Therapist Effects on Dropout in Couple Therapy

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Therapist Effects on Dropout in Couple Therapy

Kwin L. Willis

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

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ABSTRACT

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Despite the strong efficacy of couple therapy, many couples still do not benefit from treatment. Marriage and family therapy scholars have argued that therapists play a crucial role in the delivery of successful couple therapy, yet little research has documented that the therapist in couple therapy has a significant impact on outcomes. Known as the study of therapist effects, this study sought to assess the amount of variance attributed to the therapist in couple therapy outcomes. Using dropout as the outcome variable, this study analyzed data from 1192 couples treated by 90 therapists at a university-based training clinic. Results from multilevel analysis indicated that therapists in the sample accounted for 9.5% of the variance in couple dropout while controlling for initial couple impairment. Therapist gender and therapist experience did not significantly predict the effectiveness of therapists. These findings give promise to future research on therapist effects in couple therapy and encourage exploration into which therapist characteristics and behaviors contribute to successful clinical outcomes.

Keywords: couple therapy, therapist effects, dropout, explanation of variance
ACKNOWLEDGEMENTS

First and foremost, I thank my Father in heaven. He has been my reason for—and strength in—completing this work. Any good that has, or will, come of this project is because of Him and I’ll have considered myself blessed to be the instrument.

Next my beautiful companion Megan Marie who sacrificed on a more personal level than I will mention. What I will say is she was not only there with me through it all, but she felt all of it too. She did this while making her own contribution to humanity which was greater than mine.

I would like to thank my Mother and Father who sacrificed so much to instill the value of education in me. I owe so much gratitude also to my brothers and sisters that motivated me to achieve and become my best.

I have had so many mentors that I hesitate to mention any because I know that I’ll miss some of them. However, I do need to thank Scot Allgood for pushing—sometimes pulling—me toward the field of marriage and family therapy. I owe so much to Rick Miller for being my chair with infinite patience and never showing the frustration that he surely felt toward me. I’m grateful for Ryan Seedall and Dave Robinson for adopting me into their masters program. I thank my dissertation committee for their work on this project but also for the formal and informal lessons they taught me. I also had an amazing, supportive Ph.D. cohort that that kept me going.

Finally, to Kenter, Ella, Abby, and Wally, thank you for giving me my most meaningful project, and yes, Daddy is finally done with his schoolwork.
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Therapist Effects on Dropout in Couple Therapy

Research has consistently shown that couple therapy is effective (Carr, 2009; Lebow et al., 2012; Shadish & Baldwin, 2005; Snyder et al., 2006). After reviewing eight meta-analyses of more than 35 randomized controlled trials of couple therapy, Shadish and Baldwin (2003) found a large effect size ($d=.82$) for couple therapy, relative to controlled conditions. Every randomized, clinical trial of couple therapy has found treatment to be superior to no treatment (Gurman, 2011).

However, establishing the efficacy of couple therapy has come at the cost of ignoring other important variables related to couple therapy outcomes, particularly the therapists, themselves (Blow & Karam, 2017; Gurman, 2011). Randomized clinical trials of couple therapy efficacy routinely minimize the impact of individual therapists on outcomes by using close monitoring of treatment protocol adherence, uniformity of training, and treatment manuals (Davis et al., 2012). With the focus on carefully examining treatment effects in order to validate specific treatment models, researchers have gone to considerable lengths to minimize variability in how therapists deliver the treatment.

In addition, the medical model of treatment traditionally emphasized the attributes of the treatment, rather than who delivers the treatment (Wampold & Imel, 2015). The early clinical research in medicine was focused on validating the effectiveness of new drugs, with who delivered the drug to a patient seeming of trivial importance compared to the effectiveness of the drug (Bothwell et al., 2016). As clinical experimental research designs were later adopted by psychotherapy researchers, the tradition of focusing on treatment effects, while ignoring who delivered the treatment, continued (Wampold & Imel, 2015).
In response to the traditional emphasis on examining treatment effects, while ignoring the impact that therapists may have on treatment outcomes, Blow and his associates have argued for the importance of privileging the role of therapists in successful couple and family therapy treatment (Blow & Karam, 2017; Blow et al., 2007; Blow et al., 2008; Karam et al., 2015). Indeed, these scholars counter the Evidence-based Therapy Movement, which prioritizes treatment models based on empirical evidence that they are efficacious, by calling on the field of MFT to prioritize evidence-based therapists, arguing that effective therapists play a larger role in therapy success than what particular therapy model a therapist chooses to use.

