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THE EVOLUTION AND IMPLEMENTATION OF AN INTEGRATED APPROACH
TO EMOTIONALLY FOCUSED COUPLE THERAPY: A CASE STUDY

by

Heather Thompson

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

of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development
(Marriage and Family Therapy)

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2010

ABSTRACT

The Evolution and Implementation of an Integrated Approach to Emotionally Focused Couple Therapy: A Case Study

by

Heather Thompson, Master of Science

Utah State University, 2010

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There are a number of advantages to working within an integrated model framework when doing family therapy; however, few therapists test what they articulate as their model against what they really do. The purpose of this study was to test how well one therapist practiced her explicated theoretical integration in a clinical setting. Quantitative and qualitative data were gathered to answer three research questions: the level of adherence to the integration, client change, and change within the integrated model over the course of the study. The sample included three couples; data from 25 video-coded sessions, the Revised Dyadic Adjustment Scale and Outcome Ratings Scale, client case notes, and a reflection journal were analyzed to answer the research questions. Results indicate that the therapist remained true to the described integrated model; that all couples experienced change, some positive, some negative; and small changes to the model occurred. Other findings, limitations, and clinical implications are discussed.

(142 pages)

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Heather Thompson

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CHAPTER I

INTRODUCTION

Problem

As the field of family therapy progresses, the dominant trend is toward integration of ideas rather than single-model ways of working (Nichols & Schwartz, 2006). Over the past decade, more and more therapists are recognizing that “no single approach has a monopoly on clinical effectiveness” (Nichols & Schwartz, 2006, p. 354). Lebow (1987) explained that integrative approaches have a number of unique advantages including providing a broader base of interventions and treatments to allow more flexibility in client care, the ability to tailor the approach to the therapist’s style and worldview, and providing adaptability in reaching diverse client populations. However, Lebow (1987) cautioned, such approaches can be susceptible to a number of problems including “a lack of a theoretical focus, inconsistency in formulation and approach, utopian goal setting that results in interminable treatment, and too much complexity,” which can harm the therapeutic alliance and also create a “lack of parsimony in intervention strategy” (p. 2). Because of these unique advantages and problems, it is important that therapists who are drawn to multiple theoretical models be able to explicate their own personal integration and how it works to elicit change in therapy (Lebow, 1987).

As a new family therapist, I have found myself drawn to multiple models of therapy and, following this trend of integration, have developed my own personal integrative model of therapy. In my therapy, I utilize emotionally focused couples therapy (EFT; Johnson 2003, 2004, 2008a; Johnson et al., 2005; Johnson & Greenberg,

1994), solution-focused brief therapy (SFBT; De Jong & Berg, 2008; de Shazer, 1994; de Shazer et al., 2007; Thomas & Nelson, 2007), and Gottman method couple therapy (GMCT; Gottman, 1999; Gottman & Gottman, 2008) as a part of my therapeutic integration to meet the needs of the couples, families, and individuals that I see in therapy. I utilize the technique of selective borrowing as defined by Nichols & Schwartz (2006), which requires that a therapist have a solid foundation in one model while borrowing techniques from other models in a way that fits within the therapist's basic paradigm. My foundational model is EFT, with selective borrowing from SFBT and GMCT. The effectiveness of my integration and practice of my therapy is not yet established, thus the need for examining it.

Purpose of Research

The purpose of this study was to examine how well I applied my explicated integrative model and how true I stayed to this model during the course of therapy with three couples. This case study also examined how much change occurred throughout therapy for each couple and what I changed in my model throughout the process of conducting therapy with these three couples. My hope is that this study will be a positive step in better understanding how my integrative model works and will be an important component in my training and development as a marriage and family therapist.

CHAPTER II

REVIEW OF LITERATURE

This chapter will describe the basic assumptions, concepts, and interventions associated with my integration of emotionally focused couple therapy (Johnson 2003, 2004, 2008a; Johnson et al., 2005; Johnson & Greenberg, 1994), solution-focused brief therapy (De Jong & Berg, 2008; de Shazer, 1994; de Shazer et al., 2007; Thomas & Nelson, 2007) and Gottman method couple therapy (Gottman, 1999; Gottman & Gottman, 2008). Because EFT is the framework from which I conceptualize therapy, it will be described in full with a brief description of how the basic assumptions, concepts, and interventions of SFBT and GMCT fit within that framework. I will then articulate how these models work together in my own integration throughout the therapy process.

Emotionally Focused Couple Therapy

Basic Assumptions and Concepts

Emotionally focused couple therapy was developed by Susan Johnson and Les Greenberg (Johnson, 2008a) in the early 1980s “as a response to the lack of clearly delineated and validated couple interventions, particularly more humanistic and less behavioral interventions” (Johnson, 2004, p. 4). It was developed to draw attention to the importance of emotion as a powerful and key change agent in couple therapy at a time when most therapies were “affect phobic” (Johnson, 2004, p. 4).

Emotionally focused couple therapy is an integrative approach consisting of experiential, systemic, and attachment models (Johnson, 2004). The experiential

component of EFT is crucial in eliciting change. According to Johnson (2008a), there are several critical components of experiential therapies that are used in EFT, including the power of the therapeutic alliance. The therapeutic alliance itself can be healing and, therefore, the therapist should take care to be collaborative. Another key component to EFT as an experiential therapy is the importance of accepting and validating one partner's experience of the couple relationship without invalidating or marginalizing the experience of the other (Johnson, 2008a).

Emotionally focused therapists and experiential therapists share an assumption that every individual has the ability to make healthy and creative choices when presented with the opportunity (Johnson, 2008a). Further, according to Johnson, "the inner construction of experience evokes interactional responses that organize the world in a particular way. These patterns of interaction then reflect, and in turn, shape inner experience" (Johnson, 2008a, p. 108). Because of the ability of one's experience to guide the organization of one's view of the world, new experiences in therapy can help clients expand their view and make sense of the world in a new way that can be beneficial to them. Emotionally focused couple therapy also supports the experiential supposition that individual identity can be formed and transformed by relationships and interactions with others and, therefore, seeks to create new relational experiences of safety and connection (Johnson, 2008a).

Emotionally focused couple therapy is considered to be a systemic therapy in that EFT therapists recognize that problems occur due to patterns or cycles of interaction among members of a couple or family (Johnson, 2008a). What is unique about EFT is its emphasis on utilizing emotion to break these destructive cycles (Johnson, 2008a).

Emotionally focused couple therapy maintains a family systems focus by proposing that action “A” does not cause action “B,” but is a part of a “self-perpetuating feedback loop” (Johnson, 2008a, p. 109). For example, in a typical pattern of relationships in which one partner demands closeness while the other partner tends to withdraw, it is impossible to determine whether “the ‘demanding’ led to the ‘withdrawal’ or whether the ‘withdrawal’ led to the ‘demanding’ ” (Johnson, 2008a, p. 109). This reflects the systemic concept of *circular causality*.

Integral to EFT is the belief that all behavior should be considered in its context, which reflects the systemic concept of *wholeness*, or “the whole is greater than the sum of the parts” (Johnson, 2008a, p. 109). Emotionally focused couple therapy also holds the assumption that all of the components of a system maintain a consistent and predictable relationship to one another, which is an example of the systemic concept of *homeostasis*. Furthermore, EFT is systemic because of the supposition that all behavior is communicative in nature. Finally, the primary task of therapy is to interrupt negative interactional patterns in order to create new, healthy patterns (Johnson, 2008a).

A foundation of EFT can be found in a theory of adult love viewed through an attachment lens. Attachment theory, initially developed by John Bowlby (1969) as a way to understand child development, has been adapted by social psychologists Phil Shaver and Cindy Hazen as a way to understand adult close relationships (Johnson et al., 2005).

According to Johnson et al. (2005), there are ten central tenets of attachment theory that inform EFT and serve as its foundation. These include the following: (a) attachment is a primary and innate motivating force across the lifespan and is considered imperative for survival; (b) autonomy and secure dependence coexist and even

complement each other; they are not dichotomous; (c) positive and secure attachment allows for a safe haven or place of emotional comfort, security, safety, and protection; (d) attachment provides a secure base from which individuals can explore and adapt to their worlds; (e) accessibility and responsiveness create close and secure connections; (f) attachment needs are activated by fear and uncertainty; (g) separation distress is a predictable process that begins with an angry protest, clinging, depression, despair, and ultimately detachment (Johnson, 2003); (h) there are only three insecure forms of engagement: anxious, avoidant, and fearful-avoidant (Johnson, 2003); (i) views of self and other are included in attachment; and (j) loss and isolation are inherently traumatizing (Johnson et al., 2005).

These ten tenets of attachment theory guide EFT because they include inherent beliefs about the human connection. When taken as a whole, attachment theory suggests that human beings need each other to be healthy and happy. Because of this supposition, EFT works to increase a couple's ability to rely on one another by creating an environment of safety in the therapy room where couples can be vulnerable and take risks. When the tenets of attachment theory are understood and practiced in EFT, that vulnerability predictably produces secure attachment as couples learn to be more accessible and responsive to one another's needs.

Emotion Defined

In order to more fully understand why attachment and emotional experiences are important in EFT, it is critical to understand how this model conceptualizes emotion, what it is, what it does, and how it can effect change. This is important because

attachment and emotion inform my entire approach.

In EFT, emotion is defined as a “high level information processing system,” which consists of “an integration of physiological responses, meaning schemes, and action tendencies, as well as the self-reflexive awareness of this experience” (Johnson, 2004, p. 64). Essentially, emotions are the physiological responses to stimuli that we label as feelings (sadness, anger, emotional pain, joy, etc.) and that are mediated by our cognitive processes, which assign meaning. In this approach, emotion is viewed as being integral to understanding cognition and interaction (Johnson & Greenburg, 1994).

Role of Emotion

The importance of emotion is seen vividly in a romantic relationship as described by Johnson (2004) in the following interaction:

She asks him if he loves her, he grimaces and raises an eyebrow, she appraises this ambiguous response as negative and dangerous, her mouth sets and her body stiffens as for a fight. She then says, “And what is that silly grimace supposed to mean?” He looks away, and we hear her reappraisal as she says, “As usual nothing comes back—why do I ask—so stupid.” She then leans forward and attacks: “You are an emotional cripple. I don’t know why I am even here today.” Emotion has moved her into an attack position, and this response then cues a massive defensive shutdown from her partner. This process orientation to emotion opens doors for the therapist to clarify and expand, or to recast any part of the emotional response and so expand the whole. (p. 65)

Fundamentally, emotion is viewed as adaptive because it provides a response system that can quickly change how a person behaves to maintain security, increase ability to survive, or help fulfill his or her needs (Johnson, 2004). In the context of intimate relationships, emotion “tends to focus attention and orient partners to their own needs and particular environmental/social cues” (Johnson, 2004, p. 66). For example, if a person is sad, he or she may be more aware of his or her need for closeness, and also

have a heightened awareness of any signal of distancing from an attachment figure (Johnson, 2004). Emotion also colors perceptions in relationships and assists in the process of meaning construction (Johnson, 2004). For example, if a person is angry, he or she is more likely to perceive a partner's behavior as an attack.

Emotion can “prime and organize responses, particularly attachment behaviors” (Johnson, 2004, p. 66). Therefore, if a partner is anxious, he or she is much more likely to seek out his or her partner for comfort and reassurance (Johnson, 2004). Further, emotion tends to activate core beliefs about oneself, other people, and how relationships function (Johnson, 2004). For example, a husband might believe that because his wife has yelled at him about something, he must deserve it or be a failure as a person. This could further signify that his wife views him this way, which may lead him to shut down because he believes that the relationship is not safe (Johnson, 2004).

Finally, emotion is used as a tool for communication. Emotional displays draw complementary responses from others, which leads emotion to be critical in organizing interactions (Johnson, 2004). For example, expressions of vulnerability from one person tend to elicit expressions of compassion from another (Johnson, 2004).

Types of Emotion

According to Johnson (2004), emotions and emotional reactions are understood as primary and secondary. Primary emotions are the in-the-moment, direct responses to situations and include surprise, happiness, anger, hurt, sadness, fear, shame, and loneliness (Johnson, 2004). These emotions are considered to be adaptive because they tend to signal a need for support and comfort from the other (Johnson & Greenburg,

1994). Secondary emotions are the emotions used to react to and cope with difficult primary emotions. These often include jealousy, anger, frustration, and resentment. Oftentimes, these secondary emotions obscure the primary emotions and keep them out of awareness (Johnson & Greenburg, 1994). According to Woolley (2009), primary emotions usually draw partners closer together whereas secondary emotions generally push partners away from one another. While trying to connect, distressed couples often get stuck in repetitive negative cycles of interaction in which partners convey secondary emotions instead of primary emotions (Woolley, 2009).

Johnson's Definition of Relationship Health

Johnson (2008a) defined relationship health in EFT as a secure attachment bond “characterized by mutual emotional accessibility and responsiveness” (p. 112). This type of bond fosters an environment of safety in which partners are able to process and regulate their emotions, process information, resolve differences, and communicate effectively (Johnson, 2008a). In this view of health, the optimum is for a couple to be simultaneously autonomous and connected (Johnson, 2008a). Relationship distress, then, is viewed as attachment insecurity, and separation distress is typically manifested as an angry protest against the loss of connection with a primary attachment figure (Johnson, 2008a).

The Role of the Therapist

In the EFT model, the therapist is seen as a “process consultant” in “helping partners reprocess their experience and a choreographer, helping couples to restructure their relationship dance” (Johnson, 2004, p. 12), rather than as an expert who tells the

clients what their relationship should look like. The therapist oscillates between leading and following in the therapy session, and serves as a collaborator in expanding the emotional experience of the couple.

Goals of Therapy

The primary goal of therapy is to help clients expand and reorganize their emotional experiences with one another in order to develop new interactional patterns in a relationship (Johnson, 2004). In order to do this, there are three primary tasks of EFT: (a) creating a safe and collaborative alliance, (b) accessing and expanding the emotional responses that dictate a couple's interactions, and (c) restructuring those interactions in a way that helps the partners become more accessible and responsive to one another (Johnson, 2008a).

The Process of Change

There are three specific stages in which the change process occurs in EFT. All of the interventions of EFT are interwoven throughout these stages in order to facilitate the primary goal of helping the clients to expand and reorganize their emotional experiences with one another in order to develop new interactional patterns (Johnson, 2004). The first stage is *cycle de-escalation* (Johnson, 2008a). One of the most important components of this stage is the therapist's ability to connect and engage with both partners and create an alliance that allows the partners to feel safe and accepted. In this stage, the therapist assesses the relationship for conflict issues and begins to identify the negative interactional pattern in which the couple is stuck. The therapist also helps the couple discover the underlying attachment needs and emotions hidden behind the roles each

partner plays in the couple's cycle. The therapist then *reframes* or assigns new meaning to the presenting problem as the negative cycle that has overtaken the relationship (Johnson, 2008a). This helps the couple to work together against the negative cycle rather than blaming each other for their conflict.

The second stage of therapy involves *changing interactional positions* as the therapist helps the couple to identify and own attachment needs and views of self (Johnson, 2008a). This stage also includes guiding the couple to accept each other's experiences as legitimate and real. When the clients begin to understand their own needs and accept their partners' experiences, the therapist coaches them to express their needs to one another and facilitates new bonding experiences. This facilitation of the expression of needs allows the couples' interactional patterns to begin to be restructured (Johnson, 2008a).

The final stage of EFT is *consolidation and integration* (Johnson, 2008a). In this stage, the therapist helps the couple strengthen and consolidate their new cycles of interaction where attachment needs are no longer threatened (Johnson, 2008a). This is accomplished by looking at what the couple has achieved in therapy and in their relationship and helping them create their own narrative about the journey that has led them to this point. The therapist also works with the couple to create new solutions to old problems using their new patterns of interaction that are no longer overwhelmingly full of negativity and threats to emotional safety in the relationship (Johnson, 2008a).

Basic Interventions

Reflection is used in EFT as the therapist "attends to, focuses on, and reflects

poignant emotion” (Johnson, 2004, p. 78). This intervention is used throughout the therapeutic process to assist the therapist in conveying understanding of what is going on in the client’s experience and in helping focus the client on his or her experience. This helps the client feel understood and accepted. It builds the therapeutic alliance, which leads the therapy room to be considered a safe place where the therapist is seen as an ally (Johnson, 2004). Reflection in EFT is not used only as a repetition and paraphrasing of a client’s words; it is designed to help the clients “grasp and taste what may be vague and abstract” and to be the “first step in making a client’s experience vivid, tangible, concrete, specific, and active (versus something that happens to you)” (Johnson, 2004, p. 78-79). When reflection is done well, it “*directs the client’s attention* to the unfolding of inner experience, *sharpens the client’s grasp of this experience*, and *slows down* the interpersonal process in the session” (emphasis in original; Johnson, 2004, p. 78).

Validation is used to help the clients understand that they are “entitled to their experience and emotional responses” (Johnson, 2004, p. 78). The therapist helps the clients to separate their experience of a partner from that partner’s character or intentions. For example, one partner could feel accused or blamed without the other partner’s intending to accuse or blame. By conveying the position that there is nothing irrational, shameful, wrong, or strange about their responses, the therapist creates an open environment for partners to engage with their experiences, which allows the therapist to more fully expand and crystallize those experiences (Johnson, 2004).

Evocative responding: reflections and questions focus on the unclear, tentative, or emerging portions of a client’s experience (Johnson, 2004). The word *evocative* stems from the Latin word *evocare* which means “to call” (Johnson, 2004). In this intervention,

the therapist bypasses content issues of the session and goes directly to the emotional responses of the clients (Johnson, 2004). The therapist accomplishes this by using prompts and open-ended questions about bodily sensations, stimuli, meanings, desires, or behaviors (Woolley, 2009). Quite often, these prompts include the use of evocative imagery to capture more vividly the expanding details of the client's experience. These reflections are always offered tentatively in order to allow the client to try on, taste, reshape, correct, or take them on (Johnson, 2004).

In *empathic conjecture*, the therapist infers "the client's current state and experience from nonverbal, interactional, and contextual cues to help the client give color, shape, and form to his or her experience and take this experience one step further" (Johnson, 2004, p. 84). The goal is not necessarily to create insight, but to help clients find new meaning in their experiences. These conjectures or interpretations often concern attachment needs and defensive strategies. For example, a therapist may say something such as, "It's like you're a long, long way away. Where no one can hurt you, yes?" (Johnson, 2004, p. 86). Once again, these interpretations are offered tentatively and the clients are given the opportunity to correct the interpretation.

Heightening is used to intensify and highlight specific interactions and responses that appear to play a critical role in perpetuating a couple's negative interactions. The therapist will heighten these interactions and responses by repeating poignant phrases to intensify their impact, utilizing the therapist's own emotion and body to reflect how something is said (e.g., slowing and lowering the voice when talking about vulnerable emotions, leaning forward, or raising the voice when intensifying an assertive response), using metaphors to paint a clearer picture of the emotion, or blocking exits that clients

may create to get out of a particularly difficult emotional experience such as turning from their internal experience of hurt to once again blaming the partner (Johnson, 2004). Essentially, heightening is used to reorganize the clients' interactions and experiences (Johnson, 2004).

In later stages of EFT, the therapist utilizes *tracking*, *reflecting*, and *replaying interactions* to help the clients slow down and to crystallize the steps in the couple's interactional dance. For example, the therapist may say something such as, "So what just happened here? It seemed like you turned from your anger for a moment and appealed to him. Is that OK? But, Jim, you were paying attention to the anger and stayed behind your barricade, yes?" (Johnson, 2008a, p. 121).

The EFT therapist also utilizes *reframes*, especially in the context of the negative interaction cycle and attachment process. These reframes help the clients assign new meaning to certain responses and help create a more positive view of the partner (Johnson, 2008a). An example of a positive reframe would be a therapist's stating that a partner gets angry and pursues because she is afraid of losing the other partner.

Finally, the therapist *restructures and reshapes interactions*. This step is also accomplished through *enactments* as the therapist "directly choreographs new interactions between the partners to create new relationship events that will redefine the relationship" (Johnson, 2004, p. 96). An enactment is a guided experience in which the therapist coaches the couple to express their new emotional experiences and needs in direct ways to their partners (Johnson, 2004). The therapist may say something such as, "Can you tell her that you feel invisible? Can you tell her that you want her to see you?" This type of enactment creates a new dialogue between partners that allows positive

cycles of interaction and responsiveness to begin to develop where negative ones once prevailed (Johnson, 2004).

Emotionally Focused Therapy Research

Emotionally focused therapy currently is one of the “most empirically validated approach[es] to couple therapy, apart from the behavioral approaches, and has 20 years of outcome and process research to draw on” (Johnson, 2004, p. 8). Denton, Burleson, Clark, Rodriguez, and Hobbs (2000) designed the first randomized trial of EFT conducted outside of Canada with a group of researchers and students “unconnected with the originators of the EFT model” (p. 65) and that was the second outcome study known to be conducted by beginning couple therapists (Denton et al., 2000). This study utilized eight 50-minute sessions rather than the prescribed 75-minute sessions that had been used in previous outcome studies (Denton et al., 2000). This was essentially one-third less therapy than had previously been used in any EFT outcome study reported up to that point. This study found that couples had significantly higher marital satisfaction at the conclusion of the 8-week treatment of EFT based on a pretest-posttest ANCOVA analysis, $F(1, 49) = 6.66, p < .02, r^2 = .27$, compared to a wait list treatment group (Denton et al., 2000).

Integration of Models

Nichols and Schwartz (2006) stated that integration is an “unquestionably good idea” because “human beings are complicated—thinking, feeling, and acting—creatures who exist in a complex system of biological, psychological, and social influences” (p.

