THE IMPLICATIONS OF CLIENT SATISFACTION FEEDBACK FOR BEGINNING FAMILY THERAPISTS: BACK TO THE BASICS

Tracey A. Laszloffy
University of Connecticut

Several family therapy scholars (Lebow & Gurman, 1995; Pinsof & Wynne, 1995; White, Scott, & Russell, 1997) have emphasized the need for further research to evaluate the relationship between the specific types of skills beginning family therapists utilize in therapy and therapeutic outcome. The issue of how researchers endeavor to make such evaluations also is of prime importance. Most (if not all) of what is written and discussed about therapy is based upon the therapist’s rather than the client’s experience (Garfield, 1978; Gurman, 1977; Kantor & Andreozzi, 1985; Kruger, 1985). When the client’s experience of therapy is discussed, it is from the impression of therapists, researchers, and theoreticians rather than of the clients themselves (Kuehl, Newfield, & Joanning, 1990).

The problem of ignoring or minimizing clients’ perspectives in outcome research was highlighted by Stolk and Perlesz (1990), who utilized clients’ ratings of their satisfaction with therapy to evaluate the effectiveness of a family therapy training curriculum. They found that client satisfaction was lower among those clients of therapists who had 2 years of training versus those of therapists without any training. “Although trainees improved on trainer- and self-rated skill measures over the course of training, these changes were not paralleled by families’ increased satisfaction with therapy” (Stolk & Perlesz, 1990, p. 56). This perceptual incongruity points toward the importance of incorporating client feedback into outcome research, a position supported by several scholars in recent years (O’Connor, Meakes, Pickering, & Schuman, 1997; Sells, Smith, & Moon, 1996; Shilts, Rambo, & Hernandez, 1997).

This study challenged the historical marginalization/exclusion of clients’ perspectives from outcome research by relying solely on client-satisfaction ratings of therapy to assess outcome and select the sample. The sample consisted of cases where clients had rated the outcome of therapy as either “extremely satisfying” or “extremely dissatisfying.” After selecting the sample, client and therapist feedback from both groups of cases were analyzed in terms of what was considered good and not good about the therapy experience, including how the client-therapist relationship was perceived. The goal was to identify themes linked to the divergent outcomes.

METHOD

Procedure

At the on-site therapy clinic of an accredited degree-granting marital and family therapy (MFT) training program in the northeastern United States, separate phone interviews with therapists and clients were conducted within 1–2 months following case termination. Clients were informed about the project prior to the start of therapy and were told that their participation was completely voluntary. Clients who were willing to participate signed a consent form.

Among relational cases separate interviews were conducted with each member of the client system. The interviews, which were audiotaped, were conducted by eight MFT master’s students. Each interview

---

Tracey A. Laszloffy, PhD, is Assistant Professor of Marriage and Family Therapy, University of Connecticut, School of Family Studies, U Box 58, Storrs, Connecticut 06269.
began with two closed-ended questions: “Were there any changes in the presenting problem (yes or no)?” and “Please rate how satisfied/dissatisfied you are with the therapy you received/provided (on a 7-point Likert scale).” Subjects were then asked the following open-ended questions: “What was particularly good about the therapeutic experience?” “What was particularly not good about the therapeutic experience?” and “How would you describe your relationship with your therapist/client(s)?” These questions were purposely broad. Interviewers were directed to invite as much detail as possible about subjects’ perceptions of the therapeutic experience.

Sample

The sample was selected by analyzing client responses to the closed-ended questions to identify cases where the outcome of therapy was either extremely satisfying or extremely dissatisfying. Analysis was limited to these extremes as a way of capturing the striking differences between satisfaction and dissatisfaction. Cases where clients rated their overall satisfaction as a six or seven and reported a positive change in the presenting problem were placed within the extremely satisfied group (hereinafter referred to as the ES cases). Cases where clients rated their overall satisfaction as a one or two and reported no change or a negative change in the presenting problem were placed within the extremely dissatisfied group (herein referred to as the EDS cases). The remaining cases were disregarded. Of the 103 cases with completed termination interviews in the database, 13 met the criteria for assignment in the ES group and nine qualified for placement in the EDS group.

