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The Process of Couples' Experiences in a Brief Intervention

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THE PROCESS OF COUPLES' EXPERIENCES

IN A BRIEF INTERVENTION

by

D. Jim Mock

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Family and Human Development

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ABSTRACT

Exploring the Process of Couples' Experiences in a Brief Intervention

by

D. Jim Mock, Doctor of Philosophy

Utah State University, 2014

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Department: Family, Consumer, and Human Development

Though distress in couple relationships is common, many partners are resistant to formal interventions (e.g., couple therapy; couple and relationship education) due to time constraints, financial costs, and stigma. The relationship checkup offers a new alternative developed to address these concerns, but the limited research of this format warrants additional exploration. This study presents findings from qualitative research of couples' and their clinicians' experience with this format. Using a convenience sample, ten couples were recruited along with the six clinicians who administered the intervention. Partners were interviewed together and their clinicians individually using a semi-structured interview. Using a phenomenological approach, each interview was then analyzed and coded to explore couple process in the intervention. Prevalent themes that epitomized couples' experience as identified by the couples include couple motivation, therapeutic environment, internal and external change, and program response. Themes that emerged among clinicians included couple

characteristics, couple motivation, therapeutic relationship, and therapeutic change. Themes between couples and clinicians were compared, and considerable agreement was found between participant and clinician themes. These themes indicate that the intervention was successful in a number of ways, including facilitating change in couple relationships, attracting couples in various states of distress, allowing couples to overcome the typical obstacles to treatment, while fostering a more positive attitude towards future treatment. Implications and suggestions for future research are discussed.

(135 pages)

PUBLIC ABSTRACT

Exploring the Process of Couples' Experiences in a Brief Intervention

D. Jim Mock

Many couples struggle with their relationship, but resist seeking professional assistance due to concerns about time commitment, financial expense, and/or fear of stigma associated with treatment. To address these concerns the relationship checkup has been developed. Though there has been limited research of this format, there is still much to be explored. This study presents the findings from semi-structured interviews of ten couples who participated in a form of this intervention and their corresponding clinicians. Each interview was analyzed for commonalities among the responses and distilled into two sets of themes: the couples' and the clinicians'. Themes for the couples include: couple motivation, therapeutic environment, internal and external change, and program response. The themes that emerged for the clinicians include: couple characteristics, couple motivation, therapeutic relationship, and therapeutic change. While comparing and contrasting themes from these two groups considerable agreement was found. Additionally, these themes suggest success in facilitating relationship change, attracting couples in various states of distress, allowing couples to overcome the typical obstacles to treatment, and fostering a more positive attitude towards future treatment. Implications and suggestions for future research are also discussed.

DEDICATION

To all the couples who are brave enough to love and to the therapists who help them.

ACKNOWLEDGMENTS

At this time I would like to express my heart-felt appreciation to all those who helped me reach this pinnacle. I am indebted to my mentor and friend, Dr. Kay Bradford, whose patience and unconditional positive regard is not limited to his clinical work. His style of support and challenge have been exactly what I needed to accomplish this lofty goal. The other members of my committee, Drs. Scot Allgood, Lisa Boyce, David Bush, and Linda Skogrand, have also been instrumental in providing much needed feedback on this work. Dr. Skogrand in particular has been a great asset in this new and exciting path of qualitative inquiry. In addition to the wonderful staff and professors I have been fortunate to associate with in this department, I am grateful for the friends I have made, specifically my cohort, who more than once provided much needed group therapy. I am also grateful for the couples and clinicians who participated in this work. Couples therapy is not easy for the clinician, and when it is working right, it is even harder for the couple.

Special thanks belong to my beloved children: Isaiah, Malachi, Julianna, and Sophia (a child born in the middle of this process), who unwittingly sacrificed a great deal of their "daddy-time." However, the greatest sacrifice rests squarely on the shoulders of my wife, who continually made up for an absent parent without resentment or complaint - well, maybe just a little. She has been both my outlet and moral support. Shelly has always seen much more in me than I have seen in myself and for that I will always be grateful. Finally, this acknowledgment would be incomplete without a

recognition of God's hand in this process. I never would have started this endeavor

without Him, and I certainly would never have completed it.

<div align="right">D. Jim Mock</div>

CONTENTS

CHAPTER 1

INTRODUCTION

Across many cultures, relationship satisfaction is a common lifetime goal for most people (Tafardo et al., 2012). Almost all couples report high levels of relationship satisfaction at the beginning of their marriages, but satisfaction typically declines every year within the first ten years of marriage, particularly after the birth of the first child (Bradbury, Fincham, & Beach, 2000; Glenn, 1998). Extant literature suggests that at any time, 20% of married couples are experiencing distress in their relationship (Bradbury et al., 2000). For a considerable number of couples, relational distress is common, as indicated by the 40% to 50% of first marriages that will end in divorce (U.S. Census Bureau, 2005). There are several formats of intervention to alleviate couple distress; the purpose of this study is to explore couples' experiences with a brief "checkup" format of intervention.

Marital distress is associated with a host of difficulties for the individual and family system. Whisman and Uebelacker (2006) found that marital distress is associated with poor physical health and a variety of psychiatric disorders including anxiety, mood, and substance abuse disorders. They also found associations of marital distress with social impairment, including difficulties with family and friends, and with work functioning. Children in homes with high levels of couple conflict experience lower levels of adjustment, increased levels of conflict with parents, and increased levels of conflict with siblings (Bradford, Vaughn, & Barber, 2008; Fincham, 2003). Gottman (1999) found marital distress to be associated with depression, withdrawal, health problems, academic difficulties, and behavior problems in children.

Fortunately, couples have a number of options available to them to help alleviate distress. Professional help for couples has evolved over time to include several distinct forms of assistance including couple therapy, couple and relationship education (CRE), and relationship oriented publications. Despite available options, partners are often reluctant or hindered from pursuing outside professional assistance. For example, one study found that couples wait an average of six years after the onset of difficulties before consulting a practitioner (Gottman & Gottman, 1999).

In response to these concerns, interventions have been developed to encourage greater access to treatment allowing couples to address distress in earlier stages. One promising format includes the relationship checkup (Cordova, Warren, & Gee, 2001). Combining principles of couple therapy and relationship education, the relationship checkup is a brief intervention, wherein with the aid of a pre-session assessment, the clinician meets directly with a couple typically for two sessions. This format was specifically developed in an effort to compensate for some of the more typical areas of intervention resistance including time, stigma, and cost (e.g., Flemming & Cordova, 2012). However, due to the newness of this intervention, it remains a relatively unexplored format when compared to therapy, and couple and relationship education (CRE).

The purpose of this study was to examine the experiences of a sample of couples who participated in this format. This chapter will briefly discuss prominent interventions for couples (couple therapy, CRE, and relationship-oriented books) including their strengths and limitations, along with how the relationship checkup addressed these limitations. In discussing these various formats of intervention, it is important to note

that some have been found to be more effective than others; moreover, there is variance, wherein some are research-based, some are empirically supported, while others are not. For example, cognitive-behavioral couple therapy and emotionally-focused couple therapy have been extensively researched and are empirically supported (Johnson, Hunsley, Greenberg, & Schindler, 1999; Shadish & Baldwin, 2005), whereas some models such as narrative couple therapy have less empirical support (Etchison & Kleist, 2000). This introduction briefly reviews formats of couple intervention, and gives an overview of this study of a brief "checkup" format.

Couple Therapy

Couple therapy is perhaps the most established form of couple intervention. Research indicates that most couples who attend couple therapy find improvement to their relationship, including one study that found about 70% of couples finding positive change (Lebow, Chambers, Christensen, & Johnson, 2012). Couple therapy has also been linked in improvements with substance abuse (Powers, Vedel, & Emmelkamp, 2008), depression (Bodenmann et al., 2008), and anxiety (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Despite strong evidence concerning the effectiveness of couple therapy (Halford & Snyder, 2012; Shadish & Baldwin, 2005), many couples find financial costs, time restraints, and/or a lack of childcare often serve as barriers to treatment. Another obstacle is often the perception of couple therapy, including fears that the clinician will hoist all the blame on one partner or stir up old problems that are better left in the past, in the end creating more problems than the couple came in with (Fleming & Cordova, 2012).

Often couple therapy is perceived as something for more severely distressed couples, including those on the brink of divorce. Husbands, in particular, are more likely to have these concerns and resist seeking treatment (Ojeda & Bergstresser, 2008). Though research has found men just as capable as labeling and expressing their thoughts and emotions as women, it may be that they are frequently less inclined to do so (Judd, Komiti, & Jackson, 2008). Research has repeatedly found that women serve as the "relationship barometer," indicating they tend to be the first to detect trouble in the relationship and to seek treatment (Faulkner, Davey, & Davey, 2005; Mackenzie, Gekoski, & Knox, 2006). Alternative interventions, including CRE, have been developed to overcome some of these more common barriers and concerns of couple therapy, including time and financial investment, stigma, partner resistance, and lack of a preventative design.

Couple and Relationship Education (CRE)

Rather than seeing one couple at a time, CRE attempts to cast a wider net by educating a number of couples at the same time as in a class or workshop-type format. Stanley (2001) argued that in addition to being more cost-effective, it is less likely to provoke the typical fears couples face when considering couple therapy, while reducing barriers for the option of couple intervention. Though CRE has been adjusted to address the needs of couples experiencing various levels of distress. Another quality that sets CRE apart from couple therapy is its preventative approach (Markman, Stanley, Jenkins, Petrella, & Wadsworth, 2006). Research has found CRE to be an effective alternative. One study found that couples who attended premarital education experienced

improvement in marital satisfaction and a 30% reduction in the risk of divorce (Stanley, Amato, Johnson, & Markman, 2006).

Despite efforts to reach more people and to reduce stigma, couples, particularly husbands, continue to be reluctant to attend CRE (Mackenzie et al., 2006; Ojeda & Bergstresser, 2008). Larson and Halford (2011) point out a major drawback of CRE is its "one-size-fits-all" stance in that it fails to address the specific needs of the couples present in the groups. Moreover, though numerous efforts to reach wide audiences have been made, CRE continues to be limited in its use and reach (Carroll & Doherty, 2003).

Relationship-Oriented Books

Relationship-oriented books represent another alternative to couples seeking help. Arguably it is one of the least expensive choices and offers the advantage of flexibility in regards to time investment (Redding, Herbert, Forman, & Gaudiano, 2008). However, little empirical evidence supports the effectiveness of relationship-oriented books. This is not to say that some of these books do not present empirically tested ideas by scholars in the field (e.g., Doherty, 2001; Gottman & Silver, 1999; Johnson, 2008); unfortunately the average consumer may have a difficult time discerning between what is research-based and what is not. The same would hold true for an article in a magazine or on the internet where there is equal variation (if not more so). Consequently, a partner runs the risk of either implementing ineffectual concepts or, what is worse, something harmful. An obvious deficit in this format is the absence of targeted professional guidance and consultation.

Relationship Checkup

As a relatively new intervention, relationship checkups are emerging as potentially promising interventions for reaching a wider audience and having the adaptability to meet individual couple needs (Olson, Larson, & Olson-Sigg, 2009). The relationship checkup exists in a number of iterations including: Couple Checkup (Olson, 2002), the Marriage Checkup (Cordova et al., 2001), and the Great Marriage Tune-up (Larson, 2003). Combining the educational and preventative concepts of CRE and the one-on-one format of couple therapy, the relationship checkup was designed to avoid some of the pitfalls of each while building upon their strengths (Olson et al., 2009). The brief, typically two-session intervention does this in a number of key ways.

First, the name was designed to avoid the stigma of couple therapy instead using terms with more positive connotations, including "checkup" or "tune-up" (Fleming & Cordova, 2012; Larson, 2003). The intent has been to imply a more common practice, such as a scheduled appointment one would regularly make for a dentist or mechanic, using it as a tool of early intervention rather than the typical pattern of waiting until problems become severe. By being early and brief, relationship checkups may help overcome some of the more common concerns of treatment including financial cost and time commitment (Fleming & Cordova, 2012).

Second, relationship checkups are assessment based. Either in the first session or prior to treatment, partners complete an assessment (either online or in person) based on a number of relationship domains. The clinician is then able to use the results to discuss the couple's strengths and challenges (Olson et al., 2009). The clinician is able to address

mild to severe forms of distress by meeting directly with the couple with the aid of their

assessment (Cordova et al., 2005; Morrill et al., 2011), an advantage over CRE's "one-

size-fits-all" model (Larson & Halford, 2011).

Third, flexibility of treatment, assessment, and meeting directly with a clinician

allows the clinician to adjust treatment to the couple's stages of change. Partners

frequently come into treatment with varying degrees of motivation to change with

husbands likely to be less ready for change and thus reluctant about treatment (Bradford,

2012; Fleming & Cordova, 2012). This current checkup model was developed with

Prochaska and DiClemente's (1984) Stages of Change or Transtheoretical Model in mind

to address the common difficulty of partners being at differing stages of treatment

motivation (Fleming & Cordova, 2012).

Finally, this intervention can act as a point of entry for couples to receive further

treatment either in couple therapy or CRE as needed. Though it is designed to be used

with a wide range of couples from dating and engagement to long-term marriage

(Cordova et al., 2005), the overriding goal is to help couples be motivated to take care of

their relational health. Though the preliminary research has thus far been positive (see

Fleming & Cordova, 2012; Olson et al., 2009), there is still much to be learned about this

relatively new couple intervention both in terms of process and outcome.

Purpose of the Study

The purpose of this study is to explore the couples' experiences with the

relationship checkup by using a qualitative analysis of couple and therapist (i.e.,

"consultant") post-intervention interviews. Gurman (2011) suggested that researchers

need to understand the couples' processes involved in an intervention in order to help maximize effectiveness in enacting it. In contrast to outcome research, which examines whether a treatment is effective, process research examines the components of treatments – toward understanding how they operate (Sprenkle, Davis, & Lebow, 2009). Though Stewart's (2011) quantitative study of the current intervention suggests that changes in participants did occur, the unique experiences of the couples in this intervention remain to be explored, including how such experiences were divergent with or convergent from the consultants who worked with the couples. As the purpose is to understand the richness of participants' processes rather than understanding quantitative outcomes, a qualitative research method was chosen (Bogdan & Biklen, 2007). Qualitative research is particularly appropriate in process research where the goal is to better understand the patterns of experiences in a relatively new format of treatment (Bogdan & Biklen, 2007). Additionally, Vaterlaus and Higginbotham (2011) found the qualitative approach to be particularly helpful in exploring facets of programs; conjoint interviews were used to help illuminate the experiences of couples.

CHAPTER II

LITERATURE REVIEW

Though many couples desire to decrease marital distress, the divorce rate in the U.S. suggests that making the necessary changes to achieve satisfaction appears formidable. Couples may be willing to make changes in the relationship, but as Doss, Atkins, and Christensen (2003) have suggested, they may lack the knowledge of where to turn to make those changes. Couples today have many choices to turn to for relational advice, from the informal sources of family, friends, magazine articles, and internet articles, to more professional forms of assistance. This section will detail the qualities of some of these more common forms of formal treatment, including relationship-oriented books, CRE, and couple therapy, with particular emphasis given to the relationship checkup -- the intervention used in this study.

Distress and Assistance Options

Research has long documented the considerable impact of relational distress. Individuals with higher levels of relational distress experience greater work and social impairments, poorer physical health, and higher levels of anxiety, depression, substance abuse, and suicidal ideation (Snyder, Castellani, & Whisman, 2006; Whisman & Uebelacker, 2006). Unfortunately, most couples will experience periods of distress in the course of their marriage severe enough for a partner to consider divorce (Snyder et al., 2006). Overcoming relational distress is a difficult obstacle for couples to overcome without assistance. In a meta-analysis, Baucom, Hahlweg, and Kuschel (2003) found that

couples on a wait list for treatment were unlikely to make improvements in their relationship without intervention.

Magnifying this concern is the number of professional resources a couple has available to them. These choices may create confusion among couples and even service providers regarding available service; this is particularly true regarding referring couples to relationship education and couple therapy (Ooms, 2010). Adding to this concern is the difficulty the average consumer faces in differentiating between empirically-supported resources and resources founded upon anecdotal evidence or conjecture. Couples who follow the latter route run the risk of not only implementing something that is ineffective, but possibly damaging to the relationship. Given the popularity of resources that have little to no research backing, the average consumer may be less concerned about the soundness of the intervention and more concerned with bringing immediate relief.

One possible explanation as to why couples may not seek professional help could be concerns with investment of time. Many couples report time commitment as a guiding principle in choosing an intervention (Busby, Ivey, Harris, & Ates, 2007), with men in particular preferring a brief intervention (Larson, Vatter, Galbraith, Holman, & Stahmann, 2007). Considering the time restraints that many people face, couples today often require an intervention that is not only easily accessible and effective, but brief. An additional concern closely related to time is financial cost, with many couples reporting the expense of treatment as a hindrance to attendance (Cordova et al., 2001).

However, despite these concerns, a significant number of couples seek outside help to improve the quality of their relationship. In a longitudinal study of 213 couples, Doss, Rhoades, Stanley, and Markman (2009) found that 36% of these couples reported

turning to outside sources for assistance within the first five years of marriage, including relationship-oriented books, couple workshops, and/or couple therapy. The traits and efficacy of these resources are discussed below.

Relationship-oriented Books

Currently self-help books are a multimillion-dollar-per-year industry, emerging as an "integral feature of modern American culture" (Rosen, Glasgow, & Moore, 2003). A large study found that 85% of clinicians reported recommending self-help books to their clients, indicating that such books have become a common feature of treatment (Norcross et al., 2000). Aside from friends and family, books may be the first choice of couples seeking to improve the quality of their relationship. Of the 213 couples Doss and colleagues (2009) followed for five years, more couples (23%) turned to books for relational help than to other sources. Though a significant number chose more than just books, it was still more common than the 41 couples (19%) who chose CRE, and the 30 couples (14%) who chose couple therapy. Of those couples who chose relationship-oriented books, 51% did not choose any other form of relational assistance. Redding, and colleagues (2008) argued that anonymity, along with immediacy and low cost, are the probable chief reasons many couples choose books over CRE and couple therapy.