Blow’s (Blow & Karam, 2017; Blow et al., 2007) argument to privilege therapist effects over treatment effects, which involves the role of specific treatment models in the success of therapy treatment, echoes arguments that have been made by researchers of individual therapy. Therapist effects refer to the contribution made to the outcome variability that can be apportioned to therapists rather than other variables, such as the treatment model used and client characteristics (Barkham et al., 2017). The implication of therapist effects is that it matters which therapist clients see because outcomes vary between therapists (Lutz & Barkham, 2015). The study of therapist effects is different than the study of effective therapists, which examines the characteristics and behaviors of effective therapists (Barkham et al, 2017). The effective therapist research asks the questions, “why are some therapists more effective than others?” In contrast, the therapist effect research simply seeks to establish that there is significant variation in the success that different therapists experience. Wampold and Imel (2015) make the point that it is important for researchers to establish significant therapist effects before examining factors that may contribute to effective therapists. They stated, “Before a search of variables that are related
to therapist effectiveness, it must be established that indeed the therapists providing the treatment make a difference in outcomes” (p. 159).

Indeed, there is a robust literature that has found significant therapist effects in individual psychotherapy. A meta-analysis of 46 studies found an average effect size in individual psychotherapy of 3% in randomized clinical trials, where extensive efforts are made to control therapist differences, and 7% in naturalistic studies, where little attempt is made to regulate therapists’ behaviors (Baldwin & Imel, 2013). Importantly, research has found that therapist effects are consistently larger than treatment effects, with the choice of which treatment model to use accounting for less than 1% of the variance in treatment outcome (Wampold & Imel, 2015).

Blow and Karam (2017) build on the research done on therapist effects in individual psychotherapy to argue that the role of the therapist is even more influential in couple and family therapy than it is in individual therapy. They contend that “greater skills are needed when delivering interventions to couples and families. This is because in working with these cases, the therapist manages multiple… members of a family/couple in the therapy room at one time…, while at the same time keeping alliances intact with these individuals....” (p. 717).

Despite these compelling arguments for the importance of the therapist in couple and family therapy, little research has actually examined therapist effects in the field. A small study was conducted in Norway and found that 8.0% of the variability in outcome was explained by the therapist (Owen et al., 2014). However, the outcome measure that was used in the study was the Outcome Rating Scale (Miller et al., 2003), which assesses individual well-being, rather than relationship functioning or satisfaction. Recognizing the need for additional research on therapist effects in couple therapy, the purpose of this study was to examine therapist variability in couple
therapy conducted at a university-based MFT clinic, using premature dropout as the dependent variable.

**Review of the Literature**

**Therapist Effects in Couple Therapy**

Despite compelling arguments that therapists are an important ingredient in successful couple therapy (Blow & Karam, 2017; Blow et al., 2007), little research has examined therapist effects in couple therapy. A significant reason for the research emphasis on treatment effects in couple therapy was the need for the field of MFT to develop a strong empirical foundation of the efficacy and effectiveness of MFT models of treatment in order to establish the legitimacy of MFT as a mental health profession and modality of practice (Wampler et al., 2019). In addition, MFT researchers have suffered from a lack of large clinical datasets (Johnson et al., 2017) that are needed to conduct valid therapist effects research.

Only a few studies have examined therapist effects in couple therapy. One study (Davis & Piercy, 2007) used grounded theory to analyze interviews from MFT therapy model developers and their successful clients. The researchers found that therapist variables were one of the model-independent themes that contributed to successful outcomes, suggesting that attributes of the therapist were an important ingredient in successful MFT therapy. In a small study of nine therapists and 93 couples, Bartle-Haring and associates (2016) found that 4% of variability of the couple bond dimension of the therapeutic alliance over the first six sessions was attributed to the therapist. However, as part of the preliminary analysis in a study of the therapeutic alliance and dropout in individual, couple, and family therapy, authors of another study found that there were no significant therapist effects in the therapeutic alliance after one session. (Anderson et al., 2019).
One study examined therapist effects in the outcome of couple therapy (Owen et al., 2014). The study was conducted in Norway, and it involved 158 couples treated by 18 therapists. The sample was taken from couples that were seeking therapy from one of two government subsidized agencies. The average age of the clients was 38.5 and they had been together, on average, 11.8 years. All the couples were White, Euro-Scandinavian. Nine of the therapists were psychologists, eight were licensed social workers, and one was a psychiatric nurse. There was a wide range among the therapists of experience in working specifically with couples. The mean level of experience was 7.28 years, but the standard deviation was 7.14, with a range of 0 to 19 years. The number of couples treated by each therapist ranged from 3 to 18. The clients completed the Outcome Rating Scale, a measure of individual functioning (ORS; Miller et al., 2003) at the end of each session. Using a multilevel statistical model with Bayesian estimation, the results showed that the therapist level of the model accounted for 8.0% of the total variance in ORS scores for the couples and 10% of the variance in client therapeutic alliance scores. At the descriptive level of analysis, they found that the least successful three therapists had about 30% of their couples experience clinically significant improvement, while the three most successful therapists had over 75% of their couples experience clinically significant change.

