales depression and stress were not significant but were mediating variables in predicting relationship satisfaction for women.

Results from the hierarchical multiple regression analyses to determine if the Preoccupied and Dismissive attachment styles were significant predictors of depression for women are presented in Table 6.20.

Table 6.20
*Summary of the Multiple Regression Analyses for Dismissive and Preoccupied Attachment Styles Predicting Depression for Female Partners (n = 30)*

<table>
<thead>
<tr>
<th></th>
<th>β</th>
<th>SE β</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismissive</td>
<td>-2.97</td>
<td>-0.41</td>
<td>2.56</td>
<td>.02</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>2.58</td>
<td>1.00</td>
<td>2.59</td>
<td>.02</td>
</tr>
</tbody>
</table>

Note: $R^2 = .31; \Delta R^2 = .26$

Results from the multiple regression analyses showed that both the Dismissive and Preoccupied attachment styles were significant predictors of depression for women.

An illustrative model for relationships among the variables predicting relationship satisfaction for men and women is shown in Figure 3.
Figure 3  Illustrative model predicting relationship satisfaction for men (n = 30) and women (n = 30)

*p < .05, **p < .01, ***p < .001;  = men;  = women
6.8.2 Illustrative Model for Men

Results from the illustrative model for men presented in Figure 3 showed that the higher levels of attraction and lower levels of emotional distance men felt towards their partner the more satisfied they reported they were with their relationship. For men the secure attachment style was significantly correlated with relationship satisfaction and emotional distance was also a significant predictor of depression.

6.8.3 Illustrative Model for Women

Results from the illustrative model for women presented in Figure 3 showed that lower levels of emotional distance and higher levels of attraction women felt towards their partner the more satisfied they reported they were with their relationship. The Dismissive attachment style was negatively related to depression and the Preoccupied attachment style was positively related to depression.

6.9 Comparison between Pre and Post Counselling Responses

Given that the overall number of participants who responded to the post – counselling questionnaires was small (N = 20) and of these 20 participants 12 were in couple relationships it was decided to analyse post counselling outcomes using case study analysis. These results are presented in Chapter 7.

6.10 Summary of the Chapter

This chapter provided quantitative analyses on pre counselling questionnaires completed by clients who attended for relationship counselling. Results will be discussed in Chapter 9. The following chapter will explore results from the counsellor questionnaires including some comparative analyses on responses from clients and counsellors on process and outcomes in couple counselling.
Chapter 7: Case Studies

7.1 Introduction and Chapter Overview

This chapter will provide a case study analysis of the six couples who attended couple counselling together and who both completed pre and post counselling questionnaires. Of these six couples counsellor questionnaires were completed on three couples. Comparative qualitative analyses will be conducted on this data to explore in more detail some of the themes found in the quantitative analyses in preceding chapters, including relationship satisfaction, mood disorder, attachment style both pre and post counselling as well as satisfaction with the outcome of counselling. Pseudonyms have been given to both clients and counsellors to protect confidentiality. Sections 7.3 to 7.5 provide case study analysis of the three couples with pre and post counselling data only. Sections 7.6 to 7.8 will provide case study analysis of the remaining three couples and their counsellors who all completed questionnaires on the counselling experience. Section 7.9 will provide an overview of the chapter.

7.1.1 Research Question 6

In order to explore the sixth research question on changes following counselling a case study analysis was used.

7.2 Description of Measures Used in Case Studies

Measures used in the case study analyses included the Relationship Assessment Scale (RAS), the Emotional Distance Scale (EDS), the Attraction Scale (AS) and the DASS 21. Descriptive statistics for the RAS, EDS and AS can be found in Table 6.8 and in Table 6.10 for the DASS 21. Three other scales were developed for post counselling analyses; these are outlined in the following section.

7.2.1 Descriptive Analyses on Counsellor Qualities Scale (CQS), Satisfaction with the Outcome of Counselling (SWOS) and Perceived Changes Scale (PCS).

Based on results from previous research on post counselling outcomes in relationship counselling with Australian couples (Carmady et al., 2004) scales were created to measure outcomes for couples in the current study. Scores on the CQS, SWOS and the PCC ranged from 1 = “Strongly disagree” to 5 = “Strongly agree”. Descriptive analyses for the CCQ, SWOS and the PCC are presented in Table 7.1.
Table 7.1

Descriptive Statistics for the CQS, the SWOS and the PCC Post Counselling

<table>
<thead>
<tr>
<th>Variable</th>
<th>Gender</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n = 6)</td>
<td>Female (n = 6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>CQS</td>
<td>4.15</td>
<td>0.55</td>
<td>4.18</td>
</tr>
<tr>
<td>SWOS</td>
<td>3.47</td>
<td>0.91</td>
<td>3.71</td>
</tr>
<tr>
<td>PCC</td>
<td>3.03</td>
<td>1.10</td>
<td>2.77</td>
</tr>
</tbody>
</table>

7.3 Case Study 1

John, a 29 year old man, and Mary, a 25 year old woman, attended counselling for one session only. John stated that his main reason for attending counselling was to “discuss how to communicate more effectively with my partner” and issues to do with the separation of Mary’s parents. Mary stated her main reason for attending was to “learn how to resolve conflict well and sooner”. Pre and post scores on the main variables for John and Mary are presented in Table 7.2.
Table 7.2

Mean Scores on Main Study Variables Pre and Post Counselling for John and Mary

<table>
<thead>
<tr>
<th>Variable</th>
<th>John Pre</th>
<th>John Post</th>
<th>Mary Pre</th>
<th>Mary Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Assessment Scale</td>
<td>4.57</td>
<td>4.71</td>
<td>4.43</td>
<td>4.43</td>
</tr>
<tr>
<td>Emotional Distance Scale</td>
<td>3.20</td>
<td>2.20</td>
<td>2.40</td>
<td>3.20</td>
</tr>
<tr>
<td>Attraction Scale</td>
<td>4.60</td>
<td>4.00</td>
<td>4.80</td>
<td>4.60</td>
</tr>
<tr>
<td>DASS 21 Depression</td>
<td>0.98</td>
<td>0.00</td>
<td>2.03</td>
<td>4.97</td>
</tr>
<tr>
<td>DASS 21 Anxiety</td>
<td>0.00</td>
<td>0.00</td>
<td>0.98</td>
<td>0.00</td>
</tr>
<tr>
<td>DASS 21 Stress</td>
<td>4.97</td>
<td>3.99</td>
<td>7.00</td>
<td>7.00</td>
</tr>
</tbody>
</table>

Attachment Style (RSQ) Secure Secure

The profile of results from pre and post counselling scores for John and Mary reveal a couple who are both very satisfied with their relationship as measured by the RAS. They both reported low levels of emotional distance from the other and high levels of attraction towards each other. Their scores on each of the three subscales of the DASS 21 both pre and post counselling are all in the normal range indicating an absence of mood disturbance. Mary’s depression and stress scores were higher post counselling but she commented on her questionnaire “I have been feeling more flat recently because I am unhappy with my job which has some impact on my feelings at home.” Both partners showed a secure attachment style as measured by the RSQ.

7.3.1 Descriptive Analyses of Counsellor Qualities Scale, Satisfaction with the Outcome of Counselling and Perceived Changes Scale for John and Mary

7.3.1.1 Counsellor Qualities Scale (CCQ).

As described in Section 5.3.2 three scales were created to measure outcomes in the current study based on previous relationship counselling research (Carmady et al., 2004). John’s mean score on the CCQ was 4.40 and Mary’s was 4.20. The mean
score for the entire sample was 4.15 for men and 4.18 for women indicating that both John and Mary rated their counsellor very highly. Both partners said they “Strongly agreed” with their counsellor’s fairness and impartiality in dealing with them. However, John disagreed slightly with the statement, “The counsellor communicated to us clearly the changes we needed to make to improve our relationship”.

7.3.1.2 Satisfaction with the Outcomes of Counselling Scale (SWOS).

John’s mean score for the SWOS was 3.50 and Mary’s was 4.25; the mean score for men in the entire group were 3.47 and for women it was 3.71 indicating that Mary rated her satisfaction with the outcome of counselling more highly than John and more highly than for women overall as a group. Both John and Mary reported high levels of satisfaction with the counselling they received.

7.3.1.3 Perceived Changes due to Counselling Scale (PCC).

John’s mean score on the PCC was 2.75 and Mary’s was 2.50; the mean score for men as a group was 3.03 and for women it was 2.77 (higher scores on the PCC indicate lower levels of perceived change). These scores indicate that both John and Mary believed they had made considerable personal changes as a result of the one session they attended. It seemed that their counsellor’s ability to identify John and Mary’s needs being more suitably addressed by the PREPARE program was helpful for them. (PREPARE is a pre marriage series of three sessions helping couples to identify strengths in their relationship and potential problem areas).

7.3.2 Responses to the question: “What did you find most helpful about counselling?”

John commented: “The relaxed atmosphere and willingness of the counsellor to carefully listen to everything we had to say and provides a helpful guide going forward”. Mary commented: “An action plan of how to prevent conflict and resolve (it)”.

7.3.3 Responses to the question: “What did you find least helpful about counselling?”

John commented: “How unstructured the session was where I wasn’t too sure where things were going so it was little tough at times to know how much to say”. Mary commented: ‘Not much ground covered in session, moved at a slow pace”.
7.3.4 Responses to the question: “Are there any other comments you’d like to make?”

Mary commented: “We will be taking the “PREPARE” marriage counselling 3 x 1 hour sessions.”

7.3.5 Case Study Overview

While John and Mary attended counselling for only one session they both appeared to want to improve their communication with each other, especially in the area of conflict resolution. Given that Mary’s parents had recently separated it seems understandable that resolving conflict was an important issue for her to discuss in counselling.

7.4 Case Study 2

Brian is a 30 year old man and with his partner Jill, a 26 year old woman, attended counselling for 10 sessions. Brian commented that his main reason for attending counselling was to improve his relationship with Jill; Jill commented that the main reason for her was to discuss family issues that were causing conflict between them. Pre and post counselling scores on the main variables are presented in Table 7.3.

Table 7.3

Mean Scores on Main Study Variables Pre and Post Counselling for Brian and Jill

<table>
<thead>
<tr>
<th>Variable</th>
<th>Brian Pre</th>
<th>Brian Post</th>
<th>Jill Pre</th>
<th>Jill Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Assessment Scale</td>
<td>3.57</td>
<td>3.14</td>
<td>2.57</td>
<td>3.29</td>
</tr>
<tr>
<td>Emotional Distance Scale</td>
<td>3.80</td>
<td>4.00</td>
<td>3.80</td>
<td>3.40</td>
</tr>
<tr>
<td>Attraction Scale</td>
<td>3.40</td>
<td>2.80</td>
<td>3.80</td>
<td>2.60</td>
</tr>
<tr>
<td>DASS 21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>6.02</td>
<td>0.00</td>
<td>3.99</td>
<td>7.00</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>2.03</td>
</tr>
<tr>
<td>Stress</td>
<td>10.01</td>
<td>3.01</td>
<td>4.97</td>
<td>3.99</td>
</tr>
<tr>
<td>Attachment Style (RSQ)</td>
<td>Secure</td>
<td>Dismissive</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The profile of results from pre and post counselling scores for Brian and Jill indicate a couple who are still experiencing significant relationship dissatisfaction, despite the fact that Jill’s mean score was higher post counselling. Both partners’ scores were in the “apart” range based on Hendrick’s research (1988) suggesting that their relationship satisfaction scores indicated they were a couple who were likely to separate rather than a couple who would remain together. Both partners reported high levels of emotional distance from each other and also reported lower levels of attraction towards each other post counselling. Brian’s scores on the DASS 21 improved post counselling indicating less mood disturbance than pre counselling. Jill’s scores on the depression and stress subscales increased following counselling but both were still in the normal range (depression - normal range 0 – 9; stress - normal range 0 - 10).

Brian has a Secure attachment style whereas Jill’s style is Dismissive. Based on research from the Tavistock Institute (Clulow, 2001) this pattern with one insecure partner suggests that the relationship fares reasonably well if it is the man with the Secure attachment style and less well if it is the woman with the Secure attachment style.

### 7.4.1 Descriptive Analyses on Counsellor Qualities Scale, Satisfaction with the Outcome of Counselling and Perceived Changes Scale

#### 7.4.1.1 Counsellor Qualities Scale (CCQ)

The mean score response for Brian on the CCQ was 3.40 and for Jill it was 3.60 indicating that both rated their counsellor on qualities of warmth, empathy, impartiality and fairness above the mid range score of 2.50 but below the mean average for either men (4.15) or women (4.18) as a group. Given the level of relationship distress and emotional distance from each other reported by both partners even once counselling had been completed it may be that they were disappointed that their counsellor did not improve their relationship more and this may have affected how they viewed their counsellor.

#### 7.4.1.2 Satisfaction with the Outcomes of Counselling Scale (SWOS)

Brian’s mean score response for the SWOS was 2.00 and Jill’s was 2.25. These scores are below the group mean score of 3.47 for men and 3.71 for women and indicate their dissatisfaction with the outcome of counselling which was
confirmed by comments they both made on their questionnaires. Brian and Jill both responded “Strongly disagree” to the question, “If the need arose would you use the service again?” Brian responded “Not at all satisfied” and Jill “A little satisfied” to the question, “Overall how satisfied are you with the outcome of counselling?”

7.4.1.3 Perceived Changes due to Counselling Scale (PCC).

Brian’s mean score on the PCC was 5.00 and Jill’s was 4.75; these scores were higher than the mean scores for men (3.03) and for women (2.77) indicating they both believed they made few, if any, personal changes as a result of counselling. However, Brian commented on his questionnaire, “I feel hopeful about the future” which may be a reflection of his Secure attachment style and therefore an experience of a healthy attachment in relationships and a belief that relationships will work.

7.4.2 Responses to the question: “What did you find most helpful about counselling?”

Brian commented, “Some things were brought to light” and Jill commented, “The chance to talk without being interrupted”.

7.4.3 Response to the question: “What did you find least helpful about counselling?”

Brian commented, “Not enough time given on things, not much advice offered.” (Jill did not comment on this question)

7.4.4 Response to the question: “Are there any other comments you’d like to make?”

Brian commented, “Unfortunately I think it was a waste of time and money ‘cause (sic) we could have worked things out ourselves as we are now.” (Jill did not comment on this question)

7.4.5 Case Study Overview

Brian and Jill completed 10 counselling sessions but were still reporting moderate levels of relationship dissatisfaction post counselling. Brian in particular seemed dissatisfied with the time and money spent on counselling and both partners reported feeling emotionally distant from the other even once counselling had been completed. Despite Brian’s dissatisfaction with the process and outcome of counselling his comment that they were now able to work things out for themselves suggests that counselling provided them with increased skills to enable them to do this.
7.5 Case Study 3

Joan, a 31 year old woman and her partner Peter, 30 years, attended counselling for 12 sessions. Both reported the main reasons for seeking counselling were: To improve the relationship; To discuss how to communicate more effectively with each other; and To learn how to resolve conflict. Peter commented the main reason for him was, “To avoid arguments, alternative solutions and conflict resolution”. Joan commented the main reason for her was they were “Fighting all the bloody time”. Joan commented that “He was abused (as a child) and not able to come to terms with his abuse by a cousin (past) – lots of anger”. Pre and post mean scores on the main study variables are presented in Table 7.4.

Table 7.4
Mean Scores on Main Study Variables Pre and Post Counselling for Peter and Joan

<table>
<thead>
<tr>
<th>Variable</th>
<th>Peter</th>
<th>Joan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Relationship Assessment Scale</td>
<td>3.71</td>
<td>3.43</td>
</tr>
<tr>
<td>Emotional Distance Scale</td>
<td>3.60</td>
<td>3.20</td>
</tr>
<tr>
<td>Attraction Scale</td>
<td>4.40</td>
<td>4.80</td>
</tr>
<tr>
<td>DASS 21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>14.00</td>
<td>6.02</td>
</tr>
<tr>
<td>Anxiety</td>
<td>11.97</td>
<td>14.98</td>
</tr>
<tr>
<td>Stress</td>
<td>14.98</td>
<td>13.02</td>
</tr>
<tr>
<td>Attachment Style (RSQ)</td>
<td>Fearful/Preoccupied</td>
<td>Dismissive</td>
</tr>
</tbody>
</table>

The profile of results from pre and post counselling mean scores for Joan and Peter indicate lower levels of relationship satisfaction once counselling had been completed; scores for both partners were in Hendrick’s (1988) “apart” range suggesting this relationship was still in significant trouble and at risk of separation. Both partners reported moderate to high levels of emotional distance from the other,
especially Joan; yet both still reported high levels of attraction towards the other despite being dissatisfied in the relationship. Peter reported a level of depression in the clinically moderate range (13 -20) prior to attending for counselling and mild levels of stress (14 – 18). Peter’s anxiety levels were higher post counselling; in the severe range (14.50 – 19) suggesting that counselling raised some difficult issues for him causing him to feel more anxious. All three subscales of the DASS 21 for Joan were in the normal range.

The attachment styles of this couple are both insecure suggesting problems with intimacy and closeness. Based on Joan’s report, Peter’s past unresolved childhood sexual abuse was a significant factor in his inability to manage his anger and their constant fighting. However, her Dismissive attachment style may also mean that she ignores his distress and is emotionally unavailable which may increase his preoccupation with her and their relationship.

