Strategies for Length and Pacing of Treatment in the Hope Focused Approach

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While the length of therapy can vary from one session to years of treatment, overall research shows that most clients only attend between eight and ten sessions (Lowry & Ross, 1997). Approximately 35-40% of clients terminate by the third visit and 70% by the tenth (Mueller & Pekarik, 2000). The HOPE-Focused approach is typically once a week for 8-12 weeks. This range falls within the average attendance, and gives counselors an opportunity to tailor the HOPE-Focused approach to the couple's unique needs and add sessions when they feel it is needed or would be particularly beneficial. When couples therapy is not tailored to the needs of the couple it helps to predict higher relapse rates and one or two year follow up (Snyder, Mangrum, & Wills, 1993). There is no "magic" to one hour a week of psychotherapy and clinicians in various formats should consider whether other formats, like marathon marriage therapy and double length meetings are also possibilities. Before tailoring the treatment to the couple it is important to refer the *HOPE-Focused Marriage Counseling Treatment Manual* to ensure that the approach is not contraindicated.

What does the research say?

Researcher have attempted to determine what is considered to be "the good enough level" of treatment (Connell, Stiles, Miles, Margison, Evans, & Mellor-Clark, 2006). This theory suggests that more improvement will be seen in earlier sessions, with improvement at a steady rate until it reaches a good enough level at which point not much more improvement will be seen and therapy will likely be terminated. The rate of improvement and therefore the number of sessions needed to reach this level will vary depending on different things: the type of problems, characteristics of both partners, and the focus of treatment (Connell et al., 2006; Lowry & Ross, 1997).

Client expectations as a factor

Mueller and Pekarik (2000) found that the client's expectation of the length of therapy was the best predictor of the how many sessions they attended. If the couple is not expecting therapy to last long, then adding sessions may be difficult and at least require considerable persuasion which may or may not be effective. Research on predictors of couples' response to therapy can be communicated to couples to help the couple accurately predict expectations.

Using assessment information to predict treatment time needs

If the intake and assessment information show significant areas of weakness with conflict-resolution or emotional expressiveness then sessions could be added in these areas to provide a more intensive intervention (Snyder et al., 1993). Adding sessions when working with difficult couples, particularly

those with coexisting mental disorders, may be beneficial to allow additional time to build rapport, work through crises that they may bring to session, and to give the couple a chance to develop deeper understanding of the skills being taught (Snyder & Whisman, 2004).

Format Options

Various formats for couples' therapy have been shown to be effective. A study done using the strategic HOPE-Focused enrichment found that even just meeting for five sessions for a total of 5.5 hours proved to effective for raising the couples' satisfaction level (Worthington, Hight, Ripley, Perrone, Kurusu, & Jones, 1997). Another study looking at only three sessions using positive reframing and restraining techniques was also found to be effective (Davidson & Horvath, 1997). Research has also shown that therapies with a fixed time limit are more effective than those that are more flexible, suggesting a "self-pacing phenomenon" (Davidson & Horvath, 1997). This theory believes that couples' may base the pace of their improvement on the how long they expect treatment to last.

Marathon version of therapy

Another possible form of couples' therapy is marathon couples therapy or intensive marital therapy (Greendorfer, 2004; Vogt, 2001). This basically treats the therapy as a kind of retreat, where couples commit to three to five days with anywhere from three to six hours of therapy a day. It seems to mainly attract couples who view this time as a "last-ditch effort" to save their marriage, but also occasionally attracts those couples desiring enrichment or have constraints such as traveling to the place of therapy. This approach appears to best suited for those couples who are motivated, have the abilities to look at their motivations and can share their thought and feelings with their partner (Greendorfer, 2004; Vogt, 2001). High levels of domestic violence, substance abuse, untreated clinically significant mental disorders, or if one partner is easily fatigued or overwhelmed are signs that the couple is likely contraindicated for this type of work.