**Moderators of Therapist Effects**

Recognizing the variability of outcomes between therapists, individual psychotherapy researchers have examined moderators of therapist effects. Research suggests that the role of the therapist becomes more important when clients present with more severe symptoms in individual psychotherapy (Barkham et al., 2017; Johns et al., 2019). For example, one study analyzed data from 10,786 patients seen by 119 therapists. Researchers found that for clients that presented
with mild symptoms, the therapist effect was 1%; however, among clients who presented with severe symptoms, the therapist effect was 10% (Saxon & Barkham, 2012).

Research has also explored the potential moderating effects of the characteristics of the therapists. A meta-analysis of 64 individual psychotherapy studies found a small, yet significant, gender effect, with an effect size of .04 that favored female therapists (Bowman et al., 2001). However, more recent large studies of therapist effects in individual psychotherapy have found no gender differences (Chow et al., 2015; Okiishi et al., 2006; Wampold & Brown, 2005). Moreover, the two studies that examined gender differences in therapist effects in couple therapy (Bartle-Haring et al., 2012; Owen et al., 2014) did not find any gender differences among therapists.

Research on experience as a moderating variable on therapist effects has been mixed and inconsistent (Walsh et al., 2019). The majority of large studies on individual psychotherapy have found that clinical experience is not a significant moderator of therapist effects (Okiishi, et al., 2006; Chow et al., 2015). However, most studies have been cross sectional, with the analysis comparing outcome between more and less experienced therapists. A more nuanced approach is to longitudinally study therapists to see if therapists develop better outcomes as they gain experience. Multiple studies have documented therapist effectiveness across experience in training programs. One study followed the outcomes of psychotherapy trainees over a four-year period and found a significant, but modest, increase in effectiveness over the course of their training program. The authors reported an effect size of .02 for each year of experience (Owen et al., 2016). In contrast, a second study of psychotherapy trainees found that therapists declined slightly in the outcome of psychotherapy cases over the course of five years of data collection, although the proportion of premature dropouts declined (Goldberg et al., 2016). A third study
followed 22 students through their doctoral training program across over 4,000 clients and did not find differential outcomes based on level of training based on both amount of change in client outcomes and the rate of change (Erekson et al., 2017)

The research on therapist experience in couple therapy is also mixed. The study of therapist effects in the development of the therapeutic alliance found that therapist experience was positively predictive of the therapeutic alliance among female partners, but not among male partners (Bartle-Haring et al., 2016). The study of therapist effects on couple therapy in Norway found that the amount of experience that therapists had specifically doing couple therapy was positively predictive of better therapy outcomes (Owen et al., 2014). In contrast, Anderson and associates (2019) found that therapist experience was not predictive of dropout rates.

**Dropout**

The data used for this study consists of information from a university-based MFT clinic’s client management system. This system has the benefit of providing information on a large number of couple cases, but the only variable in the system that could be operationalized to measure therapy effectiveness was the number of sessions that the couple attended. Consequently, the number of sessions that the couples attended was coded to assess premature dropout from couple therapy to assess couple therapy outcome success.

Therapy dropout has been defined as occurring when a client unilaterally discontinues therapy prematurely, before recovering from the problems that led him or her to seek out treatment, and/or before completing the therapy’s specified protocol (Hatchett & Park, 2003; Swift & Greenberg, 2012). Most clients who prematurely drop out of therapy do not attend therapy long enough to reach a clinically significant level of change (Hansen et al., 2002). Premature discontinuation, or therapy dropout, has been explained as a significant problem in
individual therapy, one that stymies the effectiveness of therapeutic interventions and contributes to the impairment of individuals who suffer from mental, emotion, and relational problems that could otherwise benefit from treatment (Barrett et al., 2008; Hatchett & Park, 2003). Clients that discontinue treatment prematurely tend to exhibit poorer outcomes (Cahill et al., 2003; Lampropoulos, 2010; Pinquart et al., 2016), be more dissatisfied with treatment (Björk et al., 2009; Knox et al., 2011), and feel unmotivated to seek professional help in the future (Roos & Werbart, 2013; Swift & Greenberg, 2015; Swift et al., 2012). In these cases where symptoms persist, other systems, such as family members, friends, work associates, and employers, are also negatively impacted (Swift et al., 2012).

When clients drop out of therapy, it also affects the mental health delivery system because it can hinder clinic productivity and waste mental health funding, especially if therapy hours were scheduled for clients who are not showing up for therapy (Barrett et al., 2008; Kazdin, 1996; Swift et al., 2012; Swift & Greenberg, 2015). By skipping these sessions, the clinic has wasted hours that could have been scheduled with clients who would benefit from coming to therapy. Also, without an obvious termination, therapists may spend weeks trying to communicate with the client, taking unnecessary space in the case load.