7.5.1 Descriptive Analyses on Counsellor Qualities Scale, Satisfaction with the Outcome of Counselling and Perceived Changes due to Counselling Scale

7.5.1.1 Counsellor Qualities Scale (CCQ).

The mean score response for Peter on the CCQ was 3.60 and for Joan was 3.60. While these scores are lower than the mean scores for men (4.15) and women (4.18) they indicate reasonable agreement on counsellor qualities of warmth, empathy and fairness.

7.5.1.2 Satisfaction with the Outcomes of Counselling Scale (SWOS).

Peter’s mean score on the SWOS was 2.50 and Joan’s was 2.25 indicating dissatisfaction with the outcome of counselling. Both Peter and Joan commented that they disagreed with the statement, “I felt the counsellor addressed the problems we came to counselling about” and they did not feel their problems were handled effectively by the counsellor.

7.5.1.3 Perceived Changes due to Counselling Scale (PCC).

The mean score for Peter on the PCC was 4.00 and for Joan it was 2.75. These scores indicate that Peter did not believe he made any personal changes as a result of counselling whereas Joan’s score indicated that she did make some personal changes. Given the complexity of the issues facing this couple including past childhood and drug addiction perhaps the issues that were important for them
individually were not teased out in the sessions. When asked about the importance of issues discussed in counselling Joan responded “Extremely important” to the issues “To discuss personal issues, e.g., depression/past abuse” and “Drug/alcohol issues” whereas Peter commented that discussing personal issues was “Slightly important” for him and commented that drug/alcohol issues was “Somewhat important” for him to discuss in counselling. Peter commented on his questionnaire he was a pot smoker “I feel I need to relax”. They may have both finished counselling feeling that the real problems in their relationship were still unaddressed.

7.5.2 Responses to the question: “What did you find most helpful about counselling?”

Peter commented, “Working on issues with a mediator stops me raising my voice and my partner crying” and Joan commented, “Active listening; having a mediator; letting my partner finish what he was saying; learning more about my partner’s feelings, past and values”.

7.5.3 Response to the question: “What did you find least helpful about counselling?”

Peter commented, “Not much structure to the session, my partner and the counsellor talked too much”. Joan commented, “The counsellor didn’t concentrate on one issue at a time so I felt things weren’t really resolved or gone into at a deeper level”.

7.5.4 Response to the question: “Are there any other comments you’d like to make?”

Peter commented, “Clear changes we need to make were not communicated. Some problems not addressed, we still have many issues”. Joan commented, “Having a list of issues and dealing with each one at a time in one session, each would have been an idea. Working on why pride and ego issues are a problem would have been productive – no extraordinary results. Thanks”.

7.5.5 Case Study Overview

Joan and Peter completed 12 counselling sessions, however given the complexity of issues in their relationship including past unresolved childhood sexual abuse, drug addiction and volatile arguments it would appear that longer term couples therapy would be required in order to bring about more significant changes in their relationship. Both stated they were not living together either before or after counselling; this may be their way of maintaining emotional distance in the
relationship in a way that feels more manageable. Both have insecure attachment styles and based on the previous research into couples with insecure attachment styles (Clulow, 2001) the future of their relationship together may always be fraught with unresolved conflict from past interpersonal relationships.

7.6 Case Study 4

Jason, a 30 year old man attended counselling with his partner Anna, a 33 year old woman for 3 sessions. The main reason Jason gave for attending counselling was “lack of trust, communication breakdown” and Anna said her main reason was “I was pregnant and discovered my husband was sneaking around. I wanted him to be honest about what he had been up to so I could decide whether to stay in the marriage or not”. Pre and post mean scores on the main study variables are presented in Table 7.5.

Table 7.5

<table>
<thead>
<tr>
<th>Variable</th>
<th>Jason</th>
<th>Anna</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Relationship Assessment Scale</td>
<td>2.86</td>
<td>3.86</td>
</tr>
<tr>
<td>Emotional Distance Scale</td>
<td>4.20</td>
<td>3.00</td>
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<tr>
<td>Attraction Scale</td>
<td>4.40</td>
<td>4.80</td>
</tr>
<tr>
<td>DASS 21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>16.03</td>
<td>2.03</td>
</tr>
<tr>
<td>Anxiety</td>
<td>11.97</td>
<td>3.01</td>
</tr>
<tr>
<td>Stress</td>
<td>13.02</td>
<td>2.03</td>
</tr>
</tbody>
</table>

The profile of results from pre and post counselling mean scores for Jason and Anna reveal two people very dissatisfied with their relationship prior to counselling; their respective levels of relationship satisfaction had increased after
counselling, particularly for Jason. Both reported high levels of emotional distance from each other both before and after counselling yet still rated their attraction for the other quite highly despite the low levels of relationship satisfaction.

Both Jason and Anna were moderately depressed prior to seeking counselling and Jason was also moderately anxious prior to attending for counselling whereas Anna was mildly anxious and moderately stressed following counselling, suggesting that counselling had increased her concerns about the relationship. All other scores were in the normal range. Both partners have a Dismissive attachment style and while this is an insecure attachment style if both partners are Dismissive their relationship may still function reasonably well because they probably both use a similar defensive reaction to deal with difficult issues (Clulow, 2001).

**7.6.1 Descriptive Analyses on Counsellor Qualities Scale, Satisfaction with the Outcome of Counselling and Perceived Changes due to Counselling Scale**

**7.6.1.1 Counsellor Qualities Scale (CCQ).**

The mean score for Jason on the CCQ was 4.00 and for Anna it was 4.40 indicating they both rated the empathy, skill, impartiality and fairness of their counsellor quite highly. Their scores are similar to the overall scores found for men (4.15) and women (4.18).

**7.6.1.2 Satisfaction with the Outcomes of Counselling Scale (SWOS).**

Jason’s mean score on the SWOS was 3.75 while Anna’s was 3.50; these scores indicate reasonable satisfaction with the outcome of counselling. The mean score for the overall group of male participants was 3.47 and for women it was 3.71. Anna said she would have liked more emphasis in counselling on the issues: To decide about the future of our relationship; Intimacy/sexuality; Discuss the impact of an affair and How to communicate more effectively with my partner. Jason said he would have liked more emphasis in counselling on the issue: “How to communicate more effectively with my partner”.

**7.6.1.3 Perceived Changes due to Counselling Scale (PCC).**

Jason’s mean score on the PCC was 3.50 and for Anna it was 3.75 indicating for both of them minimal personal changes as a result of counselling. Jason commented “Not true at all” for the questions: “My experience of counselling has improved my ability to manage other relationship issues” and “I have personally
changed as a result of counselling”. Anna however commented that counselling had improved her ability to continue working on the issues discussed in counselling indicating that counselling had given her some new skills in dealing with interpersonal issues.

7.6.2 Responses to the question: “What did you find most helpful about counselling?”

Jason commented, “The openness” and Anna commented, “Hearing my husband open up about his own hurt I had caused”.

7.6.3 Response to the question: “What did you find least helpful about counselling?”

Anna said, “I still don’t know if my husband is telling the truth. His relationship with someone else wasn’t discussed enough”.

7.6.4 Response to the question: “Are there any other comments you’d like to make?”

Neither made a comment on this question.

7.6.5 Counsellor’s Comments

The counsellor commented that this couple came in crisis, “My response to their situation as an urgent situation may have helped build good contact quite quickly”. She also said, “Counselling carried out over a very limited time frame due to imminent birth of the couple’s baby, could have done more valuable and necessary work – given that trust issues were strongly involved”. The counsellor’s responses to questions about the couple’s motivation in counselling and commitment to make changes in the relationship indicated in her opinion a strong willingness by both partners to engage in the process and to make changes in their relationship.

7.6.6 Case Study Overview

It appears Jason and Anna attended relationship counselling because of unresolved issues about a possible affair and the imminent birth of their first child. This seemed to be an issue they were unable to deal with by themselves. Anna commented on how helpful it was for her to hear Jason talk about his hurt feelings. The ability to take the position of “the other” in a relationship is an essential component in a mature and healthy adult relationship and one that is based on the capacity for empathy. Given the fact that both partners have a Dismissive attachment style it has probably been more likely that the feelings of their partner have been dismissed in the past as unimportant. Hopefully a few counselling sessions may have
assisted in the process of understanding their partner’s point of view, this seems especially crucial given they are about to begin the journey together as parents.

7.7 Case Study 4

Dale, a 30 year old man and his partner Sally, a 29 year old woman attended counselling for 5 sessions. Dale’s main reason for seeking counselling was, “Planning to start a family so wanted a tune-up” and Sally commented, “Deciding to have children and wanting to discuss the way that may change us – problems around that”. Pre and post mean scores on the main study variables are presented in Table 7.6.

Table 7.6

<table>
<thead>
<tr>
<th>Variable</th>
<th>Dale</th>
<th>Sally</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Relationship Assessment Scale</td>
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<td>4.29</td>
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<td>Emotional Distance Scale</td>
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<td>1.40</td>
</tr>
<tr>
<td>Attraction Scale</td>
<td>5.00</td>
<td>5.00</td>
</tr>
<tr>
<td>DASS 21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>3.01</td>
<td>0.00</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.00</td>
<td>2.03</td>
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<tr>
<td>Stress</td>
<td>10.01</td>
<td>0.00</td>
</tr>
<tr>
<td>Attachment Style (RSQ)</td>
<td>Secure</td>
<td>Preoccupied</td>
</tr>
</tbody>
</table>

The profile of results for pre and post counselling scores for Dale and Sally indicate high levels of relationship satisfaction for both partners pre and post counselling. They both reported low levels of emotional distance from each other and high levels of attraction to their partner; these results reveal a strong relationship with mutual feelings of commitment to the relationship. Scores on the three subscales of the DASS 21 were in the normal range for both Dale and Sally even prior to
attending for counselling and yet were lower following counselling. This suggests that counselling had an impact in particular on their stress levels.

7.7.1 Descriptive Analyses on Counsellor Qualities Scale, Satisfaction with the Outcome of Counselling and Perceived Changes Scale

7.7.1.1 Counsellor Qualities Scale (CCQ).

The mean score for Dale on the CCQ was 5.00 and for Sally it was 4.20. These scores mean high levels of satisfaction reported by both partners on their counsellor’s qualities of warmth, empathy fairness and impartiality. The counsellor also commented that she made a connection with the couple as they were very open.

7.7.1.2 Satisfaction with the Outcomes of Counselling Scale (SWOS).

Dale’s mean score on the SWOS was 4.00 and Sally’s was also 4.00. These scores indicate high levels of satisfaction with the outcome of counselling for both partners. Dale did not comment on any issue as requiring more emphasis in counselling but Sally commented that the issues of parenting, communication and resolution of conflict could have received more emphasis from her perspective.

7.7.1.3 Perceived Changes due to Counselling Scale (PCC).

Dale and Sally’s mean score on the PCC was 2.75 indicating some meaningful personal changes as a result of counselling. Dale commented he felt he had personally changed as a result of counselling and both felt that counselling had improved their ability to continue working on the issues they discussed in counselling. Both commented they felt their lives had improved as a result of counselling.

7.7.2 Responses to the question: “What did you find most helpful about counselling?”

Sally commented, “The chance to sit and talk in a quiet space about problems. I liked the counsellor’s reflective manner and tendency to look for underlying meaning in things”. Dale did not make any comment.

7.7.3 Response to the question: “What did you find least helpful about counselling?”

Sally commented, “Could have been more directive - structured problem solving”. Dale did not make any comment.

7.7.4 Response to the question: “Are there any other comments you’d like to make?”

Neither partner commented on this question.
7.7.5 Counsellor’s Comments

The counsellor commented that she felt the factors that helped develop a positive therapeutic relationship with the couple were the couple’s ability to easily articulate their concerns, particularly Sally, and supervision. She also said there was a strong attachment within the couple relationship which made it easier to work with them.

7.7.6 Case Study Overview

The initial reason for Dale and Sally in seeking counselling was to work through their decision to start a family and to discuss any potential problems around this decision. Their high levels of relationship satisfaction both prior to and after counselling appear to indicate a strong connected relationship and their decision to seek counselling regardless suggests a capacity to identify possible problems areas in their relationship and to be proactive about addressing issues before they become possible areas of conflict. Dale’s attachment style is Secure and Sally’s preoccupied suggesting he might be a stable influence in the relationship, reassuring any concerns Sally may have about how things between them are progressing.

7.8 Case Study 6

James a 39 year old man attended counselling with his 34 year old partner Sophie for 15 sessions. James said the main reason he attended counselling was to “Improve communication between my wife and myself” and Sophie said her main reason was “I needed help to re-engage in my relationship and to believe that my relationship would have made me happy and was not a mediocre solution”. Pre and post mean scores on the main study variables are presented in Table 7.7
Table 7.7

Mean Scores on Main Study Variables Pre and Post Counselling for James and Sophie

<table>
<thead>
<tr>
<th>Variable</th>
<th>James Pre</th>
<th>James Post</th>
<th>Sophie Pre</th>
<th>Sophie Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Assessment Scale</td>
<td>2.71</td>
<td>2.71</td>
<td>2.29</td>
<td>3.00</td>
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<td>Emotional Distance Scale</td>
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<tr>
<td>DASS 21</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>11.97</td>
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<td>3.99</td>
<td>0.00</td>
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<td>Anxiety</td>
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<td>0.00</td>
<td>3.99</td>
<td>0.98</td>
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<tr>
<td>Stress</td>
<td>4.97</td>
<td>3.99</td>
<td>10.99</td>
<td>4.97</td>
</tr>
</tbody>
</table>

Attachment Style (RSQ) Dismissive Secure

The profile of results for pre and post counselling scores for James and Sophie reveal a couple with low levels of relationship satisfaction, high levels of emotional distance from each other and low levels of attraction to their partner, particularly for Sophie prior to attending for counselling. From these scores it appears that James feels more positively about the relationship than does Sophie even once counselling had been completed.

Prior to attending for counselling James was mildly depressed and Sophie was mildly anxious. Both these scores were in the normal range once counselling had been completed and all other scores, while in the normal range prior to counselling, decreased post counselling indicating an increase in positive mood.

7.8.1 Descriptive Analyses on Counsellor Qualities Scale, Satisfaction with the Outcome of Counselling and Perceived Changes Scale

7.8.1.1 Counsellor Qualities Scale (CCQ).

James’s mean score on the CCQ was 4.00 and Sophie’s was 5.00 indicating a very positive assessment of their counsellor’s qualities of empathy, warmth, fairness
and impartiality.

7.8.1.2 Satisfaction with the Outcomes of Counselling Scale (SWOS).

James’s mean score on the SWOS was 3.00 and Sophie’s was 4.50. These scores mean that James was less satisfied with the outcome of counselling than Sophie; in fact Sophie was extremely satisfied with the outcome.

7.8.1.3 Perceived Changes due to Counselling Scale (PCC).

James’s mean score on the PCC was 3.00 and Sophie’s was 2.75; these scores were consistent with the mean scores overall for the male participants (3.03) and the female participants (2.77). These scores indicate that both partners perceived they made substantial personal gains from having attended counselling as lower scores indicate higher perceived levels of personal change.

7.8.2 Responses to the question: "What did you find most helpful about counselling?"

James commented “It provided a way of seeing my partner’s point of view better. Sophie commented “Having someone that was listening to me and helped me make my partner listen to me; effective communication”. These comments support this couple’s satisfaction with counselling, having the experience of being heard and understanding their partner’s point of view.

7.8.3 Response to the question: "What did you find least helpful about counselling?"

James commented “Too much time allowed to air circumstances around a problem and not leaving enough time to address them or explore them”. Sophie commented “Sometimes (often) I found that 60 minute sessions was not enough which made me feel we were receiving somewhat “fragmented” counselling”.

7.8.4 Response to the question: "Are there any other comments you’d like to make?"

James commented “Although I was expecting greater results from 15 sessions I don’t want to underpin the importance of the progress that was made – which would have been unattainable without counselling”.

7.8.5 Counsellor’s Comments

While the counsellor did not make any qualitative comments on the questionnaire her assessment of this couple was of two people willing to make changes in their relationship and who were motivated to attend counselling. However, the counsellor did not feel that Sophie was committed to the relationship
continuing whereas she felt that James was committed. Given that Sophie’s attachment style was Secure and James’s style Dismissive (insecure) this difference in commitment may have been a reflection of their different experiences and expectations within close relationships.

7.8.6 Case Study Overview

Post counselling relationship satisfaction scores for James and Sophie suggest a relationship that is still experiencing difficulties and is in Hendrick’s (1988) “apart” range meaning that their profile is more similar to a separated couple than a couple who were likely to remain together. It seems Sophie’s comments about needing to find out if her relationship with James was not a “mediocre solution” expresses doubts about the future of the relationship from her perspective. James appeared to express more positive feelings about the state of their relationship once counselling had been completed; perhaps he carries the hope for both of them.