The sample consisted of 22 cases with 12 therapists (several worked with more than one case). All of the therapists were beginning-level master’s students (i.e., they had <500 hr of clinical experience) in an accredited MFT program. Ten of the 12 were female. All were between the ages of 22 and 28, except for one who was 38. Nine were European American, two were African American, and one was Asian.

Among the 13 cases in the ES group, there were three families, two heterosexual couples, and eight individuals. Among the nine cases in the EDS group there were four heterosexual couples and five individuals. The sample was fairly gender balanced. In terms of race/ethnicity, all of the clients were European American except for one Japanese male (EDS group), one Eastern Indian male (EDS group), and one Filipino female (ES group). Most of the clients were college educated. The length of therapy varied from one to 44 sessions.

Data Analysis

After selecting the sample, data analysis was initiated to answer the following research question: What specific factors/themes appear to be linked to clients’ overall satisfaction or dissatisfaction with the therapy experience (i.e., therapeutic outcome)? The data analyzed were the responses by both clients and therapists from the ES and EDS cases to the open-ended questions.

After transcribing the interview tapes, inductive content analysis was utilized to identify, code, and classify emergent themes, patterns, and categories. The researcher separately reviewed each interview transcript, identifying themes and patterns along the margins, which were used to develop a code index. During a second reading, units of data were classified according to the codes. Commonalities and differences between cases were noted. Where possible, new codes were developed and existing ones were collapsed into categories (i.e., higher order constructs that link together several codes). A third reading consisted of a reflexive, dialectical process in which codes, categories, and their relationships were further clarified and refined until the data were saturated and no new codes or categories could be developed (Bogdan & Biklen, 1998). Rival explanations and negative cases were examined to validate relationships between codes and categories (Corbin & Strauss, 1990).

FINDINGS

An analysis of the data revealed several dominant themes that are discussed below from both the clients’ and therapists’ perspectives.
The Therapist-Client Relationship

Clients' perspectives. In all of the ES cases, clients reported having a positive relationship with their therapist. Among the EDS cases, some clients reported a positive relationship, while others reported a neutral or negative relationship with their therapists. Among clients who reported a positive relationship with their therapists, “feeling connected” was a recurring theme. These clients used adjectives such as understanding, compassionate, warm, friendly, open, honest, and nonjudgmental to describe their therapists. Typical comments included, “She was so caring. I feel like we were important to her, like we mattered,” and, “He didn’t enter into any judgment calls and didn’t indicate blame or place responsibility on one over the other.” When describing how they felt in the presence of their therapists, clients made frequent references to feeling safe, relaxed, comfortable, and trusting, which facilitated vulnerability and self-disclosure and, hence, the basis for a therapist-client connection.

Among clients who reported a neutral/negative therapist-client relationship, not feeling connected was a dominant theme. These clients described their therapists as critical and judgmental. Typical comments included, “One week I would get the lecture, and my husband would get it the next week,” or, “I just didn’t like her. I thought she came down on me a lot. Not very understanding.” When therapists failed to convey compassion and openness, clients reported that they did not develop the trust and comfort they needed to disclose their feelings and experiences, which undermined a therapist-client connection.

A specific behavior that clients repeatedly associated with how connected they felt to their therapists involved validation of the presenting problem. Clients who defined their relationship with their therapists as positive also indicated that their therapist understood the problems that brought them into therapy. As one client stated, “We had some bad troubles we were dealing with, and I was a little worried to go to therapy because I didn’t believe anyone could really understand. But our therapist turned out great. She definitely understood.”

Similarly, clients who reported a negative/neutral therapist-client relationship described their therapists as failing to understand or affirm their presenting problems. One client stated, “She didn’t want to hear what I thought. She kept saying I had to bring in my husband but he wasn’t the problem, it was me. She was the professional, but how could she help me if she didn’t listen to what I said was wrong with me?” Another said, “I think he never worked with someone with an anxiety disorder because he kept trying to focus on my relationship with my parents. They’ve been dead for 20 years, and I only just developed this problem a few years ago.”