355). In order to better address the complexity of the human experience and to better serve couples, the theoretical integration in my personal model of therapy consists of a primary lens of emotionally focused couple therapy (Johnson, 2003, 2004, 2008a; Johnson et al., 2005; Johnson & Greenberg, 1994; Woolley, 2009) with selective borrowing of specific practices and interventions from solution-focused brief therapy (De Jong & Berg, 2008; de Shazer, 1994; de Shazer et al., 2007; Thomas & Nelson, 2007) and Gottman method couple therapy (Gottman, 1999; Gottman & Gottman, 2008).

Integration Basic Assumptions and Concepts: EFT and SFBT

Although EFT and SFBT have different assumptions in theory, there are some important ideas from the models that fit very well together for this specific integration. One common element between EFT and SFBT is the client-centered, nonpathologizing approach to client issues (De Jong & Berg, 2008; Johnson, 2004). Neither approach looks at clients as dysfunctional or deficient, but shares a common understanding that clients are stuck (Johnson, 2004; Thomas & Nelson, 2007). Therapists in both models are extremely sensitive to the client's perceptions of his or her experience and focus on viewing those perceptions as legitimate and valid (De Jong & Berg, 2008; Johnson, 2004; Thomas & Nelson, 2007).

Another assumption shared between EFT and SFBT is the importance of the client's language in therapy. Because of EFT's experiential roots, the clients' language is used to tap into and deepen their emotional experiences (Johnson, 2004). This is also a part of being collaborative and validating (Johnson, 2004). Solution-focused brief therapy has a very strong focus on using the client's language because, as de Shazer

(1994) described, language is not only an important way that we describe our world, language is reality. In fact, de Shazer (1994) described terms such as “marital problems,” “depression,” or “individual problems” as

simply the constructions of the users of those terms. What these terms mean is both arbitrary and unstable; that is, meaning varies depending on who is using the term and to whom it is being addressed within a specific context. (p. 9)

Meaning comes from our negotiations within that context. Essentially, every individual’s unique experience shapes his or her understanding of language, and, therefore, we can never really send messages, but only receive them because the meaning of a message is determined by the receiver (de Shazer, 1994). In my integration, the use of client language is critical because it not only assists in validating and deepening the client’s experience, but also helps me gain perspective into the client’s reality and help him or her share that reality with his or her partner.

The assumptions of solution-focused brief therapy do not include attachment theory. Because of that, in this integration, my main focus is not the assumptions of SFBT, but how the selectively borrowed interventions can assist me in fostering secure attachment by creating a shared view of the future and allowing clients to express their attachment needs. This is accomplished through the interventions that will be discussed next.

Interventions Borrowed from SFBT

In this integration, I utilize several practices or interventions from the SFBT approach to deepen and expand clients’ experiences and to help identify their positions in their negative interactional patterns. The first practice utilized in this integration is the

miracle question (de Shazer, 1994). In SFBT, the miracle question is used to help the therapist and clients build a collaborative idea of what a successful future after therapy would look like (de Shazer, 1994). This question focuses on the presence of certain things or behaviors that would exist if a miracle happened that takes away the problem that the clients have come to therapy to resolve. This question is usually prefaced with something such as, “I am going to ask you a rather strange question” (de Shazer et al., 2007, p. 6). The therapist then proceeds to describe a miracle taking place while the clients are sleeping; however, because they are asleep, they are unaware that a miracle has occurred. The clients are then asked what would be the first thing he or she would notice that would indicate to them that the problem was gone (de Shazer et al., 2007). This question can elicit emotional, cognitive, and behavioral responses and set the stage for therapy goals. This question is very systemic in nature because the therapist asks what other people would notice and what would be different in clients’ relationships if the miracle had occurred (de Shazer et al., 2007).

The miracle question can be used in the context of EFT as an experiential tool and as a guide to what the couple would like to see different as a result of therapy. It is experiential because it often elicits emotional- and attachment-related goals that may be difficult for clients to express. For example, if a wife were to respond that one of the things that she would notice in her miracle would be that her husband would kiss her in the morning and tell her how much he loves her, I could take the opportunity to expand upon the wife’s need for closeness and attachment in the relationship. I may also refer to this miracle in future sessions, especially when working in stage two (changing interactional positions; see p. 11), when helping the couple to identify and own

attachment needs (Johnson, 2008a).

Scaling is another intervention borrowed from SFBT that is helpful in this integration of therapy. Scaling is useful in setting goals as well as encouraging clients to think in a more positive, future-oriented manner. Scaling questions are also used to measure the clients' perceptions of where they are in their progress toward their goals as well as to motivate and encourage them (de Shazer, 1994). These questions ask the clients to put their impressions, observations, and predictions on a scale from 0 to 10 (De Jong & Berg, 2008). The purpose for scaling questions can be best described by de Shazer (1994) in the following paragraph:

Scales allow both therapist and client to use the way language works naturally by developing an agreed upon term ([e.g.], "6") and a concept (a scale where "10" stands for the solution and "0" for the starting point, "6" is clearly better than "5") that is obviously multiple and flexible. Since you cannot be absolutely certain what another person meant by his or her use of a word or concept, scaling questions allow both therapist and client to jointly construct a bridge, a way of talking about things that are hard to describe—including progress toward the client's solution. (p. 92)

In the context of EFT, I use scaling to check on the couple's perception of their progress and to move the clients forward in generating more positive behaviors toward one another.

EFT therapists do not emphasize homework unless it is in reference to identifying and working toward stopping the couple's negative interactional pattern (Johnson, 2004). I believe that adding some client-centered, short-term goals such as those identified in scaling what the next step would look like from SFBT helps in cycle de-escalation as the couple begins to do more positive things in their relationship while working on identifying and breaking their negative

interactional pattern.

Finally, the practice of searching for *exceptions* as borrowed from SFBT is utilized in this integration. In SFBT, exceptions questions are used throughout the therapy process to discover times when the problem is less pervasive or not happening (De Jong & Berg, 2008). Clients are also asked about exceptions in conjunction with the miracle question to discover what pieces of the miracle are already happening for the clients (de Shazer et al., 2007). “By assuming that clients have some agency in exceptions that are noted, therapy highlights the control clients may have and invests [sic] in this part of the change process” (Thomas & Nelson, 2007, p. 21).

In my integration, exceptions are very important, especially when used in the context of negative interactional patterns. I use exception questioning to discover when the clients are able to identify and slow down or stop their cycles and do something different. These experiences are heightened and attachment meanings are explored when couples are able to successfully express attachment needs rather than spiraling into their typical cycles. Exception questions are used throughout the therapy process as indicators of change and are especially helpful when assessing for cycle de-escalation, signaling the opportunity to move into stage-two work.

Integration Basic Assumptions and Concepts: EFT and GMCT

Both Johnson (2004) and Gottman and Gottman (2008) have recognized the influence of each other’s work on their respective models. Gottman and Gottman (2008)

even stated that “there is no doubt in our minds that Johnson’s EFT is a powerful basis for a couple therapy that recognizes the key role that emotion plays in the development and maintenance of intimacy” (p. 150). Johnson has also acknowledged Gottman’s research and its influence on EFT in several sources (Johnson, 2004, 2008a; Johnson & Greenberg, 1994). Johnson and Greenberg (1994) stated that Gottman’s research findings on the *four horsemen of the apocalypse* (defined later) “underlines the power of emotional experience and communication in the regulation of social interaction” (p. 4). The common assumption that negative affect plays a significant role in relationship distress and that it is critical for therapists to help couples find new ways to regulate that affect is a key element to this integration of models (Gottman, 1999; Johnson, 2004; Johnson & Greenberg, 1994).

Another common assumption of the models is that marital distress occurs through commonly repeated patterns or themes that occur sequentially throughout the relationship (Gottman, 1999). Gottman (1999) called these patterns the “music of the marriage” (p. 20) and stated that they are what must be studied and acted upon in order to help couples change. Although Johnson (2004) referred to the music as the emotions that are organizing the interaction, the common theme is that a change must happen in the process of the couple’s interaction, rather than the content about which the couple is fighting.

Once again, GMCT is not an approach that is specifically centered on attachment theory; however, the focus on creating positive affect in a relationship allows space for safe engagement, and thus provides an environment where secure attachment can develop. Gottman’s (1999) focus on eradicating behaviors that

overwhelm partners with negative affect and increase defensive strategies fits well with helping partners increase responsiveness and accessibility because the relationship is no longer threatened by those behaviors.

Interventions Borrowed from GMCT

In this integration, I borrow a few key interventions from GMCT in order to assist in cycle de-escalation. These interventions are used primarily as psychoeducation when cycle de-escalation is difficult with certain clients and is explicitly defined in the frame of the couple's negative interactional pattern. The main intervention borrowed from GMCT is the clarifying, defining, and eradicating of the *four horsemen of the apocalypse*. According to Gottman's (1999) research, when these four behaviors are highly present in a relationship, divorce can be predicted with 85% accuracy. The four horsemen include *criticism, defensiveness, contempt, and stonewalling* (Gottman, 1999).

Criticism is "any statement that implies that there is something globally wrong with one's partner, something that is probably a lasting aspect of the partner's character" (Gottman, 1999, p. 41). Criticism usually happens first in a negative interaction and often begins with statements such as, "you always" or "you never." Criticism often leads to the second horseman of defensiveness, which includes "any attempt to defend oneself from a perceived attack" (Gottman, 1999, p. 44). One of the most harmful elements of defensiveness is that it leads to not taking responsibility for the problem, implying that the other person is the guilty party (Gottman, 1999). Contempt is considered the most corrosive of the

horseman and is defined as “any statement or non-verbal behavior that puts oneself on a higher plane than one’s partner” (p. 45). This can include things such as mockery, sarcasm, belligerence, and eye rolling. Gottman called contempt “psychological abuse” and stated that it must end immediately in therapy (Gottman, 1999). Stonewalling is the final horseman and “occurs when the listener withdraws from the interaction” (p. 46). This can be exhibited by shutting down and appearing to ignore the speaker or can be demonstrated by the physical act of leaving the room.

In my integration, I define the four horsemen for couples and frame them in the context of negative interactional patterns and attachment needs. For example, in a typical pursue-withdraw pattern, I might point out that when the wife is seeking closeness and is longing to connect with her husband, she may criticize him for always ignoring her and not listening when she asks him for help in the kitchen. When the husband hears the perceived criticism, he may defend himself by saying it is not his fault that the kitchen is messy, followed by an attack or criticism of her lack of cleanliness.

Contempt could be exhibited by either member of the couple in the form of name calling or mockery, which is framed as a desperate attempt to protect oneself. Finally, the husband disengages, stonewalls, and leaves the room. This is framed as an attempt to both protect himself and to protect the relationship. In this situation, I heighten the primary emotions involved and the attachment needs that have been activated, but also remind the couple of how damaging these horsemen can be and encourage them to be cautious of them in their interactions.

The last two interventions borrowed from Gottman (1999) are *softened startup* and *repair attempts*. A softened startup involves approaching an issue in a softer way rather than a harsh attack (Gottman, 1999). This can be done in a number of ways, but is usually manifest as a concise, polite, and clear description of a complaint rather than a criticism. Gottman (1999) recommended that a softened startup be approached from a position of emotional vulnerability rather than an angry attack. Repair attempts are essentially one spouse's attempt at being the couple's own therapist. This partner may comment on the process of the communication, make a joke, or even support or soothe the other partner (Gottman, 1999). The purpose of the repair attempt is to de-escalate negativity and is helpful only if the other partner is willing to recognize the repair attempt and accept it as such.

The two interventions described above are also used through the lens of EFT as means of de-escalating negative interactional cycles. When a couple is having a particularly difficult time de-escalating their conflict, I teach them the concepts of softened startups and repair attempts as a means of explicitly describing what we are experientially doing in session, giving them a concrete way to define things they are doing to stop their negative interactional pattern at home. I do not focus on skill building as GMCT defines it per se, but am more concerned with the experiential component of therapy. Therefore, these interventions are experientially based and I point out to the couple how they already are using them in our therapy sessions to help them de-escalate at home. An example of a softened startup from an EFT perspective would be sharing a

hurt that was experienced in light of a certain behavior rather than blaming and criticizing a partner. An example of a repair attempt could be one partner's stating, "We are getting into our cycle/pattern again, and I don't want that. Can we start over?"

My Integration of EFT, SFBT, and GMCT

In my integrated model, I view everything through an EFT lens. Therapy is conducted in three distinct stages with the interventions of all models interwoven throughout the therapy process. Although explained in a step-by-step fashion, this model is not necessarily conducted in a linear way, and I cycle through the different parts of the stages in order to crystallize the couple's experience and properly heighten emotional experiences in the attachment framework.

The first stage is cycle de-escalation (Johnson, 2008a). Assessment is not separated from treatment in my model of therapy because I constantly assess my clients' needs throughout the therapy process (Johnson, 2004). However, in the first two sessions, I assess for clients' mental status through clinical interview and observation of appearance, ability to track conversation and process information, and the type of content clients bring up. If there are any indications toward danger to self or others during the interview and/or in assessment paperwork, I use SFBT questions to develop safety plans.

Beyond assessing for mental status and risk, my next objective in the first session is to build an alliance, connecting with both partners, and to create an environment of safety for emotional engagement (Johnson et al., 2005). I strive to show empathic

attunement to the clients' experiences, be genuinely curious, and accepting of the clients' realities (Johnson et al., 2005). This is done primarily through reflection and validation. The first few sessions are fairly similar across cases, with a few differences on a case-by-case basis. At the beginning of the first session, I always ask what brings the couple into therapy. The answer to this question helps me to see how each member of the couple perceives the problem and opens up an opportunity to enter into their experience. After the couple gives a basic idea of the problems in their relationship, I ask the couple to describe what their fights would look like if I were a fly on the wall. The answer to this question helps me begin to identify the negative interactional pattern that the couple is caught in, which includes identifying action tendencies, perceptions, secondary emotions, primary emotions, and unmet attachment needs that play into the pattern. This is a continuous process throughout the first stage of therapy, but I begin to get a sense of the cycle at this point and start to point it out to the couple.

In addition to these important joining and cycle-identification techniques, I usually introduce the couple to a book by Susan Johnson (2008b) called *Hold Me Tight: Seven Conversations for a Lifetime of Love*. This book was written by Johnson as a tool for both therapists and the lay public to explain how attachment works in relationships. I use it in conjunction with therapy because it contains multiple examples of couples that Johnson has worked with in identifying negative interactional patterns and re-creating comfort and connection in the relationship. I use this book to help give couples a voice for their feelings in the cycle and also give them hope that other couples struggle with and overcome some of the same types of things that they are struggling with.

When time allows, and when I feel it is appropriate, I utilize the miracle question and scaling (de Shazer, 1994) at this point in therapy to help the clients identify some goals and get a sense of where they currently feel they are in the relationship. This sometimes carries over into the second session.

At the beginning of every subsequent session, I ask what has been better in the relationship over the previous week. This is an opportunity to look for exceptions in the couple's cycle and gives me a gauge for how well de-escalation is happening. I usually split the second session for the first twenty to thirty minutes and meet with each client individually in order to assess for domestic violence and addictions, each of which might be contraindications for couple therapy. I also utilize this time to build and strengthen the therapeutic alliance with both members of the couple. I let the clients know that I am not a secret keeper; however, if difficult things are revealed in this session such as attachment injuries or a relationship trauma that "takes the form of abandonments and betrayals at crucial moments of need" (Johnson, 2004, p. 267), I will help the clients to share them in conjoint sessions when emotional engagement is safer.

When the couple joins each other for the second part of the session, I generally do an oral relationship history to get an idea of how much affection the couple is able to recall from the earlier days, identify times when the couple has been able to be vulnerable and connect with each other, and identify when and how the negative interactional pattern began and became a problem. The relationship history typically includes questions about how they met, what attracted them to each other, times they were able to rely on each other, and when they began to have problems. Throughout this session, I continue to

work on delineating the negative interactional pattern that the couple is in and begin connecting the pattern to primary emotions and unmet attachment needs.

In the third, fourth, and fifth sessions, I focus on crystallizing the clients' emotional experiences and attachment needs while reframing them in the context of their negative interactional pattern. By the end of the third session, clients should be beginning to understand their negative interactional pattern and to tap into previously unidentified attachment needs. This happens as they begin to articulate some of their needs for closeness and connection through my reframes and empathic conjecture, as well as through enactments. By the fifth session, the couple should be beginning to see less conflict as they are able to identify their cycle in real-life situations. If the couple is still highly escalated at this point, I may begin to educate them on the four horsemen of the apocalypse and may introduce softened startup and repair attempts to help the couple de-escalate more quickly. Throughout the therapy process, I periodically ask the clients to scale their current relationship satisfaction in relation to their therapy goals to help me get an idea of their improvement.

De-escalation can take anywhere from four to seven sessions depending on how quickly the clients are able to reach de-escalation and get an experiential sense of their cycle (Woolley, 2009). I recognize this when the clients are fighting less and are able to identify their cycle as the enemy that is harming their relationship. They also are able to more emotionally engage with one another in session. This stage is considered first-order change because "the positions the partners take are somewhat more fluid, but the way the interactions are organized has not basically changed" (Johnson, 2004, p. 144). This first-

order change sets the stage for further emotional engagement that can lead to second-order change (Johnson, 2004).

The second stage of therapy involves changing interactional positions as I work to help the couple to identify and own attachment needs (Johnson, 2008a). I assess for the ability to move to this stage during every session by asking SFBT exceptions questions to help identify when the couple is de-escalated enough that they can recognize the cycle as the enemy and have been able to unify and break it in many situations in their personal lives. This stage also includes guiding the couple to accept each other's experiences as legitimate and real through evocative responding and enactments. As the clients begin to understand their own needs and accept the other partner's experience, I coach them to express their needs to one another through enactments to facilitate new bonding experiences as the couple's interactional pattern begins to be restructured (Johnson, 2008a). This stage happens in two events called *withdrawer re-engagement* and *blamer softening*.

Withdrawer re-engagement involves the withdrawn partner's engaging more fully in his or her emotional experience as I use heightening, empathic conjecture, evocative responding, and enactments to coach him or her (Johnson et al., 2005). This is the most intrapsychic portion of EFT, and I spend a lot of time developing the withdrawn partner's experience. Withdrawer re-engagement is complete when the formerly withdrawn partner is able to own his or her emotional experience and attachment needs and finally take a stand with the pursuer by asserting his or her needs in a guided enactment. An example of this would be a withdrawn partner's saying to a pursuer,

I am exhausted from all this defending and numbing out. I want to feel special to you. I want you to hold off on all the criticism and quit threatening to leave me. I am not going to leave and I don't want to feel small in this relationship anymore. (Johnson et al., 2005, p. 193)

Withdrawer re-engagement must take place before blamer softening because if the more blaming partner takes a risk and asks for his or her needs to be met and a withdrawer is not re-engaged and responsive, the level of anxiety in the blaming partner escalates, which sends the cycle into overdrive and makes it even more difficult for the blaming partner to trust the withdrawing partner with his or her attachment needs.

After the withdrawer is emotionally engaged and has taken a stand, I move into blamer softening, which includes helping the blamer access his or her unacknowledged attachment needs. I use the same interventions with the more blaming, pursuing partner, except that the objective is to help the blaming partner soften and express his or her attachment needs from a new position of vulnerability (Johnson et al., 2005). The culmination of these two events amounts to a new bonding experience in which partners are able to be more emotionally accessible to one another and interact in a new way. Johnson defines this as second-order change (Johnson et al., 2005).

The final stage of therapy is consolidation and integration (Johnson, 2008a). In this stage, I help the couple “consolidate new positions and cycles of attachment behavior” (Johnson, 2008a, p. 116). This is accomplished by looking with the couple at what they have achieved in therapy and in their relationship and helping them create their own narrative about the journey that has lead them to this point. I also help the couple to create new solutions to old problems using their new patterns of interaction that are no longer “infused with overwhelming negative affect” (Johnson, 2008a). This stage of

therapy utilizes more SFBT work (scaling and exception-finding questions) than other stages and begins to address some old content issues that may not have yet been resolved. This can happen more easily at this time because the clients' problems are no longer threatening to the attachment relationship, but are simply problems (Johnson, 2004). Termination is decided collaboratively when the clients feel comfortable solving problems together in their much safer, more secure, and connected relationship.

Systems Concepts

Coming from a family systems theoretical paradigm, it is important for me to recognize how my integrative model fits within that framework. All of the models in my integration honor the systemic concept of wholeness. Wholeness suggests that all behavior needs to be considered in its context, meaning that "the whole is greater than the sum of the parts" (Johnson, 2008a, p. 109). This is evident in both EFT and GMCT's focus on patterns and sequences rather than on content (Gottman, 1999; Johnson, 2004). The idea for both models is that "one partner's behavior can only be understood in the context of the other partner's behavior" (Johnson, 2004, p. 47). de Shazer (1994) described the importance of context as well, stating that "a change in behavior or attitude does not happen in isolation" (p. 246). The importance of context in SFBT is seen in practices such as the miracle question and exception finding, because the therapist explores how others notice changes or how changes in therapy might affect others in the client's life.

Recursion is an equally important concept in all of the models used in my integration, which essentially means that people mutually influence one another, and,

therefore, it is important to attend to the different roles people play in one another's lives (Becvar & Becvar, 2006). The idea is that behavior A is a complement and context of behavior B, just as much as behavior B is a complement and context of behavior A, which ultimately means that it is impossible and unhelpful to decide which behavior led to another because they each need the other to operate (Becvar & Becvar, 2006). This is seen in EFT in the presence and identification of the negative interactional pattern that the couple is involved in, particularly with a pursue-withdraw pattern. Both behaviors are seen as logical in context. Gottman method couple therapy (1999) also looks at these patterns in the identification of the four horsemen of the apocalypse. Although Gottman (1999) suggested that criticism is the natural beginning of the four horsemen, he also acknowledged that once the horsemen are present, they mutually influence each other and result in the interactions spiraling into negative affect (Gottman, 1999).