7.9 Summary of the Chapter

This chapter explored six case studies of couples who both completed pre and post counselling questionnaires and who attended counselling together. For three of these couples their counsellor also completed a questionnaire on outcomes in the counselling process. Results from all six couples showed a mixed pattern but overall relationship satisfaction increased, emotional distance decreased and attraction to one’s partner increased following counselling. Overall levels of depression, anxiety and stress decreased following counselling but on some measures there was a difference between partner’s scores with one partner showing an increase in relationship satisfaction and the other showing a decrease. Of the six couples only one couple had a secure / secure attachment style. This couple had attended counselling for pre marriage education. The other five couples had a secure / insecure \((n=2)\) match or an insecure / insecure match \((n=3)\). Overall these six couples rated their counsellor highly on the qualities of empathy, warmth, impartiality and fairness even if these same couples reported low levels of satisfaction with the outcome of counselling. It appears that clients were able to differentiate between questions on counsellor qualities and the outcome of counselling. The next chapter will discuss findings from the counsellor questionnaires.
Chapter 8 Results: Counsellor Responses

8.1 Chapter Overview

The following chapter describes responses from the 15 counsellors who completed questionnaires on outcomes in counselling for participants in the current study. Counsellor questionnaires were completed on 18 couples and 1 female client who attended counselling alone. Section 8.2 reports on the educational qualifications and therapeutic approach used by the counsellors in relationship counselling. Section 8.3 reports on counsellor responses to their rating of the importance of reasons for attending counselling for each individual or couple. This section of the counsellor questionnaire matched the client questionnaire on reasons for attending counselling. Section 8.4 provides data on counsellor self-assessment of their therapeutic work with clients including the counsellors’ comments on the factors they believed lead to the development of the therapeutic relationship. Section 8.5 reports on counsellor assessment of therapeutic outcomes. Section 8.6 addresses research question 6, comparing client and counsellor assessment of therapeutic outcomes. Section 8.7 provides a summary of Chapter 8.

8.2 Counsellor Demographics

8.2.1 Length of Experience Working in the Agency

Fifteen different counsellors responded to the counsellor questionnaire; they completed 19 counsellor questionnaires in total as 4 counsellors completed a questionnaire on more than one client/couple. Counsellors were asked how long they had worked at the agency. Responses ranged from 1 year to 29 years, $M (SD) = 9.00$ (10.00). Eight counsellors had been working at the agency for one year or less. These counsellors were interns at the agency; they were completing one year of clinical work and receiving both individual and group supervision during this time from experienced clinicians in the agency. The remaining 11 counsellors had 3 or more years experience in relationship counselling.

8.2.2 Training, Qualifications and Theoretical Frameworks

Counsellors were given a range of options for their educational qualifications including counsellor, psychologist, social worker, family therapist or “other”. Responses are presented in Table 8.1.
Table 8.1

*Counsellor Responses to Educational Qualifications and Training*

<table>
<thead>
<tr>
<th>Profession</th>
<th>Male (n = 2)</th>
<th>Female (n = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellor</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Psychologist</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Social Worker</td>
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</table>

<table>
<thead>
<tr>
<th>Training</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency’s Specialist Couples Course</td>
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<td>6</td>
</tr>
<tr>
<td>Internship</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Post Graduate Couple Course</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

While four women stated that their training included a post graduate couple’s course a clinical placement at a counselling agency was a post graduate university coursework requirement. Therefore, the clinical placement was similar to the internship offered to participants who had attended the agency’s specialist couples course.

Counsellors were asked how often they used a range of therapeutic frameworks in their work with couples. Responses ranged from 1 = “Not at all” to 5 = “Most of the time”. From these 5-point scales 3 categories were created with responses “Not at all” and “A little” collapsed into the first category and “A lot of the time” and “Most of the time” collapsed into the third category. Responses marked as “Somewhat” formed the second category. Responses are reported in Table 8.2.
Table 8.2  
*Responses to How Often Therapeutic Frameworks Were Used by Counsellors*

<table>
<thead>
<tr>
<th>Framework</th>
<th>Not at all/ A little</th>
<th>Somewhat</th>
<th>Most of the time/ A lot of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Therapy</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Narrative Therapy</td>
<td>8</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>CBT</td>
<td>9</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Emotion Focused</td>
<td>7</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Insight Oriented</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Feminist Approach</td>
<td>10</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Gestalt Therapy</td>
<td>7</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Eclectic</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 8.2 shows that the most frequently reported frameworks were psychodynamic and eclectic approaches. The most frequently reported approach was “eclectic” which probably reflects the approach taught in most specialist training courses in couple’s therapy where exposure to a range of theoretical approaches is typically provided.

### 8.3 Counsellor Responses to Issues Discussed in Counselling

Counsellors were asked to report on the importance of issues discussed in counselling for each partner in the relationship. All 19 counsellor responses were used for these analyses as they relate to 19 different clients. Responses were rated on a 5 point Likert type scale with scores ranging from 1 = Extremely important to 5 = Not at all important. Descriptive statistics on the importance of reasons for attending counselling as reported by counsellors and clients are presented in Table 8.3.
Table 8.3
Descriptive Statistics Comparing the Importance of Reasons for Attending Counselling as Reported by Clients and Counsellors Post Counselling

<table>
<thead>
<tr>
<th>Reason</th>
<th>Client Responses</th>
<th>Counsellor Responses (on clients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male ($n = 8$)</td>
<td>Female ($n = 12$)</td>
</tr>
<tr>
<td></td>
<td>$M$  $SD$</td>
<td>$M$  $SD$</td>
</tr>
<tr>
<td>Learn how to communicate more effectively</td>
<td>4.88  0.35</td>
<td>4.67  0.49</td>
</tr>
<tr>
<td>To improve relationship</td>
<td>4.62  0.52</td>
<td>4.92  0.29</td>
</tr>
<tr>
<td>To resolve conflict</td>
<td>4.38  0.74</td>
<td>4.33  0.78</td>
</tr>
<tr>
<td>To decide about future of relationship</td>
<td>4.38  1.06</td>
<td>3.83  1.53</td>
</tr>
<tr>
<td>Influence of family background on relationship</td>
<td>3.38  1.60</td>
<td>3.17  1.40</td>
</tr>
<tr>
<td>Intimacy/sexuality</td>
<td>3.13  1.64</td>
<td>3.25  1.29</td>
</tr>
<tr>
<td>Balance between work and family</td>
<td>3.00  1.60</td>
<td>3.17  1.27</td>
</tr>
<tr>
<td>Concerns about closeness</td>
<td>2.75  1.49</td>
<td>3.50  1.62</td>
</tr>
<tr>
<td>Parenting/step- parenting issues</td>
<td>2.13  1.55</td>
<td>2.75  1.71</td>
</tr>
<tr>
<td>Impact of an affair</td>
<td>2.13  1.64</td>
<td>1.92  1.31</td>
</tr>
<tr>
<td>Concerns about commitment</td>
<td>2.00  1.31</td>
<td>2.55  1.44</td>
</tr>
<tr>
<td>Discuss personal issues</td>
<td>1.75  1.16</td>
<td>2.36  1.63</td>
</tr>
<tr>
<td>Discuss how to separate</td>
<td>1.25  0.46</td>
<td>1.83  1.11</td>
</tr>
<tr>
<td>Domestic violence issues</td>
<td>1.13  0.35</td>
<td>1.64  0.92</td>
</tr>
<tr>
<td>Drug/alcohol issues</td>
<td>1.13  0.35</td>
<td>1.91  1.38</td>
</tr>
<tr>
<td>Gambling issues</td>
<td>1.00  0.00</td>
<td>1.55  0.93</td>
</tr>
</tbody>
</table>
As shown in Table 8.3 the most frequently discussed issues reported by counsellors for both men and women were also the most frequently reported issues discussed as reported by male and female clients. The issues discussed that had a mean score of 3.5 and above for both clients and counsellors were: To improve the relationship; To decide about the future of the relationship; To improve communication and, To learn how to resolve conflict.

### 8.4 Counsellor Responses to the Therapeutic Relationship

Counsellors were asked to respond to a series of 13 statements about the development of a therapeutic relationship with clients including: “I was able to create an environment where their problems could be discussed”; “These clients could give me feedback about what was or wasn’t working for them”; and “I was able to address the problems this couple brought to counselling”. Responses ranged from 1 = “Strongly disagree” to 5 = “Strongly agree”. As 8 of the 19 counsellor responses were given by counsellors with 1 year or less experience working as a couples’ therapist mean score results are presented comparing less experienced (less than 1 year’s experience) with more experienced counsellors (3 or more years experience). Results are presented in Table 8.4.

Inspection of Table 8.4 shows that mean score responses for less experienced couples’ counsellors were higher on 10 of the variables than for the more experienced counsellors. These results suggest a trend where less experienced counsellors rated their capacity to develop a positive therapeutic alliance with their clients more highly than did the more experienced counsellors. Independent samples t-tests were performed on all items in Table 8.4 but none reached significance. Results of the independent samples t-tests can be found in Appendix H.
Table 8.4
Descriptive Statistics on Development of the Therapeutic Relationship Comparing Counsellor Experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>Counsellor Experience</th>
<th>Counsellor Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; One Year</td>
<td>&gt; Two Years</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>“I was interested in working with this couple”</td>
<td>4.75</td>
<td>0.46</td>
</tr>
<tr>
<td>“I felt relaxed in sessions with these clients”</td>
<td>4.75</td>
<td>0.46</td>
</tr>
<tr>
<td>“I was able to create an environment where their problems could be discussed”</td>
<td>4.75</td>
<td>0.46</td>
</tr>
<tr>
<td>“I was able to use everyday language when explaining things to clients”</td>
<td>4.63</td>
<td>0.52</td>
</tr>
<tr>
<td>“I tailored my interventions to the needs of this particular couple”</td>
<td>4.63</td>
<td>0.52</td>
</tr>
<tr>
<td>“I was able to give equal time to both partners in counselling”</td>
<td>4.63</td>
<td>0.52</td>
</tr>
<tr>
<td>“These clients knew they could trust me”</td>
<td>4.63</td>
<td>0.74</td>
</tr>
<tr>
<td>“I was able to be open about how I understood the problems in this couple’s relationship”</td>
<td>4.50</td>
<td>0.76</td>
</tr>
<tr>
<td>“I could laugh and joke with these clients when appropriate”</td>
<td>4.50</td>
<td>0.93</td>
</tr>
<tr>
<td>“I was able to show I understood their problems”</td>
<td>4.38</td>
<td>0.52</td>
</tr>
<tr>
<td>“These clients could give me feedback on what was or wasn’t working for them”</td>
<td>4.38</td>
<td>0.74</td>
</tr>
<tr>
<td>“Therapeutic relationship was part of what helped this couple make changes”</td>
<td>4.13</td>
<td>0.64</td>
</tr>
<tr>
<td>“I was able to address the problems this couple brought to counselling”</td>
<td>4.00</td>
<td>0.93</td>
</tr>
</tbody>
</table>

< one year experience $n = 8$; > two years experience, $n = 11$
8.4.1 Other Factors Considered Important to Therapeutic Relationship

Counsellors were asked a qualitative question about other factors they considered important in the development of a positive therapeutic relationship.

8.4.1.1 Responses from Inexperienced Counsellors.

Responses from counsellors with less than one year’s experience included: “I could affirm each partner; I assisted couple to develop a shared understanding of the relationship breakdown”; supervision, engagement skills, genuineness, respectfulness of counsellor, interest shown, non-judgmental stance, “Couple discontinued here due to changing work and travel times. They wanted to explore another office. I would have liked to have finished differently (rather than a cancelled appointment), with space to review and share thoughts about the process”; “Connection made with the couple and strong attachment within couple relationship, “Couple easily articulated their concerns” (making it easier to engage with them). “One intake session was not enough to comment on; woman had many issues impacting on her mental health and her partner was exhibiting hostility. In discussion with my supervisor made a decision to refer to another counsellor but husband did not accept new therapist”.

8.4.1.2 Responses from Experienced Counsellors.

Responses included: “Couple came in crisis, my response to their situation as urgent may have helped to build good contact quite quickly”. “Counselling (one session) only established the issue at hand; they did not attend for the following appointment”. “Only saw them for intake, they dropped out of counselling; serious drug problem for both”; “We all developed a trust, we all collaborated together to try to bring about change”; “We were dealing with sensitive issues, past sexual abuse. I wondered if counselling was threatening for them”.

8.5 Counsellor Assessment of Therapeutic Outcomes

Counsellors were asked 12 questions on outcomes in counselling and outcomes for the relationship for each couple. Responses were rated on a 5 point Likert type scale with 1 = “strongly disagree” to 5 = strongly agree”. Mean score results are presented according to counsellor experience with counsellors with one year or less experience in relationship counselling reported separately from counsellors with more than three years experience. As these responses relate to
outcomes for different couples all 19 counsellor responses have been included even though there were only 15 different counsellors who responded to the questionnaires. Results from the descriptive analyses are presented in Table 8.6.

Inspection of results shown in Table 8.6 suggest that more experienced counsellors rated outcomes for their clients more highly than less experienced counsellors on the following variables: Clients’ attainment of goals for counselling; Each partner’s understanding of the other’s point of view; Counselling helped the couple make a decision to separate; Partners were equally motivated to attend counselling; and, The couple were less distressed at the end of counselling than when they first attended. Less experienced counsellors rated outcomes for their clients more highly than more experienced counsellors on the following variables: Couple were willing to make changes in the way they communicated with each other; Couple made satisfactory progress in therapy; and Couple discontinued counselling prematurely.
Table 8.6  
*Descriptive Statistics Comparing Therapist Experience on Ratings of Outcomes for Couples Attending Relationship Counselling*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Counsellor Experience</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; One Year (n =8)</td>
<td>&gt; 2 Years (n =11)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>1. Couple were not willing to make changes in the way they communicated with each other</td>
<td>4.50</td>
<td>0.53</td>
<td>3.82</td>
</tr>
<tr>
<td>2. Couple were less distressed at the end of counselling than when they first attended</td>
<td>3.91</td>
<td>0.94</td>
<td>4.43</td>
</tr>
<tr>
<td>3. Each partner could understand the other’s point of view even if they didn’t agree</td>
<td>3.82</td>
<td>1.33</td>
<td>4.25</td>
</tr>
<tr>
<td>4. Couple were able to discuss their sexual relationship</td>
<td>3.73</td>
<td>1.27</td>
<td>3.87</td>
</tr>
<tr>
<td>5. Couple discontinued counselling prematurely</td>
<td>3.73</td>
<td>1.56</td>
<td>2.63</td>
</tr>
<tr>
<td>6. Counselling helped this couple make a decision to separate</td>
<td>3.64</td>
<td>2.06</td>
<td>4.29</td>
</tr>
<tr>
<td>7. Partners were equally motivated to attend counselling</td>
<td>3.45</td>
<td>1.37</td>
<td>4.14</td>
</tr>
<tr>
<td>8. Couple were not willing to learn new strategies in the way they deal with conflict</td>
<td>3.45</td>
<td>1.37</td>
<td>4.00</td>
</tr>
<tr>
<td>9. Couple made satisfactory progress in therapy</td>
<td>3.45</td>
<td>1.75</td>
<td>3.38</td>
</tr>
<tr>
<td>10. Couple could not resolve their differences on important issues</td>
<td>3.38</td>
<td>1.06</td>
<td>3.20</td>
</tr>
<tr>
<td>11. Separation would be a good outcome for this couple</td>
<td>3.00</td>
<td>1.34</td>
<td>2.57</td>
</tr>
<tr>
<td>12. Clients achieved their goals for counselling</td>
<td>2.89</td>
<td>1.62</td>
<td>3.71</td>
</tr>
</tbody>
</table>
8.6 Research Question 5

8.6.1 Comparison between Client and Counsellor Assessment of Therapeutic Outcomes.

Given the study’s small sample size for post counselling responses a qualitative approach was used to explore the sixth research question on the compatibility between client and counsellor responses to the therapeutic relationship and satisfaction with the outcome of counselling. Counsellors were also asked: “was the couple less distressed at the end of counselling than when they first started”. Responses ranged from 1 (strongly disagree) to 5 (strongly agree). Responses were $M = 4.13$, $SD = .81$ indicating that as a group counsellors agreed that clients were less distressed once counselling had been completed.

However, for the six couples who completed post counselling questionnaires inspection of the data revealed that three female clients had higher post DASS 21 scores than their pre DASS 21 scores, suggesting these women were more distressed following counselling. Two counsellor questionnaires were completed for these three clients. All four of these counsellor responses to the question, “couple was less distressed at the end of counselling than when they first came” responded with “totally agree”, indicating a difference between client and counsellor perspectives. While the number of participants was small and therefore results have limited generalisability, these trends raise the importance of both partners’ concerns being dealt with within the clinical setting.

Inspection of the pre and post RAS scores for the three clients with higher post DASS 21 scores revealed that two of them had post RAS scores below 2.3; these scores are similar to Hendricks’ “apart couples” scores, suggesting that these relationships were still troubled even though counselling had been completed. Some of the qualitative responses to the question: “what did you find least helpful about counselling?” included comments such as, “Not much structure to the session, my partner and the counsellor talked too much” and “Not much advice offered” and “Clear changes we need to make to improve were not communicated”.

8.6.2 Client Assessment of their Counsellor

Clients who completed the post counselling questionnaire ($N = 20$) were asked a series of questions about their counsellor. Responses ranged from 1 (strongly
disagree) to 5 (strongly agree). Questions included, “My counsellor handled the 
sessions in a skilled manner”, ($M = 4.20$, $SD = .62$); “I felt the counsellor was fair 
and impartial when dealing with us”, ($M = 4.55$, $SD = .60$); “The counsellor was 
warm and empathic when dealing with us”, ($M = 4.45$, $SD = .60$); and “I felt the 
counsellor addressed the problems we came to counselling about”, ($M = 3.75$, $SD = 
.97$). These results indicate that client responses to their counsellor were very 
favourable.