Of the 12 therapists represented in the study, one was associated with three of the cases from the EDS group. This therapist was a Korean student for whom English was a second language. Language difficulties experienced between the therapist and clients played a pivotal role in their failure to establish a positive relationship. As one client stated, “I just couldn’t get attached to him because I had a hard time understanding what he was saying. His English was limited.” In relation to these three cases, this comment by the therapist was representative: “I felt self-conscious and uncomfortable with them about my English. They looked at me like they didn’t understand me. I felt like I confused them.” It is important to add that language differences did not automatically undermine a positive relationship, as evidenced by the fact that this therapist was represented by two of the ES cases where language differences also existed but when a positive relationship was achieved nonetheless. The data did not indicate why language differences obstructed joining in some cases but not others. It also is important to acknowledge that cultural/ethnic biases may have contributed to the difficulties in joining. While clients and therapists often are reticent to name these issues overtly, they often are key factors in failed therapeutic relationships (Hardy & Laszloffy, 1994). For example, in one of the EDS cases, the therapist was Korean and the client was Japanese. While cross-cultural biases were not named as a factor undermining their ability to connect, the contentious history between Korea and Japan may have contributed to the negative relationship that evolved between the therapist and client.

Therapists’ perspectives. Therapists from the ES cases always described the therapist-client relationship as positive, while those from the EDS cases often, although not always, referred to the relationship as neutral/negative. As was the case with clients, this finding suggested a positive therapeutic relationship was a necessary, although not a sufficient condition for a satisfactory therapy experience.
Therapists who reported a positive therapist-client relationship often described their clients as trusting, open, friendly, and comfortable. Typical comments included, “We could talk about issues that would have been very volatile with a guy his age, but we had the trust.” “They were so open and warm. It was easy to like them,” and, “It made me feel good because he could really express things to me. He trusted me with sensitive things.” Therapists who reported a neutral/negative therapist-client relationship described their clients as difficult, guarded, and untrusting, and referred to their relationships with them as tenuous, distant, uncomfortable, and untrusting. As one therapist stated, “From the start I just didn’t feel comfortable with them, and I sensed that they didn’t trust me.” Another explained, “I just couldn’t join with her. I felt a distance that was in the way.”

Defining Therapeutic Goals

Clients’ perspectives. All clients from the EDS group, but none from the ES group expressed frustration concerning their therapists’ failure to establish clearly defined, mutually acceptable therapeutic goals. Hence, while some of the therapists from EDS cases were able to establish a positive relationship with their clients, ultimately, these therapists “dropped the ball” by failing to establish a therapeutic direction/goals that clients found acceptable. One client stated, “I thought we had really hit it off. She was warm and I thought she really understood why I came to therapy. I was feeling very hopeful, but as time went on I realized she was never letting me talk about what I wanted to. She didn’t want to focus on what I wanted to.” Another said, “I want to be clear she was a very good person. We never disliked her. But she wasn’t sure where to take us. She got lost, and we were just going in circles. The lack of focus was very frustrating, but none of us blamed her.”

 Therapists’ perspectives. Therapists from the ES cases did not comment about the direction and goals of therapy. Those from the EDS cases routinely raised this issue, citing their difficulties in developing a clear focus for therapy and mutually agreed upon goals. One therapist said, “I’m sure that one reason we never really connected was because I never quite got what they wanted from me. I felt inadequate because I couldn’t figure out the problem.” Another stated, “There was tension between me and the parents from the beginning. They kept insisting their son was screwed up, but the problem was their marriage.”

“Doing Something” or Being Helpful/Therapeutic

Clients’ perspectives. Clients from both groups spoke often about whether or not their therapists succeeded in “doing something,” a phrase that referred to therapists promoting new skills and behaviors that actively helped clients to challenge their problems. Clients from the ES cases consistently praised their therapists for “doing something.” In fact, they never complained that their therapists failed in this regard. Typical comments were: “It was wonderful because she taught me ways to really listen to my daughter and be there for her. Now she talks to me almost everyday,” “Our therapist taught us how to communicate better so we can talk through our situation and find an alternative that works for both of us, instead of us each trying to only get our own way,” and, “The homework was great. It made me start doing things in a structured way that otherwise I wouldn’t have done. Now I can do it on my own. Therapy was like having training wheels on my bike. Now I can ride on my own.”