Although self-help books are rarely empirically tested (Redding et al., 2008), a limited amount of research suggests self-help books for individuals can be effective in symptom amelioration (Gregory, Canning, Lee, & Wise, 2004; Hirai & Clum, 2006). However, the efficacy of relationship-oriented books remains largely unexplored empirically. Hazleden (2010) offered a strong critique of these books, suggesting that

they often ignore the systemic underpinning of a relationship but tend instead to pathologize the individual - particularly women. A common criticism is that these books promote conservative gender roles and stereotypes that promote male privilege (Blackman, 2004; Boynton, 2003).

Fortunately, a number of books written by mental health professionals and based upon empirical principles of marriage enhancement exist, such as *The Seven Principles for Making Marriages Work* (Gottman & Silver, 1999) and *Fighting for Your Marriage* (Markman, Stanley, & Blumberg, 2001). However, other popular-psychology books such as *Men Are from Mars, Women Are from Venus* (Gray, 1993) and *The Five Love Languages* (Chapman, 2004) "tend to be based on cultural conceptions of relationships or religious scripture rather than psychological research" (Doss et al., 2009, p. 24). Consequently, in addition to the obvious lack of live professional consultation, the consumer's choice of empirically supported books is at best clouded.

Couple and Relationship Education

Couples who seek a more intense form of intervention but have reservations about couple therapy have the option of attending couple and relationship education (CRE). CRE refers to any program that works with couples and individuals to change their relational attitudes and develop new ideas and skills to improve the quality of their relationship (Hawkins, Blanchard, Baldwin, & Fawcett, 2008). Unlike couple therapy, CRE provides a comparably quicker intervention lasting as little as a few hours in a single session to 10-12 hours, or even up to 30 hours stretched across multiple sessions (Stanley et al., 2006).

Initially, CRE was offered by religious organizations to help couples prepare for marriage (Ooms, 2010). Over time, secular agencies have since become involved and expanded programs to address other risk areas for couples including relationship enrichment, communication improvement, and prevention (Markman & Rhoades, 2012). Programs have also been tailored to meet the needs of a specific audience, such as low-income couples, couples who are in a subsequent marriage, and new parents (Hawkins & Fakrell, 2010). Markman and Rhoades (2012) divide CRE into three broad types: *universal prevention* programs for young happily married couples who want to maintain happiness, *indicated programs* for couples who are in the early stages of distress, and *selected intervention programs* for couples who are highly distressed, possibly on the verge of divorce. Reducing negative couple communication is a common thread among most curriculum-based programs (Larson & Halford, 2011).

Recent research has found couple and relationship education to be an effective tool in alleviating couple distress. Meta-analytic studies have found improvements in the quality of couple communication and problem-solving skills (Blanchard, Hawkins, Baldwin, & Fawcett, 2009; Hawkins et al., 2008). An additional meta-analysis found similar improvements in programs targeting low-income couples (Hawkins & Fakrell, 2010). Another study found that, in some cases, CRE prevented couple distress and dissolution (Markman & Rhoades, 2012). Recognizing the effectiveness of these programs, the federal government has provided hundreds of millions of dollars in funding for CRE programs throughout the country (Wetzler, Frame, & Litzinger, 2011).

Despite a growing number of couples expressing interest in education to improve marriage and family relationships (Brotherson & Duncan, 2004), attendance in CRE

continues to be relatively low (Morris, McMillan, Duncan, & Larson, 2011). Though current estimates indicate 300 community-based organizations around the nation have served hundreds of thousands of couples (Hawkins & Fellows, 2011; Myrick, Ooms, & Patterson, 2009), this is arguably well below their potential. Larson (2004) found a number of concerns negatively impact attendance, including program cost, time involvement, lack of willingness of the other partner, and fear of stigmatization. Unfortunately, those couples with the highest risk of distress, are often the most difficult to reach (Fawcett, Hawkins, Blanchard, & Carroll, 2010; Halford, O'Donnell, Lizzio, & Wilson, 2006).

A number of factors have been found to positively correlate with attendance. Duncan, Holman, and Yang (2007) found that partners' individual characteristics played a significant role in increasing attendance when they valued the following: the importance of marriage (particularly the extent to which the wife does), being kind and considerate, and controlling one's temper. Participants were also more likely to report personal and relational distress in such areas as lower levels of self-esteem, poorer marital communication quality, less marital commitment, less intimacy, less fulfillment with marriage expectations, and increased levels of marital conflict (Morris et al., 2011). Another study echoed these findings suggesting that couples attending CRE are relatively more likely to be distressed in their relationships (DeMaria, 2005).

Other features of CRE may also make this format a more viable alternative for couples seeking to relieve distress, particularly in comparison to couple therapy. Many couples continue to have concerns about the effectiveness of therapy and are, therefore, concerned about investing time and money in something that may not help. Due to the

cost of one session of therapy (a cost that many health insurances will not cover) and the average length of treatment (anywhere from 4 to 12 weeks, and quite possibly more), the less costly alternative of CRE may be attractive to couples. Additionally, concerns about the invasiveness and/or the stigmatization of couple therapy may also make CRE the more preferred choice (Larson, 2004).

Though couple and relationship education and couple therapy can trace their roots to the marriage counseling movement which began in the United States in the 1930s, there are several distinctions between the two. Practitioners in both areas have differing educational and credential expectations, with couple therapists typically having more rigorous training (Ooms, 2010). Couple therapists are required to have graduate degrees, pass licensing exams, and follow state regulations. Arguably, CRE facilitators with some education and training in the field may have an advantage, but the concern over no standardized expectations for educators and lack of a licensing body is disconcerting. The National Council on Family Relations (NCFR) administers the Certified Family Life Educator (CFLE) program, which is a formal certification requiring a bachelor's degree and coursework in family studies; however, one study found that facilitators of CRE without mental health backgrounds were equally effective as those who did have such training (Markman et al., 2006).

Another major difference lies in the timing and intensity of the intervention. Traditionally, CRE has taken a preventative approach with the understanding that couples who attended were not experiencing significant problems but desired to avoid such (Markman et al., 2006), whereas couple therapy has been designed to address more severe forms of couple distress after the problems have already begun in the relationship.

Though it is typically recommended that couples experiencing more severe forms of

distress seek out couple therapy instead of CRE (Hawkins et al., 2008), the distinctions

between the two have increasingly become blurred. Currently, couple therapists offer a

preventative approach in premarital counseling and CRE has increasingly offered

services for couples experiencing greater levels of distress (Ooms, 2010).

Couple Therapy

Research and practice suggests that for couples where couple and relationship

education is not adequate, couple therapy is recommended (Hawkins et al., 2008).

Though in recent years CRE has become increasingly popular, couple therapy continues

to be a common choice for couples seeking to relieve relationship distress. Often

stemming from therapeutic models for individuals and families (Broderick & Schrader,

1991), couple therapy typically involves a couple meeting one-on-one with a therapist to

discuss, and hopefully create changes in the relationship (Markman & Rhoades, 2012).

Couples typically meet with a therapist for one hour once a week, anywhere from one to

two sessions to a year or more; however, a large survey of mental health professionals

found the average number of sessions for couple therapy was 11.5 (Doherty & Simmons,

1996).

As with CRE, couple therapy represents an empirically validated intervention

available to couples (Lebow et al., 2012). In their meta-analytic study, Shadish and

Baldwin (2003) found two-thirds of couples who attended couples therapy fared better

than 70%-80% of those couples who did not receive treatment, a similar result found in

individual psychotherapy with an effect size of .84. A more recent meta-analytic study

has found similarly impressive results of 70%-75% couples experiencing relational improvement from couple therapy with an effect size of .84 (Halford & Snyder, 2012).

Despite these impressive figures, most couples are reluctant to attend therapy. Of divorcing couples, 80% to 90% report they have not consulted with a therapist (Halford, Markman, Kline, & Stanley, 2003). Couples frequently have a number of concerns that hinder couple therapy attendance, such as concerns that their problems are not severe enough to warrant therapy, that it will violate their privacy, and that it will either do more harm than good or not work at all (Markman & Rhoades, 2012). To address their concerns, most couples will seek out a member of their clergy before seeking help from a therapist (Glenn et al., 2002).

Unfortunately these concerns are not without substantiation. Though the majority of couples find relationship improvements from therapy, some find little to no improvement. In their meta-analytic study, Halford and Snyder (2012) found 25% to 30% show no measurable improvement from couple therapy. Additionally, despite some benefit to their relationships, another 30% reported that they continue to experience distress in their relationship post treatment. In follow-up studies, research also suggests that almost all treatments reveal diminishing effects over time (Lebow et al., 2012). So a slight skepticism from consumers may not be completely unfounded.

A few possible reasons for these limitations include the nature of those who seek treatment. As mentioned before, couples are often reluctant to seek therapy and wait until problems increase in severity before addressing them in therapy (Halford et al., 2003). Metaphorically, they go to the doctor when their cancer is in the final stages. As couples wait to attend therapy, their relationships tend to reach higher (and more

entrenched) levels of distress (Whisman, 2007). Additionally, partners run the risk of developing individual pathologies such as depression or anxiety which further complicates treatment and make it more difficult for a couple to benefit from therapy (Whisman, 2007). Several studies have similar findings, suggesting that initial levels of distress account for up to 46% of the variance in treatment outcome (Johnson, 2002).

One possible hurdle for this includes creating an alliance – the relationship the therapist develops with the client. This often presents a unique challenge for even the most experienced couple therapist. Alliance has been found to be a very important feature of couple therapy, predicting 5%-22% of the improvement of marital distress (Knobloch-Fedders, Pinsof, & Mann, 2004). Couples who report higher levels of distress are less likely to align with the therapist. Often couple therapists must walk a tight rope of creating a connection with one partner, while attempting to not alienate the other. Lebow and colleagues (2012) support this concept in suggesting couples experience alliance differently from those in individual therapy.

Part of this challenge lies in differing stages of change each partner can potentially be in. The stages of change model, developed by Prochaska and DiClemente (1984), posit that individuals vary in their stages of readiness for change. Partners often experience differing levels of motivation when it comes to making changes in the relationship. Wives are nearly always at a higher level of readiness, typically being in the stage of contemplation (aware of problems, and considering change), while their husbands are more often at a stage of precontemplation (little or no recognition of problems, no intention to change; Bradford, 2012; Fleming & Cordova, 2012). Bradford

(2012) suggested that interventions should target these differing levels of readiness to

help couples progress appropriately in their relationships.

Complicating this matter is the large number of psychotherapists (70%) who

practice couple therapy without any specific training in couples work (Orlinksy &

Ronnestad, 2005); they may work well with individuals but not necessarily understand

the complexities of working with couples. Even experienced practitioners with an

educational background in couple therapy can find working with couples challenging.

Though principles of individual therapy are used in couple treatment, the field of

marriage and family therapy was developed so that practitioners could be adequately

trained to work with the unique needs of couples and families. Another ongoing

challenge in the profession is the lack of empiricism in the work of many couple

therapists (Gurman, 2011). Included in this is the overemphasis on treatment modalities

and lack of emphasis on empirical outcome. Gurman (2011) argued that even adequately

trained practitioners are not always receptive to empirical feedback.

Relationship Checkup

One of the more recent versions of couple interventions is the Relationship

Checkup – the format upon which this research study is based. The Relationship

Checkup was designed to appeal to a wider audience than couple therapy (Olson et al.,

2009) and unlike CRE, is more adaptable to the individual needs of the couple. It also

responds to concerns in the field that couple interventions need to be more competency-

based, preventative, and empowering for the couple (Deacon & Sprenkle, 2001). As a

two-session format (typically), relationship checkups are similar to CRE in that they

avoid one of the more prominent concerns of couple therapy, being too time consuming and expensive (Fleming & Cordova, 2012). Generally, couples – particularly men – prefer brief interventions (Larson et al., 2007).

Building on a strength of CRE, the relationship checkup is designed to be a preventative intervention and targets couples in the early stages of distress; therefore, couples are helped before maladaptive forms of functioning become too entrenched (Gee, Scott, Castellani, & Cordova, 2002; Olson et al., 2009). However, this is not to say that highly distressed couples cannot benefit from this intervention as it is flexible enough to help couples at any distress level (Cordova et al., 2005).

To overcome much of the stigma associated with couple therapy and to encourage couples to come in early, the relationship checkup format has been described using less threatening wording such as "tune-up" or "checkup" (Cordova et al., 2001; Larson, 2003; Olson et al., 2009). These terms associated with annual practices, encourage couples to view treatment as a common phenomenon so that they come in before their problems reach a critical severity. One common aim has been to target men -- who are often more reluctant to seek help or even admit to having a problem (Mackenzie et al., 2006; Ojeda & Bergstresser, 2008). The other hope was that this format might act as a gateway for couples, helping them to be more comfortable with receiving future forms of treatment including couple therapy (Olson et al., 2009).

One of the most prominent features that distinguishes relationship checkups from both CRE and couple therapy is the use of an assessment. Participating couples complete either an in-session or online assessment in the initial stages of treatment, evaluating the couple in a number of key domains of couple functioning. This allows the attending

clinician to quickly identify and target the unique concerns of the couple, including their strengths and weaknesses (Olson et al., 2009). Knutson and Olson (2003) found assessments to be a valuable tool in relationship intervention, finding in their study a 30% improvement in couples who just completed an assessment, even without feedback. Another study found that an assessment-based program had more impact than therapist-directed or self-directed programs (Busby et al., 2007).

Because of assessments, this format can respond to criticism of the CRE format that it is too generalized for the unique needs of each couple in attendance (Larson & Halford, 2011). Utilizing a characteristic strength of couple therapy, relationship checkups also have couples meet with clinicians one-on-one allowing for a personal and individualized intervention (Fleming & Cordova, 2012). This intervention recognizes that partners come in at differing levels of motivation to make changes in their relationships which often hinders treatment (Fleming & Cordova, 2012). Checkups are designed to identify differing levels of motivation and to be flexible enough to address this.

Several iterations of this intervention format exist including Olson and Larson's *Couple Checkup* (Olson, 2002); the *Marriage Checkup* developed by Cordova et al., (2001), and the *Great Marriage Tune-up* developed by Larson (2003). Thus far, research suggests these programs have a positive impact on relationships (see the previously cited studies). With regard to the original study of the current intervention, Stewart's (2011) preliminary results suggest a positive impact of the intervention on participating couples, including improvements in their relationship knowledge and individual well-being.

Revitalize for couples. Modeled after the relationship checkup (Cordova et al., 2001), the current intervention, *Revitalize for Couples,* is a brief two-session format wherein therapists (referred to as consultants) meet with couples to develop and implement simple goals for improving the relationship. Guided by a treatment manual (Bradford, 2010), and based upon the tenets of solution-focused brief therapy, consultants accomplished this by helping couples identify relationship strengths and areas needing improvement. The manual included the five stages of SFBT as outlined by de Castro and Guterman (2008): (1) co-construct a goal, (2) discover and amplify exceptions, (3) assign tasks, (4) evaluate the effectiveness of a task, and (5) re-evaluate the goals. These five steps were the foundation of the treatment model used in this intervention, as described in greater detail below.

Prior to the first session, couples completed an online assessment comprised of a number of standardized measures designed to evaluate each partner regarding individual distress and their feelings about the relationship (the psychometric properties of these measures are not reported here as they are not the focus of the current study). Assessments were completed online by each partner individually. Individuals who lacked computer access were provided a hard copy. Assessments were in-depth, and took anywhere from 40-60 minutes to complete. The assessment survey consisted of a number of measures including the O*utcome Questionnaire 10* (Lambert & Burlingame, 1997), a measurement of individual wellbeing, the *Kansas Marital Satisfaction* (Crane, Middleton, & Bean, 2000), and the *Stages of Change Questionnaire* (Bradford, 2012), a measurement of the individual level of motivation for change in the relationship in a number of key areas (how finances are handled, sex life, parenting, etc.). Other

psychometric tests include measures of communication, feelings about ones' partner,

level of commitment, and risk for violence (see the Appendix for full list).

In the first session, consultants used the assessment results to highlight areas of

relationship strength and areas of concern. In accordance with the treatment manual and

the principles of SFBT (de Castro & Guterman, 2008), the consultant co-constructed a

few relational goals with the couple, assigning "experiments" or "tasks" to be completed

over the next few weeks by the following session. The consultant was careful to discover

and amplify exceptions of when the problem was not a problem, while focusing on areas

of success. At the end of the session couples were provided handouts or book

recommendations as needed regarding typical areas of concern for couples such as

communication, stress management, parenting, and sexual intimacy. Consultants were

strongly encouraged to allow the couple to guide the treatment process within the five

steps of the SFBT model, rather than focus on their own agenda for the couple (Nelson &

Thomas, 2007).

Two to three weeks later the consultants met with the couple to evaluate the

effectiveness of the experiments, and to discover and amplify exceptions to the problem

(de Castro & Guterman, 2008). Previous goals were re-evaluated and either adjusted for

continuing success or replaced with new ones. Additional reading materials and book

recommendations were provided as needed. At the end of treatment participants were

given the option of continuing treatment, and informed of other resources in the

community. To encourage program integrity, consultants followed a treatment manual

and received intervention training in SFBT by Thorana Nelson, Ph.D., considered an

expert in the field (e.g., Nelson & Thomas, 2007). A more detailed description of this process is provided in Chapter III.