Clients were also asked “Overall how satisfied were you with the way 
counselling was carried out?” and “Overall how satisfied were you with the outcome 
of counselling?” Counsellors were asked “How satisfied were you with the process 
of counselling for this couple?” and “How satisfied were you with outcome of 
counselling for this couple?” Pearson product moment correlations between client 
and counsellor satisfaction with the process of counselling was $r = .06$, $p = ns$; and 
between satisfaction with the outcome of counselling was $r = .11$, $p = ns$. These 
results showed there was almost no agreement between client and counsellor 
perceptions of satisfaction with either the process or outcome of counselling. 

8.6.3 Qualitative Comments about Outcomes in Couples’ Therapy

Counsellors were asked “Do you have any other comments to make about this couple’s progress in counselling or the outcome?” Responses given included those with positive outcomes and those with more negative outcomes.

8.6.3.1 Positive Therapist Comments on Outcomes.

Positive outcomes include the following comments:

- “Couple came to decide on the future of relationship, they have moved 
in together. (He) is more confident in talking to (her) and she is much 
less feisty and fiery when she gets frustrated with him…… a nice 
couple, a pleasure to work with.” (Couple attended for 26 sessions; counsellor with 3 years experience)
- “Husband presented for separation counselling and was unwavering in this. Wife initially hoped for reconciliation but ultimately accepted husband’s decision. By the end of counselling both partners appeared to have developed a degree of mutual warmth and empathy and expressed deep sadness over the loss of their relationship”; (Couple attended for
10 sessions; counsellor with 6 months experience).

- “Wonderful couple to work with – both so committed to the process. Ultimately could not get past injuries done to each other and avoid re-injuring each other, but left counselling with strong sense of this and may re-engage in the future”; (Couple attended for 26 sessions; counsellor with 3 years experience).

- “Couple’s primary reason for attending was in working through ways of dealing with an external influence (husband’s mother). While circumstances surrounding this issue did not change greatly, strategies were worked on together to enable couple to find it easier to deal with, and boundary setting, triangulation issues and family of origin work explored.” (Couple attended for 14 sessions; counsellor with 1 year’s experience).

8.6.3.2 Negative Therapist Comments on Outcome.

These comments include:

- “This was a 29 year old woman from a very distressed and dysfunctional family. She married a (name of cultural background) in order to distance herself from her background but the problems were magnified and they could not agree or communicate with each other. The children were palmed off to the Department. I did not think they were able to apply the insights from counselling. I think they would do better from individual counselling.” (Couple attended for 2 sessions; counsellor with 29 years experience).

- “I was disappointed they didn’t come back. Couple was conflict avoidant with high dependency on each other. I hope I was able to make a safe enough environment for them to work in whilst still challenging them”. This counsellor commented earlier that she felt she’d established a good relationship with these clients but they were dealing with past issues of sexual abuse and current sexual problems. The counsellor asked them why they decided to get engaged when things between them were so problematic in the relationship. The counsellor wondered if this comment threatened the couple and was the reason for them cancelling
their third appointment; (Couple attended for two sessions; counsellor with five years experience).

- “Client (female client attended counselling on her own) described relationship which was not working for her and her hope that her husband would attend counselling; he didn’t. Client described her history of eating disorder which still threatens; client was at beginning stages of unplanned pregnancy.” (Client attended for two sessions; counsellor with one year experience).

- “It’s a pity I could not join with strongly with them. They were like “Teflon”, hard to come to grips with and that’s not me usually. (Counsellor commented that both partners had a serious drug addiction; couple attended for 1 session only; counsellor with 17 years experience).

- “Counselling carried out over very limited time frame due to imminent birth of the couple’s baby. Could have done more valuable and necessary work - given that trust issues were strongly involved”. (Couple attended for three sessions; counsellor with three years experience).

- “The couple stopped counselling prematurely because I had to change the appointment time and then the couple changed it because their child had an accident at school. Would have liked two or three more sessions with them’. (Couple attended for 3 sessions; counsellor with 10 years experience).

- “The couple attended for one session only and did not show for following appointment. Counselling only established the issue at hand – not able to develop (the work) further. (I would have liked) … to urge them to continue counselling with a view to understanding the dynamics in the relationship prior to making decision to separate”. (Couple attended for one session; counsellor with one year’s experience).

- “Couple only attended an intake session and didn’t return for counselling. Male said he perceived that I was biased towards the female; I perceived I gave equal time. Male said he wanted another
counsellor but didn’t take up the offer when another one was provided.”
(Couple attended for one session – Counsellor with four months experience).

While these qualitative comments made by counsellors only relate to a small sample of the overall group of participants included in this study there does appear to be a trend with these clients that more positive outcomes in couple counselling (even if it means the couple separate) are related to attendance at more sessions of therapy than those couples who attended for only a couple of sessions and where the outcome was less satisfactory.

8.7 Summary of the Chapter

This chapter provided analysis of data from the counsellor questionnaires including comparative analyses with client responses to some questions. The most frequently reported theoretical framework relationship counsellors used was eclectic followed by psychodynamic. Clients and counsellors concurred on the most frequently discussed issues in counselling being: To improve communication; To decide about the future of the relationship; To learn how to resolve conflict and to improve the relationship. Some of the qualitative comments made by both clients and counsellors reveal the complexity of relationship counselling; couples attend for counselling at a time when stress levels are high and the relationship is in crisis.
Chapter 9: Discussion

9.1 Chapter Overview

Couple counselling has emerged as an area of important psychological practice in Australia; a literature search did not identify a comprehensive account of the research development of this specialised area. Consequently this thesis aimed to provide an up-to-date account of the development of couple counselling from its early historical beginnings where the profession was seen as an auxiliary service to mainstream services provided by disciplines such as medicine, psychology, social work and the clergy (Broderick & Schrader) to a contemporary model where the provision of relationship counselling has become a specialised field within psychological and counselling frameworks. The introductory chapters provide a detailed account of the development and history of relationship counselling in the United Kingdom, the United States and within Australia.

While relationship counselling has been provided within Australia for over 60 years there has been very little research conducted either within Australia or overseas that has explored outcomes in relationship counselling in real-life clinical settings. Following the detailed historical analysis, the current research aimed to conduct an empirical Australian study of couples who seek relationship counselling.

In this discussion findings from the empirical investigation will be discussed in the following order: firstly the research hypotheses and related findings; secondly the research questions and related findings; and finally other results including qualitative themes. Sections 9.2 – 9.8 discuss findings relating to the research hypothesis and the six research questions.

Section 9.9 discusses qualitative results from the counsellor questionnaires. Section 9.10 discusses themes from case studies of six couples who attended counselling together and who both completed pre and post counselling questionnaires. Section 9.11 gives a general overview of the study and considers the methodological limitations when conducting research in real life clinical settings. Section 9.12 and provides recommendations for future research in the area of relationship counselling.
9.1.1 Uniqueness of the Current Study

Given the limited amount of research in the area of relationship counselling in real-life clinical settings both within Australia and overseas the current study offers a unique insight into some of the factors present in heterosexual couple relationships prior to and following relationship counselling in an Australian context.

9.2 Research Hypothesis 1

The first part of research Hypothesis 1, that women would initiate counselling more often and would report lower levels of relationship satisfaction, lower levels of attraction towards their partner and higher levels of emotional distance prior to attending for counselling than men was supported. These results have been discussed in the following two sections, 9.2.1: Initiation of Counselling and 9.2.2: Relationship Satisfaction, Emotional Distance and Attraction towards one’s partner.

9.2.1 Initiation of Counselling

The results showed that women were significantly more likely to initiate couple counselling than were men. Couples in this study had reached the treatment seeking phase of counselling (Doss et al., 2003). Doss’s American study also found that women were significantly more involved than husbands in seeking marital therapy but it appears that this is the first Australian study to support the argument that women are the initiators of couple counselling when their relationship is in distress. In this sample, with the exception of one woman who reported that it was mostly her partner who initiated counselling, all women reported they had initiated couple counselling.

A small number of their male partners (two) in the current study also reported they had initiated couple counselling. Problem recognition and help seeking are two steps involved in the process of seeking counselling. It may be that if women in this study asked their partners to call the agency and make the appointment (as a sign of willingness to engage in couple therapy) women may have believed they initiated counselling whereas when men responded to such a request from their partner they may have considered they were the initiators.

9.2.2 Relationship Satisfaction, Emotional Distance and Attraction

The second part of the Hypothesis 1, that women would report lower levels of
relationship satisfaction, higher levels of emotional distress and lower levels of attraction towards their partner were also supported. These results support previous findings (Carmady et al., 2004; Isakson et al., 2006; Lundblad & Hansson, 2005; Snyder & Whisman, 2004) on the relationship between emotional distress and relationship dissatisfaction. The current study has shown that both men and women seeking relationship counselling reported levels of relationship satisfaction which appeared low when compared with Hendrick’s (1988) findings for “together” couples. Hendrick found that the mean score for “together” couples (i.e., couples still together in their relationship 6 months after initial participation in the study) was 4.34 and for “apart” couples (i.e., couples who had separated) was 3.33 on a 5 point Likert scale. The mean score for men in the current study was 3.48 and for women it was 3.05 suggesting that while women were significantly less satisfied with their relationships prior to counselling than were men, both men and women reported levels of relationship satisfaction similar to Hendrick’s “apart” couples.

Taken together these results suggest a profile for female partners in those couples seeking relationship counselling as being less satisfied with their relationships than men, they are the ones initiating counselling (and possibly identifying relationship problems in the first place), they report higher levels of emotional distance from their partners and report lower levels of attraction to their partner than do men by the time they attend for counselling. Gottman (1999) argued that women are the emotional managers in couple relationships and are more attuned to emotional discord in relationships than are their male partners. These empirical findings support clinical observations of couple therapists working in the field who report anecdotally that women are often the instigators of seeking professional assistance for problems in their male/female relationships.

9.2.3 Pre Counselling Reasons for Seeking Counselling

Another factor related to the initiation of counselling and how satisfied or dissatisfied people are with their relationship prior to attending for counselling is the reasons people give for seeking counselling. It is important for therapists to know why each particular couple seeks professional assistance and also for each person to hear what his/her partner wants to get out of counselling. Therapy will be experienced as more satisfactory by participants if they feel their concerns are heard
and responded to by the therapist. The most frequently reported responses to the question on the importance of reasons for seeking counselling prior to attending for the first session in the current study were: To improve the relationship; To improve communication; To learn how to resolve conflict; and To decide about the future of the relationship. Both men and women rated these reasons a score of four or above out of a possible score of five (where 1 = not at all important and 5 = very important) indicating that the importance of improving communication and learning conflict resolution skills in interpersonal relationships were highly regarded and desired. Results comparing men and women in couple relationships found a significant difference on the reasons, “To discuss influence of family of origin” and “To discuss how to separate” with women rating these reasons as more important to discuss in counselling than did their male partners.

Previous retrospective Australian research (Carmady et al., 2004) found that men (N = 162) were less satisfied with the outcome of counselling if they had attended counselling with a different goal to their partner. This research also found that couples who were no longer living together were significantly more likely to have attended counselling with a different goal than their partner. These findings have implications for clinical practice and highlight the complexity of working therapeutically with two clients in the room as partners may be attending for different reasons.

Doss et al. (2004) suggested that when husbands and wives present for relationship therapy they may be doing so for different reasons. In this study of 147 couples seeking marital counselling Doss et al. found little agreement between spouses on their reasons for seeking counselling. There were 19 broad and 84 specific categories given by participants as the reasons for seeking counselling in their study. They found that husbands and wives only significantly agreed on five broad categories and six specific categories and that wives reported more reasons for seeking counselling, expressed more negative emotionality and less positive emotionality than did husbands.

Findings in the current Australian study, where women reported more emotional distance and lower levels of relationship satisfaction than did their male
partners, support these American findings (Doss et al., 2004). Women also reported
two reasons to discuss in counselling as significantly more important than did their
male partners. These results support previous research that has found gender
differences in the reasons for seeking counselling both in Australia (Carmady, 2002)
and overseas (Doss et al.).

These findings highlight the importance of the therapist clarifying both
individual and couple goals at the outset of couple counselling. They also elucidate
an important clinical finding; that therapists should work within a framework that
acknowledges there may be gender differences in goals or reasons for counselling to
ensure both men and women feel that their concerns will be addressed, otherwise one
or both partners may feel dissatisfied with the process and outcome of counselling.

9.3 Research Question 1

The first research question explored whether more participants in the current
study would have higher levels of depression than is found in the general population.
While there were no significant gender differences found on the depression, anxiety
or stress subscales of the DASS 21 prior to attending for counselling the reported
levels on these three subscales were higher than is found in the general population.
Forty five per cent of the pre counselling sample reported clinically significant levels
of depression, 57% reported clinically significant levels of stress and 26% reported
clinically significant levels of anxiety. This is a higher prevalence of depression than
is found in the general population, with approximately 10% of Australians reported
to be suffering from depression at any one time (http://www.beyondblue.org.au).
Given the impact of satisfying interpersonal relationships on a person’s mental health
and sense of well-being it is not surprising that when a person experiences problems
in his/her relationship that they also report higher levels of depression, anxiety and
stress. One of the questions these findings raise however is one similar to the
“chicken and the egg question”: Which comes first? Does a person experience a
mood disorder such as depression, anxiety or stress and does this in turn affect their
relationship, or is relationship distress a precursor to experiencing a mood disorder?
Snyder and Whisman (2004) found that people who are unhappy in their current
intimate relationship are more likely to experience physical and/or mental health
problems and be slower to respond to treatment than people who are happy in their
intimate relationship. Discussion about the relationship between mood disorders and relationship satisfaction is continued in Section 9.5.

While the issue of whether depression precipitates relationship distress or relationship distress causes depression remains unresolved, findings suggest that in a clinical setting assessment and treatment of couples presenting for counselling should include strategies for managing high levels of personal distress as well as focusing on teaching couples more effective ways to communicate and to develop conflict resolution skills. How conflict is viewed by partners in an intimate relationship may be influenced by whether conflict is experienced as something intractable and irresolvable in the relationship or whether the resolution of conflict is viewed as an important relationship skill that can be learned. The notion that effective relationship skills can be discussed and practiced in couple therapy provides a sense of hope for change.

9.4 Research Question 2

The second research question explored whether couples who attend for relationship counselling are have higher levels of insecure attachment than couples in the general population. In the current study there were two methods used for calculating attachment style or type. The first method used the continuous scores obtained for each attachment style as defined by the authors Griffen and Bartholomew (1994) as Secure, Preoccupied, Dismissive and Fearful. Attachment style is determined by the highest score obtained. The second method used cluster analysis to assign participants to an attachment group based on previous theoretical findings of the existence of four attachment groups in adult populations (Bartholomew, 1990; Feeney & Noller, 1996; Feeney, 2002; Hazan & Shaver, 1994; Griffen & Bartholomew). The cluster analysis identified four distinct groups that were based on four category- two dimensional model of attachment; positive/negative view of the self and positive/negative view of the other (Bartholomew, 1990). Further details on these groupings can be found in Section 4.3.3.2. Descriptive statistics on cluster analysis of attachment scores can be found in Table 6.12. Findings relating to scores obtained from the continuous attachment variables will be referred to as attachment styles and findings obtained from the cluster analysis will be referred to as attachment groups.
Results from the cluster analysis produced four groups: one with a positive view of the self and positive view of the other (Secure); one with a positive view of the self and negative view of the other (Fearful); one with a negative view of the self and positive view of the other (Preoccupied); and one with a negative view of the self and negative view of the other (Dismissive).

Comparing Feeney’s findings (2002) with the cluster analysis results suggests that the current study’s clinical sample had a lower percentage of securely attached participants than Feeney found in a non-clinical married Australian sample ($N = 386$). In Feeney’s sample 54% of participants were securely attached and 46% were insecurely attached; in the current study 33% of the entire sample ($N = 76$) were securely attached and 67% were insecurely attached. In this sample there were only 4 couples (out of 30 couples) where both partners had a secure/secure attachment match, whereas there were 10 secure/insecure partner matches and 16 insecure/insecure matches.

Findings from Feeney’s (2002) sample are consistent with results reported by Whiffen et al.’s (2001) American study where 57% of women and 47% of men in a normative sample were classified as securely attached. Whiffen et al. compared a normative sample of couples ($N = 60$) with a clinical group of couples where the wife had experienced depression in the past year ($N = 52$). When comparing levels of secure attachment between the normative and depressed groups Whiffen found the percentages of securely attached wives was significantly lower in the depressed group (26%, compared to 57% in the normative group) while the percentage of securely attached men did not differ (49%). However, one of the limitations of the Whiffen study was that depression was only measured in the women; men’s levels of depression were not considered.

Comparison of men and women’s attachment scores in the current study reveals similar findings to Whiffen et al.’s depressed group (2001) where the percentage of securely attached people in this clinical sample is considerably lower than is typically found in the general population. These findings regarding the relationship between attachment style and depression raise some interesting questions and possible areas for future research. The question of whether depression influences attachment style or the other way around warrants further investigation.
However, attachment theory is based on the premise that a person’s primary patterns of attachment are established in infancy and these are intimately linked with interpersonal patterns of relating throughout one’s life (Fisher & Crandell, 2001). Therefore, the fact that attachment patterns are established in the formative years suggests that one’s attachment style, as either secure or insecure, precedes the development of a mood disorder such as depression. There have been many links made between the experience of early loss and the development of depression in either childhood or adult life (Bowlby, 1969; Holmes, 1993). Previous research has found a relationship between the anxious and avoidant attachment styles with depression (Lemmens et al., 2007). The current study partially supports these findings as both the preoccupied and dismissive attachment styles were significant predictors of depression for women but not for men. Given that one in four adults will suffer from a depressive illness at some time in their life (Holmes, 2002) the relationship between insecure attachment and depression warrants further investigation in future research.