Recursion in SFBT is viewed as happening in the clients' lives with spouses, family members, and friends, and is also seen in the therapist's relationship with the clients. The therapist essentially becomes a part of the system as therapist and clients co-create a new reality and mutually influence each other (Becvar & Becvar, 2006).

Finally, *communication and information processing* is a critical systemic component to all of my models in that all behavior is communicative in nature and that meaning is derived from each participant's own perceptions and experiences (Becvar & Becvar, 2006). This is evident in EFT's focus on identifying each partner's perceptions of the other's behaviors and how that activates core attachment needs and fears (Johnson, 2004). This is also seen in GMCT's focus on how the four horsemen can escalate partners into overwhelming negative affect (Gottman, 1999). Solution-focused brief

therapy also utilizes the value of this concept in the importance of language and how each person's experiences dictate the meaning assigned to any given message (de Shazer, 1994).

Purpose of Research and Research Questions

The purpose of this study was to examine how I implemented and practiced my integrated model of therapy with three couples. This study was not meant to generalize to other therapists or specific presenting problems, but was intended to be a launching point for myself as a new therapist to discover the strengths and weaknesses of my own integrated approach and further assist me in becoming skillful in a therapeutic setting.

The following research questions guided this study:

1. How well did I follow my integrated model of therapy as outlined in Chapter II?
2. When following this integrated model of therapy, did clients report meaningful changes?
3. What changed in my model throughout the course of this study?

CHAPTER III

METHOD

The current study was designed to explore one therapist's integration of emotionally focused couple therapy (Johnson, 2003, 2004, 2008a; Johnson et al., 2005; Johnson & Greenberg, 1994; Woolley, 2009), solution-focused brief therapy (De Jong & Berg, 2008; de Shazer, 1994; de Shazer et al., 2007; Thomas & Nelson, 2007), and Gottman method couple therapy (Gottman, 1999; Gottman & Gottman, 2008). The study investigated the therapist's fidelity to the integrated model, whether or not couples experienced meaningful change when the model was implemented, and what changed in this integration throughout the course of this study.

Design

This study used a mixed-methods approach utilizing qualitative and quantitative data in a multiple case study design. Case-study research has been defined as “a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information . . . and reports a case description and case based themes” (Creswell, 2007, p. 73). Those multiple sources of information can include such measures as interviews, observations, reports, documents, and audiovisual material (Creswell, 2007). Yin (2003) agreed that in order to accommodate the richness of case study research, “multiple sources of evidence” should be used (p. 4). Multiple case studies include two or more cases to be studied within the same study (Yin, 2003).

Yin (2009) stated that one of the distinct advantages of a multiple case study approach is that the evidence collected is more compelling and, therefore, the study is generally considered more robust and generalizable.

Triangulation, or “the process of using multiple perceptions to clarify meaning,” is an important concept utilized in this study (Stake, 2008, p. 133). Stake (2008) stated that triangulation is used to verify “the repeatability of an observation or interpretation” (p. 133). Utilizing this concept in practice, data were collected using an EFT/SFBT/GMCT intervention checklist, the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995), the Outcome Rating Scale (ORS; Miller & Duncan, 2000), reflection notes, case notes, SFBT scaling, and teammate and supervision consultation notes.

Sample

This study was designed to increase understanding of the therapy process when integrating EFT, SFBT, and GMCT for one therapist. Because the literature and research of both EFT and GMCT focuses primarily on couple relationships, the sample used in this study consisted of three couples who presented voluntarily to the Utah State University marriage and family therapy clinic for marital problems. Upon contacting the clinic, the participants were informed that they would be assigned to a supervised master’s level student therapist. Per clinic policy, in order to participate in this research, the clients were required to sign an informed consent for research form (see Appendix A) as well as an informed consent for treatment form (Appendix A). The therapist was the

researcher in all three cases. In order to honor confidentiality, names have been changed when discussing the cases throughout this study.

Couple 1

Allison (27) and Brandon (29) were a Caucasian couple who had been married for 6 years and had been a couple for nearly 10 years when they presented for therapy. They had no children. Brandon indicated that he was a partner with his father in running a small business. Allison indicated that she was currently working on her master's degree in education and was a teacher. Both partners indicated no religious affiliation.

The couple came to therapy reporting issues with communication and emotional closeness. Allison indicated that she wanted to be emotionally more close to Brandon, but Brandon indicated that most of the time he did not know how to be closer to Allison because he was not an emotional person. The couple also wanted some help adjusting to spending more time with each other because Brandon had been involved in a serious accident that nearly ended his life six months prior to coming to therapy. They both indicated that since then they had a lot of time together, but Allison continued to feel distant from her husband. Brandon indicated that he was fairly content with their relationship as it was, but recognized that his wife was not satisfied and, therefore, was willing to come to therapy in order to support his wife and help her feel closer to him. Both partners attended five sessions. This couple did not return to therapy after the conclusion of data collection for this study.

Couple 2

Jose, a 28-year-old Hispanic male, and Megan, a 28-year-old Caucasian female, had been married for four years when they presented for therapy. They had one child, a 1-year-old male who was present for therapy for only one session when they could not find a babysitter. Jose indicated that he worked for an electronics manufacturing company doing inventory full-time while attending college. Megan reported that she was a full-time homemaker caring for her son and her 3-year-old-nephew. At the time of therapy, the family was living with Megan's mother, her mother's partner, and her sister, which was a fairly new living situation since the family moved to Utah from a Midwestern state 4 months prior to the onset of therapy. The couple indicated that they had no religious affiliation.

The couple presented with issues of high conflict and problems with communication. Jose indicated that he believed that their biggest problems had been happening only since they moved to Utah, but Megan indicated that she struggled with his criticism and had not felt close with him for nearly the entire duration of the marriage. At the time of presentation to therapy, Megan indicated that she did not feel like she was in love with Jose anymore and was considering divorce. Both indicated that therapy was a last ditch effort to see whether or not the marriage could be saved. The couple attended 11 sessions together with each partner also attending one individual session each, making a total of 13 sessions with this couple over the course of this study. The couple attended one additional session after this study was complete and then were transferred to another therapist.

Couple 3

Jaxon (25) and Kayla (24) were a Caucasian couple who had been married for two and one-half years when they presented to therapy. They had no children. Jaxon indicated that he worked full-time for a large retail distribution center driving trucks. Kayla indicated that she worked part-time as a customer service representative for a marketing company and was also attending school part-time. Both partners indicated that they were Protestant and agreed that religion was a major part of their lives.

The couple presented with issues of high conflict and infidelity on Kayla's part. Kayla had been involved with a man in another state whom the couple had met on the internet while playing a game as a couple. At the time of presentation to therapy, Kayla admitted to texting the man, talking to him on the phone frequently, and even flying across the country to see him several months prior to therapy. Jaxon indicated that he was hurt by this and both partners wanted to improve their relationship so that Kayla would be willing to stop seeking emotional security and closeness from other men. The couple attended seven sessions over the course of this study and then did not return to therapy.

Instruments**Intervention Checklist**

An intervention checklist (see Appendix B) consisting of specific concepts and interventions from my integrated model was created for this project. The data collected using this instrument were used to answer research questions one and three. The instrument was specifically designed to identify the level of fidelity to my integrated

model and also provided a way to identify things I may have done that fell outside of my model. The checklist was created using the interventions that I deemed most important in my integration. The checklist was used by myself and another coder as we observed the video recorded sessions for each case. The checklist consists of three separate lists of interventions, one from each model. Each list includes three columns: the first column identifies the intervention, the second is an empty box that was used for tally marks identifying how frequently each intervention was used, and the last column was used to indicate a numerical total based on the tally marks. Each list also contains several empty rows at the end to provide room for interventions used from the model that may not have been in the list that both the other coder and I observed my using in the session. Finally, a fourth, empty list was created for interventions or concepts used in session judged to be from models outside of my integrated model.

The second coder in this study was a master's level student in the Utah State University marriage and family therapy program who is familiar with each of the models used in this study. This second coder utilizes aspects of each of the models that I use in her own integrated model of therapy, but conceptualizes and practices her integrated model differently. A coding manual was developed (Appendix B); the second coder and I discussed discrepancies and I made changes to the coding manual as necessary to be sure that I was accurately coding the interventions that I believed I was observing.

Sessions were selected across cases using odd numbers to select which videos would be coded. Session one was viewed from Couple 1, sessions three and five were viewed from couple 2, and session seven was viewed from couple 3. The other coder and I each watched the first session and then met to discuss our coding. Because of the

intricacies of the interventions and the second coder's lack of additional training in the model, it was not expected that we would have exactly the same numbers, but that we would be within a few of each other to determine accuracy. Overall, we were within one or two instances for each of the interventions, which was deemed acceptable, except for reflections and validations, which showed a discrepancy of five instances. After discussion, we decided that I coded some reflections that seemed to carry a validating tone as validations when she did not. I decided that this was my mistake, and we continued to code sessions three and five.

After coding session three from couple 2, I immediately realized another problem with my coding validations. I had coded 12 more validations than my second coder had. This was the impetus for a discussion on validation, which led me to change my definition in the coding manual to fit the types of validations that I wanted to code. Those changes are included in the coding manual.

Another challenge arose after coding the third session for couple 2 in terms of definitions of interventions. This session was a very intense session in which Megan shared a great deal of hurts with her partner Jose over the four years of their marriage that she had never shared before. Because of the newness of this disclosure especially early in therapy, I used an abundance of interventions to work through this new emotional experience. My second coder indicated that it was difficult for her to keep up with all of the interventions and it left her concerned about where one intervention ended and another began. After discussion, we came to the conclusion that an intervention was counted as one instance unless it was broken up by other interventions or discussion with the clients, in which case, it would be counted as separate instances.

After viewing these two sessions and making the changes to my coding manual, we each coded the remaining two sessions. Upon consultation, we found that we were much closer in our codings, which allowed me to feel more comfortable proceeding to code the rest of the sessions.

Revised Dyadic Adjustment Scale

The Revised Dyadic Adjustment Scale (Busby et al., 1995) was utilized in this study to answer research question number two with regard to client change. The couples were asked to complete the 14-item questionnaire at the beginning of each session. Data from this assessment device were used to assess each partner's perceptions of the relationship and assess for levels of satisfaction. The RDAS includes three subscales measuring dyadic consensus, satisfaction, and cohesion, with the scores from each subscale being added together to determine a total relationship satisfaction score. The clinical cutoff for relationship satisfaction on this measure is a total of 41, with lower scores indicating lower satisfaction. Within this study, the total score was used.

The RDAS has demonstrated high construct validity with its predecessor, the Dyadic Adjustment Scale (DAS; Spanier, 1976) with an r value of .97 ($p < .01$), as well as the Locke-Wallace Marital Adjustment Test (MAT; Locke & Wallace, 1959) with an r value of .68 ($p < .01$; Busby et al., 1995). This is important because the DAS and the MAT shared a correlation of .66, demonstrating that “the RDAS is an excellent representation of the domains of the DAS with less than half the items and that it is as highly correlated with the MAT as the 32-item DAS” (Busby et al., 1995, p. 302). The RDAS has also demonstrated approximately the same amount of criterion validity as the

DAS, correctly classifying cases as distressed in 81% of cases in one study (Busby et al., 1995). Further, the RDAS has shown internal consistency and split half reliability ($r = .90$ and $.94$, respectively; Busby et al., 1995). The scores of the RDAS were not used for statistical comparisons because of the small sample in this study; rather, they were used to compare total numbers across time in context with additional data from other sources to answer research question two and are presented graphically.

Outcome Rating Scale

The Outcome Rating Scale (Campbell & Hemsley, 2009; Miller & Duncan, 2000) was also used in this study as a triangulation tool to assess self-reported client change throughout the therapy process. The ORS is a brief outcome measure consisting of four questions that scale an individual's self-reported wellbeing in four areas of functioning, including individual, interpersonal, social, and overall. The original measure provides a line for hash marks along a horizontal line to indicate where an individual believes that he or she fits; for ease of presentation, the measure was altered to use a Likert scale from 1 (lower functioning) to 5 (higher functioning), allowing the individual to circle where they fit on the scale. When a client indicated a spot on the scale that was between numbers, I approximated the score using decimal points. The couples were given this measure at the beginning of each session, beginning at the second session. The ORS was used in this study to graphically depict change between sessions and over the course of therapy. Only the individual and interpersonal subscales were analyzed and tracked to depict change over time.

The ORS was created to be an abbreviated alternative to the Outcome Questionnaire-45.2 (OQ-45.2; Burlingame & Lambert, 1996), which also focuses on individual, interpersonal, and social wellbeing (Campbell & Hemsley, 2009). Campbell and Hemsley (2009) studied the ORS in comparison to the OQ 45.2 using both clinical and non-clinical samples. The instrument demonstrated high internal consistency in the non-clinical sample ($\alpha = .93$), which compared favorably to the OQ 45.2. The Campbell and Hemsley (2009) study also demonstrated a moderately strong correlation ($r = .59$) between the two devices. A Pearson product-moment correlation demonstrated that the ORS had high correlation with the OQ.45 Symptoms of Distress subscale, particularly the ORS individual and overall scales ($r = -.74$ and $-.75$, respectively; Campbell & Hemsley, 2009). Although the interpersonal scale did not show a significant correlation with the OQ-45.2, this subscale was used in this study to triangulate data from the other measures in order to get a better picture of the client's wellbeing in those specific areas.

Therapist

Because I was the therapist in this mixed-methods research project, I was the primary instrument in gathering data through administration of my integrated model of therapy with three couples, development of the coding manual and checklist, and the interpretation and presentation of data. Because of the nature of this study, I was involved in every aspect of the data collection and analysis process. Naturally, my biases, life experiences, gender, values, training, and cultural background inform how I approached the study, collected and analyzed the data, and interpreted and presented the results of analyses. I am a master's level student with one and one-half years of clinical

experience at the time of this study. I participated in a 4-day externship for the EFT model of therapy during that time and also have been involved in an EFT support group, which continues to influence my practice and likely influenced my data collection, analysis, and interpretation. I am a single Caucasian female in my mid 20s. I have lived in the state of Utah for most of my life and am a member of The Church of Jesus Christ of Latter-day Saints.

As a couple therapist I have several biases that likely affect the way I conducted therapy and collected, analyzed, and interpreted the data. I view marriage and family as the central unit of society and believe that one of the best ways to strengthen our society is by strengthening marriages and families. I also recognize that not all marriages can be saved and in some cases such as abuse and infidelity, ending the marriage may be the best option for a couple. In those cases, I try to suspend my judgment to help couples make their way through the difficult decision-making process that may end in divorce.

Case Notes

Writing case notes is one of the standard procedures and policies for the marriage and family therapy clinic, and also served as a helpful instrument in this study. Case notes were used to record the content of the session; where the couple was in terms of their negative interactional patterns, and expression of primary emotions and attachment needs; observations for within session change, and the progress or lack of progress that the couple reported making during the week prior to the session. I also used case notes to track my interventions and how the clients responded to the interventions. An assessment section in the notes allowed me to describe some of the nonverbal behaviors and

processes of the session. The case notes also included a section for describing homework assigned to clients as well as what I intended to do in the next session. These case notes are a part of the client's official clinical record. Case notes were completed within 24 hours of completion of each session used for this study.

Reflection Journal

The reflection journal was a very important instrument in this study. The reflection journal was filled out after each session, after coding each video recording, and after discussions with the second coder. The reflection journal was used to answer all research questions and included a more detailed account of my reflections on sessions, observations about how couples reacted to my interventions, when important change events occurred, and things I felt I did well or could have done differently in the sessions. It also included ideas and plans for subsequent sessions and more details about where I felt the couple was in the process of therapy in terms of stages and steps, which kept me focused. This journal also included supervisor feedback and notes from my second coder.

Solution-Focused Brief Therapy Scaling

With each couple, SFBT scaling was used in order to track client-reported changes and to triangulate data between the RDAS, ORS, client reports, and my own observations to measure change in therapy. All clients were asked the following question in regards to their relationship at the beginning of therapy with minor variations from couple to couple: "On a scale of 0 to 10, with 0 being the worst it has ever been, and 10 being where you want to be when therapy is over, where would you say you fit right

now?” At some point with each couple, I asked the couple to define what a 10 would look like, which would tell them that they were doing better in their relationship and that they did not need to come to therapy any longer. This scale was referred to with each couple to varying degrees and was used to measure relationship satisfaction in connection with the other measurement devices.

Final Outcome Questionnaire

At the conclusion of therapy, clients were asked to fill out a brief, two question questionnaire that asked clients about meaningful changes they noticed over the course of treatment (see Appendix B). I designed this measure, which each partner was asked to complete. The first question asked the clients to describe in detail what kind of meaningful changes they noticed in their relationship through the end of therapy. The second asked the clients to scale their progress on a scale of 1 – 10 where 1 was where they were when therapy began, and 10 was their goals for therapy as discussed in sessions, and then describe what put them at that number. This device was given to couple 2 at the beginning of their next session after this study had concluded, and was mailed out to the other two couples. Included with the mailed questionnaire was a letter explaining the purpose of the questionnaire (see Appendix B) and a self-addressed, stamped envelope for the couple to mail the instrument to me. Couples 1 and 3 did not return the questionnaire.

Procedures

Three couples who voluntarily sought couple therapy services at the Utah State

University Family Life Center were the participants of this study. This was a study of convenience sampling. Each of the couples was assigned to me per clinic policy procedures of rotation among other therapists. Upon arrival for the first session, the clients filled out paperwork that included informed consent for treatment, client rights and responsibilities, and informed consent for research. Clients were not required to sign the informed consent for research form to receive therapy, and only couples who signed it were included in this study. All of the couples that were assigned to me for this project signed the form. A memo from the program director was received, approving the use of existing clinic data in this study (see Appendix A) and Utah State's Internal Review Board for the protection of human subjects approved this study (Appendix A).

Couples were asked to fill out the ORS and the RDAS questionnaires before each session. The couples each participated in 50-minute sessions that consisted of my integrated model of therapy. Clients were occasionally assigned homework at the end of a session, after which they would pay for their services and reschedule another appointment on a week-by-week basis. At the conclusion of each session, case notes were completed per MFT clinic policies, and the reflection journal was filled out. Each session was recorded and video recordings of each session were reviewed by myself and the second coder as previously described. The idea behind using the second coder was to discover how closely comparable our coding was for each session to determine how well the coding manual described the interventions used in session so that I could have confidence in my coding of therapy. After we decided that our coding was in alignment with the coding manual to provide the most accurate coding possible, I coded the remaining 21 sessions. The reflection journal was filled out during viewing of the video

recordings and after consulting with the second coder. Supervision consultation notes were also recorded in the journal.

Data Analysis

I analyzed the data in this study myself. There are a number of benefits and limitations to analyzing my own data. One of the benefits is that I am very familiar with my models and my integration and, therefore, am sensitive to the nuances of the model and was able to identify significant details to the process of therapy. Further, analyzing the data myself provided me with insight into what I was doing well according to my integration as well as what I need to work on to improve my work as a couple therapist. However, my familiarity and comfort with the integration and desire to succeed may have resulted in personal biases surrounding my execution of the model. Using the second coder helped me recognize some of this bias and helped me alter some of the descriptions of the interventions to more accurately describe what I was doing as well as help me better identify what I was and was not doing myself. The reflection journal and case notes also assisted in data analysis and triangulation.

Research Question 1: How Well Did I Follow My Integrated Model of Therapy as Outlined in Chapter II?

After establishing the accuracy of the instrument in connection with what I did in session, checklist codings were examined to discover how consistently I worked within my integrated model of therapy for this study. When I discovered through this examination that I did not remain consistent with my integration as outlined in Chapter II,

I re-evaluated my approach to discover where I deviated and what techniques I used from other models. This was accomplished as the other coder and I collaborated about additional techniques used and tallied on the intervention checklist. I then evaluated how these practices or interventions fit into my model or what needed to be adjusted or changed in my model to accommodate what was done, or how the checklist could be adjusted by improving descriptions of interventions or adding interventions. Tables were created to graphically depict which interventions were used with each couple. A cross-case analysis described both narratively and graphically the number of interventions used from each model with each couple.

Research Question 2: When Following This Integrated Model of Therapy, Did Clients Report Meaningful Changes?

Multiple sources of data were used in answering this research question. Data were analyzed in two ways: (a) did clients report changes within and between sessions, and (b) did change occur over the course of therapy? Client responses were tracked on the RDAS, the ORS, in case notes through client reports and my observations, and in the reflection journal. Reports of periodic scaling were also noted in case notes and the reflection journal. In evaluating client changes for within and between sessions, and over the course of treatment, reflections in my reflection journal were triangulated with data from the assessment devices, observations, and case notes to see what was happening in terms of specific interventions or key movements in stages of therapy at the time that changes seemed to have occurred. The phrase *meaningful changes* was operationalized as any kind of change that means something to the clients, whether positive or negative.

At the conclusion of the data collection, the clients were given one last questionnaire created by myself, asking about specific meaningful changes that they had noticed over the course of therapy. This allowed the clients to define specifically what changes they had noticed. I attempted to contact couple 1 several times after the conclusion of therapy and sent them the questionnaire, but they were unresponsive to my attempts to contact them. Couple 2 filled out the questionnaire at another session after the sessions for this project were over. After not hearing back from couple 3, I called to see if they had received the instrument in the mail. Jaxon indicated that they had not seen it, but would be willing to complete it. I checked to be sure I had the correct address and sent another copy, then called two weeks later to see if they had received it. I was unable to contact either partner, but left a message asking if they had received the device and could call me to let me know. Up to this point, I have not heard back and the questionnaire has not been returned.