Program fidelity. To encourage program integrity in the original study, each consultant was provided with a treatment manual outlining the steps that they were to take in the relationship checkup, and were trained on how to follow these steps. For each case, consultants were provided a checklist to be put in each case file, outlining the steps of treatment. The principal and co-investigators followed up with each consultant on following these steps as the cases progressed. The principal investigator gave periodic supervision to consultants (both via live and case consultation) to ensure consultants were properly following the SFBT steps outlined in the manual. Consultants were also provided training in the use of SFBT by Thorana Nelson, Ph.D., specifically with the intention of using the principles of SFBT in this intervention.

Solution-focused brief therapy. Developed by de Shazer and colleagues (De Jong & Berg, 2007), Solution-Focused Brief Therapy (SFBT) is an increasingly common form of therapeutic treatment for couples (Chromy, 2007; Hoyt & Berg, 1998). One of the more prominent features of SFBT is that, rather than looking for failed attempts when the solution does not work, the therapist helps the client look for exceptions when the problem was not a problem (de Shazer, 1991). Solution-focused practitioners contend that they do not need to know a great deal about the problem, and typically assert that if anything, discussing the problem promotes the power of it. Additionally, the solution may be unrelated to the development of the problem. Typically SFBT clinicians focus solely on what the client presents, rather than delving into other problems they might feel the client has (de Shazer, 1991). Solution-focused couple clinicians are careful not to

import their view of normality for a relationship, believing that there is not one correct

way to live one's life (Metcalf, Thomas, Duncan, Miller, & Hubble, 1996). Fundamental

to this process is the importance of valuing the client's experience while allowing the

client to direct the goals of the treatment process.

Solution-focused therapists believe that language shapes reality, and thus they

consciously use optimistic language and offer hope throughout the treatment process (de

Shazer, 1994). They are particularly interested in times when the couple experienced

success, guiding them to focus on this over the times of failure. They believe in the

couples' strengths and ability to find solutions to their problems, and they steer clients

towards identifying and utilizing such (Nelson & Thomas, 2007). In this the therapists

act as facilitators, helping couples to envision future changes, encouraging positive

outcomes, and generally expressing hope in the couples.

A defining feature of the modality is brevity. Clinicians following this treatment

model do not seek to retain clients any longer than is necessary. Particularly for SFBT, it

is not unusual for a couple to complete treatment in just a few sessions (Friedman &

Lipchik, 1999). As this is a brief modality, applying it to the relationship checkup format

was a natural fit.

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Study Purpose and Research Questions

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The use of the relationship checkup, coupled with the SFBT modality is a unique

combination and a newer treatment option. Thus, relatively little is known about this

format including the experiences of couples in this intervention. Though there is a small

amount of research indicating the effectiveness of the SFBT treatment approach (Kim,

2008), research is very limited on the application of this approach to couples, particularly

the experiences of couples with this treatment model. These unknowns are the purpose

of the study.

This interest can be summarized into two research questions that are the

investigation of this study:

1.   What were couples' experiences with the process in this 2-session brief

format of treatment?

2.   What were consultants' experiences with couples' processes in this format

of treatment?

CHAPTER III

METHODS

The aim of this study was to explore the experiences of couples in a newly

developed checkup format intervention, including how the experiences of the

corresponding consultants reflected the couples' experiences. This chapter will discuss

the methods used to answer these questions. Data for this research were drawn from a

subsample of the participants in a project entitled *Revitalize for Couples* (Bradford,

2010). This pilot study was exploratory in nature, evaluating a brief two-session

intervention for couples using solution-focused principles of marital therapy. The

interviews with participants and with clinicians were conducted two to four months after

both sessions of the intervention had been completed. Open-ended, follow-up interviews

were conducted with roughly 30% of the sample (10 couples from a sample of 30), and

all six of the clinicians who worked with these couples (called consultants in the original

study).

Design

A qualitative research approach was chosen to explore this topic because of its

ability to examine phenomena as complex as the relational process in ways that would be

difficult for quantitative research, particularly to gather data to inform modifications to

the intervention. Quantitative research typically organizes data into manageable bits of

information to form a larger picture whereas qualitative research seeks to expand smaller

details to make important concepts more clear (Vaterlaus & Higginbotham, 2011).

Therefore, a quantitative exploration would be appropriate to measure the amount of change that has taken place or whether change has happened at all (see Stewart, 2011, for a quantitative evaluation of this intervention). Conversely, a qualitative study is appropriate for answering the question of how and why the change occurred, and it helps to illuminate the process even if change was not experienced.   Bogdan and Biklen (2007) suggest that researchers use a qualitative approach when there is more interest in the process rather than just the outcomes.

Qualitative research is inductive in that the researcher suspends hypothesis of the outcome until the research is complete (Bogdan & Biklen, 2007). Rather than objectively keeping distance, researchers subjectively immerse themselves in the data by personally exploring themes present in the data. In this process, researchers become the instrument through which data are recorded, organized, and analyzed for interpretation. This interpretive process allows themes to immerge in a rich, detailed description (Berg, 2009).

Within qualitative research, standard approaches are used in analysis and interpretation, such as ethnographic research, grounded theory, and phenomenology (Creswell, 2007). The aim of this research was to understand the participants' experience of the "relationship checkup" formatted intervention in depth, to focus particularly on the potential processes of change among the participants as well as the consultants and to understand the common themes among them. The phenomenological approach was deemed the most appropriate way of addressing this for a several reasons. For example, Creswell (2007) has suggested using phenomenology when the researcher is interested in commonalities across individuals and not what is unique to the individual. This approach

is used to understand the participants' perspectives in depth, and the shared-life

experience among them (Bogdan & Biklen, 2007). Another reason is that this descriptive

approach attempts to move beyond a simple explanation to find the *essence* of how

individuals experience a phenomenon. This process is often facilitated by conducting in-

depth interviews which allow the real life experiences of participants to immerge

(Bogdan & Biklen, 2007).

Participants

The study was reviewed and approved by the Utah State University's Institutional

Review Board. In the original study, couples who called in to participate in the study

were assigned to a consultant based upon the available times of the couple and the

consultant. Efforts were made to provide an equal number of participants to each

consultant, however as this was a pilot study no effort was made to randomly assign

participants to consultants.

Once all couples had completed the program, a convenience sample of 10 couples

and 6 consultants were pulled from the larger sample of 30 couples and 7 consultants

simply based on who was willing to participate (see procedure below). In the original

study, couples were recruited using flyers posted in local grocery stores, restaurants, civic

buildings, community centers, and on the campus of Utah State University. Local

newspaper advertisements were run intermittently and department professors were asked

to make announcements in on-campus classes. Advertising announced that couples

would be paid $20 to participate in a research study designed to "improve the quality of

their relationship." Of the 49 couples that initially signed up, 30 completed the program from start to finish (see below for pilot program details).

Once the intervention was complete, all 30 couples were invited via email to participate in a follow-up interview to answer questions about their experience with the intervention. Emails explained that participation would be to refine the intervention for further research purposes, and that participation was strictly voluntary. The email also stated that it would be at a time and place of the participants' choosing. The first email garnered one response. A second round of email invitations was sent out a few weeks later with the same message. This led to two more responses and brought the total to three potential couples of interest. A more rigorous third attempt to contact participants was made two weeks later by attempting to contact the remaining participants by speaking with them on the phone. Though this attempt provided eight more couples, one of these couples dropped out due to time constraints. This created a total of 10 participating couples.

It should be noted that the participants who self-selected may be different from those who declined to be interviewed in several ways. Fowler (1984) suggested that those who agreed to the interview may be more interested in the subject matter. As will be discussed below, several participants gave some indication of this. Additionally, those who have a higher education are also more likely to participate in studies (Smith, 1983); however, no statistical differences was found in education levels between those who agreed to be interviewed and those who did not.

To address some of these concerns, the 10 interview participants were compared to the 20 participants who did not participant in the interviews to see if they differed in

any significant way. In independent sample *t* tests there were no statistically significant

differences between the two groups in demographic factors (e.g., age, income).

Additionally, there was so statistically significant difference between the two groups in

pre-session assessment measures, including the *Kansas Marital Satisfaction Index* (Crane

et al., 2000) which measures relationship satisfaction, Stanley and Markman's (1992)

Measure of Relationship Commitment, and Bradford's (2012) *Stages of Relationship*

Change Questionnaire, an assessment of couple readiness for change, with one

exception. In regards to relationship commitment, husbands' scores ($t = .017$, $p > .05$)

were statistically significant, indicating that husbands (on average) in the participant

group may have been more committed to their partners than those husbands who did not

participate in the interview.

All 10 of the couples were in heterosexual relationships, nine of which were

marriages, and one a cohabitating relationship. The average length of the relationship at

the time of the interview was 5.1 years ($SD = 2.93$) with a median of 4.5 years. The men

ranged in age from 19 to 40, with a mean age of 28.8 ($SD = 6.14$) and a median age of

27.5 years. Women had an age range of 19 to 34 years, with a mean of 27.4 ($SD = 5.25$)

and a median age of 27 years. All of the participants were Caucasian. Six of the 10 male

partners reported working full-time; three reported working part-time, while one male

reported being a full-time student. One of the female partners reported working full time,

six reported working part time, two reported being full time caregivers at home, and one

reported being a full time student. The women reported a combined household income

ranging from $7,000 to $70,000, with a mean of $31,000 ($SD = $24,806$). Nine of the ten

men reported their household incomes, ranging from $8,000 to $77,000, with a mean of $35,888 (*SD* = $26,222).

Consultants were told at the beginning of the study that follow-up interviews would be conducted at the conclusion of the study regarding their experience. All six consultants participated in the study: two licensed Marriage and Family Therapists from a local community clinic and four Marriage and Family Therapist Student Interns from the Utah State University Marriage and Family Therapy Clinic. Each consultant was interviewed separately regarding their experiences with their couple(s). Consultants were not contacted until after the completion of the 10 interviews with the couples.

Procedures

Semi-structured, open-ended, in-depth interviews were conducted with the ten couples and the six consultants. Couples were interviewed together at a time and place of their choosing. Participants were allowed to choose the interview setting to help them feel more comfortable and more open to sharing their experiences. Six couples elected to be interviewed in their home and four in the consultation setting. All six consultants chose to be interviewed at the site where the interventions were conducted.

For each couple interview, the interviewer explained that the purpose of the meeting was to understand their experience in the intervention and the impact of such on their relationship. He also asked specific questions as to any critique -- both positive and negative -- the participants had of the program. The interviewer also reiterated that participation was voluntary; the couple could stop the interview at any time, the interview would be recorded, and that the transcriptions derived from the audio recordings would

be kept confidential. Beitin's (2008) suggestion to interview the couple together was followed to provide a more complete picture of their experience. Because the couple experienced the intervention together, it was decided that they would be interviewed together. Interviewing in this way allowed partners to add to each other's thoughts and synergistically create a more complete story than would have been told individually (Bennett, Wolin, & McAvity, 1988). It was also reasoned that interviewing couples together was appropriate to a phenomenological approach, where the goal is to understand co-constructed commonalities, and less on understanding what is unique to the individual. In later reporting the results, however, efforts were made to distinguish responses from husbands and wives within couples as appropriate.

Follow-up and probing questions were asked throughout the interview to obtain more detail and to provide clarity, such as, "Tell me more about that?" or "Is there anything else you would like to say about that?" For each question, the interviewer sought responses from both partners to allow both parties to be heard. If only one companion responded to a question, the interviewer would ask for the other one's input. If a partner did not agree with what was being said, the interviewer would also attempt to understand the other partner's point of view. The investigator also clarified non-verbal cues, such as, "You are nodding here, could you say more about that?" or "You seemed to react when your partner said this, could you say more about what you are thinking?" Throughout this process, the interviewer sought to understand the participants' experience of the phenomenon.

Many of these same principles were applied to the interviews with the consultants. They were also informed of the parameters of the interview process,

including their rights as participants in the study. Consultants were asked about their

experiences with their couple. Particularly, they were questioned concerning their

thoughts on the couples' change processes, when and how it happened, and what the

consultants and the couples did to facilitate this. Consultants were also asked to

comment on various aspects of the program, including suggestions for improvement.

Throughout the process, probing questions were asked to create a richer picture of their

experience. Recordings of the interviews were transcribed for later analysis.

Instrument

The semi-structured interview for the couples consisted of 17 open-ended

questions regarding their experiences (see Appendix), and the consultants received an

individual, semi-structured interview with 15 open-ended questions also regarding their

experiences. Questions were developed by the researcher in collaboration with Dr. Kay

Bradford, Utah State University. Feedback was provided by Dr. Linda Skogrand of Utah

State University, a qualitative researcher who has conducted numerous couple interviews.

Based on Dr. Skogrand's feedback a number of questions were expanded and added

upon, while some were simplified or deleted to prevent redundancy (see Appendix).

Interviews were conducted two to three months after the completion of the intervention to

allow all the original participants to complete the study.

The first questions in the couple interview focused on how the couple learned

about the program and why they chose to participate. Additional questions focused on

change including their reporting any change that did happen either individually or within

the relationship, what brought it about, and when it happened. Two questions focused

specifically on the role the consultants played in the couples' change process. Other

questions focused on the couples' critique of the intervention, including what they felt the

intervention should stop doing, start doing, and continue doing. Finally, the couples were

asked how their views of therapy have or have not changed; specifically they were asked

about their willingness to seek couples treatment in the future and to access other

resources.

Corresponding consultants who worked with the couples were interviewed within

three weeks of the completion of all the couples' interviews. The consultants were asked

broad questions about their experiences with the couple to help the consultants recall

experiences with them. Consultants were reminded of the dates consultation took place

and were given information about the couple to aid in memory. The next set of questions

focused on the consultants' views of what changed in the couple relationship, who was

responsible for this change, and when did it happen. Consultants were also asked to

reflect upon their role with the couple, specifically their role in facilitating change. The

interviewer asked about any regrets there might be, and the relationship that existed

between the couple and the consultant. Finally, the consultant was asked about the

intervention, including suggested changes, ideas for recruitment, and the role the

intervention played in helping couples access outside resources.

Analysis

Data analysis in qualitative research tends to be a nonlinear process, in that the data are

repeatedly reviewed in a cyclical pattern allowing for themes to emerge (Miles &

Huberman, 1994). Rather than remaining objectively distant, the researcher becomes the

tool of analysis relying upon his or her own insights and impressions (Dey, 1993). Miles and Huberman (1994) identified three general steps the researcher followed in qualitative data analysis: (1) data reduction, (2) data display, and (3) drawing conclusions. In this process, the researcher employed a phenomenological approach to analysis as described by Moustakas (1994).

Two research assistants were utilized in this process: Wade Stewart and Erin Henrie. Mr. Stewart, a family studies graduate student at Utah State University, who had a limited background of clinical work (he had been practicing less than a year at the time of the study and was one of the clinicians in the study) assisted with the couple data. Ms. Henrie, who was a recent graduate in Utah State University's Family, Consumer, and Human Development undergraduate program and did not have a clinical background, assisted with the clinician data (a full description of each researcher's background is provided below). Having different research assistants allowed for greater opportunity to find consensus in the participants' stories, rather than just using one person's point of view to determine this in a process described below.

First, the researcher and the research assistants participated in what Creswell (2007) described as a prolonged engagement which allowed them to get an overall feel for their respective data. The researchers immersed themselves into the data by independently reading and re-reading the transcriptions line by line. As they did so, each researcher separately created a list of significant statements that typified the experiences of the participants (Moustakas, 1994). These statements were reflective of reoccurring patterns and themes in the responses (Bogden & Biklen, 2007).

After completing this process, the researchers met together to put together their list of statements, giving each statement equal weight (Moustakas, 1994). Together the researchers formed a list of statements that did not repeat or overlap. These significant statements were then grouped together to form themes. Throughout this discussion process, the researchers attempted to agree as to what each theme should be. When there was disagreement, researchers returned to the data and discussed until a consensus was reached (Berg, 2009). Once this was completed, the researchers then created a description of *what* the participants experienced, followed by identifying *how* it happened (Moustakas, 1994).

Guba and Lincoln (1985) argued that the principles of reliability and validity in qualitative research are conceptualized in terms of trustworthiness in four aspects: credibility, transferability, dependability, and confirmability. The goal was not to erase any sign of objectivity but accept that the subjectivity of the researchers would be present in the analysis. However, reliability can be achieved in a number of ways including implementing the qualitative process of inter-coder agreement (Creswell, 2007). This was accomplished by having two separate coders who repeatedly met together to develop a consensus of coding schemes. The goal in this process was to get the coders to consistently code the data with the same codes regardless of who was coding.

Per phenomenological methodology, these descriptions were used to attempt to form a number of distinct themes. The researcher and research assistant discussed at length samples from each interview to be clear which statements fit into which code. From this they developed a list of sample statements from the text that typified each theme. Once themes were identified, the data were coded sentence by sentence

(Creswell, 2007). To facilitate consistency, each coder coded a smaller portion from several interviews and then met again to ensure they were following similar coding patterns. Once this was established, the two researchers independently combed through the data and assigned a code to every line of the relevant data from each transcript. Together, researchers determined early on which content was relevant to the research questions and left out data that proved to be irrelevant. Where more than one code was viable, researchers met together and built consensus until they agreed to one code. Throughout this process, the researchers met to examine the extent to which they had the same codes. Miles and Huberman (1994) suggest that researchers should have more than 80% agreement between them. When disagreements arose, researchers went back to the data until a final code was agreed upon.

Once this step was complete, the larger process of interpretation began. Pulling from the initial research questions, the primary researcher analyzed how these findings answered the research questions. Taking a step back from the small details found in the coding, the larger questions asked: "What does all this mean?" or "What is really important here?" and "What are the essential experiences?" This discussion took place between researchers to determine the broader themes in the data and to ensure they addressed the original research questions.