One premise of attachment theory is that early experiences in infancy affect the pattern of interpersonal relating throughout one’s life (Fisher & Crandell, 2001). The study of adult romantic attachment styles is based on similar premises to those in infant-caregiver attachment where emotional and relational patterns of behaviour are guided by internal working models of the self and on experience with prior relationship partners (Mickelson et al., 1997). Research examining the stability of adult attachment patterns using categorical measures has found that 70% of participants report the same attachment category over a 12 month period (Scharfe & Bartholomew, 1994). These findings highlight the general stability in attachment style in adult populations over time but also indicate some capacity for change in attachment style.

Given that changes in attachment in infancy can be found depending on circumstances in the child’s life it is therefore reasonable to presume that changes in circumstances in adult life could also lead to changes in attachment style (Egeland & Sroufe, 1981; Egeland & Farber, 1984; Vondra et al., 1999). For example, experience in a satisfying adult intimate relationship may result in a change from an insecure attachment style to a secure attachment style for some people. The capacity
for change from insecure attachment to secure attachment would depend on several factors including the attachment style of the partner. Changes towards insecure attachment patterns in adults have been found in participants with reported vulnerabilities such as personality disturbance, personal or family history of psychopathology and non-intact family of origin (Davila et al., 1999).

It appears that while attachment style is a relatively stable state and is largely influenced by experiences in early infancy, attachment can also be influenced by the quality of later relationships. Therefore, it is possible that an insecure attachment style could be a predisposing factor in the later development of mood disturbance such as depression in adult life, particularly if one’s adult relationship is stressful and highly conflictual. The capacity for insecurely attached persons in couple relationships to move freely between the depended on position and the dependent position is compromised as often one or both partners occupy just one position, either the depended on or the dependent position (Fisher & Crandell, 2001). Couples presenting for relationship counselling do so because they have been unable to resolve relationship issues on their own; they seek professional help often because the relationship is at risk of ending. It may be the case that couples who experience more problems in their relationship and who seek counselling are more likely to be insecurely attached and consequently lack the internal resources to repair relationship problems independently.

If relationship counsellors are more likely to be working with people in a couple relationship who have an insecure attachment style then this does have implications for clinical interventions. For example, would it be helpful for a relationship counsellor to know the attachment style of each partner in the couple relationship, and should interventions be linked to partners’ attachment styles? Similarly, some assessment of the presence of depression in either partner attending for relationship counselling would appear to be essential in order for the therapist to understand the impact of mental health issues on relationship functioning and to ensure that when relationship functioning improves through counselling that there is a corresponding improvement in depressive symptomatology.

9.5 Research Question 3

The third research question explored was whether participants classified as
insecurely attached (i.e., Dismissing, Preoccupied or Fearful attachment styles) would report higher levels of relationship dissatisfaction and higher levels of mood disturbance than people who were securely attached. Results showed that for women both the Preoccupied and Dismissing attachment styles were significant predictors of depression. For men the Secure attachment style showed a trend towards predicting depression and was a significant predictor of relationship satisfaction (as shown in Figure 3) in this moderately sized sample of participants. These findings need to be investigated further with a larger sample.

These results provide empirical evidence for the possibility that early attachment experiences may influence the likelihood of developing a mood disorder in adult life. There is also support for the argument that people choose a partner who is likely to have similar internal working models of relationships to themselves (Cowan & Cowan, 2003; Holmes, 1993; 1996).

However, the only significant attachment style predictor of relationship satisfaction prior to counselling was the Secure style, with securely attached men being more likely to report higher levels of relationship satisfaction. This trend was not found for women. From a clinical perspective it makes sense that people with a Secure attachment style and positive internal working models of both “Self” and the “Other” would be more satisfied with their intimate relationships. Secure couple attachment involves the ability to shift freely between the dependent and depended-on positions with a corresponding empathic appreciation of the partner’s emotional experience within these two positions (Fisher & Crandell, 2001).

The literature suggests that typically one or both partners consider relationship counselling for several years before they actually seek professional assistance (Gottman, 1999). In the current study approximately one third of both men and women reported that there had been problems in their relationship for two years or longer prior to seeking counselling. In fact approximately 10% of both men and women reported their relationship problems had existed for 5 years or more. The impact of relationship distress on these participants’ emotional and mental health would be considerable and is an important factor for clinicians to consider during assessment for treatment. The mean number of sessions attended by participants in the current study was eight; possibly a conservative time for treatment of entrenched
relationship problems and high levels of emotional distress.

These findings support previous outcome research that has shown that the more distressed couples are prior to entering therapy the less likely they are to report moderate and above levels of relationship satisfaction at the end of treatment (Snyder et al., 1993; Snyder, 1997). Given that previous research has found that people experience relationship problems for many years prior to seeking professional assistance (Gottman, 2000) and that high levels of distress prior to seeking counselling does not augur well for a satisfied relationship at the end of counselling, these findings suggest that early intervention is crucial.

Previous Australian research (Carmady et al., 2004) has found that people report trying a range of self-initiated strategies to improve their relationship prior to seeking couple counselling and that women try significantly more strategies than men. These strategies included reading books and literature, talking to family and friends, seeing a counsellor or psychologist individually and talking to their doctor.

Early intervention strategies aimed towards people who may be experiencing relationship difficulties could include accessible literature on the ways to improve relationship satisfaction and where to find professional help if needed. For example, information sheets in the waiting room of doctor’s surgeries that outlined: Ways to increase emotional closeness and intimacy in relationships; Strategies for resolving conflict; and Warning signs of relationship problems, could provide preventative measures for people whose relationships were in the early stages of experiencing problems and would also promote the importance of positive relationships for one’s mental health.

The internet is an accessible and rapidly expanding means of accessing information on a myriad of topics. Inserting “Relationship Problems” into a popular internet search engine revealed over 42 million sites. Australian audiences can access several sites including information provided by the Australian Psychological Society and Relationships Australia, one of the largest national providers of relationship services. Information includes: Relationship Enrichment; Relationship Difficulties; Managing Divorce and Separation; and online questionnaires that allow participants to rate their relationship or assess the impact of separation on themselves and their children. Online services allow people access to information at a time that is
convenient to them and is no doubt a convenient method of alerting people to the existence of professional services when needed.

Family therapists and relationship counsellors agree that a strong healthy adult couple relationship is the cornerstone to healthy family functioning and provides a model of intimate relating for children that benefits them in partner selection when they become adults (Crowell & Treboux, 2001; Karen, 1998; Nicholls & Schwartz, 2006). Perhaps one of the most effective ways to promote healthy adult relationships would be to support families to raise young children in secure family environments.

9.6 Research Question 4

The fourth research question explored a provisional model of the predictors of relationship satisfaction. For both men and women lower levels of emotional distance and higher levels of attraction towards one’s partner were significant predictors of relationship satisfaction. In a clinical setting, when couples are assessed for couple therapy, questions about emotional closeness and attraction towards one’s partner in the initial session may provide the therapist with a useful measure of the level of relationship satisfaction or dissatisfaction currently being experienced by partners.

For men both depression and the Secure attachment style were related to relationship satisfaction. For women the Dismissive and Preoccupied attachment styles were significant predictors of depression but not relationship satisfaction. These findings highlight the complexity of attachment patterns in adult relationships and could be an area for future research.

Given that negativity and conflict often characterise the marriages of depressed persons and that some studies have found depression often precipitates marital problems (Benazon & Coyne, 2000; Bruce, 1998; Kessler et al., 1998) it is not surprising that when people present for couple counselling they are more likely to report higher levels of mood disturbance than is found in the general population. Therefore, if relationship satisfaction increases and interpersonal conflict decreases as a result of relationship counselling a corresponding decrease in levels of depression and stress would be predicted.

However, the literature is divided on the complex relationship between
depression and marital conflict. Some authors believe that the presence of marital distress leads to depression in one or both partners (Kendler et al., 1999; Whisman & Bruce, 1999). A meta-analysis of 10 studies involving 336 depressed individuals found that marital distress accounted for 44% of the variance between depressed and non-depressed individuals (Whisman, 2001). While there is a complex relationship between depression and marital distress there is no doubt that the presence of depression in either one or both partners places considerable strain on the couple relationship (Benazon & Coyne, 2000; Lemmens et al., 2007) and on overall family functioning. These findings highlight the need for both medical practitioners and couples therapists to be cognisant of the link between relationship problems and depression and that the reason for seeking professional assistance may mask other underlying issues.

9.7 Research Question 5

The fifth research question explored whether clients individually, or as a couple, agreed with their counsellor on the factors that contributed to satisfaction with the outcome of counselling. Both clients and counsellors were asked how satisfied they were with the outcome of counselling and how satisfied they were with the way counselling was carried out. Pearson product moment correlations between these two variables were not significant indicating there was almost no agreement between client and counsellor perceptions of satisfaction with either the outcome or process of counselling. Previous research has also shown that clients and counsellors differ in their views on important moments in therapy (Manthei, 2005) and that agreement between client and counsellor perspectives only occurs about one third of the time (Cummings et al., 1992). A positive therapeutic relationship correlates with a good outcome in psychotherapy (Horvath, 2000) but some researchers have found that it is the client’s subjective evaluation of the relationship rather than the therapist’s behaviour that has the most impact on evaluation of a satisfactory outcome in therapy (Horvath). These findings highlight the complexities involved in investigating the therapeutic alliance and the necessity of establishing both client and counsellor responses to questions on the factors that contribute to satisfaction with outcomes in counselling.

It appears clients and counsellors evaluate different aspects of the therapeutic
alliance as critical for them. Clients appear to value therapist warmth, fairness, empathy and information about the problem for which they are seeking assistance (Christensen et al., 1998; Helmke et al., 2002; Parker et al., 2003; Stacey et al., 2002), whereas counsellors report the importance of interventions such as giving equal time to both partners, reframing and facilitating experience and understanding between the couple (Sells et al., 1996). Findings from the current study appear to support previous research findings that clients and counsellors may rate satisfaction with the outcome highly but may be doing so for different reasons.

Counsellors were asked a series of questions about each partner’s motivation and commitment to counselling to determine any gender differences. Therapists reported that men were more likely to be committed to the relationship continuing than women. These results support a consistent pattern of dissatisfaction for female clients in relationship counselling even after counselling had been completed. The profile of people attending for relationship counselling in the current study shows that it is women who identify problems in their relationships first, they are less satisfied with their relationships and report more emotional distance from their partners and less attraction towards their partner than do men.

There is considerable empirical research that supports the view that people who are unhappy in their current intimate relationship are more likely to have physical or mental health problems (Snyder & Whisman, 2004). These findings highlight the importance of promoting healthy adult relationships throughout the lifetime; for example, pre marriage education and groups for couples where they can learn more effective relationship skills. People experiencing relationship difficulties require affordable access to counselling services and other forms of professional assistance. For example, the first year of parenthood is a time of enormous change in the couple relationship and is often the period where low levels of relationship satisfaction are reported (Snyder et al., 1993). Children in primary school could be taught communication and conflict resolution skills as part of life skills for successful relationships.
9.8 Research Question 6

9.8.1 Changes Following Counselling

In order to explore the sixth research question on changes following counselling themes from case studies will be explored using the main study variables.

9.8.1.1 Attachment Style.

One of the advantages of using the case study approach is that individual differences can be identified that would be undetectable in group analyses where individual differences can be washed out.

Case studies were completed on six couples; these couples completed pre and post counselling questionnaires. Of the six couples only one couple had a secure/secure attachment pairing. This couple came to counselling because they intended to marry within a few months and wanted to discuss how to communicate more effectively. The counsellor referred them to PREPARE (pre-marriage course) as this was deemed more appropriate for their needs.

For the remaining five couples three had a secure/insecure attachment pairing and the other two couples had an insecure/insecure attachment pairing. Generally for all participants in the current study there was a higher proportion of insecure attachment than is usually found in the general population (Feeney, 1996) but the level of insecure attachment found in the current sample was in accordance with previous research that found a relationship between insecure attachment style and depression (Lemmens et al., 2007). Previous research has indicated that in insecure couple attachment there is a marked degree of asymmetry and rigidity in the relationship and partners have in common a lack of the flexibility and mutuality that is found in securely attached partners (Fisher & Crandell, 2001). When a secure partner is paired with an insecure partner some authors argue that the secure partner challenges the tendency of the preoccupied partner to assume the dependent position and the dismissing partner to assume neither position (Crowell & Treboux, 2001; Fisher & Crandell). This could result in relationship problems and a tendency for the insecurely attached partner to retreat from dealing with difficulties in an emotionally
adult manner.

Despite the relative stability of attachment style over time (Scharfe & Bartholomew, 1994) it appears that there is still some capacity for change in attachment style. Arguably a change in attachment style from either secure to insecure or from insecure to secure would depend on significant changes in life events (Feeney & Noller, 1996) and on changes in comfort with closeness and anxiety in relationships. Studies of partner matching provide evidence of individuals seeking out partners with a similar attachment style; these secure individuals tend to pair up with secure partners (Collins & Read, 1990; Feeney, 1994; Kirkpatrick & Davis, 1994).

While evidence suggests that secure individuals tend to pair with secure individuals it is noteworthy that such secure/secure attachment pairings were in the minority in this sample of couples who attended for relationship counselling. Possibly securely attached individuals generally have the resources to manage their own relationship difficulties and professional intervention is not required.

Findings from the current study showed that these participants seeking relationship counselling have a higher proportion of insecure attachment than is found in the general population. One of the reasons for this could be that individuals find themselves (through partner choice) in relationships that confirm their expectations of relationships (Collins & Read, 1990).

9.8.1.2 Relationship Satisfaction.

Of the six couples presented in the case studies only two couples had relationship satisfaction scores post counselling that indicated high levels of relationship satisfaction similar to Hendrick’s “together” couples. The remaining four couples had scores similar to Hendrick’s “apart” couples indicating they were at risk of separation despite having attended for relationship counselling. Relationship counselling is not a panacea for relationships in distress and counselling often brings issues out into the open that have been ignored or have not been resolved despite repeated attempts by the couple to do so. The fact that so many of the participants in the current study still reported low levels of relationship satisfaction does raise the possibility that some relationships may be beyond salvation. It is more difficult for a
couple’s therapist to work with entrenched problems that have been present for many years, where there is significant emotional distance between partners and where there is limited empathic ability to understand the situation from their partner’s perspective.

9.8.1.3 Emotional Distance.

Results comparing pre and post scores on the Emotional Distance Scale (EDS) indicated that out of the 6 couples (N = 12) discussed in the case studies 3 participants reported higher levels of emotional distance from their partners post counselling. Higher levels of emotional distance were reported by three people despite the fact that two of these three participants reported higher levels of relationship satisfaction post counselling. One participant reported a lower level of relationship satisfaction, a higher level emotional distance from her partner and a higher level of depression post counselling (depression score was in the normal range pre counselling and in the mild range post counselling). This couple were not living together either prior to, or after, counselling. Unresolved issues of childhood abuse for the male partner were reported by the female partner as a major stressor in their relationship and may have contributed to reported levels of relationship dissatisfaction, emotional distance and depression post counselling.

9.8.1.4 Depression, Anxiety and Stress.

While the depression, anxiety and stress mean scores for all participants as a group was lower post counselling for three of the six couples the female partner’s depression score was higher post counselling than prior to counselling. For these three women two of their partners had lower scores on depression, anxiety and stress and for one male partner his anxiety score was higher post counselling. For the remaining three couples both partners had lower depression, anxiety and stress scores post counselling. These findings demonstrated that a case study analysis provided a more in-depth analysis of case by case changes that be concealed in group analyses. These results show that despite attending for counselling some partners are more depressed or anxious after the experience than before. These findings have clinical relevance for therapists as some couples may finish counselling more distressed than when they began.
9.8.1.5 Comments on the Counselling Experience.

One consistent theme that has emerged from the case study analysis is the comment that often individuals felt the therapeutic setting was unstructured and that clear working goals for each session were not provided; this comment was made by men more frequently than by women. It could be the case that men respond more positively to clear goals for each session whereas women may be more comfortable with a more unstructured approach where issues are dealt with as they arise. Either way these themes suggest that in order to engage both men and women in the counselling process therapists may need to provide an outline of how the process works for each couple at the outset to ensure that individual needs are addressed. Couples could also be encouraged to talk together between sessions about how the counselling process is working for them (or not working) and to give feedback to the therapist at the beginning of the next session. In this way the therapeutic experience is one that evolves and develops for each dyad in a manner that is responsive to their needs.

Another important clinical consideration is however, that the therapist may be working with entrenched patterns of relating between partners that are resistant to change. Despite the fact that partners may state they want clear goals and structure in couple counselling, the therapist may be cognisant of deeper, less conscious issues that take time to explore and understand. For example, it may not be helpful in early sessions for the therapist to draw attention to the parallel process of problems in the current relationship with unresolved family of origin issues that emerge from either or both partners’ past histories. Often, a strong therapeutic alliance needs to be established before deeper and more complex issues can be explored.