Similar to individual therapy, dropout is a problem in couple therapy (Masi et al., 2003). In couple and family therapy, clients that discontinue treatment prematurely tend to have lower success rates (Wong et al., 2013). A recent study of 994 individual, couple, and family cases seen at a university-based clinic found that 20.6% of the clients dropped out of therapy before the fourth session, with the rate higher for couple and family cases (Anderson et al., 2019). A higher dropout rate among relational cases is consistent with the reported high dropout rates in two studies that examined couple therapy with veterans and their partners. Based on a sample of
177 couples seeking treatment at Department of Veterans Affairs medical centers, Doss and associates (2011) found that 62% of couples discontinued treatment without their therapist indicating that treatment was successful. This higher dropout rate compared to the previous study is likely due to differences in operationalizing the measurement of dropout. A more recent study, also involving veterans and their partners, found that 36.4% of the couples dropped out during the “assessment phase” of treatment (Fischer et al., 2018).

**Therapist Effects and Dropout**

No research has been conducted on therapist effects on dropout in couple therapy, and only two studies have been conducted in individual psychotherapy. Saxon and associates (2017) examined a sample of 10,521 patients treated by 85 therapists and found significant variability in therapist’s dropout rates. Using therapists’ report of dropout after the case terminated, the authors found that 12.6% of the variance in dropout was attributed to the therapist. In the second study, Zimmermann and associates (2017) conducted a study involving 707 patients treated by 66 therapists. Their study also measured dropout as whether the therapist perceived that treatment ended prematurely. The multilevel model used in the study revealed that 5.7% of the variance in dropout was attributable to the therapist after controlling for patients’ initial impairment.

**This Study**

Although MFT scholars have expounded on the importance of the therapist in treatment success in couple and family therapy (Blow et al., 2007; Blow & Karam, 2017), little research has empirically examined therapist effects in these treatment modalities. Consequently, this study aimed to fill this gap in the research by examining therapist effects on outcome, specifically dropout rates, in couple therapy, using a large U.S. sample.


**Methods**

**Data**

Data for this study came from the archived administrative records of a university-based clinical training clinic in the western region of the United States that is associated with COAMFTE-accredited masters and doctoral MFT programs. Intake data that were gathered when the clients called in for therapy and the treatment plan for each case were combined with the clinic’s billing records, which included the therapist’s ID number, type of case (individual, family, couple, or group), and the number of sessions that the clients attended at the clinic. The demographic data about each couple was taken from the partner that was listed as the lead contact for the case. The data were gathered between February 2005 and September 2018 and consisted of all clients that called into the clinic during that time. Clients seen at the clinic provided consent for research, and the clients’ information that was included in the dataset was de-identified. The archival data were stored electronically on a secured server with password-protected access to authorized users.

The archived data consisted of 2,884 couples who requested couple therapy during the 14 years that data were collected, and a total of 485 therapists were assigned a couple case during that time. To control for bias in estimation (Barkham et al., 2017; Maas & Hox, 2004), therapists were included in the study if they saw at least 10 couples, and clients were included if their therapist treated at least 10 couples. Simulation studies have indicated that a 30/10 rule (at least 30 therapists in the sample with at least 10 clients per therapist) in multilevel modeling can provide unbiased estimates (Harrow, 2002).

In addition, couples were excluded from the analyses if they came to the clinic to participate in the clinic’s Relationship Checkup program. This program is a structured series of
three sessions where couples who are students at the university are encouraged to come to clinic to assess the level of well-being in their relationship. Only when the couple is assessed as having significant relationship problems are they encouraged to continue therapy beyond the three sessions. Because the healthy couples participating in the Relationship Checkup program would be defined as having dropped out of therapy because they only attended three sessions, when, instead, they had successfully completed a relationship wellness checkup, the Relationship Checkup cases were a significant confound to the study. As a result, these 153 cases were deleted from the analyses. After applying the inclusion and exclusion criteria, the final dataset consisted of 1,192 couples who were seen by 90 therapists. In the data set, therapists saw an average of 14.1 couple cases, with a maximum of 32 cases seen by one therapist.

Sample Characteristics

Therapists in the study were current students in either the masters or doctoral MFT program. Although MSW and doctoral clinical psychology students also see clients at the clinic, none of them saw at least 10 couple cases; consequently, only MFT students were included in the analysis. The master’s program is a two-year clinical training program, where students are required to accumulate 500 face-to-face clinical contact hours before they can graduate, with 250 of those hours consisting of either couple or family therapy cases. All masters students take a couple therapy class during their second year in the program. The doctoral program consists of advanced clinical and research training in MFT. Students are required to complete the masters-level curriculum at a COAMFTE-accredited master’s program, or its equivalent, before beginning the doctoral curriculum. Doctoral students are also required to accumulate 500 face-to-face clinical contact hours, with 250 of those hours consisting of either couple or family therapy cases. The majority of the therapists (57.8%) were female; 73.3% of the therapists were
masters students, 11.1% were doctoral students and 15.6% of the therapists were first masters students and then became doctoral students at the university.