In-session reports of change were discussed at the beginning of each session when I asked, “what has been better since we met last?” This question was the impetus for discussions about change either positive or negative from week to week. Also, when a homework assignment was given, specifically in reading the book, *Hold Me Tight* (Johnson, 2008b), I asked about how it was or was not helpful. Client answers were reported in case notes and in the reflection journal. I also recorded observable changes including differences in the patterns of interaction between the clients, changes in affect or demeanor, and differences in how the clients responded to me. All of these data were examined together to create a picture of change within sessions, between sessions, and

over the course of therapy. Additionally, a summary of all changes was provided for each couple. The data are represented in both narrative and graphical formats.

Research Question 3: What Changed in My Model Throughout the Course of This Study?

All instruments were utilized to answer this research question. The intervention checklist and collaboration with the second coder provided me with specific information about what interventions I used more or less throughout the process of each session as well as identifying things I used from other models that I was less aware of. The reflection journal and case notes provided me with a forum to discuss my own observations about what I did differently throughout the therapy process with each of the couples and notice what became more consistent across cases in terms of interventions and therapy style. Data from the RDAS and ORS, as well as the cross-case analysis, provided graphical evidence of how changes in my model are correlated with client-reported change. Changes in my approach, either in terms of interventions or overall, were observed through an examination of these data and are reported in the Results chapter of this document.

CHAPTER IV

RESULTS

The purpose of this study was to discover the level of fidelity to my integrated model of therapy, with my foundational model being emotionally focused couple therapy (Johnson 2003, 2004, 2008a; Johnson et al., 2005; Johnson & Greenberg, 1994; Woolley, 2009) with selective borrowing from solution-focused brief therapy (De Jong & Berg, 2008; de Shazer, 1994; de Shazer et al., 2007; Thomas & Nelson, 2007) and Gottman method couple therapy (Gottman, 1999; Gottman & Gottman 2008); whether my integrated model led clients to report meaningful changes; and what changed in my integrated model of therapy throughout this study. The results gathered from 25 sessions with three couples discussed in Chapter III are reported below. Information from each couple will be used to answer each research question sequentially. Themes and patterns discovered through this study are also reported from specific sessions, across sessions for each case, and overall across all cases.

Research Question 1: How Well Did I Follow My Integrated

Model of Therapy as Outlined in Chapter II?

This research question essentially contained three separate components: first, the number of EFT interventions in comparison to the other two models discussed in Chapter II; second, my use of interventions outside of my specified integration; and finally, in a broad sense with each couple, how I followed my integrated model. This question was primarily answered through the intervention checklist and video coding.

Couple 1

Table 1 shows the frequency of interventions across sessions for couple 1. From an examination of this table, one can see that I used EFT interventions 248 times over the course of the five sessions they attended in comparison to 36 total SFBT interventions and only 1 GMCT intervention. This table also shows that I used 1 additional intervention outside of my previously described integrated model. This means that of the 286 total interventions observed for this couple, 87% were EFT interventions, while SFBT interventions covered just under 13%, leaving GMCT and other models sharing less than 1% of the interventions used for this couple. The three most frequently used EFT intervention included reflection, validation, and evocative responding. In the SFBT model, exceptions were the most used intervention followed closely by scaling, which was consistent with my described integration.

A number of interventions that I used fit within the framework of my models, but were not explicitly mentioned in Chapter II. Two of the most interesting interventions discovered while coding videos and reviewing the intervention checklist include psychoeducation within EFT and summarizing. Psychoeducation was used within EFT to describe how the approach works and the direction that therapy would be going. Summarizing was a non-specific intervention that I used in which I connected things that had been said in earlier sessions with what was currently going on, or summarized the process of what the couple had done in that session.

Finally, I used psychoeducation outside of EFT in session three very briefly when I described the difference between working on process versus working on content in the therapy session. Although this is not explicitly within my integrated model, it is basic

Table 1

Interventions Across Sessions for Couple 1

Session	1	2	3	4	5	Total
EFT						
Reflection	21	21	16	21	26	105
Validation	6	4	11	7	9	37
Primary emotions	2	2	5	4	5	18
Evocative responding	4	3	5	5	7	24
Empathic conjecture	3	1	7	2	-	13
Identifying and tracking negative cycle	5	-	7	1	2	15
Enactment	-	-	-	3	-	3
Reframe	2	2	2	2	1	9
Heightening	-	-	1	3	1	5
Additional EFT interventions						
Psychoeducation	-	-	1	1	3	5
Relationship history	-	1	-	-	-	1
Book homework	-	-	1	-	1	2
Summarizing	-	2	2	3	3	10
Attachment history	-	-	-	-	1	1
Total EFT interventions	43	36	58	52	59	248
SFBT						
Scaling	1	3	2	1	2	9
Miracle question	-	-	-	-	-	-
Exception finding	1	2	1	6	4	14
Homework	1	1	3	-	1	6
Additional SFBT interventions						
Complimenting	-	-	2	4	1	7
Total SFBT interventions	3	6	8	11	8	36
GMCT						
Four horsemen	-	-	-	-	-	-
Softened startup	-	-	-	-	-	-
Repair attempts	-	-	-	-	-	-
Additional GMCT interventions						
Love Maps	-	-	-	1	-	1
Total GMCT interventions	-	-	-	1	-	1
Additional interventions outside of model						
Psychoeducation	-	-	1	-	-	1
Total interventions outside of model	-	-	1	-	-	1

Note. “-” indicates 0 instances of the intervention.

systems work, seemed appropriate to me, and fit within the process and framework of what I was trying to accomplish in my integrated model.

Couple 2

Table 2 shows the frequency of interventions across sessions for couple 2. I saw this couple for 13 sessions, and, therefore, used a large number of interventions over the span of therapy. As shown in the table, I used 903 EFT interventions in comparison to 78 SFBT interventions and 13 GMCT interventions. This table also shows that I used 8 interventions outside of my model. This means that of the 1,002 total interventions coded for this couple over the span of therapy, approximately 90% were EFT interventions, with SFBT being used 7.8% of the time, GMCT approximately 1% of the time and additional interventions outside of my model being used less than 1% of the time. The most common EFT interventions were reflections and validation followed by the identification of primary emotions. The most common SFBT interventions were exception finding and complimenting, and the most commonly used GMCT intervention was the identifying of the four horsemen of the apocalypse.

The checklist shows that I used psychoeducation and summarizing within EFT with this couple as well. An additional intervention that I used within EFT was questions about meaning. Operationalized, I would ask one partner what something meant to him or her that he or she had said or that the partner had said. I asked these meaning questions 17 times with this couple.

Psychoeducation outside of EFT was a part of the additional interventions that I used with this couple. I also used an intervention with this couple that I called a

Table 2

Interventions Across Sessions for Couple 2

Session	1	2	3	4	5	6	7	8	9	10	11	12	13	Total
EFT														
Reflection	24	26	27	21	20	16	24	16	17	17	14	13	20	255
Validation	11	10	21	15	8	13	14	18	3	6	9	9	14	151
Primary emotions	10	4	21	20	12	8	11	23	3	14	1	2	7	136
Evoc. responding	6	3	11	10	7	8	11	9	7	13	1	4	11	101
Empathic conjecture	4	-	12	7	4	6	4	5	2	5	-	-	2	51
Identifying and tracking neg. cycle	5	2	12	7	4	6	3	5	3	-	-	1	-	48
Enactment	-	-	-	3	1	-	1	3	2	-	-	-	2	12
Reframe	4	1	11	10	8	5	8	5	2	3	2	2	2	63
Heightening	3	-	4	4	-	1	3	4	-	4	-	-	-	23
Additional interventions														
Psychoeducation	2	3	-	-	-	3	3	5	2	-	1	-	1	20
Relationship history	-	1	-	-	-	-	-	-	-	-	-	-	-	1
Book homework	-	-	1	1	1	2	3	-	3	2	-	-	-	13
Summarizing	-	-	-	3	-	1	2	-	-	2	-	1	-	9
Cycle homework	-	-	-	-	-	1	-	-	-	-	-	-	-	1
Meaning questions	-	-	-	-	-	-	5	-	3	2	1	1	5	17
Total EFT interventions	69	50	120	101	65	70	92	93	47	71	29	32	64	903
SFBT														
Scaling	2	2	1	-	2	-	1	-	3	-	-	-	-	11
Miracle question	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Exception finding	1	3	1	1	2	1	2	1	3	6	3	2	1	27
Homework	1	1	1	-	1	-	1	-	1	1	-	-	-	7
Additional interventions														
Building hope	2	-	-	-	-	-	-	-	-	-	-	2	-	4
Complimenting	-	6	1	-	5	-	-	-	-	-	4	-	-	16
Coping questions	-	-	-	-	-	-	-	1	-	2	7	-	-	10
Goals	-	-	-	-	-	-	-	-	-	-	-	2	1	3
Total SFBT interventions	6	12	4	1	10	1	4	2	7	9	14	6	2	78
GMCT														
Four horsemen	-	-	2	1	3	3	-	-	-	-	-	-	-	9
Softened startup	-	-	1	-	-	-	-	-	-	-	-	-	-	1
Repair attempts	-	-	1	-	-	-	-	-	-	-	-	-	-	1
Additional GMCT interventions														
Love maps	-	-	-	1	-	-	-	-	-	-	-	-	-	1
Fondness and admiration	-	-	-	-	-	-	-	-	-	-	-	-	1	1
Total GMCT interventions	-	-	4	2	3	3	-	-	-	-	-	-	1	13
Additional interventions outside of model														
Psychoeducation	-	-	-	-	-	-	1	-	-	-	-	3	3	7
Structured separation	-	-	-	-	-	-	-	-	-	-	-	-	1	1
Total outside of model	-	-	-	-	-	-	1	-	-	-	-	3	4	8

Note. “-” indicates 0 instances of the intervention.

structured separation. This intervention was suggested to me by my supervisor as an experiment, with the idea being that when the couple is separated they have as little contact as possible in order to help them discover whether they really want to be together or apart. The limiting of contact helps the couple to see what it is like to be without the partner to help clarify their desires toward repairing or ending the relationship but without the finality of divorce.

Couple 3

Table 3 shows the frequency of interventions used with couple 3. As shown in the table, I used 495 EFT interventions, which represented approximately 90% of the 547 total interventions used through the duration of this case. I also used 18 SFBT interventions representing about 3.3% of all interventions used and 27 GMCT interventions representing about 4.9% of all interventions used. I used 7 additional interventions outside of my model, which represents approximately 1.3% of the interventions used across this case. The most commonly used EFT interventions were reflection, validation, and primary emotions. The most commonly used SFBT interventions were exception finding and client-centered homework, and the most commonly used GMCT intervention was the four horsemen of the apocalypse.

In therapy with couple 3, I used more GMCT than SFBT interventions. Within EFT, I used psychoeducation of the model 16 times over the course of treatment. In reviewing the videos, I noticed that I did this when the couple would begin to escalate in session, when I seemed to feel uncomfortable, or when I did not know what to do.

Table 3

Interventions Across Sessions for Couple 3

Session	1	2	3	4	5	6	7	Total
EFT								
Reflection	28	20	11	23	22	23	11	138
Validation	11	11	12	11	14	10	5	74
Primary emotions	7	5	4	25	4	14	11	70
Evocative responding	3	6	10	9	5	8	7	48
Empathic conjecture	4	8	5	9	3	2	6	37
Identifying and tracking negative cycle	3	6	3	7	9	2	3	33
Enactment	-	-	-	-	1	3	1	5
Reframe	6	12	5	10	7	2	4	46
Heightening	-	2	1	4	-	1	1	9
Additional EFT Interventions								
Psychoeducation	2	3	2	5	1	3	-	16
Relationship history	1	-	-	-	-	-	-	1
Book homework	1	2	-	4	1	2	-	10
Summarizing	-	-	1	3	1	3	-	8
Total EFT interventions	66	75	54	110	68	73	49	495
SFBT								
Scaling	1	1	-	-	1	-	-	3
Miracle question	-	-	-	-	-	-	-	-
Exception finding	-	1	3	2	1	2	1	10
Homework	1	1	1	-	1	-	1	5
Total SFBT interventions	2	3	4	2	3	2	2	18
GMCT								
Four horsemen	-	-	1	1	9	1	5	17
Softened startup	-	-	-	1	2	1	-	4
Repair attempts	-	-	-	1	2	-	-	3
Additional GMCT interventions								
Love maps	-	-	-	1	-	-	-	1
Flooding/time out	-	-	-	1	-	-	-	1
Accepting influence	-	-	-	-	1	-	-	1
Total GMCT interventions	-	-	1	5	14	2	5	27

(table continues)

Session	1	2	3	4	5	6	7	Total
Additional interventions outside of model								
Psychoeducation	-	-	-	-	4	-	1	5
Expectations	-	-	-	-	-	2	-	2
Total Additional Interventions	-	-	-	-	4	2	1	7

Note. “-” indicates 0 instances of the intervention.

I used psychoeducation 5 times with couple 3. A second intervention that I used outside of my model was clarifying expectations. In the sixth session, Kayla brought up a complaint about a female friend of Jaxon’s sending him what she deemed as a “flirty” picture. Because the couple did not seem to have a sense of clear boundaries and expectations within the marriage about what was and was not appropriate with people of the opposite sex, we had a frank discussion about what the rules were in the marriage about friends and flirting. This is not explicitly a part of my model.

Cross-case Analysis

Table 4 represents the percentage of all interventions used within each model for all couples. The table then shows the total percentage of interventions within EFT, SFBT, and GMCT, as well as the percentage of all of those interventions across my integrated model. A visual inspection of this table shows that I used significantly more reflection with couple 1 than with other couples, and also used about half as many primary emotions and reframes with this couple as with the other two couples. With couple 3, I also used slightly more psychoeducation in EFT than the other two couples. Outside of those slightly larger differences, my EFT interventions with all three couples were fairly consistent, with about 90% of all interventions for couples 2 and 3 being EFT and just under 87% for couple 1.

Table 4

Percentage of Interventions Within and Across All Couples

	Within couple 1	Within couple 2	Within couple 3	Across couples total interventions
EFT				
Reflection	42.3% (105)	28.2% (255)	28.0% (138)	30.3% (498)
Validation	15.0% (37)	17.0% (151)	15.0% (74)	15.9% (262)
Primary emotions	7.3% (18)	15.1% (136)	14.1% (70)	13.6% (224)
Evocative responding	9.7% (24)	11.2% (101)	9.7% (48)	10.5% (173)
Empathic conjecture	5.2% (13)	5.6% (51)	7.5% (37)	6.1% (101)
Identifying and tracking negative cycle	6.0% (15)	5.3% (48)	6.6% (33)	5.8% (96)
Enactment	1.2% (3)	1.3% (12)	1.0% (5)	1.2% (20)
Reframe	3.6% (9)	7.0% (63)	9.3% (46)	7.2% (118)
Heightening	2.0% (5)	2.5% (23)	1.8% (9)	2.2% (37)
Additional EFT interventions				
Psychoeducation	2.0% (5)	2.2% (20)	3.2% (16)	2.5% (41)
Relationship history	0.4% (1)	0.1% (1)	0.2% (1)	0.2% (3)
Book Homework	0.8% (2)	1.4% (13)	2.0% (10)	1.5% (25)
Summarizing	4.0% (10)	1.0% (9)	1.6% (8)	1.6% (27)
Cycle homework	-	0.1% (1)	-	<0.01% (1)
Meaning questions	0.4% (1)	1.9% (17)	-	1.1% (18)

(table continues)

	Within couple 1	Within couple 2	Within couple 3	Across couples total interventions
Total EFT interventions	86.7% (248)	90.1% (903)	90.5% (495)	89.7% (1646)
SFBT				
Scaling	25.0% (9)	14.1% (11)	16.7% (3)	17.4% (23)
Miracle question	-	-	-	-
Exception finding	38.9% (14)	34.6% (27)	55.6% (10)	38.6% (51)
Homework	16.7% (6)	9.0% (7)	27.8% (5)	13.6% (18)
Additional SFBT interventions				
Building hope	-	5.1% (4)	-	3.0% (4)
Complimenting	19.4% (7)	20.5% (16)	-	17.4% (23)
Coping questions	-	12.8% (10)	-	7.6% (10)
Goals	-	3.8% (3)	-	2.3% (3)
Total SFBT interventions	12.6% (36)	7.8% (78)	3.3% (18)	7.2% (132)
GMCT				
Four horsemen	-	69.2% (9)	63% (17)	63.4% (26)
Softened startup	-	7.7% (1)	14.8% (4)	12.2% (5)
Repair attempt	-	7.7% (1)	11.1% (3)	9.8% (4)
Additional GMCT interventions				
Love maps	100% (1)	7.7% (1)	3.7% (1)	7.3% (3)
Fondness and admiration	-	7.7% (1)	-	2.4% (1)
Flooding/Time out	-	-	3.7% (1)	2.4% (1)

(table continues)

	Within couple 1	Within couple 2	Within couple 3	Across couples total interventions
Accepting influence	-	-	3.7%	2.4%
			(1)	(1)
Total GMCT interventions	0.3%	1.3%	4.9%	2.2%
	(1)	(13)	(27)	(41)
Additional interventions outside of model				
Psychoeducation	100%	87.5%	71.4%	81.3%
	(1)	(7)	(5)	(13)
Structured separation	-	12.5%	-	6.3%
		(1)		(1)
Expectations	-	-	28.6%	12.5%
			(2)	(2)
Additional interventions outside of model	0.3%	0.8%	1.3%	0.9%
	(1)	(8)	(7)	(16)

Note. Numbers in parenthesis indicate actual number of intervention instances.

In terms of selective borrowing from the other models, there was more variance between couples in how much of each model I used. I used almost twice as many SFBT interventions with couple 1 than with couple 2 and four times as many as with couple 3. I used nearly five times more GMCT interventions with couple 3 than couple 1 and about a third more than with couple 2. The percentage of interventions outside of my model with all couples was around 1% or less, with couple 3 seeing the most outside interventions at 1.3%.

Research Question 2: When Following This Integrated Model of Therapy, Did Clients Report Meaningful Changes?

This research question was answered by triangulating several points of data including client responses on the RDAS and the ORS, in case notes, the recorded client reports, my observations, and the reflection journal. The RDAS was administered before

every session and the ORS was administered every session except the first. I also answered this research question through periodic scaling and exception finding regarding positive changes the clients noticed through the process of therapy. Reflection journal notes were also used to connect my observations with the assessment device scores, checklist observations from videos, and case notes to determine specific interventions or key movements in stages of therapy. Finally, all three couples were sent a final questionnaire that I designed that asked specifically about the changes that they had seen in therapy and asked one last scaling question of their progress at the end of therapy.

This research question will be answered in two parts. The first part of this question will be clients' reports of changes within and between sessions. The second part reports changes reported over the entire course of therapy.

Part One: Did Clients Report Changes Within and Between Sessions?

At the beginning of each session, every couple was asked what was better during the previous week. All couples reported positive changes at times during the week prior to the therapy session. Couples 2 and 3 also indicated negative changes at times during the week prior to therapy sessions. This question will be answered first by both graphical and narrative depictions of scores on the RDAS and ORS; second, by client report; and finally, through my observations and interpretations. Because it is difficult to observe between session changes, comments about my observations and interpretations will be primarily related to within session changes that I observed over the course of therapy with each couple.

Couple 1 instrument scores. The couple's scores on the RDAS are shown in Figure 1. According to the RDAS graph, the couple's scores did not fluctuate much between sessions. When they first presented to therapy, Brandon scored 42 points on the RDAS, which is one point above the clinical cutoff score of 41 (with lower scores indicating lower satisfaction). Allison's initial score of 38 was 3 points below the clinical cutoff, which was consistent with her reports of being more distressed in the relationship than Brandon. Brandon's highest score was at the beginning of session two with a score of 47, which was the biggest difference in scores for either partner. Brandon's final score in the last session was 44, which showed an improvement of 2 points overall. Allison did not ever score above the clinical cutoff, with her highest score being 40 at the beginning of session four. She ended up with a 38, which was the same score that she started with at the beginning of therapy.

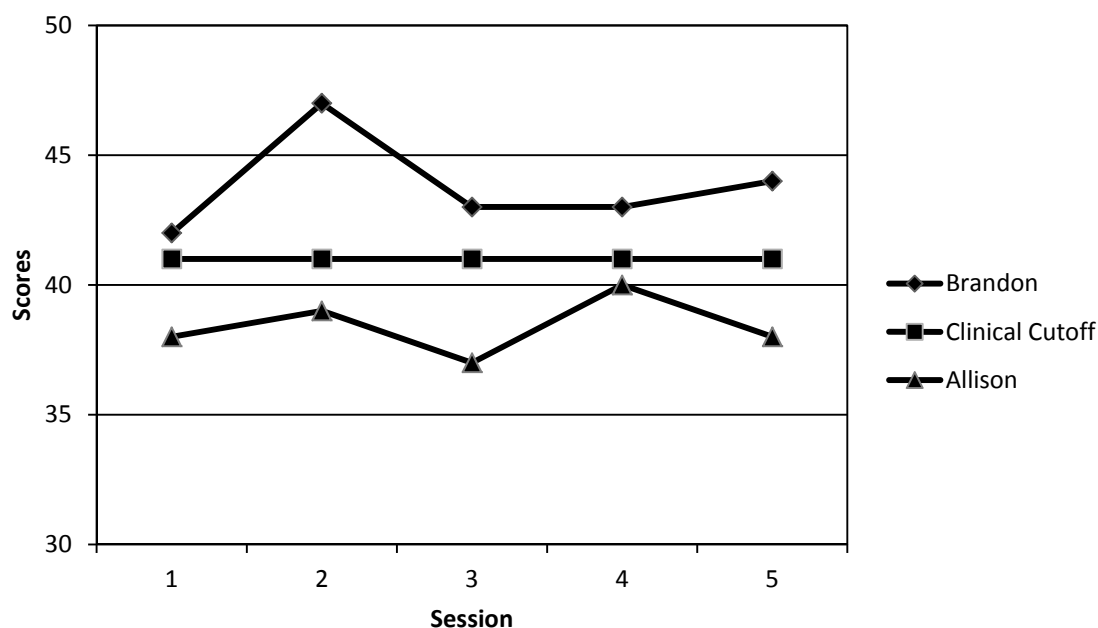


Figure 1. Couple 1 change in RDAS total scores.