9.8.1.6 Summary of Case Study Findings.

This study of Australian couples seeking relationship counselling found significant gender differences. Women were the initiators of relationship counselling; they were less satisfied with their relationships and reported higher levels of emotional distance from their partners than did men. The main reasons participants gave for seeking counselling were to improve communication, to improve their relationship, to resolve conflict and to decide about the future of their relationship.
These reasons for seeking relationship counselling are consistent with previous findings both within Australia (Carmady et al., 2004, 2005) and overseas (Doss et al., 2004).

Findings from the current study support previous research on the relationship between secure attachment and relationship satisfaction (Lemmens et al., 2007; Whisman, 2001) where secure attachment was found to be a significant predictor of satisfaction with one’s relationship. Previous research has also found that when there is a depressive illness in one or both partners considerable strain is placed on the marital relationship (Benazon & Coyne, 2000; Lemmens et al.). The current research found a higher level of depression, stress and anxiety than is found generally in the Australian population (Lovibond & Lovibond, 1995) and raises the issue of the complex relationship between marital distress and depression.

Case study analysis of the six couples reported has revealed some interesting themes that would not have been evident from group analysis. Some individuals were more distressed following counselling and less satisfied with their relationships despite their counsellor rating the outcome of counselling as favourable.

9.9 Counsellor Questionnaires

9.9.1 Counsellor Qualifications and Experience

Of the 15 counsellors who responded to the questionnaire 10 had qualifications as a psychologist, 4 stated their qualifications as a counsellor and 1 as a social worker. All 15 counsellors had completed post graduate training in couples counselling, 11 of these had been completed within the agency. Seven counsellors had been working at the agency for one year or less indicating these counsellors were still completing their post graduate training in couples work and were working in a non paid capacity. The agency offers clinical placements to psychology, social work and family therapy students. The remaining eight counsellors were salaried staff with three or more years experience in relationship counselling. The range in experience in relationship counselling varied from 1 year to 29 years. The most commonly used therapeutic framework by all counsellors was an eclectic approach followed by psychodynamic and insight-oriented approaches. Given the complex issues that couples bring to relationship counselling which include: Problems with
communication and conflict resolution; Mood disorders; Addictions; Affairs and sexual dysfunction; it is not surprising that therapists need to draw on a range of theoretical frameworks and models and also adopt an educative approach in order to tailor interventions for each individual couple who attends.

9.9.2 Important Issues Discussed in Counselling for Clients and Counsellors

The most frequently discussed issues in relationship counselling reported by both clients and counsellors with a mean score above 3.5 (out of a possible score of 5) were: To improve the relationship; To decide about the future of the relationship; To improve communication; and To learn how to resolve conflict. These results highlight the importance of developing interpersonal and conflict resolution skills in personal relationships. It appears that both clients and counsellors approached counselling aiming to improve the relationship and to develop more effective ways of managing conflict. These are of course essential skills required in any relationship whether it is at an interpersonal, group or community level.

9.9.3 Counsellor and Client Assessment of Therapeutic Outcomes

Counsellors were asked if the couple were less distressed once counselling had been completed; mean scores were 4.13 out of a possible score of 5 indicating that as a group counsellors reported that clients were considerably less distressed following counselling. However, inspection of the client data revealed that 3 of the 12 participants reported higher post DASS 21 scores following counselling, indicating that some participants were in fact more distressed once counselling had been completed.

Mean scores on the Counsellor Qualities Scale (CQS) were above 4 for both men and women out of a possible score of 5 (extremely satisfied) indicating clients’ ratings of their counsellor’s skills, empathy, warmth and fairness were very high, even though these same clients may not report that their relationship had improved. It appears that clients distinguish between counsellor qualities (as positive) and satisfaction with the outcome of their counselling (sometimes less positive). It is noteworthy that counsellors in this study rated themselves quite highly on creating a therapeutic environment that was attuned to the needs of each couple or individual although this did not always accord with client perceptions.
Client and counsellor ratings on satisfaction with the outcome of counselling were quite different, possibly indicating that counsellors’ perceptions of their clients’ feelings were sometimes inaccurate. Even in this modestly sized sample differences between client and counsellor ratings on the outcome of counselling were considerable. These results highlight the complex dynamic that operates in the therapeutic environment. Most counsellors would agree that a strong therapeutic alliance is important for change (Hampson et al., 1999; Helmke et al., 2002) but counsellors should be mindful that when there are two clients sitting in the therapy room all three people may be having quite different experiences.

In the current study there were 19 counsellor responses to questions on outcomes for each individual and each couple who attended for counselling from 15 different counsellors. Seven of these counsellors had less than one year’s experience as a couples’ therapist and eight counsellors had two years or more experience. Therapist ratings of outcomes for couples by the more experienced counsellors were higher than for the less experienced counsellors on the following variables: clients’ attainment of goals for counselling; partners were equally motivated to attend counselling and the couple were less distressed at the end of counselling than when they first attended. There was a trend for the less experienced counsellors to rate outcomes for clients more highly than the more experienced counsellors on the following variables: couple were willing to make changes in the way they communicated with each other; couple made satisfactory progress in therapy and couple discontinued counselling prematurely.

The small number of counsellors completing questionnaires reduced the possibility of measuring statistically significant differences comparing between more experienced with less experienced counsellors. Nonetheless these findings provide a unique insight into some of the factors that contribute to satisfactory outcomes in couples counselling within an Australian clinical setting from the counsellors’ perspective.

9.10 General Discussion and Limitations of Current Study

While relationships are an intrinsic part of human life it appears that many people experience significant problems in their interpersonal relationships and
require professional assistance. While relationship counselling services have existed in Australia since 1948 there has been limited research conducted on the outcomes of relationship counselling either within Australia or overseas. While empirical or efficacy studies have contributed enormously to our understanding of the minutiae of factors that facilitate changes in personal relationships the conditions required in efficacy studies often do not mirror those found in real-life situations.

Real-life therapy is invariably adapted to the particular needs of the client and frequently can continue until the client feels his/her problems have been addressed. When people contact a professional for help with relationship problems they are usually experiencing significant levels of distress. Herein lies one of the dilemmas of conducting real-life research; recruitment of participants occurs at a time of great stress for most people and may make it less likely that people agree to participate in a real-life research project. However, effectiveness research is crucial to the field of couple counselling in order to further develop both theoretical frameworks for treating relationship problems and also the clinical expertise required in the treatment of relationship dysfunction. Couples who present in real-life clinical settings are usually grappling with multiple and more complex issues than those found in research trials (Christensen & Heavey, 1999; Johnson, 2003) and therefore research conducted in clinical settings needs to work within these parameters.

9.10.1 Discussion of Main Study Variables

Results from the current study showed that these Australian clients attended counselling with significant levels of personal distress and relationship dissatisfaction. Overall as a group there was a higher level of insecurely attached people than is generally found in the population, suggesting that people who attend for relationship counselling may experience problems in their relationships due to life-long patterns of problematic relationship experience.

9.10.1.1 Attachment.

Given that attachment is a relatively stable trait across time and that early patterns of attachment provide a template for patterns of relating throughout one’s lifetime, these findings raise some critical issues regarding the importance of stable and secure experiences in early childhood. The pattern of attachment styles found generally in the population (Feeney, 1996) is different to the patterns found in the
current study with less securely attached people and more insecurely attached people found in this current sample of Australian couples seeking relationship counselling.

Feeney (1996) suggests that researchers should be mindful of the patterns of partner matching when conducting attachment research but perhaps more importantly from a clinical perspective, is that clinicians should adopt assessment methods to determine attachment style for individuals in each couple and to develop the therapeutic skills necessary to work with the various combinations of attachment style and their impact on adult partnering and subsequent relationships. The current study highlights the need for further research into attachment patterns in established couple relationships.

9.10.1.2 Relationship Satisfaction.

Participants attended counselling with low levels of relationship satisfaction and high levels of emotional distance reported towards their partner. The mean scores on relationship satisfaction for four couples portrayed in the case studies were still within Hendrick’s (1986) range that predicted “apart” couples suggesting that even after counselling these participants continued to be unhappy with their relationships. These findings have implications for future research and also for therapists working in the field of relationship counselling and suggest that even after counselling some relationships are still at risk of ending. Further research with a larger sample could help to identify the effect of couple counselling on relationship satisfaction.

9.10.1.3 Impact of Gender on Relationship Satisfaction.

Findings from the current study showed a significant gender difference regarding the initiation of counselling and relationship satisfaction. Women were more likely to be the initiators of counselling, they were more likely to report feeling dissatisfaction with their relationship, to be less attracted to their partners and to feel more emotionally distant from their partners than were men prior to attending for counselling. Gottman (1999) has found that women are often the “emotional managers” in relationships and will be the first to identify problems and want to address these with their partner. In a clinical setting these findings may influence the progression of couple’s therapy, particularly if the therapist also female. Men may find themselves in a therapeutic setting where his female partner and the female
therapist are talking the same “emotional language”; he may feel marginalized when the process he would like adopted includes setting goals and developing strategies to “fix” the problem. If the therapist is informed about the impact of gender on research outcomes in couple therapy he or she may be able to address some of the different expectations men and women may have in the counselling setting.

9.10.1.4 Impact of Counselling on Mood.

The proportion of people seeking relationship counselling with clinically significant levels of depression, anxiety and stress was considerably higher than is found in the general population. The reasons for this could be because of the complex relationship between depression and attachment style; that insecurely attached people are more likely to be depressed and insecurely attached people are more likely to experience problems in their personal relationships than securely attached people. Most participants were less distressed once counselling had been completed indicating that relationship counselling had a significant impact on people’s general mental health. There was a significant decrease in levels of depression and stress following counselling suggesting that even though many relationships were still in trouble small changes in relationship satisfaction appear to have contributed to a significant improvement in general mood.

9.10.2 Methodological Issues

Some of the methodological constraints in conducting research in real life clinical settings include difficulties associated with recruiting people at a time when they are distressed and preoccupied. Agencies providing a range of relationship counselling services understandably want to minimise the level of anxiety and stress for clients in accessing services. Research partnerships may be one way to overcome the dilemma that arises between the need for more real-life research and protection of the privacy and confidentiality of clients seeking services. Also agencies could contribute to the type of research that would be required and the manner in which research is conducted. In this way clinical and academic expertise would be combined with one informing the other; efficacy research informing effectiveness research and vice versa. Statistical significance is one aspect of research but clinical significance and clinical relevance are crucial factors to consider in order to engage therapists in research programs (Johnson, 2003).
Another methodological constraint in the current study was the difficulty in recruiting both partners in the relationship to complete pre and post questionnaires. Participants need to see some tangible benefit for themselves before agreeing to participate in research programs. Even modest incentives such as gift vouchers appeared to increase the participation rate at all stages of the recruitment process in the current study.

Other constraints in the current study included the length of the questionnaire, which was limited by the agency involved, to a completion time of 15 minutes. Shorter questionnaires may not capture all of the complexities involved in couple relationships and the difficulties couples might be encountering. Therefore, clinical research projects targeted at specific relationship issues may provide more detailed information for both clinicians and researchers alike. Respondents in the current study were also asked to participate at a stressful time in their lives. Couples experiencing domestic violence were screened out of the current study at the agency’s request to ensure no additional stress and strain was placed on these couples. These restrictions on the sample highlight both the difficulties in conducting real-life research as well as highlight areas for future research.

The modest sample size in the current study made complex analyses such as multi level modeling untenable. Research into couple relationships has to account for the issue of non independence of members of a couple; larger sample sizes in future research may help to elucidate some of the trends found in the current study.

9.1 Conclusion

In conclusion, the current study investigated the complex relationship between attachment styles, mood and relationship satisfaction/dissatisfaction in the context of relationship counselling. Study findings demonstrated the high level of personal distress experienced by people attending for couple counselling. These findings can contribute to a greater understanding that when couples present for relationship counselling the problems they are seeking help for may be having a significant impact on their mental health, their sense of well-being and overall family functioning. This highlights the need for comprehensive assessment and effective treatment in clinical settings that focuses on both interpersonal as well as intrapersonal factors. It is hoped that these findings may guide and inform clinical
practice.

The barriers to conducting real-life research should not hinder effectiveness research being undertaken. It is only through a cross fertilisation of findings from both empirical and clinical settings that further understanding of the variables that influence satisfactory outcomes in couple counselling can be gained.

9.12 Recommendations for Future Research

The current study has highlighted several areas for future research. These include:

- Further exploration of the attachment field in adult relationships and in particular the relationship between attachment style, depression and relationship satisfaction for those couples attending for relationship counselling
- The relationship between mood disorders and relationship satisfaction
- Research into the use of a brief relationship satisfaction measurement (such as the RAS) given to clients prior to the first session and as a post counselling tool to measure change could provide valuable information for clinicians and clients alike. It is necessary to balance the complexity of measures used with time constraints in both research and clinical settings.

While other measures of relationship satisfaction and functioning such as the MSI-R (Snyder, 1997) provide a more comprehensive profile of 13 different domains in a couple’s relationship this measure takes at least 20 minutes to complete. The time taken to complete a lengthier questionnaire would be an important factor to consider in the midst of a busy counselling agency and would require clients either arriving 20 minutes earlier than their appointment to complete the questionnaire or for it to be posted to the clients prior to their first appointment. Most clients would need to see the personal benefits of completing questionnaires before they would agree to commit extra time to complete questionnaires prior to their first session.

- A brief depression scale such as the one currently used by General Practitioners in Australia when completing a Mental Health Care Plan for 12 funded sessions to see a psychologist. In order for therapists to consider using measurement tools they would need to see the clinical
relevance and to be trained in interpreting the data obtained. Unless questionnaires are brief neither therapists or clients would be willing to consider their application or to see their usefulness.

Currently the Australian Federal Government’s Mental Health Care Initiative only covers individual therapy. Research findings arising from couples counselling studies such as the current study should strengthen the recommendation of many couple’s therapists that relationship counselling should also be funded under this initiative. Given that higher incidence of mental health issues such as depression is consistently found in people who present with relationship issues it would appear that mental health issues are not solely an individual problem but in fact arise out of problematic interpersonal relationships. Such research supports the argument that relationship problems warrant Federal Government funding for mental health issues.

- The development of a questionnaire for couples’ counsellors that evaluates outcomes for individuals in a relationship as well as evaluate couple dynamics.

As shown by the current study evaluating outcomes for each couple is a vital component of relationship research but individual differences may be overlooked in this process. Future recommendations for further research in relationship counselling include consultation with therapists working in the field to ensure there is clinical relevance to research studies. It would be a research study in itself to ask therapists to identify the areas of clinical work they consider relevant to investigate in real-life clinical settings. While there are many complex variables that contribute to satisfactory outcomes in relationship counselling the area deserves more attention in the research field.

While the proliferation of online counselling services has taken the therapeutic community into a new level of service provision it should be remembered that relationship counselling is about relationships and while online surveys and questionnaires may be helpful to obtain a profile of people’s mental health or relationship satisfaction there can be no substitute for the benefits of a real life relationship; of two partners sitting with a therapist and exploring the known and unknown territory of their interpersonal relationship; to be able to show a therapist the problematic dynamics they may be struggling with. It is at this level that
interventions can be made that both partners can see as beneficial; there are many advantages in the personal approach.

Healthy experiences of relationships in childhood increases the chances of having healthy relationships in adulthood. Couple therapy is an integral part of mental health services, not only for the couple and their family but also for the wider community. The field of couple therapy has developed considerably from the days in the late 1940’s when church based agencies offered marital therapy usually provided by untrained volunteer counsellors. The relationship counselling field has become more professional and has developed an expanding body of literature over the past 50 years that has aimed to further understanding of who seeks relationship counselling, for what reasons is counselling sought and what actually works in counselling.

Any outcome research that evaluates the effectiveness of couples counselling should be longitudinal to investigate whether the gains achieved in therapy are maintained over time. Despite the limitations of the current study results nonetheless provide a unique picture of some of the factors that further understanding of the complex dynamics that operate within intimate relationships and the impact of seeking professional assistance. As the demand for research funding increases and the pool of funds available decreases it will become crucial that clinical relevance directs future research. Psychologists will continue to play a significant role in the future in the field of couple therapy both as researchers and clinicians; both areas of expertise are crucial to further our understanding of the complex dynamics that operate within the clinical setting.

9.13 Summary of Clinical Recommendations

Findings from the current suggest several clinical interventions for couples therapists, these include:

- The importance of establishing the goals for therapy for each person as partners may be attending for different reasons
- Based on the current research there is likely to be a gender difference on factors such as relationship satisfaction, emotional distance and attraction when couples present for relationship counselling with women being less satisfied with their relationships than men
• When couples present for relationship counselling either one or both partners may be clinically depressed; a thorough assessment of the impact of relationship distress on each partner’s mental health should be encouraged
• Even after couples therapy has been completed relationship satisfaction may be still low or even lower than prior to couples counselling

Future research in the area of couple’s therapy includes collaboration between researchers and clinicians to ensure that any future research focus has clinical relevance for practitioners and for people seeking assistance.
References


Australian Bureau of Statistics. Marriages and Divorces, Australia, 2001 (cat. no. 3310.0) released on 22 August 2002.