Clients from the EDS cases made repeated references to their therapists failure to “do something.” Typical comments included, “We weren’t going anywhere, and she didn’t seem to know what to do. We’d just blow up in therapy like at home. It was the same thing, and it didn’t change. We still screamed our brains out, just in a different place,” “We didn’t get what we needed, so we changed to a new therapist who gives us skills for talking constructively and conflict resolution skills;” “We felt like we were starting one topic one week and then we went into something entirely different the next. She didn’t do anything really,” and, “She cared about me, but it didn’t change anything. I’m still depressed. I still can’t stand my family, and they still think I’m crazy.”

 Therapists’ perspectives. Only therapists from the ES cases believed they had been helpful/therapeutic (i.e., therapist version of “doing something”). Sample comments included, “This was such a gratifying case. Several changes resulted just through me helping him replace his negative tapes with positive alternative ones,” “He learned several ways to regain control when he starts to feel out of control,” “She made some
improvements in her relationships with her family. We had one very helpful family session where she was finally detriangulated from her parents' marriage.” With one exception, all of the therapists from the EDS group said they had failed to be helpful/therapeutic. Typical comments were, “It wasn’t too good because nothing got resolved. I didn’t help them,” and, “I just didn’t know how to address his difficulties. I felt helpless and ineffective.”

**Insight and Emotional Expression: A Factor Identified Only by Clients**

Clients from both the ES and EDS cases favorably referred to having obtained insight about their problems and opportunities to vent feelings and express emotions. This was reflected in statements such as, “It helped me understand some of the issues that were bothering me,” “We went through a family tree, which was helpful because we learned how our relationship is affected by our relationships with our families,” “It got my daughter to open up more in terms of what she was thinking and feeling,” and, “It was a relief to be able to talk about my life and let out my feelings.” While all clients valued gaining insight and venting emotions, these experiences were not associated with satisfaction. Several of the clients who mentioned these experiences as a favorable aspect of therapy were nonetheless from EDS cases.

**Factors Identified Only by Therapists**

There were two themes raised only by therapists. First, therapists from both groups identified their ability to learn from the therapy as something that was good. One therapist stated, “It was great because I learned so much about working with couples. I made mistakes, but it helped me to become a better therapist.” Second, therapists referred to struggling with their emotional reactions in therapy either in terms of anxiety (therapists from both groups) or reactivity (only therapists from EDS group). As one therapist stated, “I was stressed out the whole time. I was worried I was screwing up so I could never relax” (anxiety). Another said, “I was reactive. He pushed my buttons because he was so sarcastic and angry” (reactivity).

**Areas of Incongruence between Therapist-Client Perceptions**

Occasionally there were incongruities between clients’ and therapists’ perceptions. Among the ES cases two therapists expressed doubt about whether or not they had helped their clients, although their clients reported a positive change due to the therapy. Among the EDS cases, two therapists described their relationships with the clients as positive and indicated that they understood the nature of the presenting problem. However, these clients described the relationship as neutral/negative and did not believe their therapists understood their problems.

**SUMMARY AND IMPLICATIONS**

The findings of this study indicated that clients and therapists had remarkably congruent perceptions of the therapy experience. Client and therapist feedback pointed toward three basic tasks that seemed to shape therapeutic outcome. The first involved establishing a positive client-therapist relationship. While this did not guarantee a satisfying outcome, it was an essential precondition. Several scholars (Anderson, 1992; Friedlander, Wildman, Heatherington, & Skowron, 1994) have noted that despite the obvious importance of relationship skills, there is a dearth of MFT literature devoted to addressing this aspect of the therapy process. In this study, a positive relationship involves such qualities as perceiving the client or therapist as warm, open, honest, nonjudgmental, and understanding. Only two specific tangible behaviors emerged from this study. The first was whether or not therapists validated the presenting problem. The second was whether or not clients and therapists avoided the frustration and distance associated with language differences.