A visual inspection of Figure 2 shows Allison's ORS scores over the course of therapy. There are no clinical cutoffs for the ORS; however, lower scores indicate lower satisfaction. Because there are no clinical cutoffs for the ORS, these scores are used to triangulate information with the RDAS for consistency across time. Allison's scores after the first session paralleled her scores on the RDAS, with her individual score being 3.4 out of 5 and her relationship satisfaction 2.4. Her individual score stayed the same in the third session, but rose to 4 for the final two sessions. Interpersonally, Allison's scores were consistent through all sessions at 2.4. These scores are consistent with the RDAS scores in showing that Allison saw very little change between sessions.

Brandon's scores on the ORS are displayed in Figure 3. Brandon's scores were not as consistent with his RDAS scores as Allison's were. Brandon began therapy with an individual score of 4 points and an interpersonal score of 2, which was both lower than

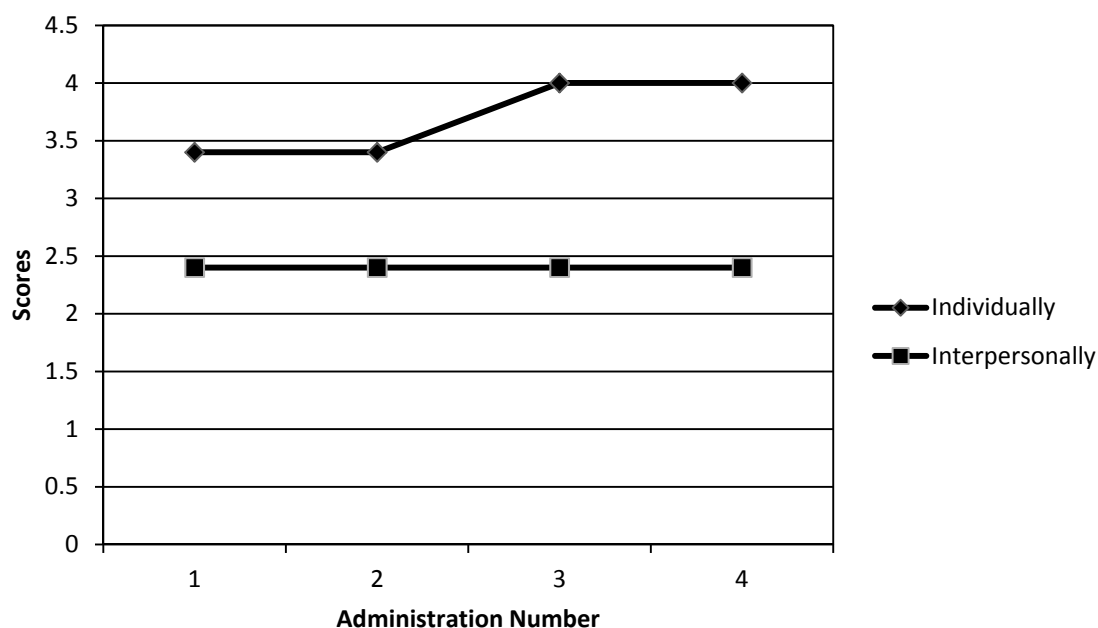


Figure 2. Allison's ORS scores across sessions.

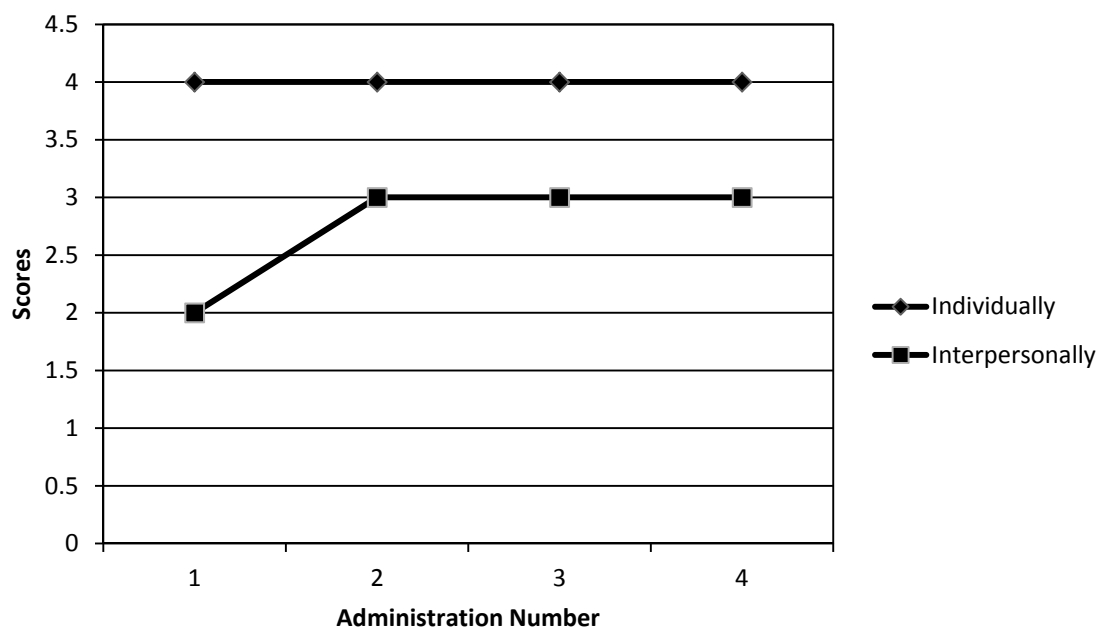


Figure 3. Brandon's ORS scores across sessions.

Allison's and not consistent with his high score of 47 on the RDAS after the first session. His individual score stayed constant throughout treatment and his interpersonal score rose to 3 in the third session and stayed constant through the remaining sessions.

Couple 1 client report. When Allison and Brandon first came to therapy, Allison was complaining that she wanted to be emotionally closer to her husband and that she felt that she was a lower priority for him than his work and his friends. Brandon indicated that he did not feel distant from his wife, but recognized that she was not happy and was willing to come to therapy if it helped her feel closer to him.

In the first session with this couple, I scaled their relationship satisfaction with 0 being the worst it had ever been and 10 being where they wanted to be at the end of therapy. They both indicated that they were currently at about 5. In the second session, both partners reported improvement in their relationship over the week, including

spending more time together and having better conversations. Allison scaled her satisfaction as 5.5 and Brandon scaled his as 6. During this session, the couple also defined 10 (or where they wanted to be in their relationship when therapy was over) as more comfort; time together; saying, “I love you” more; being excited to see each other; more consistency in Allison’s moods, which tended to fluctuate with her concerns about the relationship; and both partners would be more happy. In the third session, both partners again indicated that things were going better, although I did not ask for a scaling of that change.

By the fourth session, the partners both indicated that they had moved up another step on their scale to 6. In this session, Allison in particular mentioned specific changes that she had noticed between sessions including that she felt closer to her husband, was feeling more appreciated and loved, and that they were being more physically affectionate. Brandon agreed that things were getting better for them. By the fifth session, both partners indicated that things were much better for them. Allison scaled her satisfaction as 6.5 and Brandon scaled his as 7.5. The couple remarked that between sessions they had a good conversation where Brandon expressed some hurts and Allison comforted him and was responsive to his needs. Brandon also pointed out that Allison was a lot happier and more supportive of him. He also remarked that he had seen her making a lot more effort in the relationship. Allison indicated that they had been talking more openly and that it had been getting easier to talk to him, which she indicated was really nice. The couple did not return for more sessions.

Couple 1 observations and interpretations. I noticed a few specific changes within sessions that seemed to be meaningful to this couple. Within each session

Brandon expressed himself more and Allison noticed more positive things in their relationship. This was especially evident with Brandon in session four. As the session progressed, he became more and more emotionally vulnerable, describing in detail how much he appreciated Allison's help when he was in his accident. He told her how much it meant to him that she was the one who saved him and took care of him while he recovered. At the end of his disclosure, he reached out and held her hand, which was the first physical reach that I had seen him do in therapy. Following is an excerpt from my assessment in the case notes about his disclosure:

[Brandon] seemed to be much more emotionally available in this session especially when it came to expressing his emotions surrounding his accident. He visually teared up as he talked about how much it meant to him to have her support. After disclosing he even physically reached out to her and held her hand. . . . This seemed to be like an important session for him to express [his own] vulnerability.

Another within session change that I noticed with Allison came in session five. She seemed to be noticing her part in their cycle as evidenced by her ability to talk more about the cycle in session and what she did to contribute to it. I also observed her commenting more on Brandon's emotions.

One final change that I noticed in this couple was Allison's recognition of her discomfort with "intense emotions." Prior to the fifth session, Allison had not realized that she handled difficult emotions with humor and when we talked about it, her face appeared both confused and concerned. I noticed that when she talked about it, her voice got quieter and she verbally identified the primary emotions of hurt, embarrassment, and rejection that Brandon told her about between sessions. She explained her joking response to his physical and emotional reach as possibly making it harder for Brandon to

talk to her, even though that is what she really wanted. This resulted in her taking a step back and re-evaluating how she responded. Further, she said that she felt badly that she reacted this way and that she wanted to be better with her own emotions. This helped me to see that Allison was concerned about how she had affected Brandon and that she was beginning to understand her own emotional world a little better.

Couple 2 instrument scores. The RDAS scores for couple 2 are plotted in Figure 4. Because each partner met individually with me once each, they recorded eleven RDAS scores even though the case consisted of thirteen sessions. Both Megan and Jose started therapy with scores below the clinical cutoff with scores of 35 and 36 points respectively. After the first session, Jose's score rose to 42 and stayed consistently around the clinical cutoff with his lowest score being 38 points at the beginning of session four. Jose's highest score was 44, which he reported in both sessions eight and nine; his final score was right at the clinical cutoff of 41 points. Megan's scores followed a roller-coaster pattern over time, but did not demonstrate the level of positive changes that Jose's did by the end of therapy. After the first session, her score dropped to 29 points and went as low as 26 at the beginning of session four, which is 15 points below the clinical cutoff. Her highest score was 38 at the beginning of session eight. Megan ended therapy with a score of 28, which is 13 points below the clinical cutoff.

An examination of Figures 5 and 6 shows the ORS scores for couple 2 across therapy. Jose began therapy with an individual score of 4 after the first session. His score rose to 5 in the third session, which was his highest individual score. Jose's lowest individual score was 1 in sessions eight, 10, and 11. He ended the study with a final individual score of 4. Jose's interpersonal score began at 2 points and was as high as 4 in

session six and as low as 1 in sessions eight and 11, finally ending the study with a score of 2. These scores are not consistent with his RDAS scores: his highest RDAS score was individual score of 4. Jose's interpersonal score began at 2 points and was as high as 4 in session six and as low as 1 in sessions eight and 11, finally ending the study with a score of 2. These scores are not consistent with his RDAS scores: his highest RDAS score was in session eight, but that also conflicted with his lowest individual and relationship scores on the ORS for that session.

Megan started out with an individual score of 2. Her highest individual scores were in sessions four, five, and 13. Her lowest individual score was 1 in sessions eight, 10, and 12. Her highest interpersonal score was 3 in sessions 10, 12, and 13. Her lowest interpersonal score was 1 in sessions four, six, seven, and eight. Megan's scores are

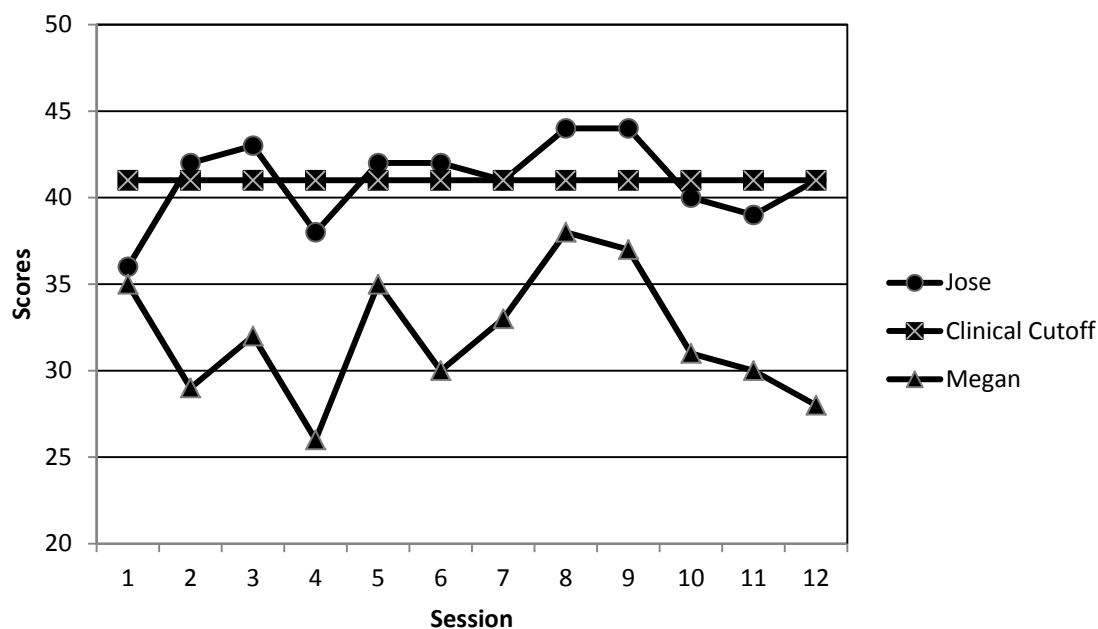


Figure 4. Couple 2 change in RDAS total scores.

somewhat inconsistent with her RDAS scores, particularly her low scores in session eight, in which she scored her highest RDAS score of 38. Another interesting inconsistency is her higher scores on the ORS in the last three sessions of therapy when her RDAS scores were falling.

Couple 2 client report. When Megan and Jose presented for therapy, they were both highly distressed. They both indicated that therapy was a last ditch effort to save their marriage. At intake, they reported spending very little time together because of Jose's work and school schedule. The scaling question for this couple went as follows:

On a scale of 0-10, where 10 is where you want to be when you get out of therapy and 0 is the worst it has ever been, what does that 10 look like? What's happening there that you guys would be able to say, "Man I'm glad we went and saw Heather, our relationship is so much better"?

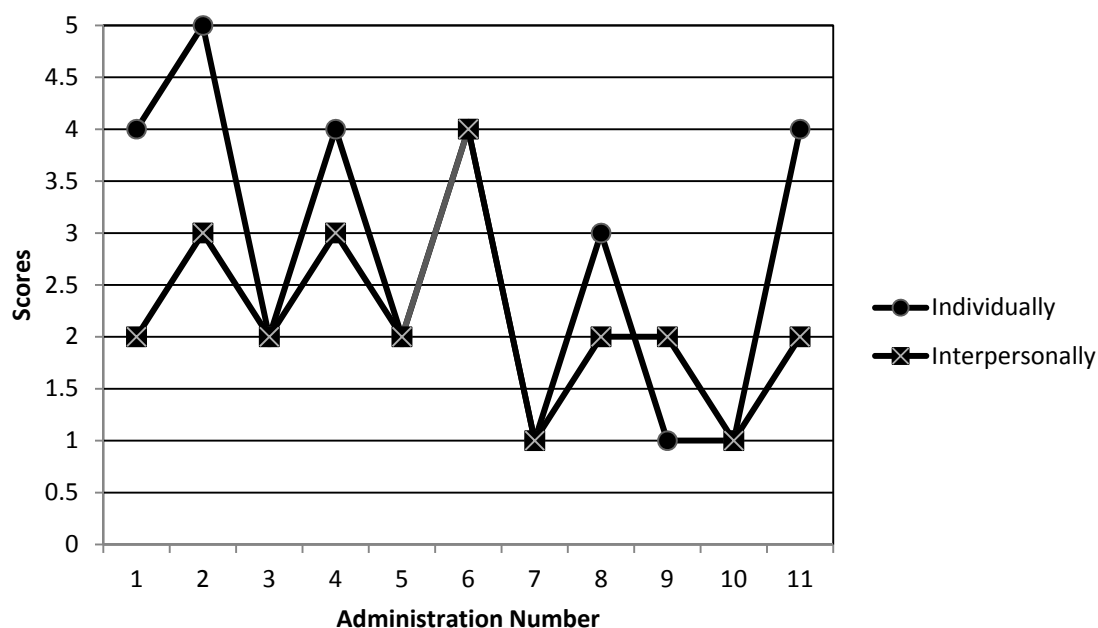


Figure 5. Jose's ORS scores across sessions.

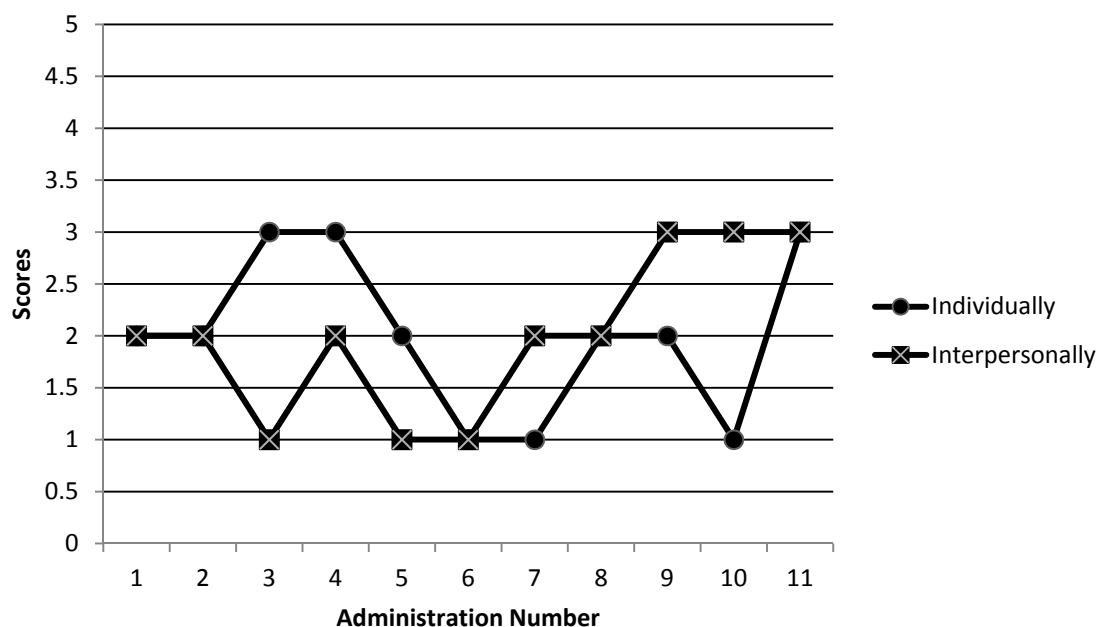


Figure 6. Megan's ORS scores across sessions.

The couple then identified 10 as talking more about their future together; spending fun time together outdoors; cooking together; for Megan to feel more appreciated and feel like Jose was proud of her; and for both partners to say, "I love you" and mean it. With that definition of 10, I scaled where they perceived their relationship to be with 0 being the worst it had ever been and 10 being where they wanted to be at the end of therapy; both partners scaled the relationship at 0.

By the third session, the couple indicated a small amount of improvement on their scale and reported that they had moved up to .5. The couple began to describe more small positive changes happening through the fourth, fifth, and sixth sessions. They both indicated that they were fighting less and that they were talking more. Jose even indicated that he was beginning to see his wife differently and was beginning to

appreciate her more. Megan also indicated that she was beginning to see Jose as less critical and feeling that she could trust him more. The couple also began reading *Hold Me Tight* (Johnson, 2008b) and indicated that they could see their pattern in the book and could identify with some of the couples.

By the seventh session, Megan indicated that she was up to about 3 on her relationship scale and Jose indicated 2.7. When asked about these changes, Megan indicated that she felt much safer with Jose and Jose stated that Megan was letting him hold her more. Megan even went on to say that things were starting to “feel like it’s supposed to feel” when she cuddled with her husband. Jose further stated that they talked about their feelings more, that he was beginning to understand better what Megan was going through, and that things were much more pleasant between them. However, Megan indicated that although she wanted to believe that these were permanent changes, she was still afraid that they might not last and still was unable to be vulnerable enough with Jose to be sexually intimate with him.

In the eighth session, the couple indicated that Megan had disclosed a one-time sexual affair with an ex-boyfriend about a month and a half before therapy began. They both stated that this was a big blow to the relationship. Jose, however, indicated that he still wanted to work things out and Megan commented that she was surprised by Jose’s support in the matter. In the ninth session, the couple indicated that they had done some more reading of *Hold Me Tight* (Johnson, 2008b) and that it was helpful in explaining their experience. The couple reported sliding back on their scale after the affair disclosure, with Jose going to 2.25 and Megan going all the way back to 1.

In the 10th session, the couple indicated that things had been horrible the week before and that they were considering divorce again. They reported that over spring break they finally had some time together, and that it was a disaster. Megan indicated that she knew that if they had a relationship where they were together more often that they would definitely be divorced. In the remaining three sessions, both partners reported things continuing to worsen. Jose moved out of their home after the 11th session at Megan's request, but both partners continued to say that they wanted to work on the marriage.