Factors That Improve Couple Counselling
A Joint Project Between (Name of Agency) and Swinburne University of Technology

Information Sheet for Participants

Description of the Study

This research aims to explore the factors that contribute to clients' experience of satisfaction with couples' counselling. There has been little research to date that looks at outcomes for clients in relationship counselling. It is hoped that the results of this study will help couples receive more effective services in the area of couples counselling. Participation in this study is voluntary. You may withdraw from the study at any time. A decision not to participate or to withdraw from the study will not affect your access to services at (Name of Agency) in any way. If you chose to participate you will be asked to fill out two questionnaires, the first questionnaire is enclosed in this package. In recognition of the time taken to complete the first questionnaire, upon receipt of your completed questionnaire you will be sent a $25 Coles Myer voucher. The second questionnaire will be mailed to you after you have finished counselling. You may be asked to volunteer to complete a third questionnaire 12 months after counselling has finished. Each questionnaire will take approximately 15 minutes to complete.

Your questionnaire responses will remain confidential. You may decide to discuss the questionnaire in your counselling, some people find this helpful. However, the counsellor you see will not be informed that you are a participant in the study during the time you are attending for counselling unless you decide to tell him/her. The counsellor will also be asked to complete a questionnaire on his/her perceptions about your counselling progressed after you have finished counselling.

Confidentiality:

All the responses and questionnaires will remain confidential. The researchers have undertaken to adhere to the following rules of confidentiality:

1. Participants will be allocated an identity code for research purposes. This code will replace names on questionnaires for recording purposes.
2. Data for this study will be analysed in group-form. Therefore, no personal information can be identified from the results. For example, the results will be reported in the form of "95% of couples reported that they would recommend the service to others in a similar situation".

The results of this study may be published. If you are interested in the results, you can contact the Administration at (Name of Agency) who will provide you with a summary of the results when the study has been completed.

If you choose to participate, please complete the enclosed consent forms and the first questionnaire (the Pre-Counselling Questionnaire). You can return the questionnaire in the reply paid envelope or hand the sealed envelope to the reception staff member when you attend for your first counselling session. The researcher will collect the sealed envelopes from Relationships Australia.

If you have any questions or queries please contact the principal researchers on the numbers below.

Associate Professor Ann Knowles on (03) 9214 8205
Dr. Greg Murray on (03) 9214 8300 or
Ms. Adele Carmady on 0417 130 054

Your time and effort in participating in this project would be very much appreciated.
APPENDIX B
FACTORS THAT IMPROVE COUPLE COUNSELLING

Pre-Counselling Questionnaire

This research aims to explore the factors that contribute to clients’ experience of satisfaction with couples counselling. Many people find it helpful and interesting to participate in studies that ask questions about their experience of counselling. There has been little research to date that looks at outcomes for clients in relationship counselling. Your participation will further our understanding of what makes a difference for clients. Please do not discuss the questionnaire, or your responses, with your partner. The questionnaire should take you about 10 minutes to complete. Please attempt to answer all questions. Thank you for your participation in this study.

Section 1

Reasons for Attending Counselling

Name: .................................................................................................................. Age(in years): .........................

Gender: (please tick) ☐Male ☐Female

1. Which branch of (Name of Agency) did you attend? (please state)

...................................................................................................................................................

2. Who first initiated relationship counselling? Please circle the response that best describes, in your opinion, the person who initiated counselling.

<table>
<thead>
<tr>
<th>I did</th>
<th>Mostly me</th>
<th>Mutual decision</th>
<th>Mostly my partner</th>
<th>My partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

3. In your opinion, how long have there been problems in your relationship?

<table>
<thead>
<tr>
<th>Less than 6 months</th>
<th>Less than 12 months</th>
<th>1-2 years</th>
<th>2-5 years</th>
<th>More than 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

4. How long have you been thinking about seeking counselling?

<table>
<thead>
<tr>
<th>Less than 6 months</th>
<th>Less than 12 months</th>
<th>1-2 years</th>
<th>2-5 years</th>
<th>More than 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
5. Couples attend counselling for various reasons. Please consider the following reasons for attending counselling and indicate how important each reason is for you in attending counselling. **Please indicate how strongly you feel by circling one number for each reason.**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Not at all important</th>
<th>Somewhat important</th>
<th>Neutral</th>
<th>Slightly important</th>
<th>Extremely important</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To improve our relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Decide about the future of our relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Parenting, step-parenting/children's issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Discuss issues of intimacy/sexuality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Discuss the impact of an affair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. How to communicate more effectively with my partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. How to resolve conflict</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Achieving a balance between work/family issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. Discuss how to separate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>j. Discuss the influence of my family background on our relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>k. No idea</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Other (please specify the reason)

---

**Section 2**

**Current Mood**

6. These questions relate to the relationship for which you are seeking counselling. Please circle the number of the response that best describes your current feelings about your relationship (**Please circle one number for each question**).

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Not at all satisfied</th>
<th>A little satisfied</th>
<th>Somewhat satisfied</th>
<th>Quite satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
b. How well does your partner meet your needs?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Not much</th>
<th>Somewhat</th>
<th>Quite well</th>
<th>Totally meets my needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

c. How good is your relationship compared to most?

<table>
<thead>
<tr>
<th>Much worse than others</th>
<th>A little worse than others</th>
<th>As good as others</th>
<th>A little better than others</th>
<th>A lot better than others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

d. How often do you wish you hadn’t entered into this relationship?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>A lot of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

a. To what extent has your relationship met your original expectations?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

b. How much do you love your partner?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

c. How many problems are there in your relationship?

<table>
<thead>
<tr>
<th>None</th>
<th>A few</th>
<th>Some</th>
<th>Quite a few</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>h. I am still attracted to my partner</th>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>i. I feel we have the right physical “chemistry” between us</th>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>j. My partner fits my ideal standards of physical beauty/handsomeness</th>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>k. Sexual intimacy is an important part of our relationship</th>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree a little</td>
<td>Neutral</td>
<td>Agree slightly</td>
<td>Agree strongly</td>
</tr>
<tr>
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</tr>
<tr>
<td>l.</td>
<td>Strongly disagree</td>
<td>Disagree a little</td>
<td>Neutral</td>
<td>Agree slightly</td>
<td>Agree strongly</td>
</tr>
<tr>
<td>m.</td>
<td>My partner keeps most of his/her feelings to him/herself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>n.</td>
<td>My partner and I need to improve the way we settle our differences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>o.</td>
<td>There are some things my partner and I just can’t talk about</td>
<td>1</td>
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<td>q.</td>
<td>Whenever I need it most my partner makes me feel important</td>
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<td>r.</td>
<td>My partner does many different things to show me that he/she loves me</td>
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<td>4</td>
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<tr>
<td>s.</td>
<td>It is sometimes easier to confide in a friend than in my partner</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

7. These questions relate to how you have been feeling recently. Please read each statement and circle a number 0, 1, 2 or 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

<table>
<thead>
<tr>
<th></th>
<th>Did not apply to me at all</th>
<th>Applied to me to some degree, or some of the time</th>
<th>Applied to me to a considerable degree, or a good part of the time</th>
<th>Applied to me very much, or, most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I found it hard to wind down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>I was aware of dryness of my mouth</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>I couldn’t seem to experience any positive feeling at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>I experienced difficulty breathing (e.g., excessive rapid breathing in the absence of physical exertion)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5.</td>
<td>I found it hard to work up the initiative to do things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.</td>
<td>I tended to over-react to situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7.</td>
<td>I experienced trembling (e.g. in the hands)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>I felt that I was using a lot of nervous energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9.</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10.</td>
<td>I felt that I had nothing to look forward to</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
11. I found myself getting agitated

12. I found it difficult to relax

13. I felt down-hearted and blue

14. I was intolerant of anything that kept me from getting on with what I was doing

15. I felt I was close to panic

16. I was unable to become enthusiastic about anything

17. I felt I wasn’t worth much as a person

18. I felt I was rather touchy

19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, missing a beat)

20. I felt scared without any good reason

21. I felt that life was meaningless

8. Is there anything else you think we should know about how you have been feeling recently?

☐ No (go to Q9) ☐ Yes (please specify)

________________________________________________________

________________________________________________________

________________________________________________________

Section 3

Expectations of Counselling

The following questions relate to your expectations of counselling. Please consider each question and indicate your response by placing a circle around the number that best describes your current feelings.

9. How helpful do you think counselling will be?
Section 4

Relationships and Me

13. The questions in the next section concern how you cope, think and feel in general and are not necessarily related to your reasons for seeking counselling. Please read each of the following statements and rate the extent to which it describes your feelings about close relationships. Think about all of your close relationships, past and present, and respond in terms of how you generally feel in these relationships. Please circle the number that best represents how you usually think or feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all like me</th>
<th>Somewhat like me</th>
<th>Very much like me</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I find it difficult to depend on other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. It is very important to me to feel independent</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. I find it easy to get emotionally close to others</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. I worry that I will be hurt if I allow myself to become too close to others</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. I am comfortable without close emotional relationships</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. I want to be completely emotionally intimate with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. I worry about being alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. I am comfortable depending on other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. I find it difficult to trust others completely</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. I am comfortable having other people depend on me</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Section 5

My Family

14. What is your marital status? (Please tick one box)

   Married
   Living in a de facto relationship
   Separated
   Divorced
   Widowed
   Never been married

15. Which of the following best describes the household in which you live? Do you (please tick one box)

   Live in a couple family with dependent children ONLY
   Live in a couple family with dependent and independent children
   Live in a couple family with independent children ONLY
   Live in a step family household with dependent children ONLY
   Live in a step family household with dependent and independent children
   Live in a step family household with independent children ONLY
   Live in a couple family without any children
   Live with other members of the community e.g. shared house
   Live alone

Thank you for taking the time to complete this questionnaire. Please place the completed questionnaire in the reply paid envelope and seal the envelope. You can either hand the envelope to the administration staff member when you attend for your first counselling session or mail the envelope to the researchers. Sealed questionnaires handed to the administration staff at (Name of Agency) will be collected by the researchers.

If you have any questions or queries regarding this research please contact:

Adele Carmady on 0417 130 054 or email: acarmady@swin.edu.au.
APPENDIX C
FACTORS THAT IMPROVE COUPLE COUNSELLING

Post-Counselling Questionnaire

Now that you have finished counselling can you please complete this second questionnaire about what the experience of counselling was like for you. Please do not discuss the questionnaire or your responses with your partner. The questionnaire should take about 15 minutes to complete. Please attempt to answer all questions. Thank you for your participation in the study.

Section 1

Reasons for Attending Counselling

I.D.Code: ………………………

1. How long ago did you finish counselling? (weeks) ……………………………………….

2. How many counselling sessions did you attend with your partner? …………………

(If you cannot remember the exact number of sessions you attended either on your own or with your partner put down the approximate number of sessions attended)

3. How many sessions did you attend on your own? ………………………………………

4. Couples attend counselling for various reasons. Please read the following list of reasons and indicate how important each reason was for you in attending counselling. Please indicate how strongly you feel by circling one number for each reason.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Not at all important</th>
<th>Somewhat important</th>
<th>Neutral</th>
<th>Slightly important</th>
<th>Extremely important</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To improve our relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Decide about the future of our relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Parenting, step-parenting/children’s issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Issues of intimacy/sexuality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Discuss the impact of an affair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Discuss how to communicate more effectively with my partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. To learn how to resolve conflict</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
h. Achieving a balance between work/family issues

i. Discuss how to separate

j. Discuss the influence of my family background on our relationship

k. Concerns about my commitment to this relationship

l. Concerns about closeness to my partner

m. Discuss personal issues e.g. depression/past abuse

n. Domestic violence issues

o. Gambling issues

p. Drug &/or alcohol abuse issues

q. No idea

r. Other (please specify the reason)

5. Given all the above reasons you have indicated as the reasons for attending counselling what was your main reason? Please specify one reason only.

...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................

Section 2
My Relationship

6. The following section relates to your level of satisfaction with the relationship for which you attended counselling. Please circle the response that best describes your current feelings about your relationship.

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little satisfied</th>
<th>Somewhat satisfied</th>
<th>Quite satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

b. How well does your partner meet your needs?
### c. How good is your relationship compared to most?

<table>
<thead>
<tr>
<th>Much worse than others</th>
<th>A little worse than others</th>
<th>As good as others</th>
<th>A little better than others</th>
<th>A lot better than others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### d. How often do you wish you hadn’t entered into this relationship?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>A lot of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### e. To what extent has your relationship met your original expectations?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### f. How much do you love your partner?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>Quite a bit</th>
<th>Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### g. How many problems are there in your relationship?

<table>
<thead>
<tr>
<th>None</th>
<th>A few</th>
<th>Some</th>
<th>Quite a few</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### h. I am still attracted to my partner

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### i. I feel we have the right physical “chemistry” between us

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### j. My partner fits my ideal standards of physical beauty/handsomeness

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### k. Sexual intimacy is an important part of our relationship

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### l. I have important needs in our relationship that are not being met

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree a little</th>
<th>Neutral</th>
<th>Agree slightly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>m.</td>
<td>My partner keeps most of his/her feelings to him/herself</td>
<td>Strongly disagree</td>
<td>Disagree a little</td>
<td>Neutral</td>
</tr>
<tr>
<td>n.</td>
<td>My partner and I need to improve the way we settle our differences</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>o.</td>
<td>There are a lot of things my partner and I just can’t talk about</td>
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<td>3</td>
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<td>My partner always responds with understanding to my mood at a given moment</td>
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<td>It is sometimes easier to confide in a friend than in my partner</td>
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<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

7. The next question again relates to the issues discussed in counselling. Here we would like you to indicate if you would have liked more emphasis given to any of these issues, in your counselling. Please circle the response that best describes the level of emphasis given to each item discussed in counselling.

<table>
<thead>
<tr>
<th></th>
<th>Not discussed</th>
<th>Emphasis adequate</th>
<th>Would have liked more emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>l.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>m.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>n.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>o.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>p.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>q.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>r.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>s.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Section 4

**Current Mood**

8. The next series of questions relate to how you have been feeling recently. Please read each statement and circle a number 0, 1, 2 or 3, which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

<table>
<thead>
<tr>
<th></th>
<th>Did not apply to me at all</th>
<th>Applied to me to some degree, or some of the time</th>
<th>Applied to me to a considerable degree, or a good part of the time</th>
<th>Applied to me very much, or, most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>I found it hard to wind down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b.</td>
<td>I was aware of dryness of my mouth</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c.</td>
<td>I couldn’t seem to experience any positive feeling at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d.</td>
<td>I experienced difficulty breathing (e.g., excessive rapid breathing in the absence of physical exertion)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e.</td>
<td>I found it hard to work up the initiative to do things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f.</td>
<td>I tended to over-react to situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>g.</td>
<td>I experienced trembling (e.g., in the hands)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>h.</td>
<td>I felt that I was using a lot of nervous energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>i.</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>j.</td>
<td>I felt that I had nothing to look forward to</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>k.</td>
<td>I found myself getting agitated</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>l.</td>
<td>I found it difficult to relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>m.</td>
<td>I felt down-hearted and blue</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>n.</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>o.</td>
<td>I felt I was close to panic</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>p.</td>
<td>I was unable to become enthusiastic about anything</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>q.</td>
<td>I felt I wasn’t worth much as a person</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>r.</td>
<td>I felt I was rather touchy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>s.</td>
<td>I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, missing a beat)</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>t.</td>
<td>I felt scared without any good reason</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>u.</td>
<td>I felt that life was meaningless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
10. Is there anything else you think we should know about how you have been feeling recently?

- ☐ No (please go to Q11)
- ☐ Yes (please specify)

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

Section 5

Changes Due to Counselling

11. The following questions relate to any personal changes in your life that are due to the counselling you received. Please read the following statements and circle the number that best describes your experience.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very true of me</th>
<th>A little true of me</th>
<th>Neutral</th>
<th>Not very true of me</th>
<th>Not true at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I learnt a lot about myself in counselling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I feel that my experience of counselling has not improved my ability to continue working on the issues we discussed in counselling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. My experience of counselling has improved my ability to manage other relationship issues.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. My life has improved as a result of counselling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. I have personally changed as a result of counselling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

12. The following questions relate to your feelings about the counsellor you saw. Please read the following statements and circle the number that best describes how you feel.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly disagree</th>
<th>Disagree somewhat</th>
<th>Neutral</th>
<th>Agree somewhat</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. My counsellor handled the sessions in a skilled manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. My counsellor was a likeable person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. I felt the counsellor was fair and impartial when dealing with us</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. I felt the counsellor was warm and empathic when dealing with us</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. I felt the counsellor was helpful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
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<tr>
<td>---</td>
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<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>f. I felt the counsellor addressed the problems we came to counselling about</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. The counsellor communicated to us clearly the changes we needed to make to improve our relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. I felt the counsellor wanted to discuss issues other than those we came to counselling about</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. The gender of the counsellor was important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>j. Putting both likeability and skill level of my/our counsellor aside, my/our problem was managed in an effective manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

13. The next series of questions relate to other areas of the service you received. Please indicate your responses by circling the response that best describes how you feel.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. As a consequence of counselling I am now more aware of the changes I need to make in my relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I felt that the fee we paid was fair for the service we received</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. If the need arose, I would use the service again</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. I would recommend the service to others in a similar situation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Overall, how satisfied are you with the way counselling was carried out?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Overall, how satisfied are you with the outcome of counselling?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

14. Were you and your partner living together when you came to counselling?

☐ Yes ☐ No

15. Are you and your partner living together on a permanent basis now?

☐ Yes ☐ No
16. What did you find most helpful about counselling?
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
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...........................................................................................................................................