As suggested by Creswell (2007), two validation strategies were used in this study: case triangulation and peer review. Triangulation is the process wherein two or more methods or data are used to confirm the findings (Patton, 2001). In this study the codes and themes from the participants were compared to the codes and themes from the consultants for corroboration or divergence. A peer review is an independent third party

whose role is to question the findings of the research. It was his or her role to challenge

the assumptions of the researchers, exploring hidden biases, while providing the

researchers the opportunity to test and defend their ideas. The doctoral examination

committee, and particularly Dr. Skogrand, who has acted as a peer reviewer on a number

of projects, served as a peer reviewer on this research project.

Researcher's Role

Another key feature of the phenomenological approach to analysis is that the researchers

disclosed their own experiences with the phenomenon. Moustakas (1994) suggested

doing this as a way of identifying and setting aside researchers' own personal

experiences, so they are more available to the unique experiences of the participants.

Though it is suggested that the researchers' background or biases cannot be separated

from interpretation (Creswell, 2007), the goal is to allow the participants' true

experiences to emerge, unfiltered by the researchers' experiences. In doing so, the

researcher needs to practice reflexivity, be self-aware of personal bias both seen and

unseen, and be open about it in the writing process. In the effort to do so, I endeavored to

self-disclose my experience with this phenomenon now.

To be transparent in acknowledging how my personal experiences influenced the

perceptions of couples' process, and thus the potential influence of my experiences on the

study results, I will share a few pieces of demographic information. One of the reasons I

chose to become a licensed Marriage and Family Therapist (LMFT) and eventually to

pursue a doctoral degree in Human Development and Family Studies is because of how

important I feel that family relationships are, and particularly how important the couple

relationship is. It is my belief that this is one of the most important relationships people have in their lives. It is also clear by my advanced degree that I am someone who values education. An additional influence is my level of income. Though as a student I would not technically consider myself in the middle-class, I grew up in it and continue to think and act as one who is. Additionally, I am an active member of a conservative church (The Church of Jesus Christ of Latter-day Saints [LDS]) and subscribe to and maintain many of the beliefs therein, including those that pertain to couple relationships.

Most of these demographic characteristics are also true of Wade Stewart, who assisted in data coding: he is a married Caucasian male, an active member of the LDS church, a trained MFT (not yet licensed), and a doctoral student with a middle-class background. He was also one of the consultants in the original study. Erin Henrie is a single Caucasian female, also from a middle-class background, with no specific religious affiliation. She is not a clinician, and she was recently accepted into a family studies graduate program.

In terms of experience with intervention, I have never participated in a relationship checkup, nor have I been a participant in couple therapy or CRE, though I have attended individual therapy and a little family therapy for some help with one of my children. However, I am currently in practice as a LMFT and have been so for the past nine years. As such I have met with many couples. Frankly, I have found working with couples to be the most challenging part of my work. I have been witness to various relationship dynamics – from screaming matches and bitter resentment, to forgiveness and bliss.

As a husband quickly approaching my 16th wedding anniversary I have had my own share of ups and downs. These experiences have shaped how I feel marriage should be, and they have not diminished my belief that couples have the ability to improve their relationship. I have seen how one partner has the power to make changes in the relationship, and that two working together can really create something special. I have also seen that a truly happy marriage takes work, which is probably why it is rarer than it should be. I have a firm belief in the virtues of patience, forgiveness, and willingness to try.

It is these beliefs and experiences that shape my view of the couple relationship process as well as how I interpreted and analyzed the data. Particularly, my background as an LMFT inclined me towards seeing systemic patterns in couple interaction. I have seen couple therapy work as the couple was willing, but recognize these changes tend to happen in more subtle ways than on a grand scale based on the willingness of the couple. Consequently, I expected to see some change happen most likely in a small way and according to the commitment level of the couple.

CHAPTER IV

RESULTS

This chapter presents the findings from the qualitative data analysis of interviews conducted with couples and their corresponding clinicians regarding their experiences in a brief marital intervention. It will delineate the distinct themes consistently found in couples' and clinicians' responses. These findings addressed the research questions: 1) What were couples' experiences with the process in this two-session brief format of treatment? 2) What were consultants' experiences with couples' processes in this format of treatment?

For the couples who participated, five distinct themes emerged in their responses: motivation (clients' readiness for change and motivation towards attending the intervention), therapeutic environment (the space created by clinicians for clients to share), internal change (changes in clients' internal processes including cognitions and emotions), external change (changes in clients' external processes, particularly behaviors), and program response (general client response to the program). The terms "client" and "participant" are used interchangeably.

For the clinician consultants who participated in the program, four themes in regards to the couples' process emerged: couple characteristics (challenges, strengths, and general patterns of interaction), client motivation (couples' level of motivation to attend treatment), therapeutic relationship (what the therapist did to create trust in the therapeutic relationship), and therapists' facilitations of change (what the therapist did to bring about change in the relationship). This section will first review couple themes

followed by clinician themes. The terms "clinician," "therapist," and "consultant" are used interchangeably. In summary each theme and subtheme are as follows: (1) Couple Themes (a) Client motivation (internal motivation; external motivation), (b) Therapeutic environment (open environment, therapeutic technique, therapists' characteristics and attitudes), (c) Internal change (awareness of interpersonal processes, communication, acceptance, perceptual change of therapy), (d) External change (communication changes, conflict diffusion, general behavioral change), (e) Program response (assessment response, response to intervention directives, session format response); (2) Clinician Themes (a) Couple characteristics (distress level, patterns of interaction, couple strengths), (b) Client motivation (motivation towards relational improvement, openness to the intervention, motivation as a result of treatment), (c) Therapeutic relationship (connection, developing trust), and (d) Therapists' facilitations of change (communication, increased awareness, change of pattern, therapeutic technique).

<div align="center">**Client Themes**</div>

Client Motivation

According to couples' reports, participants had many reasons why they chose to attend treatment. Generally, these reasons can be divided into two subthemes of motivation: internal motivation and external motivation. Either there was something about the couple that led them to attend (internal motivation) or there was something about the intervention that encouraged them to participate (external motivation). Some partners had distressing issues in their relationship they wanted addressed while others simply wanted to strengthen the relationship absent of any real concern. As described

below for a large number of partners, the financial incentive played a role, with a significant number reporting that participating in a study was important to them.

Internal motivation. All of the couples interviewed, including either one or both partners who participated in the study, indicated that they were motivated to improve the quality of their relationship. For example, Wife 1 reported that she frequently read marriage improvement books (*The Seven Love Languages* and *Men Are from Mars, Women Are from Venus*) so that she could be a "better wife." Often one or both partners said they were motivated to improve the relationship. Two husbands remarked that they were as "equally motivated" to make adjustments in their marriage as their wives were (Couples 3 and 6); one husband explained that he was more motivated than his spouse, and his partner conceded that this was so. However, Husbands 1 and 9 described themselves as initially resistant to participating, but then warmed up to it as treatment progressed.

Partners from a slight majority of the couples (Couples 1, 4, 6, 7, 8, and 10) approached the intervention as a pre-emptive measure; they did not think they had any serious "problems to work on" but wanted to make sure things stayed that way. Husband 8 illustrated their attitude when he said they, "just wanted to make sure we're on the right road." Three couples (Couples 6, 7, and 8) specifically did not think they needed counseling but thought it would be "good to talk." For partners of four of these six couples, the intervention was approached as something "fun" which was similar to two other couples who reported they enjoyed improving their marriage. The remaining four (Couples 2, 3, 5, and 9) had areas of distress that they wanted addressed, particularly

related to emotional distance, conflict, and separation. Husband and Wife 5 related the

following:

> Husband 5: Our tempers get out of control and we will get in a fight over some
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> little thing and it will snowball into a really big fight and by the time we are done
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> with the big fight we can't even remember the small fight that started it.
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> Wife 5: I think that's why I noticed it [the advertisement] because I was looking
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> in the paper and it caught my attention because we had just gotten in a fight.
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> Husband 5: She saw it in the newspaper and brought it to me and we both thought
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> it would be a good idea to get some help with the relationship; some professional
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> help.

Three of the four couples who had indicated problems acknowledged that they

were experiencing frequent and/or intense conflict in the relationship in addition to higher

levels of distress (Couples 2, 3, and 5). For example, Husband 9 could see "walls

building between us," and both partners wanted to get a handle on things before they got

worse, but reported that they were generally experiencing lower levels of distress when

they entered the program. Couple 3 had previously separated for an undisclosed length

of time and had recently moved back in together at the start of treatment. Additionally,

Couples 2 and 9 were already considering therapy when they came upon the study.

Though each of the four couples had discussed making changes in their relationships,

Couple 2 was the only one who indicated they had started making those changes prior to

treatment.

> Wife 2: We had talked about starting counseling so when we saw the ad, we were
>
> like, "Free money, free counseling, it works!"

Husband 2: We were planning to see a counselor anyways together so it was a perfect opportunity.

Interviewer: When did you start making changes in the relationship, before, during or after the session?

Husband 2: I think some things had started before.

Interviewer: Before you went in?

Wife 2: Yeah and just the decision that things need to change, like we were both in that place where things needed to change and we were both ready.

External motivation. As mentioned above, the honorarium provided along with the lack of cost was a motivating factor for many participating couples. Either one or both partners from eight of the ten couples reported that monetary reasons influenced their choice to attend while the remaining two couples reported it made no difference. However, Couple 3 was split in their attitude; the wife found the money a motivating factor while the husband, though he thought it was good, explained he "could take it or leave it." Seven couples remarked that the honorarium ($20, paid upon completion of the study) was a motivating factor; six couples specifically mentioned the word "free" or alluded to it when asked about their reasons for attending the study. One husband and two other couples reported that they would not have attended it if there had not been financial incentives, as illustrated by Couple 8:

Wife 8: I think being free was a thing because it does cost a lot for counseling and I'm always looking to improve myself and our marriage.

Husband 8: With our financial situation we probably wouldn't have done it without it being free.

However, financial incentives were not the only reason provided for attending. For partners in five couples, the idea of participating in a study was also a motivating factor. Couple 7 made no mention of compensation as a reason for joining the study. Three couples (Couples 6, 7, and 10) specifically commented that they did this because they "liked supporting research" or being part of a research study.

Therapeutic Environment

The second theme that emerged from participant data was the therapeutic environment. An integral part of this intervention included the clinician creating an environment where each partner could feel open to address concerns in the relationship. Specifically, the treatment manual emphasized therapist congruence, positive regard, and empathic understanding. Thus, clinicians were trained to develop a forum where partners could tackle normally conflict-ridden issues that otherwise may not be discussed. An important part of this process was that each partner felt that they had an opportunity to speak and to be heard by the clinician and ideally by his or her partner. Though the various modalities of therapeutic treatment suggest different ways to achieve this, all therapists, as prescribed by the modality used in this study (Solution Focused Brief Therapy), were encouraged to use their own personalities to achieve this. Based on commonalities of response, the theme of therapeutic environment was broken down into three subthemes: open environment, therapeutic technique, and therapists' characteristics and attitudes.

Open environment. All couples indicated that the environments created by the clinicians provided a place where they were able to open up and discuss concerns.

Partners from seven couples specifically used the term "open" to describe their experiences in session and used such phrases as, "I felt comfortable opening up to her" (Wife 1), "it was an open forum to talk about them (my issues)" (Husband 6), or "it just invited that openness" (Husband 7). Other couples provided similar sentiments stating, "It's a safe place to say what's bothering me" (Husband 3) and "I felt like I could talk to him and could say things" (Wife 8).

Notably, partners from Couples 2, 3, and 5, the couples already experiencing some relational distress, indicated that they went into the intervention with the expectation that therapy would be a place where they could be open. However, either one or both partners from all couples remarked that the clinician played a role in facilitating this safety in the environment. For eight couples (Couples 1, 3, 4, 5, 6, 7, 8, and 9), the partners explained that they enjoyed having an impartial party outside of their dyad to act as a sounding board. Speaking of his relationship with the consultant, Husband 7 put it this way:

> It allows you to be more open, if you feel like you can say something without having some kind of a judgment back upon you. It just opens that. It makes you more open to sharing and I think he did a good job with that.

Other couples echoed similar sentiments explaining that it was a good thing to have someone acting as a "mediator" (Couples 1, 3, 5, and 6), a "third person/party" (Couples 4, 6, and 9) or someone "unbiased" (Couple 9). Husband 6 summed this up when he stated "Yeah, and it was good to have a third person to kind of mediate. Maybe we wouldn't have otherwise brought up or talked about [these issues] but we were able to there."

Therapeutic technique. Participants reported that therapists used varying techniques to develop this environment. Not surprisingly, a number of partners (in Couples 1, 4, 7, 8, and 9) pointed to the clinicians' "listening" as a key feature for creating that safety and for opening the dialogue. One wife explained it this way, "She seemed very willing to listen, she seemed open-minded" (Wife 4); her husband added, "She was very personable." When asked what those traits meant for them, Wife 4 stated, "Just made us more willing to talk and listen."

Therapists also encouraged spouses to listen to each other. Couples 2, 4, 5, 6, 7, and 9 stated that the clinician would encourage both partners to speak and avoided letting any one spouse dominate the conversation. In some instances, this process would happen organically as Wife 4 expressed "Just letting us talk and telling both sides of the story." Couples 1, 6, and 8 added to this concept when they suggested that the therapist was "laid back" or "not too pressing." Partners of Couples 5, 6, 9, and 10 were somewhat surprised that their therapist let the couple "run it a little" and allowed the couple to lead the session.

However, in other instances the clinician had a more directive approach possibly avoiding a couples' normal pattern of discussion as highlighted by Wife 9:

I think one major thing was in that first session she sat down and noticed that I was stepping up and taking most of the answers and she said, "Well I want to hear from him now." And she helped me learn to just deal while I hear what he has to say.

Sometimes the therapist would direct the partners to speak to each other rather than to the therapist. At other times the therapist would challenge the clients' behavior either in

session or at home, and some clinicians would push the couple to stay focused on the issue at hand. Wife 10 summed it up this way:

> It was nice to have the consultant there too though because if we were talking at
>
> home, we have a tendency to go off and do something else or the topic changes
>
> and we wouldn't come back to the key point we were talking about. So we
>
> wouldn't have had the same results talking at home.

Other techniques included pointing out processes or patterns the couple was previously unaware of (Couple 1, 5, and 7). Partners also noticed therapists reflected back what they heard, asked clarifying questions, or reframed what they heard in a different way (Couple 1, 6, and 7). Finally, Couples 3 and 5 enjoyed the clinician's sense of humor and saw it as a way that they were able to connect with him or her and to feel more comfortable in session.

Therapists' characteristics and attitudes. Seven out of the ten couples (1, 2, 4, 5, 7, 8, and 9) explicitly were appreciative of the warmth and caring attitude of their therapist. Participants expressed that they liked it when the therapist was genuine with them, and that in turn helped partners feel emotionally closer to the therapist, so they would, consequently, view the therapist as a "nice" person. Wife 9 stated, "Such a nice lady. And you could tell that she really felt, she was connected. And even knowing her for five minutes I felt like she understood us and there was a connection." Wife 1 added simply, "She was just really nice. When we were talking or when I would say something, I felt like she really cared." Referring to the same therapist, Couple 9 and 10 appreciated that the therapist was "chipper" or "positive." Another clinicians' couple appreciated that

the therapist "wanted us to succeed" (Wife 7) and were surprised by how much the therapist seemed to enjoy his work (Husband 7).

Not all couples seemed to need a continually warm and emotive therapist. Couple 3 appreciated the direct nature of their clinician and stated:

Husband 3: He seemed pretty upfront. He is friendly but he is kind of a no BS kind of a guy. He doesn't say things to make us feel good or give us the answers we want.

Wife 3: He is a straight talker.

Interviewer: Does that make him a good match for you guys?

Wife 3: Yeah, because we are the same way.

Both Husband and Wife 3 also liked that they could challenge the therapist, and that he could "take it." Other partners (Husband 4 and Husband 8) felt like their therapist was knowledgeable and educated, creating a strong sense of credibility. However, though Husband 9 generally liked the therapist, upon seeing the lack of wedding ring on the therapist's finger, he worried a little that he might not understand their situation as well as a married person might.

Internal Change

The third theme that emerged from participant interviews centered on internal change. One of the more prominent features of a couple's experience with this intervention was the transition they experienced in their thoughts and feelings. All couples described having experienced some degree of change in their internal processes. One significant subtheme found in the data was the idea of awareness. Often participants

became more aware of their own cognitive process relative to their marital interactions, their partner's internal experience, or what needed to change in the relationship. Partners also reported becoming more aware of the need to communicate with each other, an additional subtheme in the data. Many couples learned that they needed to be more communicative in their relationship. This awareness was often experienced in conjunction with the next subtheme, acceptance. While some partners learned that they needed to communicate more, other partners learned that they needed to say less and listen more – and particularly show less criticism and complaint. They stated that they learned to be more accepting by learning to let go of false assumptions and unrealistic expectations in favor of being more patient and understanding. A final subtheme emerged as couples described their experience with the intervention: perceptual change of therapy. Couples reported beginning to see therapy in new and unique ways, including several partners who originally were more skeptical.

Awareness of interpersonal processes. Though partners became more aware of many unique things, a common insight found among nine out of ten couples included seeing their partner's wants, needs, and behaviors in a new light. The openness in session allowed partners to hear things they may have never heard before, uncovering issues of concern to their spouses.

> Husband 1: A lot of the things that came up in the first session were things I
> hadn't even thought about. I was like, "You have to tell me this kind of stuff or I
> won't know."
> Wife 1: Yeah, I thought he should know. Now I realize I need to tell him things
> that he just doesn't think about just like girls would.

Couples described bringing up and discussing issues that were of concern to them. Many of the couples who went in thinking, "that they did not have anything to work on" were surprised to realize that there were issues that could be addressed (Couples 1, 2, 3, 6, and 8). Often partners did not realize how much something was bothering the other person or that their partner felt the way they did, as illustrated by Wife 6's experience:

And it made me realize that it wasn't something that you know if he wanted to talk about something one night I would be like I don't want to talk tonight. At the session if he brought it up it was like "Wow, this is a big deal to him and I'm not communicating to him or listening to him when he wants to talk."