Couple 2 observations and interpretations. There were a number of observable changes in this couple within therapy sessions. An important one came in session three. Prior to session three, Megan expressed some of her complaints about her relationship with Jose, but was always very tentative about her complaints and, following her complaint, would almost seem to be apologetic. In the third session, Megan expressed more of her complaints that she had not previously shared and identified the fact that they had been occurring for the entire duration of the marriage rather than the previous 6 months as Jose had suggested earlier in therapy. She also identified the contempt that she experienced from her husband. She appeared to be more assertive in this session than she had been up to that point.

Within sessions four through seven, Megan became more expressive of her needs and began to share a number of hurts that she had never shared before in their relationship. Jose also became softer in these sessions and was receiving her comments without the criticism that he had in the past. Further, he became much more emotionally

expressive about his care for her. I remarked on this change specifically within the fourth session in my case notes for that session:

[Jose] appeared to be more emotionally engaged and open in this session as evidenced by his tears and softer approach with [Megan] about her withdrawal. [Megan] still appears to be fairly distant, but her assertiveness in stating her needs shows some potential for more re-engagement. She was also fairly emotional when sharing her attachment needs.

I also noticed within these sessions that the couple talked about their cycle in session and acknowledge their roles in it. Probably the most significant change that I noticed was in session eight, when Megan disclosed her infidelity to her husband. Although he was hurt, Jose said that he wanted to stay with Megan and try to work things out. At one moment in the session, while Megan was describing her remorse for the infidelity, Jose slid his chair closer to her and took her hand. This was the first time in therapy that they had any physical contact. This was evidence that Jose was becoming more attuned to Megan's emotions and was willing to reach out and comfort her. Also, within this session and for the first time in therapy, Megan said that she loved Jose, which was a new level of vulnerability for her.

Negative changes occurred within session 10 after the couple had much more time together the previous week because of a break in school work. In this session, some of Megan's ambivalence about whether she wanted to remain married to Jose returned, as evidenced by her repeating in session that she did not want to hurt him, but did not know what the right thing to do was (in reference to divorce). Jose seemed sadder than he was previously as evidenced by his increasingly teary responses to her speaking about her lack of love for him.

Couple 3 instrument scores. The RDAS scores for couple 3 are plotted in Figure 7. At intake, Kayla scored 6 points above the clinical cutoff of 41 with a score of 47. Her highest score was 48 points in the second session and her lowest score was 38 in the final session, which is three points below the clinical cutoff. Jaxon started therapy with a score of 38 points on the RDAS and reported his highest score of 44 in the second session. His lowest score was 24 in the fourth and seventh sessions, which is 17 points below the clinical cutoff and 14 points below his intake score. Kayla started out above the clinical cutoff, but her score dropped to clinical levels by the end of treatment. Jaxon's scores started off below clinical levels, rose above clinical levels in the second session, but fell to clinical levels for the rest of treatment.

Kayla's and Jaxon's ORS scores are reflected in Figures 8 and 9. Kayla's highest individual score was 4 points in session six. Her lowest individual score was 2,

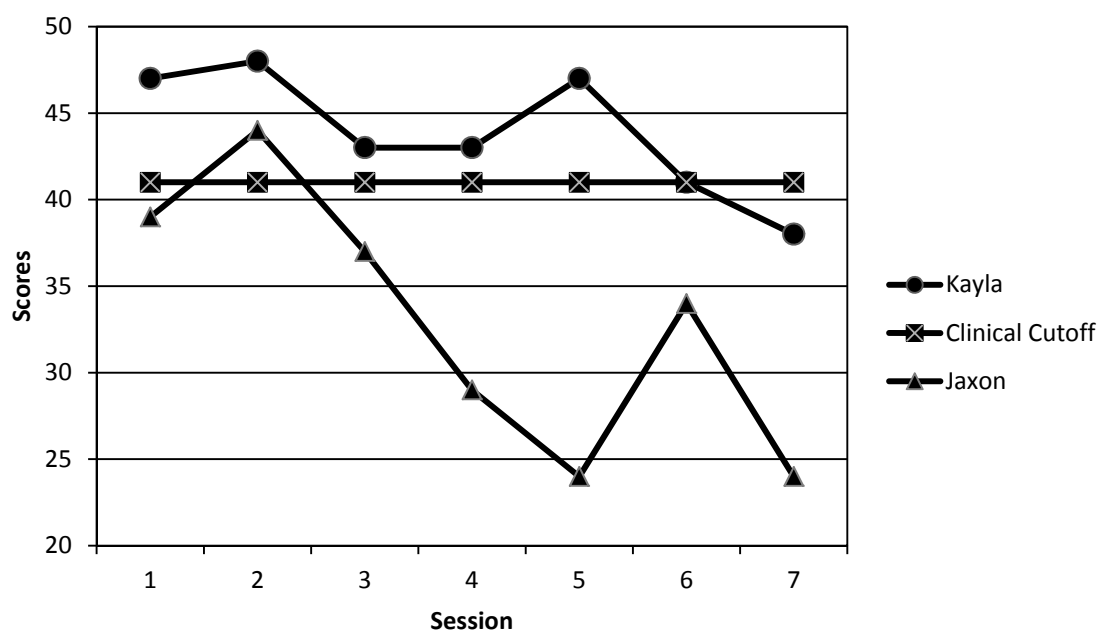


Figure 7. Couple 3 change in RDAS total scores.

which she reported in sessions three, five, and six. Kayla's highest interpersonal score was 4 in sessions four and seven and her lowest score was 3 in sessions two, three, five, and six. Jaxon's highest individual score was 4 in session's two, three, and five. His lowest individual score was 2 in sessions four and seven. Jaxon's highest interpersonal score was 4 in sessions three, six, and seven and his lowest score was a 3 in all other sessions. Neither partner's interpersonal scores correlated well with their RDAS scores: where the ORS scores remained consistent and high, the RDAS scores dropped over time. The interpersonal scores on the ORS for both partners in the last session were actually better than at intake, which is the opposite of their RDAS scores.

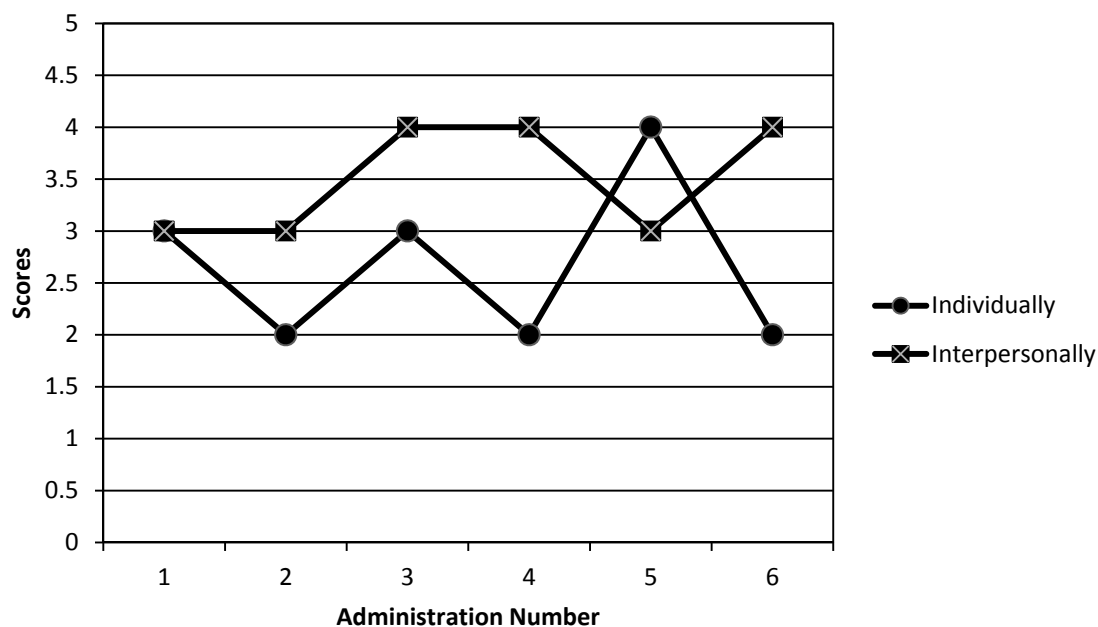


Figure 8. Kayla's ORS scores across sessions.

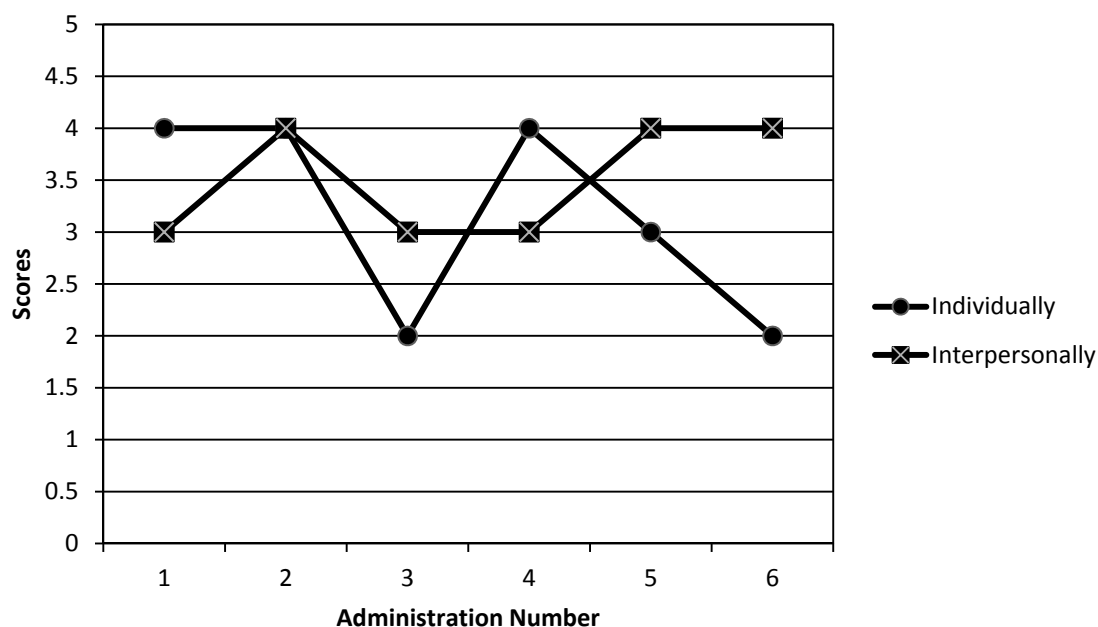


Figure 9. Jaxon's ORS scores across sessions.

Couple 3 client reports. Kayla and Jaxon originally presented for problems with high conflict and communication, along with Kayla's having an emotional affair with a man in another state, which she refused to end at intake. I asked the couple the following scaling question:

If you were to scale your relationship on a scale of 0-10, where 0 is the absolute worst it's ever been, and 10 is where you want to be when you are done with therapy, where would you guys say you fit right now?

Jaxon scaled the relationship at 5.4 and Kayla scaled it at 6. I forgot to have them define what 10 would look like when therapy was over and things were better. In the next session, the couple indicated improvement on their scale up to 7 for each of them.

In the third session, Kayla and Jaxon revealed that they had not shared with me all the details of the infidelity, which was hurting their relationship. Kayla admitted that she

had had phone sex with the other man right before she flew out to see him. In the fourth session, the couple reported that things had gotten worse and they both said that they were considering divorce. Kayla had ended her relationship with the other man, but they both said they were fighting more.

Things began to improve for the couple over the fifth and sixth sessions as they reported recognizing their cycle more and beginning to fight against it. They also got the *Hold Me Tight* book (Johnson, 2008b), which they both indicated was helpful. When scaled, Jaxon indicated that he was at 4 and Kayla indicated that she was back to 6, which she indicated was better than the previous session even though scaling did not occur in that session. Other positive changes that the couple indicated in this session included being more open and honest with each other and having more trust and confidence in their relationship.

In the seventh session, the couple came in distressed again and Kayla was complaining that Jaxon had called her unlovable and did not seem to be trying to improve the relationship. The couple did not return for their next scheduled appointment.

Couple 3 observations and interpretations. This couple had several important sessions in which they demonstrated many changes. One of the most notable changes was noticed in session four. At the beginning of the session, both members of the couple appeared to be visually upset. Jaxon physically looked shut down and withdrawn as he held his hands in his pockets and turned away from Kayla. Kayla seemed to be very agitated and began to cry early in the session as she described that no matter what Jaxon did, he could not comfort her, and her fear was that she was not connected to him at all. The couple indicated that they were thinking about getting divorced. As we processed

their emotions and as they shared some things within an attachment frame, the couple physically began to become closer and even began smiling, touching each other, and joking. In my reflection journal, I commented on this within-session change:

It was really interesting to watch the process of the session because at first they had a couple of little cycle moments where they would engage with each other and argue, then when I would stop that they both retreated to their corners with her looking out the window and leaning toward it and him leaning and looking at the mirror. About halfway through the session when I really heightened their attachment needs they both started to engage more. . . . It was amazing to watch them move toward each other. . . . By the end they were touching arms and looked at each other more and indicated that they had more hope.

In sessions five and six, the couple seemed to really begin to grasp their negative cycle. They seemed to have a better understanding of how their actions affected each other. By the sixth session, both partners seemed to be more comfortable sharing their emotions with each other and seemed to be tuning in to each other a little more as demonstrated when Jaxon acknowledged that their fight had made Kayla feel unimportant. The couple came into this session with Kayla's appearing agitated and Jaxon's appearing more shut down, but by the end of the session, Jaxon identified what he had been doing that week to perpetuate their cycle and verbally recommitted to Kayla to work harder in their relationship. By the end of the session, the couple had embraced twice.

Part Two: Did Change Take Place Over the Course of Treatment?

The RDAS was administered to each client before each session. The ORS was administered before the second session and before every session thereafter. The initial scores on each of these measures were considered a baseline to measure change as

treatment progressed. These measures are used in triangulation with my clinical judgment and reflections in my reflection journal as well as client reports during sessions.

Couple 1 instrument scores. The scores on the RDAS seemed to reflect little change over the course of treatment for this couple (see Figure 1). Brandon started therapy with an RDAS score of 42 points. Over the course of treatment, his score improved by 2 points, ending at a score of 44. Allison's RDAS score at the end of treatment was the same as she started out with: 38 points.

The ORS for both partners reflected a similar story. Allison's interpersonal score stayed the same from beginning to end of treatment at 2.4 (see Figure 2). The largest change came in the individual scores, which changed from 3.4 to 4 at the end of treatment. Brandon's individual scores stayed consistent throughout treatment at 4 (see Figure 3). He did, however, report some changes interpersonally, going from 2 to 3 points by the end of treatment.

Couple 1 client report. The clients reported a few meaningful changes over the course of therapy. By the end of therapy, both partners reported that they recognized their cycle and avoided getting into it more often. They both indicated spending more time talking and they both reported feeling more comfortable talking together in general. Brandon also said at the end of therapy that he had more desire to find out what was wrong when Allison was "down." Further, both partners indicated that Brandon was being much more expressive emotionally than he ever had been and that Allison was beginning to realize that although she wanted that kind of emotionality from Brandon, she did not quite know how to deal with it once she got it. She indicated that she never really thought about how she used humor to cope with "intense emotions," as she

described it, and we spent a session working on that. Brandon told her that it hurt him when she responded to his emotional expression with humor and that he did not think that she was taking him seriously. Allison also indicated that she had moved up through the course of therapy from 5 to 6.5 on their relationship scale, and Brandon indicated that he moved from 5 to 7.5.

Couple 1 observations and interpretations. Probably the most noticeable change that I noticed over the course of therapy was Allison's willingness to re-examine her role in the cycle and change her approach with Brandon to get the emotional connection that she wanted. She especially began to demonstrate that in session four when she commented on what she was doing to perpetuate the cycle and continued that way of speaking in their final session. Brandon's ability to disclose vulnerable emotions as he did in session four also appeared to be meaningful and the fact that he was able to continue that at home that evening, according to their reports, demonstrates an increase in his emotional availability over the course of therapy.

Couple 1 summary. By observing the changes noted in the RDAS and ORS scores, client report, and my observations, the data show that Brandon showed improvement interpersonally but not necessarily individually over the course of therapy. As Brandon's interpersonal scores improved, Allison's individual scores improved, even though her interpersonal scores did not.

Couple 2 instrument scores. The RDAS scores for Jose actually showed an increase in satisfaction of 5 points over the course of therapy from 36 at intake to 41 at the end of treatment, which is considered the clinical cutoff. Conversely, Megan's scores

dropped over the course of treatment from 35 at intake to 28 at the end of treatment, reflecting a drop of 7 points.

Neither partner's ORS scores were consistent with their RDAS scores. Megan's ORS scores actually improved in all categories from 2 points after the first session to 3 at the end of treatment. Jose's ORS scores also showed an interesting trend across treatment with his overall score improving from 2 points after the first session to 4 at the end of treatment. His individual and interpersonal scores were the same at the end of treatment as the beginning with scores of 4 and 2, respectively.

Couple 2 self report. Couple 2 seemed to be making meaningful changes through session six, which was before the disclosure of the affair. Until then, the couple mentioned several positive changes, including Jose's reporting that he was more able to talk about his feelings and better understood his wife's point of view. Megan stated that she felt safer with him and that she felt that he appreciated her more and even that she actually felt that he cared, which was very different from her reports at the beginning of therapy.

By session seven Jose reported being up to 2.7 from 0 on his relationship satisfaction scale and Megan reported 3 from her earlier scaling of 0. However, after the affair disclosure and more time together, the couple fell tremendously and Megan asked Jose to move out. When filling out the outcomes questionnaire I designed, Megan indicated the following in terms of meaningful changes:

At different times throughout therapy we were communicating better and [were] able to share thoughts and feelings. It was nice to be able to share with my partner without being criticized. The negative behaviors and conversations had decreased at times. At this time things are starting to go back to how they were. Things I say are questioned and deemed unnecessary or not right.

When asked to scale her relationship on a scale of 1 to 10 with 1 being where they were when they started therapy and 10 being their therapy goals, Megan indicated 1. She stated, “While things started to get better before, I feel we have gone back down even further than when we started sometimes.” When asked about meaningful changes, Jose indicated on his document, “I was asked to leave. We can’t talk. There’s always tension. Nothing is working out.” When asked his point on the same scale, he indicated “-15.”

Couple 2 observations and interpretations. Over the course of therapy, it appeared that Megan and Jose made some positive changes. One of the most notable was Megan’s ability to be more assertive about her needs, especially evidenced in session four. Further, she seemed to identify more of her hurts during each of the sessions and express them to her husband during enactments. Jose seemed to soften over the course of therapy as evidenced by his tearful declarations of love and appreciation for his wife in several sessions after therapy began.

Negative changes happened in later sessions after the couple spent more time together, which led to their separation. I observed Jose’s becoming more frustrated as evidenced by his verbal expressions of frustration and desire to know whether Megan wanted to remain married to him or not. Megan also began demonstrating more shutting down behaviors and her ambivalence had returned at the end of this study.

Couple 2 summary. By observing the changes noted in the RDAS and ORS scores, client report, and my observations, the data show that both Megan and Jose experienced positive changes. Although Jose’s final ORS scores were the same as his intake scores, his improvement on the RDAS and self-reports along with my observations

showed that he became more aware of how his behaviors affected his wife and led to greater overall appreciation for her. Megan experienced negative changes in the relationship, but seemed to show improvement individually and interpersonally as she became more aware of and assertive about her needs.

Couple 3 instrument scores. Jaxon's RDAS scores showed the most dramatic drop of all study participants with a beginning score of 38 and an ending score of 24. Kayla also suffered a drop in score on the RDAS over treatment with an intake score of 47 and an ending score of 38.

On the ORS, Kayla's scores dropped on her individual scale, but rose on her interpersonal scale. Her individual scale score dropped from 3 to 2 points, while she actually gained a point on her interpersonal score going from 3 points after the first session to 4 at the end of treatment. Jaxon's ORS scores were inconsistent with his RDAS scores. His interpersonal scale rose from 3 points at the beginning of therapy to 4 at the end, while his individual score dropped from 4 to 2.

Couple 3 client report. Over the course of treatment, both partners in couple 3 indicated that they were being more open and honest with each other but still did not feel closer. They also indicated that they were having more moments where they did something different in their cycle. In the last session of therapy, Jaxon acknowledged that he had not been trying to improve the relationship and Kayla shared more of her needs for Jaxon's honesty and closeness, which led them to embrace several times during the last session. When I contacted Jaxon after therapy ended, he indicated that they were doing much better and fighting less.

Couple 3 observations and interpretations. The most meaningful change that I noticed with couple 3 was their increased ability to identify their negative interactional pattern and their positions in it. Both partners began to identify their behaviors in the cycle and the kinds of responses that were elicited from the other partner, as evidenced by Jaxon's stating that his part in the cycle made Kayla feel unimportant even before she articulated it in later sessions.

This couple also experienced some negative changes that appeared to begin in the third session when Kayla revealed that she was in love with the man that she was having an affair with. After this revelation, Kayla stopped having contact with the other man, but Jaxon shut down more in the following sessions and demonstrated more defensiveness, especially in the fourth session when he told Kayla, "I'm sorry, but I have trust issues now; I've never had that before." His scores continued to drop from that point and he did not demonstrate a turn around until the final session when Kayla confronted him about not trying and he agreed to try harder in the relationship. He seemed to be more emotionally engaged than he had ever been in previous sessions as evidenced by his physically turning toward her, maintaining eye contact, and physically putting his arm around her.