17. What did you find least helpful about counselling?
...........................................................................................................................................
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18. Are there any other comments you would like to make?
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................
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Thank you for taking the time to complete this questionnaire. Please place the completed questionnaire in the reply paid envelope and return by mail to Swinburne University. If you have any questions regarding this questionnaire or the research please don’t hesitate to contact the researcher:

Adele Carmady on 0417 130054 or by email acarmady@swin.edu.au
APPENDIX D
Factors That Improve Couples Counselling

A Joint Project Between (Name of Agency) and
Swinburne University of Technology

Counsellor Questionnaire

1. How long have you worked at (Name of Agency)? ……………………….. (years)

2. What are your educational qualifications? Please place a tick in the box/boxes that best describe your qualifications.
   - Counsellor ☐
   - Psychologist ☐
   - Social worker ☐
   - Family therapist ☐
   - Other (please specify)……………………………………………………………………

3. What training/qualifications do you have in relationship counselling?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………

4. To what extent do you use the following frameworks in your work with couples?
   Please circle the response that best describes how much you use each approach.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>A lot of the time</th>
<th>Most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Family therapy/ systems approach</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. Narrative therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c. Cognitive/behavioural therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d. Psychodynamic approach</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e. Emotion focused therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f. Insight oriented therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g. Feminist theory/approach</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h. Gestalt therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>i. Eclectic (an amalgam of approaches)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Other framework (please specify)

5. Given that there may be more than one theoretical influence on your work, which approach most influences your work?

6. Clients involved in this research completed a pre-counselling questionnaire on their reasons for attending counselling. Clients were asked to rate the importance on the following list of issues for them in attending counselling. Can you please indicate the importance (in your opinion) of each issue for both partners separately for couple …………………….. (ID Code). Please retain the order you have identified each partner (i.e. partner 1 or partner 2) for later questions.

   i. PARTNER 1

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>Extremely important</th>
<th>Quite important</th>
<th>Neutral</th>
<th>A little important</th>
<th>Not at all important</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To improve the relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Decide about the future of the</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Discuss parenting, step-parenting/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>children’s issues</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>d. Discuss issues of intimacy/sexuality</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>e. Discuss the impact of an affair</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Discuss how to communicate more</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>effectively with partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Discuss how to resolve conflict</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>h. Discuss balancing work/family issues</td>
<td></td>
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<tr>
<td>i. Discuss how to separate</td>
<td></td>
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</tr>
<tr>
<td>j. Discuss the influence of family</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>background on the relationship</td>
<td></td>
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</tr>
<tr>
<td>k. Discuss concerns about commitment to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>this relationship</td>
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<td></td>
</tr>
<tr>
<td>l. Discuss concerns about closeness in</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>this relationship</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>m. Discuss personal issues e.g.,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>depression / past abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Domestic violence issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Gambling issues</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>p. Drug &amp; /or alcohol abuse</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
ii. PARTNER 2

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>Extremely important</th>
<th>Quite important</th>
<th>Neutral</th>
<th>A little important</th>
<th>Not at all important</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To improve the relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. Decide about the future of the relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c. Discuss parenting, step-parenting/children’s issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. Discuss issues of intimacy/sexuality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e. Discuss the impact of an affair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. Discuss how to communicate more effectively with partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g. Discuss how to resolve conflict</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>h. Discuss balancing work/family issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>i. Discuss how to separate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>j. Discuss the influence of family background on the relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>k. Discuss concerns about commitment to this relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>l. Discuss concerns about closeness in this relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>m. Discuss personal issues e.g., depression / past abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>n. Domestic violence issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>o. Gambling issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>p. Drug &amp; /or alcohol abuse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

7. How long did this couple attend for counselling with you? ............(weeks)

8. These questions relate to the therapeutic relationship you developed with this couple. Please circle the response that best describes your understanding of the factors that contributed to the development of the therapeutic relationship with these clients.

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>Strongly disagree</th>
<th>Disagree somewhat</th>
<th>Neither agree or disagree</th>
<th>Agree somewhat</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The therapeutic relationship was part of what helped this couple to make changes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b. I was able to show I understood their problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree somewhat</td>
<td>Neither agree or disagree</td>
<td>Agree somewhat</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>---</td>
<td>------------------</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>c.</td>
<td>I was able to use everyday language when explaining things to these clients (not technical language I might use with a colleague)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d.</td>
<td>I was able to create an environment where their problems could be discussed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e.</td>
<td>I could laugh and joke with these clients when appropriate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f.</td>
<td>I felt relaxed in sessions with these clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g.</td>
<td>I was able to give both partners equal time in counselling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h.</td>
<td>These clients could give me feedback about what was or wasn’t working for them</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i.</td>
<td>These clients knew they could trust me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j.</td>
<td>I was interested in working with this couple</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k.</td>
<td>I tailored my interventions to the needs of this particular couple</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>l.</td>
<td>I was able to be open about how I understood the problems in this couple’s relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>m.</td>
<td>I was able to address the problems this couple brought to counselling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

9. Are there any other comments you would like to make about the factors you considered important in the development of a positive therapeutic relationship with this couple?

..........................................................................................................................................................
..........................................................................................................................................................
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..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................
10. These questions relate to the outcomes for couple (IDcode) .................

In your opinion what were the outcomes for this couple in counselling? (Please circle the number that best describes the outcome for each question)

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree somewhat</th>
<th>Neither agree or disagree</th>
<th>Agree somewhat</th>
<th>Strongly agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Client/s achieved their desired goals for counselling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>b. <strong>Partner 1</strong> was not motivated to attend counselling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>c. <strong>Partner 2</strong> was not motivated to attend counselling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>d. Couple were not willing to make changes in the way they communicated with each other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>e. Couple made satisfactory progress in therapy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>f. Couple could not resolve their differences on important issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>g. Each partner could understand the other’s point of view even if they didn’t agree with their partner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>h. <strong>Partner 1</strong> was willing to make changes in this relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>i. <strong>Partner 2</strong> was willing to make changes in this relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>j. <strong>Partner 1</strong> was willing to look at the influence of family background on the relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>k. <strong>Partner 2</strong> was willing to look at the influence of family background on the relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>l. Couple were willing to learn new strategies in the way they deal with conflict</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>m. Couple were able to discuss their sexual relationship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>n. Couple discontinued counselling prematurely</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>o. <strong>Partner 1</strong> was committed to this relationship continuing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>p. <strong>Partner 2</strong> was committed to this relationship continuing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>q. Counselling helped this couple make a decision to separate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
r. Both partners were equally motivated to attend counselling

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
</table>

s. Couple were less distressed at the end of counselling than when they first attended

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
</table>

t. Separation would be a good outcome for this couple

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
</table>

11. Is there any intervention you would have liked to make, but did not?

☐ Yes  ☐ No

(If no, go to q12) If yes, please specify the intervention/s you would have liked to make.

……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..

12. How satisfied are you with the outcome of counselling for this couple?

<table>
<thead>
<tr>
<th></th>
<th>Extremely dissatisfied</th>
<th>Quite dissatisfied</th>
<th>Some what satisfied</th>
<th>Quite satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>This couple</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

13. How satisfied are you with the process of counselling for this couple?

<table>
<thead>
<tr>
<th></th>
<th>Extremely dissatisfied</th>
<th>Quite dissatisfied</th>
<th>Some what satisfied</th>
<th>Quite satisfied</th>
<th>Extremely satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>This couple</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

13. Do you have any other comments you would like to make about this couple’s progress in counselling or the outcome?

……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………..

Thank you for taking the time to complete this questionnaire. If you have any queries regarding this research please contact Adele Carmady by email:

acarmady@swin.edu.au or on 0417 130054.
APPENDIX E
Factors That Improve Couple Counselling

A Joint Project Between (Name of Agency)
And Swinburne University of Technology

Information Sheet for Administration Staff

(Name of Agency) and Swinburne University are undertaking a joint research partnership to explore the factors that contribute to a satisfactory outcome for couples who attend for relationship counselling. We aim to recruit 50 couples to participate in this research across the Victorian branches of (Name of Agency). The (Name of) branch is currently involved in another research project and will not be included in this current study.

Administration staff will be the first point of contact for clients when they ring the agency seeking counselling and will be the first person to discuss the research project with clients. Administration staff will ask prospective clients if they would like to receive an information package about the research project in the mail. Clients can decide if they would like to participate or not after they have read the information package. Participation is entirely voluntary and clients may withdraw from the study at any time without any effect on their access to services. Clients who agree to participate will go through the same intake and waiting list procedures as clients who do not want to participate, i.e., participation in the study will not mean an earlier appointment for those clients than if they choose not to participate.

Each partner will be asked to complete one questionnaire before their first counselling session and another questionnaire after they have finished counselling. The first questionnaire will take about 10 minutes to complete and the second questionnaire will take about 15 minutes to complete. Administration staff will mail the first questionnaire to the clients before they attend for the first session and the researchers mail post the second questionnaire to the clients once counselling has finished. Recruitment for the research project will occur during the period July 2003 - May 2004.

We are seeking couples who contact the agency for counselling and intend to come to counselling together. Each person who completes and returns a pre-counselling questionnaire will be reimbursed with a $25 Coles Myer voucher. After the routine intake process has been completed and the referral is for a couple attending together, the following information about the study can be read out to the client:
“(Name of Agency) is undertaking a joint research project with Swinburne University in Victoria into the factors that contribute to client satisfaction with relationship counselling. The study involves couples who attend relationship counselling together. Would you be interested to receive some information in the mail about this study? After you have read the information you can decide if you would like to participate in the research project or not. If you decide to participate and return a completed questionnaire you will receive a $25 Coles Myer voucher in recognition of the time you have given to the project.”

Some questions you may be asked:

Do I have to be involved in this study?
Participation is entirely voluntary and people may withdraw at any time.

What if my partner doesn’t want to participate but I do?
Ideally both partners should complete the questionnaires but if your partner decides not to be involved an individual can still complete the questionnaires.

If I participate will I be able to have an earlier appointment?
Participation will not mean that clients are given an earlier appointment.

Who will see the questionnaires?
The questionnaires are confidential, only the researchers will have access to the completed questionnaires.

Will my counsellor know that I am a research participant?
Counsellors will not be told that clients are participants in the study unless the client/s chooses to tell the counsellor they are involved in the study.

How long will the questionnaire take to fill out?
There are two questionnaires to be completed. One will be sent to you before your first counselling session and should take about 10 minutes to complete. The second questionnaire will be mailed to you after you have finished counselling and should take about 15 minutes to complete.

What will I get out of being involved in this research?
Most people find it interesting to be asked questions about what was helpful for them in counselling. There is little research into the area of what makes a difference for people who attend for relationship counselling in Australia. Your participation will contribute to further understanding in the area of relationship counselling.

Who are the researchers?
Staff from Swinburne University with experience and expertise in the areas of relationship and individual counselling, academic research and ethical issues.

If clients have any other queries or questions about the research they can contact one of the researchers: Adele Carmady on 0417 130 054 or email: acarmady@swin.edu.au.
FACTORS THAT IMPROVE COUPLE COUNSELLING

A Joint Project of (Name of Agency) and
Swinburne University of Technology

Statement of Informed Consent

I, ................................................................., consent to taking part in the study as described in the Introductory Statement sheet. I understand my rights as a participant in this research. The aims of the study have been explained to me and I understand them. Any questions I have asked have been answered to my satisfaction. I have been advised that the results of this research may be published but that my personal details will remain confidential and I will not be individually identified in any way. I voluntarily consent to participate and I understand that I may withdraw at anytime.

If you have any comments or complaints to make on this research project, please contact either Associate Professor Ann Knowles on (03) 9214 8205 or the Chair, Human Research Ethics Committee, Swinburne University, Hawthorn, on 9214 5223.

Name of Participant: .......................................  Signature:........................................
(to be printed)
  Date:....................................................

Name of Researchers:  Assoc. Prof. Ann Knowles  Signature:........................................
      Dr. Greg Murray  Signature:........................................
      Ms. Adele Carmady  Signature:........................................

Please retain this copy for your records
APPENDIX G
Dear Participant,

Thank you for participating in the joint research project between (Name of Agency) and Swinburne University. Your participation in this research will assist us to explore the factors that contribute to clients’ experience of satisfaction with couples’ counselling. It is hoped that the results of this study will help couples receive more effective services in the area of couples counselling.

In recognition of the time taken to participate in this research, please accept this gift of a Coles Myer voucher and two movie vouchers.

If you have any questions or queries please contact the principal researchers on the numbers below.

Associate Professor Ann Knowles on (03) 9214 8205
Dr. Greg Murray on (03) 9214 8300 or
Ms. Adele Carmady on 0417 130 054

Your time and effort in participating in this project has been appreciated.
Descriptive Statistics and T-test Analyses on Development of the Therapeutic Relationship Comparing Counsellor Experience

<table>
<thead>
<tr>
<th>Variable</th>
<th>Counsellor Experience</th>
<th>Counsellor Experience</th>
<th>t (17)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; One Year</td>
<td>&gt; 2 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>1. “I was interested in working with this couple”</td>
<td>4.75</td>
<td>0.46</td>
<td>4.73</td>
<td>0.47</td>
</tr>
<tr>
<td>2. “I felt relaxed in sessions with these clients”</td>
<td>4.75</td>
<td>0.46</td>
<td>4.45</td>
<td>0.69</td>
</tr>
<tr>
<td>3. “I was able to create an environment where their problems could be discussed”</td>
<td>4.75</td>
<td>0.46</td>
<td>4.36</td>
<td>0.81</td>
</tr>
<tr>
<td>4. “I was able to use everyday language when explaining things to clients”</td>
<td>4.63</td>
<td>0.52</td>
<td>4.64</td>
<td>0.50</td>
</tr>
<tr>
<td>5. “I tailored my interventions to the needs of this particular couple”</td>
<td>4.63</td>
<td>0.52</td>
<td>4.64</td>
<td>0.67</td>
</tr>
<tr>
<td>6. “I was able to give equal time to both partners in counselling”</td>
<td>4.63</td>
<td>0.52</td>
<td>4.00</td>
<td>1.23</td>
</tr>
<tr>
<td>7. “These clients knew they could trust me”</td>
<td>4.63</td>
<td>0.74</td>
<td>3.91</td>
<td>0.83</td>
</tr>
<tr>
<td>8. “I was able to be open about how I understood the problems in this relationship”</td>
<td>4.50</td>
<td>0.76</td>
<td>4.36</td>
<td>0.81</td>
</tr>
<tr>
<td>9. “I could laugh and joke with these clients when appropriate”</td>
<td>4.50</td>
<td>0.93</td>
<td>4.09</td>
<td>0.94</td>
</tr>
<tr>
<td>10. “I was able to show I understood the problems in this couple’s relationship”</td>
<td>4.38</td>
<td>0.52</td>
<td>4.09</td>
<td>0.70</td>
</tr>
<tr>
<td>11. “These clients could give me feedback on what was or wasn’t working for them”</td>
<td>4.38</td>
<td>0.74</td>
<td>4.00</td>
<td>0.89</td>
</tr>
<tr>
<td>12. “The therapeutic relationship was part of what helped this couple to make changes”</td>
<td>4.13</td>
<td>0.64</td>
<td>3.60</td>
<td>0.52</td>
</tr>
<tr>
<td>13. “I was able to address the problems this couple brought to counselling”</td>
<td>4.00</td>
<td>0.93</td>
<td>4.18</td>
<td>0.98</td>
</tr>
</tbody>
</table>
List of Publications


APPENDIX J
Swinburne University of Technology

Human Research Ethics Committee Certificate of Approval

Project Title: Factors that improve couple counselling

HREC Register No.: 03/11
Chief Investigator: Knowles, Assoc Prof A
Other Investigators: Ms Adele Carmady
Dr Greg Murray
Dr Andrew Bickerdike

For period from: 04-Jul-03  To: 30-Aug-06
Approved for (max): 50 male participants
and 50 female participants

Approval is granted subject to the following conditions:
Researchers are required to immediately report anything which might
warrant review of ethical approval of the protocol, including: (a) serious or
unexpected adverse effects on participants; (b) proposed changes in the
protocol; and (c) unforeseen events that might affect continued ethical
acceptability of the project. If the research project is discontinued before
the expected date of completion researchers must inform the HREC

A progress report must be submitted annually.
A final report must be submitted at the conclusion of the project.
Special Conditions as indicated below.

Professor K. Pratt
Chair, Human Research Ethics Committee
Monday, 23 May 2005
Ms Adele Carmady
28 Gladstone Avenue
Northcote
VIC 3070

23 October, 2009

Dear Ms Carmady,

**RE: CHANGE OF THESIS TITLE**

At its meeting held on 20/10/2009 the Research Higher Degrees Executive Committee approved your application to change your thesis title to “An Exploration of Psychological Characteristics of People Seeking Relationship Counselling in an Australian Clinical Setting.”

Yours sincerely,

Prof Pam Green
Director for Graduate Studies
Swinburne Research
Tel: 9214 5224
Email: pamgreen@swin.edu.au

c.c. Assoc. Prof. Ann Knowles
    Prof Michael Gilding [H24]