Notably, comments often suggested that as partners became aware of such issues, they often remarked on what they themselves could do, or intended to do, to improve the relationship.

Partners became more aware of each other's likes and dislikes (Couple 2, 7, and 8), of unhealthy relational patterns (Couple 5 and 9), and of "complacency" in the relationship (Wife 3). "So essentially I learned I needed to take a couple of steps back in controlling of the relationship and he needed to take a couple steps forward in the controlling of the relationship and find that balance" (Wife 9). Some partners stated that they had developed a greater appreciation for what their spouses were contributing to the relationship (Couple 2 and 8) or that they needed to be contributing more (Couple 2, 8, and 10). They began to see how important it was "to spend time together" (Husband 2), or in the case of Couple 9, they needed to find new ways of approaching an area of disagreement by taking a break before discussing a difficult subject. Partners also saw themselves differently such as realizing the need to be less self-centered in the

relationship (Couple 3, 8, and 9). Others saw that they were already doing a good job

(Husband 8) or that they needed to initiate more self-care (Husband 7). Consequently,

quite a few partners became more aware of how to more appropriately fulfill their

partners' needs (Couples 1, 2, 3, 7, 8, and 9).

Though areas needing to change were often brought out in therapy, the

assessment played a valuable role for many of the couples (Couple 1, 3, 4, 5, 6, 7, and

10). Participants frequently reported that it helped them to think about areas that could be

improved in their relationship even before entering treatment. Husband and Wife 2

expressed:

> Wife 2: I think so, just thinking about the questions. Some of those things I don't
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> think about.
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> Husband 2: Yeah, daily you don't think about those sorts of things and some you
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> do but a lot you don't.
>
> Wife 2: Some of them were, yeah just day-to-day things and others were like "I
>
> haven't thought about that before."

However, couples remarked that the assessment was particularly helpful when the

clinician shared the results with them. Couples frequently remarked that this is when

they first started seeing that their partners saw something differently or were concerned

about something that they had never mentioned. Although couple strengths were also

part of what was presented by the therapist, therapists also suggested areas that couples

could improve which would frequently get them thinking. When asked about their

experience from the assessment results, Husband and Wife 3 stated:

Wife 3: It reflected the negative things that I do. Then there was also a scale kind

of like how happy you are or how satisfied you were. And I was way more

satisfied than he was. And I think that it showed that I was way more satisfied

than he was in the relationship and I am selfish in the relationship and I get a lot

of my needs met and he doesn't.

Husband 3: Yeah, and it was helpful to have a physical representation to, I mean

you can talk about your relationship all you want. But if you kind of sit down and

are all, "Whoa in this area we have a deficit. In this area we seem to be doing

well."

Communication. In discussing concerns, Couples 1, 2, 3, 4, 5, and 10 stated they

had improved their communication or learned that they needed to. Often the session

provided these same couples the opportunity to improve their skills and to develop new

ones. Referring to the changes in their relationship, Husband 1 remarked, "I don't think

major changes, but I think it's helped our communication. I think it's easier to talk about

stuff that's maybe bothering us more than before." Wife 10 explained:

So I felt really good about it, a new tool I can use to help us communicate better,

we haven't tried before, and he feels that it will work. It was a successful thing.

We had been talking about how the methods that I use when I get frustrated, he

doesn't like and weren't working. The silent treatment doesn't work. Getting

upset or yelling doesn't work, or telling him over and over again something

doesn't work….yeah, so I learned that if it's something really important I need to

look him in the eye and be specific and focus when I tell him and then if it still

doesn't work out. If he forgets or just something doesn't happen right instead of

getting upset about it we need to sit down together and he used the words that he

wanted me to say and those were, "Let me teach you something."

By addressing issues that were bothering them, a number of couples became more aware

of a need to discuss issues rather than ignoring them (Couples 1, 2, 3, and 4). These same

couples also learned that they needed to communicate rather than making false

assumptions. Wife 4 explained:

> We talked about this and I assume I know what he is thinking in a situation and I
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> am mad about it and I was really ticked. I was ticked for quite a while about this.
>
> Talking to our therapist we had decided it is probably best to not assume what
>
> someone is thinking. Obviously from the eye roll he is annoyed but really I don't
>
> have any idea what he is annoyed about. So I can say to him "Okay now I am
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> ticked….I want you to know that before I blow up and be mad at you for another
>
> month." So we just need to communicate to each other.

As part of learning not to quickly jump to conclusions and to become more aware of each

other's needs, spouses learned that they needed to listen more (Couples 3, 6, and 10).

Acceptance. In addition to being better listeners and becoming more

communicative, a number of couples learned that they needed to let things go and be

more accepting of each other's faults (Couples 1, 2, 4, 8, 9 and 10). Partners remarked

that their anger did nothing to improve the situation and that a better option was to let go

of it, particularly when it came to the "little things." As mentioned above couples learned

to avoid making snap judgments about their partner's motives. They learned that they

needed to be less controlling and to allow their partner to have more of a say.

Perceptual change of therapy. The interview data suggested that often these positive experiences in treatment led couples to view therapy in a new light. Many couples stated they felt much more positive about therapy and felt more confident in its ability to strengthen relationships (Couples 3, 4, 5, 6, 7, 8, 9, and 10). Four husbands said that their experience helped remove some initial skepticism of treatment (Husbands 1, 5, 8, 10). Often couples shifted their perception of couple therapy from being a last ditch effort to prevent marital dissolution to using it as a tune up.

> Husband 10: Yeah we would be more open about talking to somebody and how we should talk about it. Anything you do more than once you are going to do better at it.

> Wife 10: I totally agree. Like before I think the general view of marriage counseling or any counseling is you only go if you are messed up or on the brink of divorce or if you are suicidal or something like that. You don't really want to tell people that you are going to therapy because then they ask what's wrong. You can say nothing is wrong we just want to make our marriage better. That is how I feel now. Before I felt you shouldn't go to therapy unless you really need it and looking back on it, we did need it. We weren't on the brink of divorce but it was really good for our marriage.

Three couples in particular who had had negative experiences with therapy in the past indicated that this was an improvement upon their last situation and that it had restored their faith in marital therapy (Couple 2, 3, and 10). Indeed, couples 2, 3, and 9 continued treatment with their clinician upon completion of the study. Two other couples (7 and 10) had such a positive experience that they recommended therapy to others.

External Change

   The fourth theme that emerged from participant data was external change. Frequently, changes in internal processes were accompanied with changes in behavior. As couples approached their partners and relationships differently, they made the decision to do things differently. In this intervention, each couple was presented a copy of their results containing graphs and charts explaining where their relationship was strong, and where improvement was needed. Building upon this, clinicians would then co-create with the couple behavioral goals to accomplish by the follow-up session. Couples frequently reported that seeing the results along with co-creating goals often led to behavioral changes in the relationship. These changes can be divided into three smaller subthemes: changes in communication, conflict diffusion, and general behavioral change.

   Communication changes. As previously mentioned, this intervention allowed all couples to open up during their sessions. However, quite a few of those couples reported that they continued this pattern on their own outside of the session (Couples 1, 2, 3, 4, 6, 8, 9, and 10). In addition to changes in thinking, the assessment results were a starting point of behavioral change that got Couples 1, 3, and 8 communicating more. Partners who became more comfortable discussing issues in session were then able to carry this skill into the home. Additionally, couples were frequently assigned goals that would challenge them to improve communication outside of session. Consequently, couples described themselves communicating about more issues related to the relationship than they normally would have done and that they would spend more time communicating in general.

Wife 2 remarked, "I mean we talk almost, hopefully, every day. But we don't necessarily talk about what's going on. So just carving that time out and making it specifically for things that we need to talk about." As part of improved communication, partners reported being guided to improve their listening skills. Wife 3 specified, "I think it reminded me that the big thing, the listening thing, it reminded me that I have a huge deficit in that. And he still needs a listener. So it kind of made me look at myself and work on that." This same wife echoed others' remarks in that she learned to sit and listen rather than her typical response of "trying to fix it."

Conflict diffusion. In addition to improving communication, couples also reported being better able to prevent conflict. As couples developed communication skills, they learned to address issues that would normally be evaded as illustrated by Husband 6's comments, "I think it opened the communication up more than anything and that was what was good about it. We had to communicate about things that we otherwise would have avoided."

Partners reported that they were able to discuss things rather than holding it in and that helped to reduce resentment and head off future conflict. Particularly five couples (Couples 2, 4, 6, 8, and 9) explained that they learned how to express themselves, felt freer to express their "feelings," and became more comfortable discussing concerns.

Husband 2: Yeah we both tend to be type of people that keep things in so we won't really say anything and think it will get better, but it doesn't. So I guess we really learned how to talk to each other and how to express what our issues were and our concerns.

This open communication prevented, as one couple put it, "a smaller issue from becoming an [larger] issue" (Wife 4) while allowing some couples to discuss issues "as they came up" (Husband 8).

Partners often learned to deal with challenges in their relationships in different ways rather than the more common pattern of becoming angry. Partners learned to "just let it go" (as Husband 2 put it) in a number of ways. They may have simply chosen not to get angry over something that would normally anger them, reminding themselves to either "relax" or "not worry" as Wife 8 remarked or "quit being so controlling" as Wife 9 stated. Other partners would do things to help their spouses out, rather than criticizing behavior. Several spouses reported success with trying to be more "understanding," including trying to understand each other's perspective or how the other was feeling. Husband 8 explained, "If she does get frustrated that I didn't pick up something instead of thinking, 'Why is she getting mad at me?' I just try and look at her perspective more."

For Wife 9, being more understanding involved her allowing her spouse time to cool off rather than pushing to discuss a concern right away; that allowed both parties to be less reactive and to possibly discuss the issue at a later time when there would be less friction. This process also included being more patient with each other and foregoing their expectation of mind reading, which led to their actually discussing the issue.

In addition to improving the quality of their resolving conflict, several couples specifically stated that they had less conflict in their relationship since the intervention (Couple 8, 9, and 10). These couples remarked that conflicts were handled more quickly. Others remarked that their conflict became less intense or changed in other ways including "less yelling and screaming" (Wife 9). Wife 5 remarked that she can "now

make eye contact when we're arguing," a phenomenon she described as meaningful to her partner.

General behavioral change. Couples also made a number of small unique changes in their patterns of relating. Four couples (Couples 2, 7, 8, and 10) reported that they started treating each other more kindly, and started doing things that they knew their partner liked.

> Husband 7: I don't think we've changed how we see the other person. We've had the good fortune of having a fairly strong marriage foundation so that's been really helpful. It was more just little things that we could do for each other to demonstrate love and to grow in that relationship.

Couples attempted to be more sensitive to each other's needs, looking beyond themselves to the relationship. Couple 3 decided to go out for their anniversary, something that they normally would not have done.

These individual changes did not go unnoticed. A systemic change would take place in the relationship as change in one partner would often lead to changes in the other followed by a general change in the relationship.

> Wife 8: I think you have really improved a lot on that. I usually go to work and think okay when I get home I will wash dishes and then go to bed and I will come home and he has already washed the dishes and fed the dog.

> Husband 8: It's a physical thing but the emotional or mental part is also changing that way and it's less physical and noticeable but I have noticed more love.

Another wife remarked:

Wife 10: So as I am trying to modify my behavior and watching him modify his

behavior it makes our relationship stronger and so, therefore, I am more in love

with him. And I am happier with our relationship because I can see what we are

both trying to do to make it better. It grows together.

As described above, when participants saw their partners make changes for them, they

felt more loved, and this served as motivation to return that love and make their partners

happier.

However, it should be noted that not all couples experienced such a positive

reaction in their partners. Wife 5 noted that as she tried harder, he would "try less" which

led to greater frustration for her. As originally stated, this couple did experience more

distress going into treatment. Another one of the originally distressed couples, Couple 3,

also saw changes that were not necessarily for the better. After starting treatment, she

moved back in with him, but then during this time he had an extra-marital affair. Though

the couple did report making limited improvements in the relationship, this affair

obviously represented a major setback. It should be noted that this couple was one of the

three who continued in therapy after the checkup was finished.

Couples also varied as to when they described the change taking place in their

relationship in relation to the intervention. Interestingly, participants were evenly split as

to when the changes in their relationship started happening: either during session or

outside of it. Couples 1, 2, 4, 5, and 10 saw the changes originating inside of session,

whereas Couples 3, 6, 7, 8, and 9 felt that the changes in their relationship took place

either in between the sessions or after both of them. Couples 3 and 8 felt that these

changes in particular started in between the sessions. Couple 5 and 9 reported that the

changes they had made were more temporary with both partners of Couple 5 stating that

though treatment was enlightening, few behavioral changes in the relationship lasted.

Husband and Wife 9 did feel that they had made changes but were not doing quite as well

as when they first left treatment.

Program Response

The previous sections discussed what the client brought to the intervention, what

the therapist contributed, and then the participants' response to the therapist. This section

will discuss the final theme that emerged from the participants' descriptions of their

experience: response to components of the actual program. Though interventionists

were given some leeway, they were following a specific protocol with each client. This

section will summarize their response to the program, dividing it into four subthemes:

assessment response, response to intervention directives, and session format response.

Assessment response. All participants were asked about the assessment portion

of the intervention, and a slight majority had positive things to say about it. As stated

before, the assessment often acted as a starting point getting couples either thinking or

talking (Couple 1, 3, 4, 5, 6, 7, and 10). However, some did express divided opinions on

the assessment. For five couples, one or both partners' comments indicated they felt

positively towards it. In two couples, either one or both partners were generally critical.

In one couple, spouses were split between positive and negative sentiments. For the

remaining two couples, partners did not indicate whether it was positive or negative

experience.

Some couples did like having the results presented to them and being able to discuss it directly with their therapists (Couples 1, 3, 6, 7, and 10). Three of these couples also liked that the therapists would focus on the positive aspects on their relationship when using it. Husband 3 liked the visual aspect of the results (the charts and graphs), while Husband 6 remarked that he liked the option of doing it at home (clients were given the option of taking the assessment online).

However, partners from four couples felt that the assessment was "too long" or that "it took too much time" (Couples 1, 3, 6, and 9). Here, it should be noted that the assessment survey could take up to one hour to complete. Three participants commented that the questions were repetitive and did not like having to take the assessment multiple times (Couples 4, 7, and 9). However, one participant did remark that they liked the repetitiveness because then they could see their progress. Others found some of the questions to be "confusing" because they said the questions switched from having to be answered positively to having to be answered negatively and back again. This made it difficult for participants to keep track. Finally, partners in Couples 5, 6, and 9 would have liked to see the assessment results being used more in their sessions. Some of their comments do seem to indicate that it was not used to the extent that was intended. Husband 6 stated:

I remember I took a lot of time filling that stuff out and I was like, "Oh then we can talk about this." I didn't feel like that was used too much in our session. I thought maybe we would pull it out and talk about it. I think we looked at it but the one page we typed up all these answers; I don't even think we looked at it much.

Response to intervention directives. As per protocol, each couple created their own goals with the assistance of the clinician. Participant response to the goals provided was generally positive (Couples 1, 3, 4, 8, and 10). Additionally, none of the participants had anything negative to say about the goals. A number of couples reported that they liked being assigned to do things to improve their relationship, finding this experience helpful. They also liked having the goals written down. Couple 7 indicated they still had the goals posted on their fridge as a reminder. Goal follow up – also part of the intervention protocol – had a lot of positive response, wherein five couples (Couples 3, 4, 7, 8, 9, and 10) specifically stated that they liked having this accountability. Husband 10 stated that he would not have completed the tasks otherwise.

Though not required, clinicians were encouraged to recommend books or provide handouts based on the needs of the couple. Three couples remarked that a specific book was recommended to them. One couple found the book to be helpful, another couple did not, and the final couple did not state either way. Three different couples commented that they received handouts and had similar responses. One couple liked the handout, while for the other two the handouts did not make an impression.

Session format response. Generally, couples response to the program was positive. Five couples (Couples 2, 4, 6, 8, and 10) described their experience as "really helpful," others stated "it was good" or "really good." Husband 8 explained it this way:

> I think this is really helpful and there were some things you guys did that just me and her couldn't do alone. Just the knowledge he had we couldn't find in a book. You can't replace a person's knowledge. So that was good.

Four out of ten couples (Couples 4, 5, 6, and 10) were surprised that the intervention was different from what they expected. Often couples anticipated treatment to be more directive. Husband 8 expected the therapist to focus almost exclusively on sex. Wife 5 expressed dismay with the non-directiveness of treatment. She had been in individual therapy in the past and was disappointed that this format of therapy did not fit with her previous experience. However, a few other partners (Couples 6, 9, and 10) felt differently, stating that they liked the opportunity of being able to take the lead. Husband 10 summarized it this way, "I really liked how the consultant let us propel our own conversation."

The number of sessions was another point of discussion for couples. Though the majority of couples felt that the number of sessions was sufficient, several couples (Couples 1, 3, and 5) felt they needed more for it to be helpful. Of those three, Couple 3 continued in treatment and was consequently pleased that they were able to do so. However, Wives 1, 5, and 9 suggested that issues were brought up that were not quite resolved. Both Wife 1 and Wife 5 in particular indicated that they had quite a few concerns they wished had been more resolved. Although Wife 1 reported a generally positive experience, she also expressed:

> Yeah well one thing though that I kind of didn't like about it I guess is that it opened up so many things and then it just didn't get fixed. Like I wanted them all, I just remember leaving and thinking we brought up this and this and I just felt overwhelmed with all these things we brought up and there are still issues.

These concerns may have been why Wife 1 turned down the offer of additional treatment or possibly given the couple's financial status as students, she was concerned about the

financial cost however nominal. Wife 5 also turned down the option of continuing

treatment, which may be related to some of her concerns with her experiences in the

intervention. Wife 9 explained that a sensitive issue was brought up at the very end of

the second session, but gave no indication this experience was particularly concerning for

her. Wife 7 also expressed an interest in an additional session. However, her tone was

more positive, in that she found it so helpful another session would be supportive. One

exception to this was Couple 4 who felt like two sessions was enough, particularly in

light of considering themselves as not "having a lot of issues."