Slightly more than half of the persons in the relationship who called the clinic for an appointment were females (53.7%), while 47.3% were males. The average age of the female lead contacts was 39.77 ($SD = 10.67$), and the average age for the male lead contacts was 40.37 ($SD = 10.23$). The majority of the couples (84.3%) were married, 4.2% were either divorced or separated, and 11.5% were in a relationship, but not married. In regard to racial distribution, 83.0% of the sample reported being White, 12.2% as Hispanic, and 4.8% as representing other races. The mean number of years in the relationship was 6.64 years ($SD = 7.61$), and they had a mean of 2.37 ($SD = 1.75$) children. Nearly one-third (30.3%) of the partners had at least a bachelor’s degree.

**Measures**

**Therapists**

The independent variable for this study was the therapist. Each therapist had a unique numeric identifier in the clinic administrative database that was used to group the couples who were seen by each therapist. The numeric identifier was an arbitrary number assigned by the clinic when the therapist started their program of study.

**Therapist Gender and Experience**

The name of the therapist, as well as their numeric identifier, was included for each case in the clinic’s administrative database. In order to determine the gender and experience of each therapist in the study, clinic administrators looked at each of the therapists’ names and assigned them as either male or female. Therapist experience was determined by whether the therapist was a masters student or a doctoral student. The clinic administrators were familiar with the
therapists who had been trained in the clinic, which made it possible for them to accurately assign each therapist to a category of gender and experience level. There were 14 (15.6%) of the therapists that were masters and then doctoral students in the program. These therapists treated 111 (9.3%) of the couples in the data set. Cases seen by these therapists were either assigned as a masters-level case or a doctoral-level case depending on when they were seen by the therapist. In other words, the administrator examined the dates that each couple was seen and assigned that case to either masters or doctoral categories. The administrators recorded each therapists’ gender and experience code in an SPSS file that contained the therapists’ ID. They then sent the SPSS file with the gender and experience codes to the researchers, who merged this new dataset, which only contained the variables of ID, experience, and gender, with the larger dataset that contained all the other variables. In this way, the researchers only worked with de-identified datasets.

**Dropout**

There are a number of ways to operationalize therapy dropout, with basing it on the number of sessions that clients attend being a common and accepted strategy (Swift & Greenberg, 2012). An important rationale for this strategy is that the dose-effect research literature has found that clients need to attend a minimum number of sessions for treatment to be effective (Lambert, 2007). From the dose-effect perspective, failure to attend at least a minimum number of sessions suggests that the treatment was not effective in eliminating symptoms or meeting treatment goals. The disadvantage to using session count to operationalize dropout is that some clients may be incorrectly coded as nondropouts, suggesting successful treatment, even if they see few gains after completing many sessions (Swift & Greenberg, 2012). While this operationalization of dropout misses some nuances of premature discontinuation, some
researchers argue that it is more objective than therapist judgement, which can be biased and flawed (Garb, 2005; Grove et al., 2000).

In addition, research suggests that there may not be much difference between dropout rates operationalized by number of sessions as opposed to when dropout rates are operationalized by completing a treatment protocol. Masi and associates (2003), using a sample that included individuals, couples, and families, found no statistically significant difference in dropout rates when dropout was operationalized by session count, therapists’ perception of whether treatment goals were completed, or therapists’ report that the client unilaterally quit coming to therapy sessions. Also, in Swift and Greenberg’s (2012) meta-analysis of dropout rates for studies in individual therapy, the percentage of clients dropping out of therapy was almost identical regardless of whether dropout was measured by the number of sessions (18.3%) or having completed a treatment protocol (18.4%). In addition, in a study of 177 couples in therapy, Doss and associates (2011) found similar rates of dropout when dropout was defined in nine different ways, including number of sessions attended.

Based on these reasons, for this study, dropout was operationalized using a dichotomous variable based on the number of sessions attended by the clients at the clinic. If clients attended fewer than four sessions at the clinic, they were considered to have discontinued treatment prematurely. Defining dropout as the couple attending less than four sessions followed a precedent set by other studies in the field, with three sessions being considered enough time to complete assessment and treatment plans but not enough time to provide adequate treatment (Anderson et al., 2019; Fischer et al., 2018).
Initial Relationship Functioning

Initial relationship functioning was assessed in order to control for the severity of relationship impairment among the couples coming for therapy. It was measured using the Global Assessment of Relational Functioning (GARF; American Psychiatric Association, 1994). The GARF is a therapist-rated measure and is scored on a scale of 0 to 100, with lower scores being more indicative of maladaptive relational patterns and higher scores indicating more functional relationship patterns. The GARF has good interrater reliability (.71) and strong validity (Stein et al., 2009). The GARF scores were extracted from the therapists’ formal diagnosis of the couple, which they were required to submit when completing the client’s treatment plan. Each partner was given a GARF score. In the rare case when the partners’ GARF scores differed, an average was taken of the two scores. In cases in which a score was entered for one partner and not the other, the entered score was used.