Couple 3 summary. By observing the changes noted in the RDAS and ORS scores, client report, and my observations, the data show that Jaxon and Kayla experienced both positive and negative changes. It appears that both partners experienced some negative individual changes especially around the disclosure that Kayla was in love with the man with whom she was having an affair. This was reflected in the RDAS and ORS scores, as well as the clients' reports. However, interpersonally,

both partners showed some improvement, particularly in the last session when Jaxon admitted that he had not been trying to help improve the relationship and expressed a new willingness to work in the relationship. There was also an increase in physical affection in the later sessions and both partners had begun to express their needs more.

Research Question 3: What Changed in My Model Throughout the Course of This Study?

Data from all instruments were used in answering this research question. The intervention checklist and collaboration with the second coder provided me with specific information about what interventions I used more or less throughout the process of each session and to understand my model better. The reflection journal and case notes were used to provide me with a forum to discuss my own observations about what I was doing differently throughout the therapy process with each of the couples and notice what became more consistent across cases in terms of interventions and therapy style. Data from the RDAS and ORS provided me with graphical evidence of how these changes in my model affected client-reported change.

One of the first things that I noticed that changed in my model was my lack of use of the miracle question. When I began writing and developing this project, I was using the miracle question with most of the couples I worked with in therapy, but in the case of these couples, I found scaling, using 10 as where they wanted to be when therapy was over and things were better, to be a more helpful and concrete intervention.

When I began this project, I designed my intervention checklist to include the interventions that I deemed most important to my model. In looking at my video

codings, I discovered that I used additional interventions within EFT that I found to be important with each couple. I also recognized more interventions from GMCT that I found to be important and helpful with each couple, most specifically with couple 3, even though I still used a relatively small number of GMCT interventions overall. Within SFBT, I also discovered that there were additional interventions that I found helpful for each couple, such as coping questions and complimenting. I also noticed that I tended to use SFBT more as the study went on in the hopes of developing more hope for couple 2. Essentially, the fundamental change that I noticed over the course of therapy with these couples is that my model became more flexible as I noticed other things that could be more useful to each couple.

One surprising change that I noticed was my lack of enactments in early sessions with all of my clients. This lack of enactments was different from what I perceived myself doing with other couples not involved with this study. This discovery has led to additional findings that will be further discussed in the discussion chapter of this document.

CHAPTER V

DISCUSSION

The purpose of this study was to determine how my integrated model of couple therapy was applied, what kind of changes clients experienced during therapy in connection with using this model, and what changed in the model over the course of this study. Three couples who presented for marital therapy participated. Twenty-five therapy sessions were conducted across three cases. Each session was video recorded and coded with an intervention checklist. Case notes and a reflection journal were used to report the course of each session as well as my observations about the process of the session or changes that were noticed. The RDAS was administered before every session, and the ORS was administered before the second session and every subsequent session. The results of this study suggest that I applied interventions consistent with my integrated model of therapy, with the addition of psychoeducation and two other nonspecific model interventions within two of the cases. This application of therapy was shown to be beneficial to every couple in certain ways.

The organization of this chapter is guided by the results chapter and research questions. The following sections discuss the results of this study as well as unexpected findings, implications, and limitations.

Research Question 1: How Well Did I Follow My Integrated Model of Therapy as Outlined in Chapter II?

Across all three cases, it appears that I stuck very closely to my integrated model

with a few additions. As mentioned in the results section, I actually discovered that I used more interventions from all of the models than I previously described, which says to me that I am even more true to the models than I thought that I was. In my video codings, I recognized that I was very consistent with EFT as my foundational model and incorporated attachment language into most of my interventions whether they were EFT, SFBT, GMCT, or the few interventions I used outside of these models.

There were a few interventions that fit within the models that provided some surprising results for me. Within EFT, I used much more psychoeducation about the approach than I recognized. According to Johnson (2008a), part of the process of being a transparent therapist can include sharing how and why the therapist intervenes the way that he or she does. In looking back at the videos and checklist, I recognized that I often jumped to educating about the process of EFT and where the couples were going when I sensed discomfort from the couple or when I was unsure of what to do.

Another intervention that I was surprised that I used as frequently as I did was complimenting from SFBT, especially with couples 1 and 2. According to De Jong and Berg (2002), compliments are a way of building hope and drawing on client strengths that have either helped them in the past or in the present. With both of these couples, I tried to draw on their strengths and successes between sessions, especially for couple 2 because of their high level of distress. Whenever they reported progress, I tried to highlight their effort and how it benefitted their relationship according to their report. My goal in this was to help them recognize their own progress and gain hope for saving the marriage.

The most significant deviation from my outlined model was my use of psychoeducation outside of EFT. I discovered that I used this with all of the couples at one point or another. Most of the time, it had to do with a contextual situation that the couple was in. In the case of couples 2 and 3, the majority of the psychoeducation that I did had to do with educating about infidelity because both couples had experiences with infidelity that were hurting their relationship. The psychoeducation used with couple 1 was very brief and had to do with educating them about working on the level of process instead of content in therapy. In reviewing the videos, my use of psychoeducation seemed to be used in the context of attachment needs and the EFT framework.

Through this project, I have learned that I am very true to my EFT framework and selective borrowing. This means to me that I effectively conceptualize therapy from an emotionally focused and attachment framework, which also guides my use of interventions and concepts from other models.

Research Question 2: When Following This Integrated Model of Therapy, Did Clients Report Meaningful Changes?

The results of this study seem to show that although meaningful changes occurred for all couples in one way or another, changes were not always in the direction of relationship repair. One interesting finding in this regard was the differences in the changes within couples. For example, in couples 1 and 2, the partner who was least distressed in the marriage actually saw slight improvement on their RDAS scores over time, whereas their more distressed partners did not. This difference was emphasized in couple 2 where Jose's RDAS score went from 5 points below the clinical cutoff to the

clinical cutoff at the end of therapy while his wife, Megan, dropped 7 points over the course of therapy. This may be because the less distressed partner in both couples was beginning to see their partner's hurts more and had begun to appreciate them more over the course of therapy. This was evidenced by Brandon when he was able to express his appreciation to Allison for saving his life and helping him recover, and was also demonstrated by Jose who verbally acknowledged that he was realizing more and more how important Megan was to him.

The more highly distressed partners, however, did not demonstrate improvement in their satisfaction, either in their scores or in their reports, suggesting that more work needed to be done in stage one to help them engage more with their own emotional experiences as well as their partners. This was especially evident with Megan and Jaxon of couple 2 and 3. This could further suggest that even though both couples had been able to identify their cycles, they had not yet reached the point in stage one where they recognized the cycle as the enemy of their relationship and fight together against it (Johnson, 2004). Both of the more distressed partners in these couples were the withdrawing partners in their relationships, and if they had not yet gained an experiential sense of their cycle and had a chance to do something differently, it would make sense that they were still more distressed at the conclusion of therapy. Additionally, even if the less distressed person was beginning to understand the hurt, the more distressed partner could not yet trust the other.

In therapy outside of this study, I noticed that the pursuing partners in other couples noticed improvement before the withdrawing partners, which may have to do with the fact that they felt more heard in therapy than they had previously in their

relationships. Withdrawers, in my experience, do not tend to see as much improvement until stage two, when they begin to take a stand with the pursuing partner and the pursuing partner is able to be responsive to those needs. However, these are anecdotal data and are not necessarily applicable to all couples.

Another interesting finding with regard to meaningful changes was the lack of consistency in scores between the ORS and the RDAS, particularly for couples 2 and 3. Megan's RDAS scores dropped by the end of treatment; her ORS scores, including her interpersonal scores, actually showed improvement. One potential reason for this could be the lack of explanation included in the ORS for the meaning of the numerically anchored score choices. The ORS is a very simple instrument with only four subscales, but they are not elaborated upon. A good example of this potential confusion came in the seventh session with couple 2. Megan had indicated that she felt that her relationship with Jose was improving and even scaled herself at 3 for relationship satisfaction. On her ORS for that session, she had marked 1s on her interpersonal, individual, and social subscales. Her RDAS scores at this time were also inconsistent with her self-reports of improvement. When I asked her about the difference in scores, especially on the interpersonal subscales, she commented that the interpersonal scores reflected other problems with her family at the time, but that she really felt better in her relationship with Jose. This could demonstrate that the instrument may not have been measuring what I had anticipated for the purposes of this study. I believe that I may have been more confident in the reliability of these scores if the interpersonal portion of the instrument clearly defined interpersonal relationships as a relationship between partners rather than ambiguously mentioning family and close relationships. Another possible explanation

could be that the instrument is sensitive to daily fluctuations in mood. This would require further research to determine, but is a possibility.

Another surprising finding with my measurement devices was the lack of consistency with client reports via in-session scaling. This happened with all couples. Couple 1 reported that they saw improvement from 5 to 6.5 on Allison's satisfaction scale and from 5 to 7.5 on Brandon's scale. Neither their ORS or RDAS scores matched the improvement they reported experiencing. This could reflect a lack of sensitivity of the instruments. This could also mean that the three instruments were measuring different things. The RDAS is designed to measure marital satisfaction while the ORS was designed to get an overall picture of individual wellbeing. One thing I discovered through this study is that the ORS seems to be less sensitive to changes that may be related to therapy or the couple dyad specifically. In comparison, SFBT scaling was used with each couple to define specific changes or progress related to the relationship. Because the scale stated the condition that 10 is where the couple wants to be when therapy is over and the relationship is good, it may be more sensitive to changes that are specifically happening in the relationship than either the RDAS or the ORS. However, SFBT scaling also could demonstrate a disadvantage because I am giving it as the therapist and could therefore influence clients' answers if they are hoping to please me or show me that things are getting better, even if they are not.

Regardless of the inconsistencies in the RDAS, ORS, and scaling, the one consistency is that there were ups and downs throughout the course of therapy for all couples during stage one work. This is both expected and normal for stage one work, which is focused on de-escalation.

Regarding resolution of problems, my integrated model did not appear to fully resolve any of the couple presenting complaints. In fact, with these couples, we never fully got out of stage one work. Small steps toward change were made with each of the couples, all clients reported gaining a better understanding of their own negative patterns of interaction, and all were able to demonstrate increased emotional availability and responsiveness to one another. Clients also seemed to feel more validated in their emotions, with fewer concerns that their emotions were inappropriate or out of control. These results are common and expected within stage one work that strives to identify the negative cycles of interaction and pinpoint primary emotions (Johnson, 2004). However, couples 1 and 3 terminated therapy before moving into stage two, and couple 2 had begun work in stage two when the affair disclosure and increased time together moved us back to stage one. This is important because real and lasting changes happen in stage two of this integrated model (Johnson, 2004). I have found that sometimes getting through stage one can take much longer than I had anticipated.

While conducting this study, I joined a listserv of fellow EFT professionals. Often, I noticed other professionals at different levels of training also expressing the sentiment that stage one work is very time consuming and often can take months before couples really get an experiential sense of their cycle and begin to work together to fight against it. One therapist posted a comment about working in stage one in response to Sue Johnson's request for ideas for a webinar that encapsulates the difficulties I encountered. She replied that she would like additional help with

couples who can't seem to get out of Stage One—won't/can't work together to fight the cycle. Seems that every couple that joins together and de-escalates does well in Stage Two—some take a short time, some a long time in Stage Two, but

they all do well. But some couples seem to not be able to form a team, work together, buy into the common enemy thing. Sometimes, there is substance use and it seems to prevent forward movement . . . , other times, de-escalation just doesn't seem to happen, and I could use help with such couples. And it's not always that they are so volatile—they just won't work together. (K. Shore, personal communication, May 4, 2010).

I also meet monthly with an EFT support group with other professionals in my area who have shared similar experiences in working with couples in stage one. Emotionally focused couple therapy is designed to go slowly as the therapist enters the client's experiences and helps them experience each other differently (Johnson, 2004). This is especially true in cases of infidelity, which adds an element of complexity that requires more thought, care, and time.

Because of the complexity of working in stage one and de-escalating the negative interaction cycle, clients can also cycle back into stage one, even after they have appeared to be prepared to move into stage two if certain criteria for stage two work have not been met (Woolley, 2009). Emotionally focused couple therapy is not a linear model, which could have been a limitation for this study in terms of brief therapy because of the dynamics of moving couples through the stages, especially when infidelity is a factor. Prior to beginning this study and through the duration of it, I met with two couples outside of this study who had also experienced infidelity. Therapy took nine months for the first couple, and six months for the other, but both couples were able to repair their relationships through this integration of therapy. Time is an important factor in rebuilding trust and opening couples to being vulnerable when they have been deeply betrayed.

In essence, the steps in stage one work are to connect and engage with both

partners and create an alliance; identify conflict and relational issues; identify the negative cycle; access unacknowledged primary emotions and attachment needs underlying the cycle; reframe the problem in terms of the cycle, which is deemed the enemy; and help the partners to unite to fight against it (Johnson et al., 2005). When looking at it this way, one could consider this study a positive experience because I had worked through at least three of the four steps of stage one with all of the couples. I believe that I built a good alliance with each client, all couples reported more understanding of their own and their partners' emotional worlds, and every participant began to recognize their parts in the negative cycles of their relationships. Stage one is difficult and setbacks are to be expected, especially when infidelity is present. However, because none of the couples got out of stage one, these changes are considered both positive and expected.

Because none of the couples got out of stage one for this study, this study has proven to be an excellent opportunity to evaluate the stage one work that I am doing. It is imperative that stage one work is done well in order to assure that clients continue therapy and are able to work through stages two and three of therapy. Everything that I have learned while examining the work I did in stage one will help me with couples in the future to make stage one more effective and helpful in moving throughout the entire therapy process.

One additional important thing must be taken into consideration. This study concluded toward the end of my clinical work in my program and couples 2 and 3 were both made aware toward the end of the study that I would be finishing up clinical work and transferring them in a few weeks. This could have contributed to the reason that

couple 3 did not return to therapy after the last session, especially after ending on a positive note. When I contacted Jaxon, he indicated that while they were doing much better, they were also very busy with the end of the semester and would return to therapy if they had any additional problems. Had my clinical work continued, I would have scheduled a follow up appointment after the semester ended to continue our work. I imagine that my ability to stay with my clinical work could have also been beneficial to couple 2.

Research Question 3: What Changed in My Model Throughout the Course of This Study?

The results of analyses of data in this study show that I did not change very much in my model over the course of this study. The most noticeable change was my lack of use of the miracle question as delineated in Chapter II. This is significant to me because SFBT was a large part of my early training and in the past, I had used the miracle question quite frequently. When I began writing and developing this project, I was using the miracle question with most of my couples, but as I met with each couple in this study, I did not think it would be as helpful as it was with some other clients. When I have used it with other clients outside of this study, it sometimes yielded less helpful responses because some clients interpreted a miracle to be magic, which led to some unrealistic and unhelpful miracle pictures. In reflecting on the videos and my perceptions of what I was doing, I believe that although the language of the miracle question was not the same, the principle of the miracle question was still utilized with my scaling, with 10 being what the couple wanted their relationship to look like at the end of therapy. I did not think that

the miracle question, as formally described, would be particularly useful to any of the couples in this study and, therefore, utilized it in principle rather than the way the miracle question is traditionally used.

As previously mentioned, I did notice a few additional interventions that I did not specifically mention in Chapter II, but I did not see these as major changes to my model and they seemed to fit within my EFT attachment framework. I realized that I use even more EFT interventions than I had originally specified. To me, this means that I am more true to EFT than I realized. I also recognized more interventions from GMCT that I used that I did not think much about before this study. I believe that this may have had something to do with attending a conference in which I learned more about GMCT and from watching a fellow colleague using the appreciation activity with one of his couples and seeing some positive changes for them. Essentially, the fundamental change that I noticed over the course of therapy with all couples is that my model became more flexible as I noticed other things that could be more useful to the couples that I saw.

Perhaps one additional thing that changed in my model is my perception of it. Through this study, I discovered that although this model can be helpful, it has its limitations. One of my core assumptions is that people want to change and that couples have a desire to be closer (per attachment theory); therefore, while asking questions of all of the couples, I kept the attachment frame in mind. This did not work very well for couple 2. This change in my model will be explained in more detail in the unexpected findings section of this document.

Unexpected Findings

One of the most important things that I learned through this process is that I am not utilizing enactments enough in my therapy. Enactments help couples to practice in session what I am trying to help them learn to do at home (Johnson, 2004). If I am not doing enactments, I lose a lot of the experiential component of EFT that can be powerful in change. According to my intervention checklists, I did fairly well keeping the primary emotion in the room with every client and did fairly well utilizing my other interventions; however, without the corrective emotional experience of an enactment, primary emotions are much less meaningful. I saw this across therapy with all of my cases.

In most of my training and in most of the training videos I have watched, enactments have been reserved for moving toward stage two work, in creating new emotional experiences and restructuring patterns of interaction. However, in working through this project with my couples and with further training, reading, and understanding, I have found that enactments can be helpful throughout the entire process of therapy. I recently watched a training video in which a therapist did several small enactments in the first session based on small indications of primary emotions and attachment needs, as well as positions in the cycle. These small enactments set the stage for more emotionally connecting ones down the road and also provided the couple with some hope that the other partner cared about them and wanted to change. Once again, the enactments were not huge emotional disclosures at this point, but small indications that each partner was invested in the relationship.

According to Johnson et al. (2005), enactments are used in all stages of therapy,

but earlier enactments have less emotional intensity than later stage enactments. I noticed that my lack of enactments in earlier sessions made it more difficult and awkward for my clients to turn and talk to each other when the emotional intensity was higher. This lack of early enactments became glaringly obvious when I asked Brandon from couple 1 to share some of his deeper emotions and appreciation for Allison's saving his life and taking care of him after his injury. After he shared some vulnerability and reached out to her, she did not know how to handle his "intense emotions," which led her to joke and laugh uncomfortably while telling him that she wanted to hear more of that—a very mixed message for him. As he shared his feelings, Brandon reached out to her and took her hand. When she joked about it, he pulled his hand away. This was one of the first times that I arranged enactments, so I was unaware that she was uncomfortable with these types of emotions and was unable to coach things as well as I would have liked to. If I had helped Allison experience the sharing of less intense emotions with Brandon in earlier sessions, helped Brandon not pull away, or otherwise slowed this interaction, it may not have been as uncomfortable for them and could have had more potential for closeness and connection. Another hypothesis I have is that if I had used enactments earlier with this couple, I may not have gone as deeply as quickly with Brandon in this session, which may have led to both of their discomfort. Although this experience may have indicated to me that I need to use enactments more, it also seems that this incident carried a lot of power for both members of the couple and could have additionally provided the impetus for Allison to learn more about her discomfort with intense emotional experiences. In that case, this situation carried more positive learning opportunities for both members of the couple, as well as for myself as the therapist.

Couple 1 is not the only couple with which I missed opportunities for enactments that may have led to additional emotional engagement. In session three with couple 2, Megan disclosed some long-time experiences of feeling contempt from Jose that led her to feel extremely inadequate and hurt. This session was filled with new emotions that had not been disclosed before, and although it was different territory, it was also an opportunity for new emotional experiences that could have been elicited through enactments. The experiential component was missing in this session and I wonder whether they would have felt safer after this disclosure had they had practice sharing difficult things with each other rather than with the therapist.

At times, I was unsure of where to go when there was high intensity in the room. When these situations happened, or when the couple would get frustrated with what was happening in the therapy room, I would change roles from a process consultant to an educator to try and help them (and me) feel more comfortable with what we were doing in therapy. I noticed that I did this especially with couple 3. There were several times when we would go through the session identifying their negative interactional patterns, primary emotions, and attachment needs, and then the couple would turn to me and tell me that they still felt distant from each other. They would tell me that even when they recognized their pattern and were able to stop it, they still did not feel close. After looking at videos, I noticed that at these times, I would turn into an educator and explain EFT and what we were trying to accomplish to help them grow closer together. As I watched myself explain that I was trying to help them experience each other differently, I realized that I was losing the experiential component that is so powerful in EFT, not with myself explaining the closeness that they should feel, but with their sharing their new

emotional experiences with each other in the form of enactments. Essentially, I discovered that my lack of enactments and my tendency to educate seemed to be related to one another.

Another major discovery that I had while coding my videos had to do with the apparent failure of therapy with couple 2. As I watched the sessions again, I realized that Megan had been very hesitant to acknowledge progress and to demonstrate commitment to the marriage. True to EFT fashion, I acknowledged her fears and tied them in to empathic conjectures about attachment longings and fears. She would agree with these conjectures and was even able to share some of these fears and longings with Jose through some enactments in therapy. Until her disclosure of her infidelity, I felt very good about the direction we were going and her ability to open up and share some of these things. I did not find out until later that there were many more hurts that had happened in their marriage that led her to have very little faith in the potential of repairing the relationship. Later, after they had separated, I saw her individually and she further disclosed that she had lost a child shortly after birth before she met Jose. She told me that Jose had been very unsupportive of her grief over the loss of her child and essentially had asked her on several occasions when she was going to “get over it.” I began to realize that the hurts obtained through the duration of this marriage were so severe that a short stint of therapy most likely would not be enough for them and that this couple seemed to be losing hope.

The revelation of the affair and attachment injury also led me to question whether this marriage could be saved at this point or if Megan was already checked out. This was an important lesson for me to learn. I believe that I have a tendency to be somewhat

idealistic and have a high amount of faith in my integrated model of therapy. This couple allowed me to look at the potential that some marriages cannot be saved and that sometimes people choose to come to therapy too late. This does not necessarily mean that it was too late for Megan and Jose, but it opened my eyes to that possibility not only with them, but with couples in therapy generally.