Clinician Themes

As mentioned previously, clinicians were interviewed as a validation strategy to

triangulate the data obtained from participant interviews (Creswell, 2007). Though a

clinician cannot speak *for* a spouse (only the spouse can do that), interviews with the

couple's clinician provided an additional perspective into the experience of the couple

including other possible explanations. Frequently, a couple's description of the

intervention was closely related to what the clinician described but there were times when

the therapists saw things a little differently. As a third party, the clinician could provide a

different perspective of couple dynamics and clarify his or her role in working with the

couple.

This section will discuss the emerging themes of the clinicians' experiences of

participants subdivided into four sections: couple characteristics, client motivation,

therapeutic relationship, and therapeutic change. Each of these themes was found to have

smaller subthemes as discussed below. The following is a summary of interview data

from the six therapists who participated in the study. It should be clarified that the first

therapist met with Couples 1 and 2, the next met with Couples 3 and 7, the third met with

Couple 4, the fourth with Couples 5 and 6, the fifth with Couple 8, and finally the sixth

therapist met with Couples 9 and 10.

Couple Characteristics

In their description of couples' experiences, clinicians frequently noted the

various traits that couples presented with. They noted couples who were experiencing

distress in their relationship along with those that appeared to them to experience little.

They also described interaction patterns in areas of communication and power, noting

such phenomenon as who talked more and who tended to sit back silently along with who

had more control in the relationship. Finally, they described couple strengths such as

those partners who were highly dedicated to each other. Additionally, consultants had

the advantage of a detailed summary from each partner's assessment, with

psychometrically validated instruments outlining many of the couples strengths and areas

needing improvement. Clinicians reported utilizing this understanding to guide their

intervention process. The following is an overview of the clinicians' experience of the

couples' backgrounds divided into three subthemes: distress level, patterns of

interaction, and couple strengths.

Distress level. The relationship checkup format was designed to both attract and

accommodate couples with various levels of distress (Morrill et al., 2011). Based upon

the responses of the clinicians, it would appear that this format was able to achieve this.

Through their observations, therapists reported three couples (Couples 6, 7, and 8) had

little to no distress in their relationship when they started treatment, nor did any significant concerns appear as things continued. They may have brought up issues to address as treatment progressed, particularly when they were presented with the assessment results and directed to develop goals, but they did not appear to be points of severe frustration, only areas of minor annoyance.

Either one or both partners of Couples 1, 4, 9, and 10 presented with more specific concerns they wanted to address in treatment with either one or both partners experiencing higher levels of distress than was typically found in the less distressed couples mentioned above. However, the therapists described these couples optimistically. Speaking of Couple 10, the clinician stated, "They both seemed very much in love with each other. There were some issues. They needed more than just a touch-up, but it wasn't like there were conflicts going on that hardened them towards each other." Therapists noted that these couples did describe having challenges in areas such as communication, making time for each other, parental stress, or having gender roles too narrowly defined, but appeared to be very committed to each other. Clinicians reported that these concerns were either apparent to both partners before entering treatment (Couple 4 and 10), or unspoken before treatment, but were allowed to come out in the process of the intervention (Couple 1 and 9).

Clinician interview data indicated that the remaining three couples (Couples 2, 3, and 5) presented with higher levels of distress, and had prior to treatment discussed issues with each other that they wanted addressed. Each of these couples brought difficult obstacles to the intervention. Both Husband and Wife 2 had children from prior marriages and were experiencing parenting difficulties. Additionally, they both had

family of origin issues that contributed greatly to current struggles. Husband 2, along with Wife 5, had been hurt by a previous relationship that was making trust difficult for them. Couple 3 had been separated for the past two years and had just moved back in together. This couple had also experienced substance abuse and infidelity, adding strain to the relationship. Couple 5 had not known each other long before moving in together, and had experienced high levels of conflict since the onset of the relationship.

Patterns of interaction. Clinicians noted that partners had ways of interacting with each other often manifest through their communication patterns, particularly how willing they were to discuss their concerns. Sometimes this was in contrast to the distress the clinicians noted in the couple, as in Couple 3. These patterns were also noted to be shaped by partners who desired to have control in the relationship. Four couples (Couples 3, 6, 7, 9, and 10) were identified by their clinicians as having "good" communication skills, in that they were "very open" or "very honest" and "clear" with each other. These couples were identified as being able to discuss issues, particularly as they became identified by the clinician – though some couples were able to do this on their own (Couples 3, 7, and 10). Some couples had partners who were different in their willingness to share (Wife 1 and Husband 8), which presented the couple with their own unique challenges. The clinician for Couple 1 remarked, "He was kind of reserved. She was more open with her emotions. I could tell she felt rejected and invalidated and inadequate by his lack communication, this kind of disconnect." The clinician for Couple 9 reported they experienced a similar challenge, except that both partners were reluctant to bring up a concern as the clinician described, "for fear of what the other person's

reaction might be." However, both of these couples were able to discuss the concerns in treatment in an open way once they were broached in treatment.

These patterns of communication would often manifest themselves in another relational pattern identified by the clinicians: that of power and control. Some spouses were described as being the "dominant one" or the one who "liked having control." Partners would also be described as either being "demanding" or being "more laid back," suggesting that some spouses wanted more from their partner or were more concerned about maintaining the relationship, while the other was less so. Another way of conceptualizing this process was expressed in terms of a "pursuer-distancer" pattern. The "pursuer" was described by clinicians as a spouse who is attempting obtain more emotional attention and/or presence from their spouse and the "distancer," was the spouse who is resistant to providing it. The implication was that the pursuer was the one more interested in improving the relationship, while the distancer was more content to not disturb the status quo. Couple 6's clinician described it this way:

> And I just remember them not being able to connect as well. And he was actually the pursuer which I thought was interesting because usually it's the woman who is the pursuer but he was. He was the one who wanted to work on stuff, to say let's do this lets do that pretty motivated to change the relationship.

Couple strengths. Despite the various challenges, clinicians commented on the positive aspects they saw present in these relationships. The therapists were impressed with how much partners "cared" for each other and the love that they saw, which helped them in their work with the couple. The consultant for Couple 10 expressed:

It was a really good experience working with these two. They both seemed very much in love with each other. There were some issues. They needed more than just a touch-up but it wasn't like there were conflicts going on that hardened them towards each other. So they loved each other, they liked each other, and I felt like it was a good experience. They came in very open to me as a person, to me as a therapist, to the therapeutic process, the consultation process. And it was like we already hit the ground running because they were both friendly, both open, both wanted to change and we worked together really well overall.

Clinicians described the couples in other ways including being "happy," void of conflict or being "on the same page," suggesting unity between partners. Therapists also described their experience working with the couples as "fun" or "great to work with." This strength-based perspective of the couple was in keeping with the philosophy of Solution-Focused Brief Therapy. This perspective was maintained even when some clinicians experienced the couple as more challenging. While acknowledging Couples 3's difficult history, the clinician for Couple 3 noted their attempts to "comfort each other" and the couple being "playful together." For the clinician of Couple 2 -- another couple who had challenges, her recognition of this couple's positive qualities helped her to be a stronger advocate for them. She explained it this way:

There was still that love. And you could just tell that they cared a lot about each other….It helped me. Because even though there was all this kind of negative things, it helped allow me to still have hope. 'Okay, you have all these odds stacked you, but you guys still love each other and you still have hope. I believe in you.' It kind of helped me be more of a cheerleader.

Couple Motivation

The second theme that emerged from the clinician data was their perceptions of client motivation. All of the clinicians commented on the couples' motivation, and suggested that couples frequently came in motivated to be in the intervention and/or to make improvements in their relationship using such phrases as, "wanting to make changes" or with a desire "to make the relationship work." A few partners who were reported to be initially resistant to the intervention became more open to it through the course of treatment. Some partners who initially did not think they need to make any changes became more motivated to make changes in their relationship once treatment ensued. Therapists also noted differences between what couples wanted to get out of the intervention. While some partners were more interested in a simple tune up for an already healthy relationship, others wanted to address more serious concerns. Generally, three subthemes emerged from consultant's description of couple motivation: motivation towards relational improvement, openness to the intervention, and motivation as a result of the intervention.

Motivation towards relational improvement. Consultants for most couples (Couple 4 being the sole exception) described either one or both partners as being invested in making relational improvements, using such phrases to describe partners as "being committed to making the marriage work" or "willing to work on the relationship." Consultants also stated that partners had a "desire to connect," wanted to "go from good to better," or "were ready for something new." Some couples were described as coming because they wanted something better than what they already had even if things were already at a pleasant state. The therapist of Couple 8 stated it this way:

They were ready for something new. They weren't a conflicted couple, they were

in a good place to begin with. They just had a lack of a way to deal with some

things, a lack of coping mechanisms. They came in looking for something more

and asking for a suggestion.

Openness to the intervention. One term that repeatedly showed up in clinician

descriptions was the concept of "openness." Couples were frequently described as

coming in either "willing" or "ready" to talk to the therapist or being "open" to treatment.

Partners were also described as being willing to be open to each other or each other's

"experience." Though partners may have been ready to make changes in their

relationship, partners were not always equally motivated to attend therapy.

Indeed, according to therapist reports, partners in four couples (1, 4, 6, and 8)

differed in their initial motivation to be there. Although it may be assumed that if neither

partner wanted to be in treatment they would have been unlikely to participate in the

study to begin with, one partners' willingness to try the intervention was most likely

enough to get them in the door. In the case of Couples 1 and 4 the husband was

described as the more reluctant party. Though Husband 1's clinician indicated he became

more motivated towards the intervention (as highlighted below), the clinician was never

aware of the reasons for this reluctance. Husband 4's consultant explained that the

husband feared being scapegoated for the problems in the relationship. She summarized

it this way:

He never wanted to come to therapy. He was afraid that they would come in and

he'd have to sit there, and she's going to say all this bad stuff about me. He told

me that he liked the format and he felt like he wasn't being zoomed in on as the

problem.

According to the clinicians for Couples 6 and 8, the wives were reportedly not resistant to

the process but appeared less motivated than their husbands to work in session.

Consultants also noted the husbands to be more "engaged" or "motivated" in treatment

than their spouses. Couple 6's consultant stated, "He was the one who wanted to work on

stuff, to say let's do this lets do that. He was pretty motivated to change the

relationship."

      Motivation as a result of treatment. Clinicians noted that as couples became

more aware of areas of concern in their relationship, they were frequently motivated to

make relational changes. For example, Couple 1's consultant described the husband as

becoming motivated to make changes in the relationship after talking with his wife about

her concerns in session. The consultant said:

> But even recognizing more so that it was problem. And that they needed to get
>
> that sorted out. Because I don't think he realized how much that did bother her.
>
> That was probably one thing, they probably tried to start making changes…. And
>
> I asked the question, "Do you think you did that because you knew you were
>
> coming to see me today? Or do you do it because you wanted to?" And he said,
>
> "I did it because we had talked about it, and I wanted it to change." So I think by
>
> the second session three or four weeks later, within a month, those small changes
>
> like that started happening.

Specifically, clinicians for partners in five of the couples (1, 2, 3, 4, and 8) reported

seeing changes in motivation as the spouses participated in the intervention. Two couples

(2 and 4) were described to have "become more hopeful" as a result of treatment and more willing to implement the changes. Couple 8 was described as having more "energy towards making changes," while the clinician for Couple 3 explained that the couple, "strengthened their resolve to work things out."

Therapeutic Relationship

The third theme that emerged from the clinician data was commentary on the therapeutic relationship. Clinicians reported attempting to establish what was often referred to as a relationship or "connection" with the couple, in an attempt to create a "safe environment for them to come and work things out together" (consultant for Couple 6). Clinicians frequently viewed this as a way of helping participants feel comfortable disclosing their concerns as well as helping them to trust the clinician's suggestions and directives. Additionally, clinicians observed partners' responses to these overtures and would make adjustment to help this along. This process can be broken down into two subthemes: the connection the clinicians felt existed between them and their clients (connection) and what therapists did to create this crucial relationship (developing trust).

Connection. Almost all therapists spoke positively of their connection with the participants. They frequently identified the concept of "connection" as a way of describing the strength of the relationship they had with the couple such as "being able to connect" or having a "good connection" (clinicians for Couples 2, 7, 8, 9, and 10). Other consultants described this connection in terms of the relationship such as having a "great working relationship" or describing "the relationship between us was strong" (Couples 3, 6, 9, and 10). More concretely this described how the clinician felt that the participant

trusted them along with how well they were able to work together. Couple 10's therapist summarized his experience this way, "It was a good relationship. They both trusted me, they were both very open with me and it definitely facilitated the work. I felt like we were working together as a team."

Developing trust. Therapists reported consciously attempting to create this relationship using a variety of techniques. One of the most prominent features of this process was a number of clinicians' attempts to create a place where all parties could "share" (clinicians for Couples 1, 5, 6, 8, 9). When asked about facilitating this, the clinician for Couple 9 explained:

> I think part of it was just developing a good relationship with them, making them feel comfortable, and making them feel like it was a safe environment. Letting them know that sometimes even if we think things are a big deal it doesn't mean we still can't talk about it even if it frustrates us.

Several consultants (clinicians for Couples 1, 3, 8, and 9) mentioned trying to "lighten the mood," by "using humor" or being "relaxed" and "informal" with participants as a way of helping participants to feel more comfortable and relaxed themselves. Speaking of Husband 1 who was initially more resistant, his consultant described, "He seemed to be fairly comfortable after he got in here. I tried to be a little more inviting, make some jokes, lighten up the situation so it wasn't so, 'I can't believe we're here.'" In addition to lightening the mood, therapists were also conscious to be "warm and kind" (clinicians for Couples 2, 3, and 5). A few clinicians (Couples 2 and 8) were also focused on helping their clients see therapy as a "positive" thing, particularly given Couple 2's previous negative experiences with therapy.

Consultants also reported attempting to create an environment where both partners felt like they could speak up. Many clinicians referred to attempts to make each spouse feel heard (clinicians for Couples 1, 2, 4, 5, 6, and 8). The consultant for Couple 6 stated:

> I noticed that he was a little bit more pursuing and she was a little bit more
>
> withdrawn. She needed more of a voice and he needed a little bit less of one.
>
> And so I tried to make it a little bit more equal.

Part of this process required several therapists to "draw the other partner out" (consultants for Couples 1, 5, 6, and 8), including encouraging the more quiet partner to communicate by speaking more directly to them, asking them more direct questions, or "using their name" more. Though the clinicians for Husband 1 and Husband 6 reported some success in drawing them out, the clinicians for Wife 6 and Wife 8, provided no indication of whether their efforts were successful.

Therapeutic Change

Consultants frequently described another common theme in their work: therapeutic change. This change refers to both what the clinician did to help the couple and the couples' response to the intervention. Clinicians described seeing couples change in many positive ways – and a few negative ways – in terms of improving communication and becoming more relationally aware. They noted the changes couples made in their pattern of interaction, and the overall timing of these changes. As directed by the program, consultants generally used Solution Focused Brief Therapy and at times broke away from it as part of the latitude within the manual's five steps, which also

became part of the dialogue they provided. Again, it should be noted that SFBT allows for the clinician to do what he or she thinks is best for the client, even when it was does not overtly appear to be SFBT related. Overall there are four subthemes that encapsulate these ideas of change: communication, increased awareness, change of pattern, and therapist technique.

Communication. All of the clinicians commented on improvements and changes in the communication process both in and out of session, with six couples reportedly being able to directly improve their communication (Couples 1, 2, 3, 6, 8, 9, and 10). Clinicians described couples being able to "discuss their relationship," to cover typically "challenging" areas in a "new way," or address concerns that would normally go hidden (Couples 1, 2, 5, 6, 8, 9, and 10). Couple 10 therapist:

And I feel like we got to a good place. They got into their emotions, expressed what was going on, and at the same time were able to express what they want, what they want to see happening. So as, as early as, early in the first session, we started seeing some, some change happening.

Couple 9's therapist explained it this way:

But it seemed like in going through the session a lot seemed to surface. He was finally able to come out and say, "I need space."… He had never felt like he had been able to tell her that until they came into first session.

Therapists felt that couples were able to discuss challenging issues in ways that would normally be difficult to do, surpassing couples' more typical patterns of avoidance and conflict. For some this allowed the normally quiet partners to speak (Wives 1 and 6,

Husband 9). For others, it challenged both partners to quit making assumptions about

each other (Couple 4 and 10).

      Increased awareness. Clinicians reported seeing a number of partners develop

new realizations about themselves, their partners, and their relationships in session.

Partners were described as becoming more aware of their partner's "experience" or

"perspective" (clinician for Couple 1, 2, 5, and 8), seeing their partner in a different way

(Couple 4, 5, and 6), or coming to greater understanding of their partners' emotional

experience (clinician for Couple 1, 2, 9, and 10). The consultant for Couple 1 described

the couple process she witnessed this way:

> Talking to them, recognizing those emotions that were underlying those problems
>
> -- that helped them. That's the biggest thing I helped them do. I remember in the
>
> first session there was a moment when she got emotional when they were
>
> discussing having a child.... So I think discussing those emotions was very helpful
>
> for them in making a decision that way. It was a pivotal moment when they
>
> finally understood each other.

Clinicians also explained that for some, partners developed a greater recognition that

their partner was trying (Couples 2 and 4), or that their actions were bothering to their

partner (Couples 1, 4, and 9). Consultants also reported that for some couples awareness

in these different areas help some partners consider making changes in the relationship

(Couples 2, 4, 8, and 9). The consultant for Couple 4 reported:

> But he did seem touched by the fact that that she was crying and he said that he
>
> didn't know that that was so important to her. That he recognized that she does
>
> do a lot. That even though he might come home and the house isn't perfect and

things, but that she really is doing a lot. And that there are times when he really

can pitch in rather than being critical, pitch in and help her a little bit more.