While this approach is not intended to resolve all the couples' problems, it does provide an opportunity for self-evaluation and gaining a deep understanding of marital problems (Greendorfer, 2004). It allows for continuity and the benefit of not having to end the session just as something was beginning to be accomplished. By providing this type of intensive format it can lead to a significant increase in the number of positive interactions between the partners, which may provide a dramatic shift in the relationship dynamics and begin to restore hope (Vogt, 2001). However some disadvantages include having to take time off of work and other responsibilities and cost, since few insurance companies cover this type of approach (Vogt, 2001).

Application to the HOPE approach

HOPE therapists should ask themselves the following questions. 1) What do the questionnaires and individual sessions with each member of the couple point to in regards to the severity of the problem and motivation for change? 2) What is the couple's expectations of therapy (including length) , as these factors need to be considered in determining the appropriate length of therapy. 3) Are there factors that favor a condensed or brief version such as practical constraints, low couple motivation or couple desire for condensed format.

There are 3 main themes that we believe are essential to a full Hope model of treatment: communication, emotional bond and forgiveness. These condense the C's described in Worthington's textbook in to three main themes. Communication includes not only communication but conflict resolution and cognitions. Emotional bond includes closeness, central vision, core values and commitment. Forgiveness includes confession and forgiveness. Therapists may spend variable amounts of time in the 3 themes based on the couples needs, expectations and motivations.

Annotated Bibliography

Barkham, M., Connell, J., Stiles, W. B., Miles, J. N. V., Margison, F., Evans, C., & Mellor-Clark, J. (2006). Dose–effect relations and responsive regulation of treatment duration: The good enough level. *Journal of Consulting and Clinical Psychology, 74*, 160-167.

It is assumed that early sessions of therapy have a large effect on improvement, but that as the number of sessions increases the rate of improvement increases more slowly. The good enough level model of improvement suggests that clients and therapists end therapy when the client has reached a good enough level of functioning. For clients who began with lower levels of functioning, those who had fewer sessions achieved a higher reliable and clinically significant improvement than clients who attended more sessions. It is assumed that once a good enough level of functioning has been reached, clients and therapists alike are more accepting of lesser gains as treatment requires more time and effort.

Lowry, J. L., & Ross, M. J. (1997). Expectations of psychotherapy duration: How long should psychotherapy last? *Psychotherapy, 34,* 272-277.

Members from APA Division 29 (Psychotherapy) were surveyed on their expectations of how many sessions are necessary to successfully treat clients so that they arrive at a higher level of functioning. Overall, it was expected that 30-40 sessions are needed to successfully treat a client. However, those rates vary according to client diagnosis, as well as the age, gender, therapeutic orientation, and experience of the therapist.

Mueller, M., & Pekarik, G. (2000). Treatment duration prediction: Client accuracy and its relationship to dropout, outcome, and satisfaction. *Psychotherapy, 37,* 117-123.

This study examined factors involved in the number of sessions attended by clients. While a history of an eating disorder in the client, the client's education level, the therapist's degree all contributed to the number of sessions attended, the client's expected number of sessions to be attended was the biggest predictor. Clients who attended fewer sessions than expected had lower satisfaction with therapy, but had a better outcome with the specific problem they identified as their treatment target (Client Rating) and their overall subjective distress (Client Well-Being).

Wood, N. D., Crane, D. R., Schaalje, G. B., & Law, D. D. (2005). What works for whom: A meta-analytic review of marital and couples therapy in reference to marital distress. *The American Journal of Family Therapy, 33*, 273-287.

Previous meta-analytic research on marital and couples therapy studied the effectiveness of treatments for mild, moderate, and severe levels of marital distress. However, various measures of marital distress will result in different outcomes (i.e., mild distress as measured by the Dyadic Adjustment Scale is comparable to moderate distress as measured by the Marital Assessment Test). In this study, MAT scores were converted to DAS scores to arrive at a uniform definition of the levels of marital distress. In couples with moderate marital distress, Emotionally Focused Therapy was found to be significantly more effective than isolated Behavioral Marital Therapy.