Analysis

Because of the nested nature of the data, with multiple couples being seen by the same therapist, the data were not independent. Each couple had the same therapist as at least 9 other couples, and those couples grouped under one therapist experienced couple therapy in ways that were more similar than those couples seen by other therapists. The statistical tests traditionally used in clinical research, such as analysis of variance and multiple regression, assume that observations are independent from each other. The violation of this assumption increases the risk of Type I error, indicating that the statistical test falsely found a significant result (Kenny & Hoyt, 2009).

Consequently, multilevel modeling was used in these analyses in order to account for the nonindependence of observations. Like the traditional analysis of variance and regression, the
multilevel model assesses variance between and within groups, but the multilevel model reduces bias in hypothesis testing by partitioning error terms across different levels in the model (Kahn, 2011). Because this study used a dichotomous dependent variable (dropout), the study employed a multilevel logistic regression model.

The objective of the analyses was to calculate the average dropout rates among groups of clients seen by the same therapist and test to determine if the average dropout rates significantly differed between therapists. The particular statistic within multilevel modeling that assesses differences between therapists is the Intraclass Correlation Coefficient (ICC). The ICC indicates the proportion of variance attributed to a nesting factor (Kenny & Hoyt, 2009), and in the case of these analyses, indicates the percentage of the variance in dropout that is attributable to the therapist (Baldwin & Imel, 2013). The analyses were conducted in three steps. First, an empty model that included no control or predictor variables was tested in order to calculate a base ICC. Second, level of couples’ initial relationship impairment was added to the model as a Level-1 control variable in order to examine the degree of therapist variance, while controlling for the difficulty of the cases. Third, therapist gender and therapist experience were added to the model as Level-2 predictors to test their ability to explain differences in dropout rates between therapists. The analyses were run using Stata (StataCorp, 2019).

Because the dependent variable is dichotomous, rather than continuous, the formula for calculating the ICC was modified. When the dependent variable is continuous, the ICC is calculated by dividing the between-therapist variance by the sum of the between-between-therapist variance and the individual-level (level-1) variance. However, in the case of a dichotomous dependent variable, there is no direct estimate of the individual-level variance (Austin & Merlo, 2017). Consequently, the ICC cannot be calculated in the standard way. A
common alternative to the standard formula of the ICC that accounts for the dichotomous nature of the dependent (level-1 variable) is to set the level-1 variance at 3.29, which is the standard logistic distribution (Merlo et al., 2006; Sommet & Morselli, 2017).

**Results**

Overall, 29.4% of the couples dropped out of therapy before the fourth session. The dropout percentage for the therapists ranged from 0% (the therapists with the least dropouts) to 78.9% (the therapist with the highest percentage of dropouts). Four of the therapists in the sample (4.4%) had zero dropouts. The highest quartile of therapists had 27 dropouts out of 287 couples (9.4%). The lowest quartile of therapists had 154 dropouts out of 295 couples (52.2%). Table 1 shows the two quartiles of therapists ranked by their dropout proportion.

The first model, or unconditional model, was used to estimate the percentage of variance in dropout explained by the therapist. The ICC (therapist effect) for the unconditional model was \(0.093\) (\(\chi^2(1, 1,191) = 21.05, p<0.001\), 95% CI [0.05, 0.17].

The second model included a Level-1 predictor, initial couple impairment, in the analysis to control for relational impairment of the couples seen by each therapist. The impairment data had 483 (41%) cases that were missing because many of the therapists did not give a GARF score as part of their treatment plans. A logistic regression was used to see if patterns of missingness of couple impairment were associated with the dependent variable. The logistic regression showed that missing impairment data was positively associated with dropout (beta = 1.36, p<.01).

The missing impairment data were missing at random (MAR). The data were not considered missing not at random (MNAR) because there was no theoretically apparent reason that missing GARF scores were due to the measure itself or the observed value (Jansen et al., 2006).
When the probability of missing data of an observed variable depends on another observed variable, the data are considered missing at random (Heitjan & Basu, 1996). The assumptions of MAR should be substantively reasonable (Little & Rubin, 2019). In this case, the data were not considered missing completely at random (MCAR) because the missing data were not independent of observed and unobserved data (Li, 2013).