The therapist for Couple 8 explained succinctly, "Change of perception led to the change

of behavior. Certainly, it opened up their mind to a new possibility and looking at that

new possibility, operating under those new realities led them to behave a different way."

Change of pattern. Consultants also noted that couples described changing

patterns in their interactions with each other outside of session (Couples 1, 2, 3, 4, 6, 8,

and 9). Some couples were reported to have become more "trusting of each other,"

"acting with more patience" instead of becoming angry, became "less controlling,"

became more unified and "started spending more time together" (Couples 2, 3, 4, 5, 6, 7,

and 8). Additionally, change was often systemic insomuch that change in one partner

initiated change in another (Couples 1, 2, 4, 6, and 9). Couple 4's therapist explained:

And he said he came home one day and the sink the full of dishes, and normally

he would've made some kind of comment that she would've found demeaning.

Because his assumption was, "You're sitting around all day, you're home all day

– you can't do the dishes." Instead of doing that he stopped and said, "Honey,

can I help you do the dishes?" And she wound up helping him as he helped do

the dishes, and he said it changed the whole atmosphere and they were able not to

fight and they didn't go through the three days of ignoring each other afterwards.

When asked specifically when these changes occurred (either in session, out of session,

or both), consultants for Couples 1, 4, 7, and 9 said their couples made changes outside

of session, Couples 3, 5, and 6 stated that most change was in session, and Couples 2, 8,

and 10 were said to had made changes all throughout.

Therapeutic technique. As directed in the program manual, clinicians used SFBT as their primary mode of treatment, with all six therapists explicitly referring to doing such. However, the client-centered philosophy of SFBT provides clinicians latitude to apply other techniques as the clinician sees in the best interest of the client even if it is not inherently a SFBT technique. Two therapists did express concern regarding whether they were able to stick to the model, with three other therapists stating that they did stray at times with the couples they worked with. Though the consultant for Couple 7 did not find the couple very challenging, he did comment that he would have strayed from it had the couple been more challenging. Two other clinicians echoed this comment, suggesting that when things became more challenging they fell back on other modalities of treatment, including those they were more familiar with.

One of the primary areas where couples strayed is in dealing with couples' emotion. Three therapists suggested concern whether SFBT could adequately address emotion but understood that both the program and the model granted them the liberty to "do what works." Frequently therapists pushed clients "to go deeper" and address "underlying emotions" (Couples 1, 4, 5, 6, 8, and 10). Clinicians would also push clients to go towards the emotion rather than "running away from it." The therapist for Couple 5 expressed it this way:

> 'Cause I felt like that's what they needed. Because the underlying emotions, 'cause she was almost -- she had tears in her eyes and was starting to kind of go somewhere else I could tell. So to bring her back here I had her just kind of describe the emotions she was feeling in the moment and I kind of tried to coach him on what responses he might give that would help her feel more comfortable.

Three therapists stated that they used techniques drawn from Emotionally Focused

Therapy, as somewhat demonstrated above, with one of the three clinicians stating that he

also drew from Structural Therapy.

Summary

Though clinicians followed a protocol in presenting this intervention, each was

given some leeway to do what they felt best for the couple. However, despite this

variation, couples generally reported similarities in how the intervention impacted them.

Couples reported changes in their motivation, both their internal and external processes,

and responded to the therapeutic environment the clinician provided and to aspects

inherent in the program. Not unlike the participants' experiences, the consultants also

commented on the motivation of the couples, the role the couple background played in

treatment, the relationship between themselves and the couples they worked with, and

what the clinician did to facilitate growth in each couple's relationship.

CHAPTER V

DISCUSSION

The purpose of this study was to explore the experiences of those who participated in a new brief intervention that combined elements of couple therapy with CRE. This study used a qualitative analysis and was guided by two questions: (1) What were couples' experiences with the process in this two-session brief format of treatment? and (2) What were consultants' experiences with couples' processes in this format of treatment?

Overall, the response to the program was quite positive, as indicated by one or both partners for 9 out of the 10 couples who participated (Couple 5, whose experience was more mixed, was the one exception to this). Many partners reported that they came away making improvements in their relationship, including coming to a better understanding of each other and becoming more open with each other. Clinicians also indicated seeing elements of growth and change in the couples' relationships, particularly in terms of communication. Couples' experiences also provided considerations for how this intervention could be improved.

Another major finding in this study was similarity between the couples' descriptions of their experiences and the clinicians' description of the couples' experiences. Consequently, the themes for the participants and their clinicians largely overlap. This chapter will discuss these experiences, comparing and contrasting them from both the couples' and clinicians' points of view. It will also discuss how these findings compare with current literature. There were three themes that were found to be

largely similar among both the couples and clinicians: couple motivation, therapeutic relationship, and therapeutic change. These common themes will be discussed first, and the one theme unique to clinicians (couple characteristics). The first section will discuss both the couple and clinician theme of couple motivation (including the couples' motivation towards the program and making changes in their relationship as seen by couples and their clinicians). This will be followed by a discussion of another shared theme: therapeutic environment and therapeutic relationship (the environmental and relationship factors that took place between the couple and clinician that shaped treatment, as seen by couples and their clinicians). Next the couples' themes of internal change, external change, and program response will be discussed in conjunction with the clinician theme of therapeutic change, describing the changes couples made in their relationship in relation to the intervention as seen by couples and their clinicians. Following this will be a discussion of a theme unique to clinicians – some of which differences may be attributable to role (i.e., participant versus clinician), and couple characteristics (the clinicians' perception of the couples' background). Finally, this chapter will address limitations and implications for future research.

Couple Motivation

Both participants and clinicians discussed couple motivation, and their views were largely convergent. One of the aims of the relationship checkup model is to tailor intervention to the level of motivation the couple and help them become more motivated (Fleming & Cordova, 2012). In treatment, client motivation has more recently been identified as a necessary component of treatment success, including a large study of

clinicians and researchers in the field (Blow & Sprenkle, 2001; Lambert, 1992). In this study motivation was described by both couples and clinicians in two ways: first, motivation in attending treatment, and second, in making improvements in the relationship. Couples and their clinicians reported that the couples came in generally motivated towards those factors with a few exceptions, including a few partners who indicated they were normally resistant to the idea of couple therapy.

Unlike couples traditionally seen in couple therapy, couples and clinicians reported that the majority of the couples (seven out of ten) came in less motivated by distress in the relationship and more out of a desire to either catch concerns before they formed or because they simply enjoyed improving the quality of their relationship. Both clinicians and couples agreed that three couples came specifically due to distress that they wanted addressed in treatment. This is consistent with another finding wherein this format has been found to appeal to couples with different levels of motivation towards treatment, including attracting couples not originally considering couple therapy (Morrill et al., 2011).

One notable finding was that partners often displayed different levels of motivation by both couple and clinician report. Previous research suggests wives are typically more ready to make changes in the relationship than their spouses and that husbands on average tend to be either unworried or reluctant with regard to treatment (Bradford, 2012; Bradford, LaCoursiere, & Vail, 2010; Mackenzie et al., 2006; Ojeda & Bergstresser, 2008). Both the clinicians and couples identified husbands who were less motivated towards being in treatment, but there was some disagreement as to who each of those husbands were. Husband 1 stated he was initially the more reluctant party, a

phenomenon also identified by his clinician. However, two other husbands had differing

accounts between themselves and their counselors. Husband 9 stated he was the more

reluctant party to the idea of counseling but his clinician provided no indication of such

when asked about the couples' motivation. The clinician for Husband 4 described his

initial resistance in great detail particularly his fear of being scapegoated; however, he

made no mention of this in his interview. Despite all of this each of these husbands and

their clinicians reported that the husbands got something positive out of treatment. By

his own account Husband 1 got more out of the intervention than his spouse did. With a

few exceptions most partners either reported or were described as moving to a more

positive place including thinking more about the changes they need to make and actually

making them.

In this study, husbands were not always reported as the more reluctant party. Two

husbands (Husbands 6 and 8) were described by the consultants as more motivated

towards counseling than their wives, in that their wives were not as enthusiastic about

working on the relationship. This is somewhat different than the couples' reports, where

Husband 6 did report that he was *equally* motivated as his wife but the couple gave no

indication that he was more so. Couple 8 gave no indication that either spouse was more

or less motivated than the other. Regardless of who was more motivated in treatment,

these findings along with the ones mentioned above are consistent with the research

suggesting partners frequently present in treatment at differing levels of readiness for

change (Doss et al., 2003), which can present a challenge in the treatment process.

Moore, Tambling, and Anderson (2013) found that spouses pressured into attending

treatment were more likely to have lower levels of motivation. Though it is not always

clear if and when one partner is more motivated to than the other, both partners did attend

suggesting this format has the potential to appeal to a large variety of couples, including

couples where one partner is less motivated to do so.

Therapeutic Relationship

Another key feature of the program's success was connection between participant

and clinician. Participants and clinicians both discussed therapeutic environment and/or

relationship, and these views were largely convergent. Most of the couples and their

therapists indicated that they had a good working relationship with each other. This

relationship was also conjointly described as playing a valuable role in treatment, helping

to facilitate gains made therein. Often referred to as therapeutic alliance, the working

relationship between clinician and client is considered an essential ingredient of therapy

(Garfield, 2004). Though important, the concept of therapeutic alliance has not been

discussed in relationship checkup literature. However, two meta-analyses provide

mounting evidence that this relationship is an essential feature of treatment success

(Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Davis, Lebow, and

Sprenkle (2012) pointed out that this relationship plays a large role in determining

therapeutic outcome and has traditionally been overshadowed by specific intervention

outcome research.

Though most of the partners had a positive experience, two wives (Wife 1 and 5)

had some challenges to their relationship with the clinician that their respective clinicians

gave no indication of in their report. This suggests an unfortunate possible breakdown in

the therapeutic relationship. Wife 1 had mentioned a time when she felt like the therapist

wasn't getting her. Wife 5 expressed concerns that treatment did not go in the direction she would have liked. Interestingly, the clinicians for both couples mentioned a desire to draw the husband in, including the clinician for Husband 1 (as noted before, he was admittedly reluctant). Couples therapy is a balancing act wherein both partners need to be engaged in the treatment process. As mentioned earlier, both Wife 1 and Wife 5 decided not to continue treatment for reasons made unclear. The breakdown of the therapeutic relationship may be the culprit. Research has consistently found that a poor working alliance is related to premature termination of treatment (Blow, Sprenkle, & Davis, 2007; Horvath & Symonds, 1991; Martin et al., 2000). Unfortunately, clinicians are not always aware of when this breakdown is happening. Couples are distressed have been found to be more likely to have a strained therapeutic alliance (Knerr & Bartle-Haring, 2010).

Therapeutic Change

All partners who participated in this study (including the partners who were not quite as positive about their experience) stated that they had seen improvement in their relationship. Likewise, clinicians also stated that they witnessed changes in couples' relationships that were surprisingly similar to what the partners had described. Couples were more able to describe changes in their inner states specifically in terms of internal changes such as thoughts as well as behavior change, and both participants and clinicians described partners improving their communication, becoming more aware and accepting of their partner's emotional needs, and accomplishing other small changes in their behavior.

Both clinicians and couples described being able to make improvements in the quality of their communication in that they were able to discuss normally challenging topics while approaching them in a new way. This is consistent with Cordova and colleagues' (2005) finding of improved communication among 74 couples using the *Marriage Checkup.* Couples and their clinicians also stated that partners increased in their awareness of their partner's emotional needs and often became more attentive to those needs. Couples specifically were able to describe changes in their behavior and described these changes including being more patient with each other and treating their partners with more kindness, which in turn helped them to feel more connected and improve their sense of relationship satisfaction. These findings are consistent with the research of Gee and colleagues (2002), who found that couples who participated in the *Marriage Checkup* improved their marital satisfaction significantly from pretreatment to posttreatment and maintained their satisfaction at a one month follow-up.

Couples attributed these changes to the opportunity to be in an environment where they could openly express their emotional needs. Cordova and Scott's (2001) intimacy theory suggests that when partners are encouraged to engage in emotionally vulnerable behavior with each other in a safe environment, they are more likely to increase their sense of intimacy with each other, which in turn improves relationship satisfaction. Similarly, Cordova and colleagues (2005) also found that partners became more accepting of each other, became more motivated to attend to the quality of their relationship, and experienced a deeper feeling of intimacy in their relationships.

Another shift described by partners, though not by therapists, was couples changing view of therapy. Couples explicitly stated that they developed more positive

views towards couple treatment. A number of partners as a result of the intervention became more open to seek out treatment in the future. Some partners described a shift in their views in that they no longer felt that they had to be in a high state of distress to seek out treatment. Of particular note, this change of perception included both wives and husbands, including Husband 4 who was initially resistant to attending. This is consistent with one study that found that couples who participated in a Marriage Checkup became more motivated to attend treatment in the future (Morrill et al., 2011).

Assessment

A largely promising feature of this intervention, also found in other relationship checkup models, is the use of the assessment. The use of assessments in couple interventions have been identified as a valuable tool in interventions for couples, particularly in the relationship checkup model (Larson, 2003). Despite misgivings about issues such as length, many couples (seven out of ten) explicitly noted that the assessment was a valuable tool in the couple's relationship growth, including three couples who indicated just taking the assessment led to some initial changes in thought and/or behavior. This finding is consistent with another study wherein couples reported a 30% improvement in relationship satisfaction by taking a relationship assessment without any feedback (Knutson & Olson, 2003). Couples frequently stated that the gains from the assessment were further amplified as clinicians met with the couples to provide the assessment results. Larson and colleagues (2007) have similarly found that couples improved in major relationship areas when they were presented with clinician feedback on their assessments results. Two clinicians confirmed that they liked having the results

to review with their couples and members of five couples (Couples 1, 3, 6, 7, and 10)

directly stated they liked being able to discuss assessment results with their therapists.

The Brief Format

Another area of interest was the number of sessions. Most couples (seven out of

ten) were content with the number of sessions with one couple indicating they could have

gotten by with just one (Couple 4). This is consistent with findings by Cordova and

colleagues (2005), wherein couples were found to be satisfied by the brevity of the

relationship checkup model. One of the basic tenets of the relationship checkup is to

provide an entryway for further treatment as needed, particularly for couples

experiencing greater levels of distress (e.g., Olson et al., 2009). Each couple in the

program was given the option of continuing treatment beyond the initial two sessions if

they desired. Most couples declined the offer but it is notable that two couples (Couples

2 and 3) who were experiencing greater levels of distress did continue treatment beyond

the initial two sessions. These couples who chose to go on indicated additional treatment

was very helpful. This suggests that for some couples (particularly for those in distress)

the program was successful in acting as an entryway for treatment.

SFBT

As stated earlier, clinicians in this intervention followed the treatment manual,

which provided a broad framework grounded in the Solution-Focused Brief Therapy

model of treatment (de Castro & Guterman, 2008; Nelson & Thomas, 2007). This model

of treatment intentionally allowed the participants to have more control over the direction

of treatment (within the structure of SFBT's five steps), as well as flexibility for

therapists to tailor treatment to couples' needs. Partners from a number of couples

(Couples 1, 6, 8, 9, and 10) stated that they appreciated how much the clinician allowed

the couple to create their own agenda and to talk about what was important to them.

Several couples noted that this helped them to feel more open with their clinician.

Clinicians were also cautious to maintain this stance in treatment but appreciated the

flexibility to do what they felt was in the best interest of the client.

It should be noted that one partner, Wife 5, stated she did not prefer this format as

it had not fit her earlier experiences of more directive therapy. This is consistent with

one qualitative study using SFBT with couples that found that some couples did not

prefer their clinician taking an "overly collaborative stance" with them, in that it did not

fit the couples' expectations for therapy (Odell, Butler, & Dielman, 2005, p. 10).

Additionally, there is some evidence to suggest that couples who are more emotionally

reactive (such as Couple 5) prefer more direction in treatment, while couples less

emotionally reactive are okay with less (Beutler et al., 2004).

Couple Characteristics

Similar to other relationship checkup formats, one of the initial aims of this

intervention was to attract and serve couples with a wide variety of backgrounds

including those experiencing various stages of distress (Cordova et al., 2005), with the

dual goal of preventing couple distress and providing access to treatment for couples

already in distress.   Based on clinician's descriptions of couples, and confirmed by

partner's reports in the interviews, it would appear that this intervention was successful in

these aims. It attracted the seven couples (Couples 1, 4, 6, 7, 8, 9, and 10) that both the

couples and clinicians reported experiencing either moderate to no distress in the relationship, as well as three remaining couples (Couples 2, 3, and 5) who were experiencing higher levels of distress. These findings are consistent with Morrill and colleagues' (2011) study of 215 couples, wherein they found this type of intervention was able to attract couples at varying levels of distress.

Another aim of this intervention was to provide an impetus to help couples be proactive in their relationship, including helping them address relational concerns either prior to problem formation or to address problems as they might arise (Gee et al., 2002; Olson et al., 2009). Six of the self-described lower distressed couples described themselves as approaching the intervention in a similar manner, in that it gave them a tool to be proactive in improving their relationship either before problems started or became too unmanageable. These findings were also consistent with other previous findings (Cordova et al., 2001; Morrill et al., 2011) wherein this format appealed to couples who were seeking to be proactive in helping their relationship to grow.

In working with couples, clinicians also frequently described couples' patterns of interaction. Clinicians frequently noted the ways in which the partners interacted with each other as a way of identifying what needed to change in the couple's relationship. Davis and Piercy (2007) found that unlike individual therapy, couple therapists conceptualize problems in terms of interactional cycles and focused on altering patterns of interaction. In their discussion of common therapeutic factors of change in couple therapy, Davis and colleagues (2012) also reiterate that disrupting dysfunctional relational patterns of interaction is a standard goal of couple treatment. Several partners

stated that the intervention became a place where they could discuss their concerns in a new way, and consequently changed the way they communicated about problems.