One additional hypothesis is that the level of emotional vulnerability that it would take to work through those issues of grief in couple therapy may have been too intense for her at this stage. Megan's attachment injury related to a lack of support from Jose around the loss of her child helped me realize that assessment in stage one is critical. In EFT, attachment injuries such as Jose's lack of support are best dealt with in the context of the relationship, because support from the partner is the only thing that can fully heal that injury. However, at this point, the couple was separated and preparing to transfer to a new therapist. The revelation of Megan's hurt, coupled with the affair disclosure helped me realize that I may have moved too quickly with this couple. Also, because of the timing of the ending of my graduate studies and leaving therapy, I was unable to properly work through these things as I would have if I had the time to do so. My own mental and emotional state, considering that I was almost finished with my graduate studies, may also have contributed to a lack of hope because I knew I would be unable to continue working with them.

I discovered the power of infidelity on a relationship and how difficult it is to repair through this process. Both couples 2 and 3 had experiences with infidelity in their relationships. Kayla, the wife in couple 3, was having an emotional affair with another man. Initially, I asked Kayla whether she could end the relationship to work on her

marriage and she said she would not. One of the contraindications for EFT is ongoing infidelity (Johnson, 2004). At that point, my primary goal was identifying the couple's negative cycle to hopefully show Kayla that the marriage could potentially be saved if she gave up the relationship with the other man. I did not anticipate the negative consequences on Jaxon through this process.

In the third session of therapy, Kayla and Jaxon revealed that they had not shared all the details of the infidelity with me, that it had not stopped, and that Kayla believed she was in love with this other man. I framed the infidelity within the cycle and validated both of their positions. In processing this, I used the metaphor of the threat of divorce or her leaving for another man as a guillotine hanging above their heads making it impossible to have emotional safety as long as it was there. I asked them to remove the threat of divorce or leaving while we were working in therapy. I also asked Kayla to end her relationship with the other man to give the relationship a chance to work. They both agreed; however, I had already started to open Jaxon to some emotional vulnerability that was not safe for him at that point. Using this metaphor and insisting that Kayla end her relationship was something I should have done as soon as I learned about the infidelity.

By the fourth session, the couple was on the brink of divorce because of the continued fighting; Jaxon reached out to Kayla and disclosed a problem he was having with pornography, his own pseudo-attachment; and Kayla was not responsive to him. Kayla had ended the relationship with the other man, but in the previous three sessions, I had primed Jaxon for emotional vulnerability and when he took a risk with Kayla outside of session, it was not well received. This, coupled with the hurt sustained from Kayla's disclosure that she was in love with the other man, strongly affected Jaxon. Prior to that

disclosure, I do not think he understood the level of the Kayla's infidelity and that realization, in connection with her lack of responsiveness to his bid for connection, was devastating for him. This has taught me that EFT absolutely cannot be done with ongoing infidelity in any form.

Clinical Implications

This study informs my practice in a variety of ways. First, I have realized the importance of using enactments appropriately in therapy and how detrimental it can be to not use them enough in an experiential type of therapy. This discovery will be very helpful to me in my future practice and will lead me to check on myself more frequently to see if I am doing them. I have also learned to be cautious of my tendency to use psychoeducation as a crutch when I am feeling uncomfortable. In the future, I will be attending to how much psychoeducation I use and recognize that as an opportunity to utilize enactments that I could be missing. Further, I can be more attuned to when enactments are appropriate based on my reflections in the video coding and reflection journal.

I have learned the value of doing my own video process research. This study has been valuable to me in learning how to look critically at my own therapy and see what I am doing well as well as what I am missing. This lesson will continue with me as I progress in my field, knowing now that if I feel myself getting stuck, it is wise to go back and review sessions to see what I have missed in terms of patterns, verbal and nonverbal cues, and opportunities for connection. This understanding can be helpful even when

video recording is not available by looking back at case notes and evaluating patterns.

The learning experience of doing my own process research is invaluable.

I have learned that this approach does not necessarily assist in relationship repair for couples who are already checked out of the marriage and for couples in which ongoing infidelity is a factor. However, it could be helpful when couples want to separate in a safe environment. This finding will lead me to be more client-centered in the future and also to be more directive in terms of ending infidelity before continuing with therapy.

This experience with these couples has taught me a lot about my current level of clinical maturity. As a new therapist, my level of experience with infidelity is fairly low, and as I learn more and am more able to integrate my model with my experiences, perhaps I will be better able to help other couples with issues of infidelity.

Finally, the most important clinical implication that came from this study was the changes that I saw in myself. In earlier chapters, I spoke of first- and second-order change as important concepts in creating lasting change in couple relationships. I did not however, recognize until the conclusion of the study that some important first- and second-order changes had occurred within myself as a therapist.

The first-order changes that I noticed had to do with the specific interventions that I noticed were important to me. Not arranging enactments early on, as well as not using the miracle question as outlined in Chapter II are good examples of those changes. These are basic changes in the mechanics of what I do, but not necessarily changes in the process and meaning of what I do. The second-order changes that I noticed had to do with my conceptualization of what I do in therapy. I learned the value of following my

instincts as I watched the videos and that although it is important to trust and follow a model, it is also important to trust myself. Further, I have learned the importance of going slowly within the model and staying present with my clients. This project is no longer about producing a good document for a graduate program, but has become a project in self-growth and development that will remain invaluable for the duration of my career. My thinking and understanding are now more flexible and I can now see that although I still have a lot to learn, I am capable of doing it.

Limitations

There are many limitations to this study. As the primary researcher as well as the therapist administering the interventions, there is some clear bias in my interpretations of the results of this study. Further, I created the checklist looking for the specific interventions that I deemed appropriate for this study, wrote the case notes and reflections journals, and coded the therapy. The second coder also had biases that may have affected the way she coded the videos. Additionally, it is possible that because of my focus on this specific integration, I may have missed opportunities to use other interventions or tools outside of my model that could have been helpful to the couples that I saw.

The sample size in this study was small, consisting of only three couples who were selected via convenience sampling from the Utah State University marriage and family therapy clinic. Although the clients represented some diversity in cultural background, the sample is relatively homogeneous. Generalizing to other therapists was not an aim of this study, however, it would have been more helpful to have a larger sample from which to gather ideas about my own therapy.

Reliability of the checklist was not empirically established, but negative case data from the second coder and my own observations provided information that helped me to revise and clarify concepts within the checklist and coding manual to make it more useful to me in this study. It was very helpful for me to observe my own therapy for interventions and practices that I did not realize I was doing or when I was doing them.

A limitation of instruments was demonstrated by the lack of correlation between the RDAS and the ORS scores. This may be because the RDAS and the ORS are measuring different things. This made triangulating the data difficult, but the addition of SFBT scaling, client reports, and my own reflections helped me make some sense out of the data. Additionally, the RDAS is focused on the improvement of the couple and the ORS is more focused on the improvement of the individual. This is important because both the individuals and the relationship are a part of the recursive process of change, but it is difficult to make sense of the data when they do not correspond. This limitation, however, is significant and could be noted for future research on whether the two instruments are measuring the same constructs because of the lack of specificity on the ORS. Further, this limitation in these instruments has implications for my own therapy in the future, in that it makes me more cognizant of the need for researching the potential limitations of any other instruments I may use.

Conclusion

This study contributes to my understanding of the application of my integrated model of couple therapy. I maintained fidelity to my model as described with the addition of a few interventions from each model. The couples in this study demonstrated

at least some meaningful changes (e.g., Megan's new assertiveness and Jose's increased appreciation for his wife) even if they ultimately did not show positive results or move out of stage one.

Although my study did not seem to be successful in terms of relationship repair for at least two of the three clients that I saw, this study was tremendously helpful for me as a clinician in evaluating my own therapy. The results of this study will be useful to me as a way of working in the future and ultimately will help me be more helpful to my clients in my own practice throughout my years as a therapist.

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Sage.

APPENDICES

Appendix A

Informed Consent for Treatment

Informed Consent for Research

Memo from the MFT Director

IRB Approval Letter



Case #:
Therapist:

Marriage & Family Therapy Clinic

INFORMED CONSENT FOR TREATMENT

I understand that treatment with the Utah State University Marriage and Family Therapy Clinic may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with my relationships. I am aware that my therapist will discuss alternative treatment facilities available with me, if needed.

My therapist has answered all of my questions about treatment with the Utah State University Marriage and Family Therapy Program satisfactorily. If I have further questions, I understand that my therapist will either answer them or find answers for me; or that I can contact the Director of the Clinic, Dr. Scot Allgood, (435) 797-7433. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist.

I understand that graduate students in family therapy conduct therapy under the close supervision of family therapy faculty, and that therapy sessions are routinely recorded and/or observed by other Program therapists and supervisors.

I understand that all information disclosed within sessions is kept confidential and is not revealed to anyone outside the Program without my written permission. The only exceptions to this are where disclosure is required by law (where there is a reasonable suspicion of abuse of children or elderly persons, where the client presents a serious danger or violence to others, or where the client is likely to harm him/herself unless protective measures are taken or when there is a court order to release information).

I agree to have my sessions recorded for therapeutic and supervision purposes.

This form is to be signed by all participating clients/children 7-18 must provide signatures as assent.

Signed: _____

Date: _____



Department of Family, Consumer, and Human Development
 USU MFT Program
 2700 Old Main Hill
 Logan UT 84322-2700
 Telephone: (435) 797-7430

Date Created: October 2, 2008; Page 1 of 3
 USU IRB Approval 11/10/2008
 Approval Terminates: 11/09/2009
 Document IRB Password Protected per IRB Administrator

INFORMED CONSENT FOR RESEARCH **Utah State University Marriage and Family Therapy Program**

Introduction/ Purpose Faculty and students at the USU Marriage and Family Therapy Clinic sometimes use therapy information for research studies. This information includes the forms you fill out, notes used for your therapy sessions, and videorecordings. Research helps us find out more about how therapy works and how effective it is. We are asking to use your information for future research. You are not required to allow your information to be used for research purposes. If we do not have your permission to use your information for research, it will be used for therapy purposes only.

Procedures If you agree to have your information used in research, you will not be asked to do anything different from what you do already. Consenting or not consenting to allow your information to be used in research will not affect your therapy at the MFT clinic in any way.

Risks Because you are not being asked to fill out any new forms or do anything different in therapy, there is no added risk or discomfort. We follow state and federal guidelines for the protection of medical information.

Benefits There may not be any direct benefit to you from using your information for research. The investigators, however, may learn more about how therapy works at the MFT clinic and how effective it is. Therapists who use the information for research may benefit because their therapy skills may improve; in this case, it is possible that allowing us to use your information may improve your therapy.

Explanation & offer to answer questions Someone has explained our request that we use your clinic information for research and answered your questions. If you have other questions or problems related to using your information for research, you may contact Professor Scot Allgood, the director of the MFT Program, at 797-7433.

Extra Cost(s) There are no extra costs or benefits to you for agreeing to allow your information to be used in research.

Voluntary nature of participation and right to withdraw without consequence Giving us your permission to use your information for research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. Your information would then be used for therapy purposes only. Your therapy or other services will not be affected in any way.

Confidentiality Just as with therapy, your therapy records will be kept confidential, consistent with federal and state regulations. Only the professors and students in the MFT Program have access to the information, which is kept in a locked file cabinet in a locked room in the Family Life Center. Your therapy information that includes names, addresses, etc. is kept for 10 years, consistent with state law regarding medical information. Any information that is used for research will have this identifying



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INFORMED CONSENT FOR RESEARCH Utah State University Marriage and Family Therapy Program

information erased or blacked out. If you decide to not give us your permission to use the information for research, your clinic file will be identified with a colored dot so that the information is not used for research. If you do give us permission, no reports about the research will include names or any other identifying information.

Information from videorecordings of your therapy may also be used in research. Videorecordings are typically destroyed when the graduate student therapists finish at the MFT Clinic. Any recordings that are used for research will also be destroyed when the student finishes the research. Transcripts of the recordings or other written records of what happens in the therapy sessions may be kept, but they will include an identifying code only and not your name(s) or any other identifying information. Informed Consents for Research that include your signature(s) will be kept in separate locked filing cabinets.

IRB Approval Statement The Institutional Review Board for the protection of human participants at USU has approved this research study. If you have any questions or concerns about your rights or a research-related injury, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu. If you have a concern or complaint about the research and you would like to contact someone other than the research team, you may contact the IRB Administrator to obtain information or to offer input.

Copy of consent You have been given two copies of this Informed Consent for Research. Please sign both copies and retain one copy for your files.

Investigator Statement "I certify that the research study has been explained to the individual(s) by me or my research staff and that the individual(s) understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."

Signature of PI

Scot M. Allgood, Ph.D.
 MFT Program Director
 435-797-7433

Signature of Participants By signing below, I agree to allow my clinical information at the MFT Clinic to be used in research.

Utah State UNIVERSITY

Department of Family, Consumer, and Human Development
USU MFT Program
2700 Old Main Hill
Logan UT 84322-2700
Telephone: (435) 797-7430

Date Created: October 2, 2008; Page 3 of 3
USU IRB Approval 11/10/2008
Approval Terminates: 11/09/2009
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INFORMED CONSENT FOR RESEARCH Utah State University Marriage and Family Therapy Program

Participant's signature _____

Date _____

Witness _____

Date _____

Child/Youth Assent: I understand that my parent(s)/guardian is/are aware that my therapy information may be used in research and that they have given permission. I understand that it is up to me to decide whether I want the information used in research even if my parents say yes. I understand that if I give permission that my name will not be used in the research. If I do not want my information used in research, I do not have to give permission and no one will be upset if I don't want to or if I change my mind later. I can ask any questions that I have about this study now or later. By signing below, I agree to allow my therapy information to be used in research.

Name _____

Date _____

Permission granted? ☐ Yes ☐ No

ID # _____



Marriage and Family Therapy Program
2700 Old Main Hill
Logan UT 84322-2700

May 17, 2010

This memo is to verify that Heather Thompson has been approved to use data from the USU Marriage and Family Therapy Clinic for her thesis.

Thank you

A handwritten signature in cursive script that reads "Scot Allgood".

Scot Allgood
Marriage and Family Therapy Program Director



Appendix B

Coding Manual and EFT/SFBT/GMCT Checklist

Revised Dyadic Adjustment Scale

Outcome Rating Scale

Final Outcome Questionnaire

Coding Manual

Emotionally focused therapy checklist: The EFT checklist is used to identify my use of the following interventions within the EFT framework; reflection, validation, primary emotions, empathic conjecture, evocative responding/questioning, reframe, identifying and tracking negative cycle, enactment, and heightening. Because several of these interventions and concepts can be difficult to differentiate and often overlap, these operational definitions will assist in coding.

Reflection is used to help me identify with the clients experience and assure the client that I am understanding what is happening for them. Reflection is operationalized as my repetition of what the client said to me either in the client's words or in my own words in an attachment frame or using primary emotion. Because reflection in this model is not just about parroting back the clients' response, but is about taking the client to the leading edge of their experience, reflection can happen concordantly with a reframe.

Validation is used to reassure clients that they are entitled to their experiences and that they are legitimate and real. I also use validation to separate one partner's experience from the other partner's character or intentions. Operationalized, I may use phrases like, "so this is how you experience it?", or "for you it feels very different." It can also be operationalized as anytime I normalize an experience or legitimize a new emotional experience as difficult or scary. Again, primary emotions are used a lot in validation. A validation can also happen concurrently with a reflection if the reflection is used to legitimize the client's experience. For example, if a client were to say something to the effect of, "I just don't know if I can trust him enough to open up to him. I know

that he would just tell me to grow up and stop being childish”, a validating reflection would sound something like, “It’s just not safe for you to open up and show him this part of you, because you are afraid that he would think you are being childish, and that would hurt you”. This statement validates the fear that she is feeling, but is also a fairly simple reflection.

Primary Emotion can be operationalized as anytime I either explicitly define primary emotions or when I identify them in the context of what the client is explaining. Primary emotions include surprise, happiness, anger, hurt, sadness, fear, shame, and loneliness (Johnson, 2004).

Empathic Conjecture is used to help clients create new meaning in their experience as I tentatively offer empathic interpretations of their experience based on my observations of their body language, words, or demonstration of new emotion. Operationalized, this would be seen as I interpret their description of their experience as either a defense strategy (a way to protect oneself or the relationship), an attachment longing (or a desire to be close to the other), or an attachment fear (being afraid that they may be abandoned or rejected) (Johnson et al., 2005). It may also be operationalized as I interpret an emotional experience inquiring about primary emotion associated with a secondary emotion. For example, “You get so angry when you see him shut down, but it seems like you might also feel hurt and afraid that you are not important to him.”

Evocative Questioning/Responding includes prompts or questions directed at slowing down the process of the session and intensifying the emotions that may be occurring below the surface. Operationalized, this is seen when I ask something like,

“what is happening for you when...?” This can include an emotion or even a bodily response such as “what happens in your body when...?”.

Reframes are often used in the context of the negative interactional pattern or in the attachment frame. This is operationalized as I externalize the negative cycle and label it as the enemy that is keeping them from being close rather than one partner or another having inherent deficiencies. It can also be seen when I frame a secondary emotion as a response to an attachment need. This could include statements like, “when you get angry because you see that she is not listening to you it’s like something inside of you says, I need you to hear me. I need to know that I matter to you.” Reframes can happen concurrently with empathic conjecture and identifying and tracking the negative cycle.

Identifying and Tracking Negative Cycle can be operationalized focusing on the process of the couple’s disagreements and defining it as a cycle or pattern that they have gotten into. I track this throughout the therapy process and sometimes point it out if it begins to happen in the session or when a couple describes an argument that they have had outside of therapy.

Enactments are operationalized by my telling one partner to share a new emotional experience with the other. I will explicitly ask one partner to turn to the other and repeat to them what they just shared with me and often times I will repeat back to them what they said using the attachment frame.

Heightening is a tool used to intensify the client’s emotional experience in order to create deepened engagement with his or her emotions. This is operationalized by repeating key emotional responses over and over in different ways, using myself as the therapist by leaning in closer, slowing down the pace of my speech, and speaking in a

softer voice, using images or metaphors to describe their experience, or keying into and repeating metaphors or images that they have used. This can also happen while creating enactments as I ask a partner to share what they said to me and repeating it to them in the attachment frame and with the intensity of emotion that they were showing. One of the best ways to operationalize this is to use the acronym RISSC (Johnson et al., 2005). This acronym symbolizes when I *Repeat* key metaphors, use *Images* or metaphors, use *Simple* attachment explanations, speaking *Softly*, *Slowly*, and use the *Client's* words. When this is all happening at once, I am heightening.

Solution-focused brief therapy checklist. The SFBT checklist is used to identify my use of the following interventions: miracle question, scaling, exception finding, and client centered homework.

Miracle Question is operationalized by my asking a question about the clients going to sleep one night and waking up to a miracle that had occurred, only because it happened while they were sleeping, they don't know that it happened. My question centers around going through their miracle day and indicating the things that they would notice happening that would tell them that a miracle has happened.

Scaling is operationalized by my putting their problem on a scale of 0-10 with 0 being the worst the problem has ever been and 10 being where they want to be when therapy is over and they have accomplished their goals. This can be identified anytime I ask about where they are on their scale or when I help them identify the terms of the scale (i.e. what would a 5 or a 8 or a 10 look like).

Exception Questions are operationalized in a couple of ways. Anytime I ask about what has been better since we met, that is a form of exception finding. I might also

ask what has been different or better in their cycle or pattern in the previous week, or ask about times the couple has been able to be vulnerable with one another.

Client Centered Homework can often happen within scaling as I ask the couple what one small thing their partner can do for them or they can do together as a couple to move them up on their scale. This may also happen by identifying one small thing they can do to improve their relationship or make them feel closer to one another during the week.

Gottman method couple therapy checklist. The GMCT checklist is used to identify my use of the following interventions: four horsemen of the apocalypse, softened startup, and repair attempts.

Four Horsemen of the Apocalypse is an intervention that is used explicitly as I define the four horsemen of criticism, contempt, defensiveness, and stonewalling to the couple. This could also be operationalized when I point out the four horsemen in the context of the couple's negative interactional pattern.

Softened Startup is another explicit intervention in which I define softened startup and give examples of how they could use it to slow down their cycle. I also might point out when one partner is able to use a softened startup rather than a harsh criticism to fight against their cycle.

Repair Attempt is identified by my educating the couple about how they can make repair attempts or bids to stop their cycle. This could come in the form of them restating something to clarify or even pointing out that what they are doing is getting them into the cycle and offering to start over.

Intervention Checklist

Client ID:

Session #:

Date of Session:

Date of Review:

Reviewer:

EFT		
Intervention	Times Used	TOTAL
Reflection		
Validation		
Primary Emotions		
Evocative Responding		
Empathic Conjecture		
Identifying and Tracking Negative Cycle		
Enactment		
Reframe		
Heightening		
Hold Me Tight Homework or Reference to Reading		
Psychoeducation		
Summarizing		
Relationship History		
Attachment History		
Meaning Questions		
Cycle Homework		

SFBT		
Intervention	Times Used	TOTAL
Scaling		
Miracle Question		
Exception Finding		
Homework		
Compliments		
Building Hope		
Coping Questions		
Goals		

GMCT		
Intervention	Times Used	TOTAL
Four Horsemen		
Softened Startup		
Repair Attempt		
Love Maps		
Fondness and Admiration		
Flooding/Time Out		
Accepting Influence		

Interventions falling outside of outlined integration

Model/Intervention	Times Used	TOTAL
Psychoeducation		
Clarifying Expectations		

—
—
—

Client ID _____
Date _____

Final Outcome Questionnaire

Please take a moment to fill out this brief questionnaire based on your experience throughout the entire duration of therapy with Heather. If you run out of room you may use the back of this paper.

Since the beginning of therapy, what kind of meaningful changes did you noticed in your relationship through then end of therapy? Please describe in detail what they are and how they are meaningful to you.

On a scale of 1 to 10, with 1 being where you were when therapy began, and 10 being where you wanted to be when therapy was over (as has been discussed in therapy), what number would you have ranked your relationship when therapy ended? What puts you at that number?