Multiple imputation is considered an appropriate method to deal with data that are MAR (Sterne et al., 2009). It leads to more accurate results, compared to mean imputation and list-wise deletion (Johnson & Young, 2011; Rubin, 2004). Multiple imputation creates copies of the dataset, with each dataset having the missing values imputed differently. Estimates of parameters are then averaged across the number of imputations (Royston, 2004). The data were imputed twenty times, and separate models were run for each imputed dataset. The average ICC from the twenty imputations was .095 ($\chi^2(1, 1,191) = 22.72, p<0.001$), 95% CI [0.05, 0.17], when controlling for patient impairment.

The third model included therapist gender and therapist experience as level-2 predictors, along with patient impairment as a level-1 control variable, to examine the extent to which these two level-2 variables explained variation among the therapists. The odds ratio for therapist gender was .81 ($p=.29$), and the odds ratio for therapist experience was .71 ($p=.18$), indicating that neither therapist gender nor therapist experience predicted variance in therapists’ dropout rates (see Table 2). Because of the possibility that including those therapists who saw couples both a masters students and doctoral student may bias the results about the effect of therapist experience on dropout, the analysis of the third model was also conducted with those therapists who were both in the masters and doctoral program omitted from the analysis. The results were the same as the original Model 3 that included them. In addition, because of the large number of
missing values of the GARF score, Model 3 was rerun without including couple impairment as a control variable. Results indicated that therapist gender and therapist experience were not significant, which is the same as when couple impairment was included in the model.

**Discussion**

Although MFT scholars have argued that therapists play a vital role in successful delivery of couple treatment (Blow & Karam, 2017; Blow et al., 2007; Karam et al., 2015), little research has been conducted to test that argument. In response, this study sought to determine if there are significant therapist effects in couple therapy. Findings from the study suggest that therapists account for 9.5% of the variance in couple dropout, when controlling for initial client impairment. This estimate is a little higher than the 8.0% found by Owen et al. (2014) in the other study that examined therapist effects in couple therapy, and it is somewhat higher than the 7% found in naturalistic studies in individual therapy (Baldwin & Imel, 2013; Saxon & Barkham, 2012). When comparing these results with individual psychotherapy studies that also examined therapist effects on dropout rates, the therapist effect of 9.5% found in this study are in between the 12.6% reported by Saxon and associates (2017) and the 5.7% reported by Zimmermann and associates (2017).

While 9.5% is not a big proportion of the variance in an absolute sense, this variability in outcomes between therapists makes a meaningful difference. In this study, as shown in Table 1, an effect size of 9.5% translated into a sizable difference in dropout rates, with the most effective quartile of therapists having an average dropout rate of 9.4%, while the least effective quartile had an average dropout rate of 52.2%. This is in line with Wampold and Brown’s (2005) findings, which showed that with a 5% therapist effect across 581 therapists, the top quartile of
therapists had an effect size of .47 compared to the effect size of .20 for the bottom quartile of therapists.

In addition, researchers have pointed out that a small percentage of explained variance among therapists can have a large cumulative impact over time. Imel and associates (2015) conducted a simulation study of 50 therapists who had a caseload of 30 clients who they saw for eight sessions. Based on an therapist effect of .10, which is similar to the effect size found in this study, and an average positive response rate to therapy of 50%, the authors calculated that that the most effective therapist would have 101 of their clients (out of a possible of 120) respond favorably to therapy over a one year period, while only 18 clients seen by the least effective therapists would positively respond. Over a five-year period, the number of positive responses would be 507 and 92, respectively.

Thus, the results of this study provide empirical support for the argument that therapists are an important ingredient in successful couple therapy (Blow & Karam, 2017; Karam et al., 2015). Marriage and family therapy model developers have suggested that the therapist is a salient model-independent factor in effective treatment (Davis & Piercy, 2007). The finding that therapists account for a significant proportion of the variance in couple outcomes makes sense when considering the argument that greater skill is needed in relational therapies (Blow & Karam, 2017). While this study does not establish that the therapist effect in couple therapy is significantly greater than the therapist effect in individual therapy, it indicates that therapist effects in couple therapy are comparable to, if not greater than, those found in individual therapy.

The results of the study showing that therapist gender was not a significant moderator of therapist effects is consistent with previous research. Owen and colleagues (2014) did not find a significant relationship between therapist gender and couple therapy outcome, and Bartle-Haring
and associates (2016) did not find a significant relationship between therapist gender and the development of the therapeutic alliance. These results also parallel what has been found in individual therapy which has shown that therapist gender does not significantly influence outcomes (Beutler et al., 2004; Chow et al., 2015; Okiishi et al., 2006; Wampold & Brown, 2005).