The second task involved therapists establishing clear, mutually agreed upon goals with clients regarding the direction of therapy. According to Adams, Piercy, and Jurich (1991, p. 278), various therapists (de Shazer, 1985; Fisch, Weakland, & Segal, 1982; Haley, 1976) “have stressed the importance of obtaining clear and concrete goals as a principal task of the initial session.” However, while successful completion of this task kept viable the potential for a satisfying outcome, it was still not enough to ensure satisfaction.

The third and final task involved therapists “doing something,” which referred to behaviorally oriented,
concrete interventions such as teaching communication skills; teaching conflict-resolution skills; assigning tasks; blocking negative, repetitive interactions; reframing negative behaviors/interactions; and detriangulating scapegoated members. The types of interventions associated with therapists “doing something” drew from a range of family therapy models, which is consistent with increasingly popular integrative and eclectic approaches to family therapy (Carr, 1997; Pinsof, 1994; Sprenkle & Bischof, 1994).

Most family therapy trainers are probably aware of these three tasks in one form or another, perhaps begging the question, “So what’s new?” The answer may be “not much,” and yet, the value of this study may reside not in its revealing something new and yet unrealized but, rather, in its reminding us of something old and often forgotten. Despite the complexities of therapy, the factors that divide an extremely satisfying from an extremely dissatisfying outcome, at least from clients’ perspectives, may be grounded in “the basics.” For beginning-level therapists in particular, less may be more. Beginning therapists often are confused and overwhelmed by what they perceive as the daunting mystery, magic, and complexity of therapy. While it is important to know as much theory and technique as possible, there may be a developmental advantage to offering a simple framework for understanding “what this therapy stuff is all about.” In addition to having new therapists struggle with the complexities, it may help to also give them a basic, straightforward framework, incorporating the three tasks identified in this study.

Another implication involves the usefulness of combining opportunities for insight and emotional expression with more behaviorally oriented, concrete interventions. This position has been advocated by some family therapists (Duncan & Solovey, 1989) who have developed approaches that blend emotion and insight with structured, concrete interventions. For example, consider Kiser, Piercy, and Lipchicks’s (1993) use of charts and scaling strategies and Kuehl’s (1995) solution-oriented genogram.

While therapists reported feeling anxiety and reactivity in therapy, only the latter was associated with dissatisfying outcomes. Accordingly, trainers and supervisors might benefit from attending to “self-of-the-therapist” issues as a way of helping trainees identify, distinguish between, and negotiate their emotional reactions in therapy, especially with regard to reactivity (Aponte, 1994; Nelson, Heilbrun, & Figley, 1993).

LIMITATIONS AND FUTURE DIRECTIONS

Because this study’s sample was relatively small and context specific, it is necessary to caution against making generalizations. If the same research design were implemented with several different samples and researchers and similar results emerged under different conditions, it would greatly enhance reliability. Regarding validity, the use of triangulation in terms of multiple data sources (client and therapist feedback) and multiple interviewers could be expanded to enhance the trustworthiness of the results (additional sources of data, multiple analysts; Moon, Dillon, & Sprenkle, 1990; Patton, 1990). Moreover, in future studies subjects could rate therapy in terms of the three tasks and provide an overall satisfaction rating. Responses regarding the three tasks could be used to make predications about therapy outcome, which could then be compared against the satisfaction rating to assess the relationship between these tasks and therapy outcome.

The lack of a dialectical data-gathering process common to qualitative research constituted a limitation. Because the data were gathered prior to the outset of this study, questions that arose from the initial data could not be further explored. Future studies would benefit from dialectical data gathering. Further exploration could shed light, for example, on why language differences undermined the establishment of a positive relationship in some cases but not others.

This study yielded three basic tasks that beginning therapists can utilize to enhance clients’ perception of a satisfying therapeutic outcome. As the field moves toward briefer models of therapy, effectiveness research, and a focus on clients’ perspectives, studies like this can contribute to family therapy practice by encouraging trainers, researchers, and clinicians to remember the value of “going back to the basics.”
REFERENCES


NOTE

1. Among relational cases, all members of the client system had to meet the requirements for selection into the sample.