Limitations

The findings of this study should be considered in light of its limitations. One limitation is that interviews were conducted with partners together as a couple rather than individually. Although this allowed couples the opportunity to react to each other, build consensus in their statements, and to establish differences, it may have inhibited some participants' responses. With the presence of their spouses, partners may have felt more constrained in their explanations. Additionally, though attempts were made to help both the couples and the consultants feel comfortable (chatting beforehand and answering any questions or concerns upfront), both parties could have been influenced to provide socially desirable responses and/or responses agreeable to the interviewer. This study also could have been strengthened by the collection of follow-up interviews to ascertain the longevity of impact of the intervention.

Another limitation of the study involves the sampling process. This study used a convenience sample over the less biased approach of using random sampling. All couples who completed the original study were contacted to participate in follow up interviews, with participants self-selecting for the interview process. Though ideal for an in-depth qualitative study, this along with the small sample size of 20 participants (ten couples) and their six clinicians makes the findings less generalizable. The homogeneity among the sample, including the lack of racial diversity (all participants were Caucasian), also make the findings less generalizable. Participants' responses may not represent the

feelings and experiences of other couples utilizing this type of intervention. However, it should be noted that the study was an initial investigation of a new intervention, and generalizability and representativeness were not the goal of the study at this point.

This study primarily examined experiences within a brief format of treatment; thus, the research focus was on the intervention format. However, some concern also remains about the fidelity of the consultants to the program, particularly in consideration of the flexibility inherent in the program manual. Consultants were provided a SFBT program manual containing five basic steps of treatment, received training on implementing such, and follow-ups. Both couples and clinicians reported certain key elements of the program including providing assessment results, co-creating goals, and following up on those goals. However, the data also make it clear that clinicians moved beyond these steps in going in directions they felt their clients needed creating some variance in how the intervention was administered. Although couples received relatively similar treatment and the SFBT model itself and the treatment manual allowed for that flexibility, there remains some variance in what couples received. Although consultants receive training is how to use the assessments, by both the couples' and clinicians' reports, the results were not always presented in a consistent manner and it may be that the assessment results could have been used to greater advantage.

One final note includes considering the roles the researchers played in the interpretation of the data. As expressed earlier, though a researcher's backgrounds and biases cannot be separated from the interpretation in qualitative research (Cresswell, 2007), the goal in phenomenology is to allow the voices of all the participants to emerge unfettered. As a practicing marriage and family therapist, who has worked with many

couples, I have my own opinions on what good treatment should look like. These experiences, along with my personal life (married for over 15 years), has also influenced how I view optimal couple functioning. Though I was very cautious to not get in the way of what was being said, there may have been themes and ideas I was more apt to pick up on. Consequently, working with both a clinician and a non-clinician as research assistants – each with their own unique backgrounds and differing points of view, strengthened this process. Additionally, having the input of other researchers outside of the study were a valuable resource in encouraging participants' stories to come forward unfiltered by my own opinions. Despite all these efforts, though acceptable in qualitative research, phenomenology argues that it is impossible to truly speak for a reality outside of ourselves (Cresswell, 2007).

Implications for Future Research

The findings of this study suggest that this format is able to help address concerns found in traditional couple treatment including the costliness of couple therapy and the lack of individual tailoring in CRE. The intervention appeared to lower these barriers to treatment and changed people's minds to be more favorable to therapy; however many additional aspects could be examined. Generally, the couples who participated were largely non-distressed and two of the couples who indicated some desire and need to continue did not. More research needs to be done to determine if this type of intervention would be equally effective with more highly distressed couples, and if so what components of the intervention should be adjusted to meet the needs of such. Additional research should also be conducted to determine more specifically what factors help

couples (including those who are more highly distressed) to become more favorable towards future treatment. In the same vein, more exploration may shed light as to what could make the program more appealing to those distressed couples. Equally important is the need to properly train clinicians in appropriately dealing with these distressed couples, particularly in light that it may put the therapeutic relationship in jeopardy. Clinicians need to be able to identify when a breakdown happens and what they can do to mend such.

Another consideration is the implementation of the assessment. Though the assessment was a valuable tool and response to the assessment was positive, a few concerns expressed by partners and clinicians may help make the assessment an overall more positive experience for all parties. Partners from couples felt the assessment was too time consuming (Couples 1, 3, 6, 9), and others were frustrated with questions they found confusing (Couples 4, 7, 9), suggests that the assessment could be adjusted to make it easier for those participating. However, judgment would have to be used because the assessment instruments were extant, psychometrically validated measures. Some couples may benefit from more explanation of the assessment including the benefits towards the couple, which may help the couple to feel more positively towards taking it.

Another feature of this study was a that a large majority of the couples (8 out of 10) reported the cost played a valuable role in their attendance, including helping the more reluctant partners to get past initial resistance. Many couples remarked that both the lack of cost, in addition to the honorarium, played an important part in their attendance. This was perhaps surprising considering the small honorarium of $20, but for many couples this was just enough particularly in consideration of couples' reported

mean income level ($31,000 by wives and $35,000 by husbands). Though it is hoped that couples are motivated just by the need to improve their relationship, it would appear financial cost should not be overlooked. Considering the larger financial costs to society for relationship dissolution -- $300 million in the state of Utah (Schramm, 2006), incentives – or at least low- or no-cost services – may be a small price to pay for such a preventative measure. More research could be done to determine how effective the lack of cost and/or financial incentives play in encouraging couples to attend treatment.

Finally, consultants may need more training on how best to handle a couple who is doing relatively well, particularly how they can make a strong couple stronger. Though couples were more likely to describe themselves in terms of "proactive," clinicians did not. Additionally, a few clinicians stated feeling unsure of what to do next with a couple doing so well. Essentially therapists tended to view the couples as having concerns that needed to be worked on or not, or to have some level of motivation towards making changes and/or treatment or not. This may be an indication of clinicians' tendency to view their clients much the same way that physicians view patients. Typically people do not show up to their doctors when they are healthy and want to stay that way, but rather when they are sick. The Solution-Focused model was chosen with this phenomenon in mind, taking seriously SFBT-based ideas that clients have important innate strengths, and that their own wellness and solutions are innate. Not surprisingly, as indicated by the research, couples typically do not attend therapy unless they are in a more severe state of distress (Doss et al., 2009). Therefore, clinicians may need additional training on how to best strengthen an already well-functioning couple.

Concluding Remarks

This study sought to more fully understand the phenomenological experience of those participating in a unique couple treatment format. Based on the experiences described by the couples and their corresponding clinicians, it would appear that this intervention was a positive experience for the participants and was generally successful in its aims. Though the majority of couples were non-distressed, couples typically described experiencing improvements in their relationship due to their participation. Additionally, it attracted its intended target of couples in varied states of distress.

The data suggest that participants generally liked the brief format, which allowed couples to overcome obstacles to treatment in terms of time and cost, and some of the data suggested that participants became more positively inclined towards professional marital support. The openness of the intervention also engendered partner discussion of previously unknown issues as well as ongoing concerns. These experiences were confirmed by the considerable agreement in themes that emerged from the participant data and the clinician data. Pending further research, the "checkup" format may be a viable format that addresses some of the limitations of existing couple interventions.

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APPENDIX

Interview Questions

Participant

- How did you learn about this program?
- What were some of the motivations to attend *Revitalize?*
- Tell me about your experience with your consultation.
- How well were you able to address some of the issues that were causing you concern?
- What has changed in your relationship, your partner or yourself since meeting with your consultant? (Either behavior or perception)
- What brought about this change? What contributed to your making progress?
  - (*If you felt there wasn't much progress*, can you talk about why there wasn't much change?)
- What was going on at the time when you felt change was taking place?
- At what point in the intervention did the greatest amount of change come about – during the session, before the sessions, in-between sessions, after sessions
- Was there anything that happened that was detrimental to the relationship?
- Was there anything helpful about the relationship with the consultant that facilitated change?
- What did your consultant either do or say to facilitate your work?
- In this program, what do you think we should
    a. stop doing? (what didn't you like about the program)?
    b. start doing? (what could we do to make our program work better?)
    c. Keep doing? (what did we do that worked for you?)
- How has this changed your views in regards to couples therapy, particularly in attending couples therapy in the future?
- To what extent do you think this program helped couples to use other resources (for example, books, more therapy, the Marriage Handbook, relationship classes).
- Is there anything else you'd like to add that would help us understand your experience in this couples consultation?

- **Thank you** for your participation!

Consultant (after prompts of the session)

- Tell me about your experience with this couple.

- What change, if any, do you believe took place?

- At what point do you think this happened?
    - What brought about this change? What did you see each person doing?

- Who do you feel made the change: husband, wife, both?

- What do you think *you* did that brought about that change?

- Tell me about any pivotal moments of change in the consultations.

- Is there anything you wish you have done differently?

- Any comments on your working relationship with this couple

- Talk about your thoughts about this 2-session format.
    - What are the pros?
    - What are the general successes?
    - What are the cons?
    - What are the general challenges or barriers?

- Talk about successes and challenges regarding recruitment. (Any comments you have regarding why people did attend or why people stayed away?)

- To what extent do you think this program helped couples to use other resources (for example, books, more therapy, the Marriage Handbook, relationship classes).

- Is there anything else you'd like to add that would help us understand your experiences as a consultant?

- **Thank you** for your participation!

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EDUCATION

Ph.D. Candidate
Family and Human Development, Family Studies Emphasis, Spring 2014
Utah State University, Logan, UT
Major Professor: Kay Bradford, Ph.D.
Dissertation: *Exploring the process of couples' experience in a new intervention*

Master of Science
Marriage and Family Therapy, August 2005
Loma Linda University, Loma Linda, CA – COAMFTE Accredited program
Major Professor: Lolita Domingue, M.S.

Bachelor of Science
Marriage, Family and Human Development, August 2001
Brigham Young University, Provo, UT

TEACHING EXPERIENCE

Adjunct Lecturer, Southern Utah University

FLHD 3360: Divorce and Remarriage
Fall 2013
- Instructed small (16 students) upper division course on personal, family, and legal aspects of divorce and remarriage
- Provided students with learning assessment activities such as reflection papers and group activities to help students internalize course concepts
- Integrated current research into class discussion, reading, and assignments

Graduate Instructor, Utah State University

FCHD 3210: Families and Cultural Diversity - Online Course
Summer 2011, Spring 2012, Summer 2012 & Spring 2013
- Taught upper division online courses (40+ students) regarding serving culturally & ethnically diverse families in the community using Blackboard and Canvas systems

- Created a series of video interviews with members of minority populations to enhance real life learning
- Engaged learning using a number of online practices, including Camtasia PPT presentations, videos, discussion boards and assignments that challenged students to get outside of their comfort zone

FCHD 3210: Families and Cultural Diversity
Spring 2011, Summer 2012 & Summer 2013
- Provided instruction for upper division undergraduate course (44 students) & (7 students)
- Developed assignments based on real world situations to prepare students for field entry
- Collaborated with community and university contacts to set up panel discussions

FCHD 2400: Marriage and Family Relationships
Fall 2010, Spring 2010 & Fall 2011
- Instructed several large undergraduate course (100+ students) on couple and family relationships
- Augmented teaching with technological resources, including I-Clickers, videos, online resources

Teaching Assistant, Utah State University

FCHD 3510: Infancy and Early Childhood Development
Fall 2012 & Spring 2013
- Teaching assistant for Kaelin Olsen, M.S. and Gina Cook, Ph.D. for classes of 40+ upper division undergraduates
- Prepared and taught lectures, created quizzes, set up online components and graded assignments

FCHD 2400: Marriage and Family Relationships
Fall 2009
- Assisted Tom Lee, Ph.D. with 105 upper and lower division students
- Developed and taught lectures, prepared and graded exams, and graded papers

FCHD 4900: Pre-Practicum Skills in Family and Human Relationships
Fall 2008 & Spring 2009
- Served as teaching assistant for Bryan Ramboz, Ph.D. in a class of 40+ upper/lower division students
- Participated in class instruction, curriculum development, grading exams, grading papers, and entering grades

CLINICAL EXPERIENCE

Part-Time Therapist 2005-Present
Family Services, Cedar City, UT; Logan, UT; Salt Lake City, UT; Colton, CA
- Provided treatment services to individuals, couples and families in a religious-based counseling center, with an emphasis in serving college-age clientele
- Expert in working with couples and families along with clientele struggling with depression, anxiety and sexual addiction
- Co-developed and led group for men struggling with sexual addictions, including providing psychological education and experiential exercises

Clinical Therapist 2007-2008
Intermountain Specialized Abuse Treatment Center, Salt Lake City, UT
- Provided therapeutic treatment for domestic violence offenders, adult and adolescent sex offenders, victims of domestic violence, and victims of sexual abuse
- Conducted group therapy with domestic violence offenders, adult sex offenders, and juvenile sex offenders
- Participated in the Domestic Violence Council of Salt Lake City and received training in juvenile and adult sex offender treatment
- Assisted completion of court ordered evaluations; corresponded with judges, probation officers, and DCFS caseworkers

Clinical Therapist 2006-2007
San Bernardino County Department of Behavioral Health, San Bernardino, CA
- Provided therapy and other mental health services for at-risk child/adolescent population and their families
- Assessed and provided treatment recommendation for adults with severe mental illness
- Served a racially and ethnically diverse population on site and at local schools
- Worked as part of a multidisciplinary team alongside psychiatrists, psychiatric nurses, psychologists, social workers and education professionals
- Maintained compliance with state health care requirements and treatment recommendations

Clinical Therapist Intern 2004-2005
Loma Linda Marriage and Family Therapy Clinic, Loma Linda, CA
- Provided therapy to individuals, couples and families at a community clinic
- Implemented play therapy and other experiential activities with children and families
- Created and implemented treatment plans

Stepparent Education Program Facilitator 2004-2005
Loma Linda Marriage and Family Therapy Clinic, Loma Linda, CA
- Developed and implemented an eight week course on co-parenting
- Created and delivered materials and homework assignments for parents in stepfamily formations

Anger Management Program Facilitator 2004-2005
YMCA Anger Management Program, San Bernardino, CA
- Facilitated anger management group for court mandated clientele
- Developed and evaluated material based on current research and practice

CLINICAL CREDENTIALS

Licensed Marriage and Family Therapist, Utah, 2008-present

AAMFT Approved Supervisor Candidate, Trained in August 2012

Marriage and Family Therapy Trainee, California, 2005-2007

RESEARCH EXPERIENCE

Graduate Research Assistant, Elizabeth Fauth, Ph.D., 2011-2012
- Researched effectiveness of an intervention to assist caregivers of individuals with dementia
- Assisted in creating data sets, data entry and maintaining data collection
- Mentored team of four undergraduate students in the research process

Graduate Research Assistant, Kay Bradford, Ph.D., 2009-2011
- Researched a clinical intervention for couples based on Solution Focused Therapy
- Assisted with intervention development, clinician training and assessment tool creation
- Participated in the sample recruitment process and collaborated participation
- Created and conducted qualitative interviews with research participants and clinicians
- Performed data entry and analysis for both quantitative and qualitative data
- Supervised three undergraduate researchers with various research responsibilities

Graduate Research Assistant, Brian Higginbotham, Ph.D., Linda Skogrand, Ph.D., and Kay Bradford, Ph.D., 2010-2011
- Researched a statewide, extension sponsored, couple education initiative
- Assisted with writing literature review

- Entered quantitative data and created transcriptions of interviews
- Trained and monitored undergraduate students in data entry

Graduate Research Assistant, Kim Openshaw, Ph.D., 2008-2009
- Researched technology assisted clinical intervention for couples living in rural areas
- Created learning modules for couples based on current research and therapeutic practice
- Contributed to a literature review section
- Supervised two graduate students in developing the intervention and writing

PROFESSIONAL EXPERIENCE

Graduate Student Representative 2011-2012
Department of Family, Consumer, and Human Development
- Nominated as the graduate student representative for the department
- Responsible for coordinating and implementing faculty/student social events
- Acted as a liaison between graduate students and faculty
- Informed students of scholarship opportunities within the university

PROFESSIONAL PRESENTATIONS

Mock, J., Olson, J., & Fauth, E. (2012). *Family conflict and behavioral symptoms in the person with dementia: Associations with caregiver burden.* Poster presented at the Intermountain Graduate Research Symposium. April 5, 2012, Logan, UT.

Mock, J., & Bradford, K. (2011). *Opening the door: Making couples therapy more accessible.* Poster presented at the National Council on Family Relations Annual Conference, November, 19, 2011, Orlando, FL.

Stewart, J.W., Bradford**, K.**, & **Mock, J.**, (2011). *Change in relationship knowledge after a brief couple intervention.* Poster presented at the National Council on Family Relations Annual Conference, November 18, 2011, Orlando, FL.

Bradford**, K.**, **Mock, J.**, & Stewart, J. W. (2011). *Couple consultation: Outcomes of a brief couple intervention.* Poster presented at the American Association for Marriage and Family Therapy Annual Conference, September 23, 2011, Fort Worth, TX.

Bradford, K. & **Mock, J.** (2010). *Between Therapy and Education: A Brief Couple Intervention.* Poster presented at the National Council on Family Relations Annual Conference, November 18, 2010, Minneapolis, MN.

PROFESSIONAL ORGANIZATION MEMBERSHIPS

Member, American Association of Marriage and Family Therapists (AAMFT), 2012-2013

Student Member, National Council on Family Relations (NCFR), 2010-2012

PROFESSIONAL DEVELOPMENT

Graduate Instructor Forum, 2009-2012
- Participated in monthly teaching forum conducted by Associate Professor, Troy Beckert
- Received and integrated instructional feedback from several professor mentors