This study found that therapist experience was not a significant moderator of therapist effects in couple therapy. While the results are consistent with most research on individual psychotherapy (Chow et al., 2015; Kraus et al., 2016; Okiishi et al., 2006; Wampold & Brown, 2005), they differ from Owen and associates’ (2014) study of couple therapy in Norway. The difference in the findings between the current study and the Norway study may be due to two reasons. First, there was a substantial difference in the range of therapist experience between the two studies. The therapists used in the current study were all trainees in either a masters or doctoral program. Although the doctoral trainees had significantly more experience than the masters-level trainees, most of them still had limited experience, with almost all of them still unlicensed. In contrast, the average number of years of experience from the study in Norway was 7.3 years, with a standard deviation of over 7.0, and a range of 0-19. Thus, the lack of range in the therapist experience in the current study may account for the finding that therapist experience was not a significant predictor of therapist effects.

Second, therapist experience was measured differently in the two studies. While the current study measured therapist experience by whether the therapist was in the masters or doctoral program, the Norway study assessed the amount of experience specifically doing couple therapy. Based on Blow and Karam’s (2017) argument that couple therapy requires more therapist expertise than individual therapy, it makes sense that the Owen and associates (2014)
used the amount of experience doing couple therapy, specifically, as opposed to doing psychotherapy, in general. This may also account for why the Norway study found that experience was a significant predictor of therapist effects, while many studies on psychotherapy have not found that therapist experience is a significant predictor (Chow et al., 2015; Kraus et al., 2016; Okiishi et al., 2006; Wampold & Brown, 2005). Thus, the differences in the findings between the current study and the couple therapy study in Norway may illustrate the nuanced relationship between therapist experience and therapist effects (Walsh et al., 2019) and the need to operationalize therapist experience in a number of ways in order to best understand the relationship between therapist experience and therapist effects. For example, some scholars have pointed out that little research has examined the “quality” of therapist experience as opposed to the “quantity” of therapist experience and that with deliberate practice, therapists can improve their outcomes (Chow et al., 2015; Goldberg et al., 2016; Miller et al., 2014)

**Limitations and Future Directions**

The major limitation of the study was the limited number of variables available for analysis. The measurement of the dependent variable, premature dropout, was limited to the number of sessions attended because no data were available to measure dropout from the attending therapist’s perspective. In addition, only data for therapist gender and therapist experience were available to be included as Level-2 predictors of therapist effects. Additional predictor variables would have increased the richness of the analysis. A second limitation is that the range of experience among the therapists was substantially restricted because the therapists were all participating in masters and doctoral-level training programs. As a result, the therapists were generally inexperienced and had not accumulated enough hours for licensure.
Despite these limitations, this study represents the first large-scale study that examined therapist effects in couple therapy outcome. Future research needs to examine additional ways of assessing couple therapy outcome, such as measures of relationship functioning that will enable researchers to assess therapist effects in change in relationship functioning from the beginning to the end of therapy. Future research needs to further examine the role of therapist experience as a moderating variable, using a wider range of therapist experience. Also, researchers need to examine more predictor variables, such as disciplinary training (psychology, MFT, social work, etc.).

After research has formed a more robust knowledge base of therapist effects, and their moderators, in couple therapy, the next step is to examine the factors that characterize effective therapists. Having established that some therapists are more effective than others when doing couple therapy, what are the characteristics and in-session behaviors that differentiate effective from less effective therapists? The essence of this question is captured well in a statement that Gurman made in a paper that he wrote about narrowing the clinician-researcher gap in couple therapy. After acknowledging the absolute efficacy of couple therapy as well as the field’s advances in cultural awareness and theory development, Gurman stated that, “There is a compelling need in couple therapy to move beyond the question, ‘What works?’, and even beyond the question, ‘How does it work?’, to the question, ‘How do they work?’” (Gurman, 2011, p. 288), they, referring to the therapists themselves. Thus, future research needs to further examine therapist effects and then move toward understanding the characteristics and behaviors of effective therapists.
References


Lampropoulos, G. K. (2010). Type of counseling termination and trainee therapist–client agreement about change. *Counselling Psychology Quarterly, 23*(1), 111-120.


http://dx.doi.org/10.1002/9781118625392.wbecp109


Table 1 *Top and Bottom Quartile of Therapists Ranked by Dropout Proportion*

<table>
<thead>
<tr>
<th>Therapist</th>
<th>Couples Treated/ Dropouts</th>
<th>Prop.</th>
<th>Median Sessions*</th>
<th>Therapist</th>
<th>Couples Treated/ Dropouts</th>
<th>Prop.</th>
<th>Median Sessions*</th>
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<td>16/7</td>
<td>0.44</td>
<td>4.00</td>
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<td><strong>6.00</strong></td>
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*Note.* *Median number of sessions attended by therapist’s couples*
Table 2 *Model Comparisons*

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<tr>
<td>Experience</td>
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*Note.* *p*<.05