

AN EPISTEMOLOGICAL CHECKUP: THE EXPLICATION, APPLICATION, AND  
EVOLUTION OF AN INTEGRATED THEORY OF COUPLES THERAPY

by

McKenzie L. Christensen

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)

Approved:

---

Thorana S. Nelson, Ph. D.  
Major Professor

---

Kathleen W. Piercy, Ph.D.  
Committee Member

---

Kevin Barlow, M.S.  
Committee Member

---

Byron R. Burnham, Ed.D.  
Dean of Graduate Studies

UTAH STATE UNIVERSITY  
Logan, Utah

2009

## ABSTRACT

An Epistemological Checkup: The Explication, Application, and  
Evolution of an Integrated Theory of Couples Therapy

by

McKenzie L. Christensen, Master of Science

Utah State University, 2009

Major Professor: Dr. Thorana S. Nelson  
Department: Family, Consumer, and Human Development

When clinicians practice therapy without a clear theoretical foundation, they lack direction and purpose. When training to be a marriage and family therapist, understanding and clarifying one's integrated theory and practice of therapy is essential. This mixed methods study was designed to elucidate and apply my theory of therapy in order to identify fidelity to my model as well as understand the effects it has on clients. This study also focused on how experiences in each session of therapy influenced the next session.

Three couples who presented for therapeutic services at the Utah State University Marriage and Family Therapy clinic participated in the study. Ten therapy sessions were conducted. Each session was videorecorded and coded with an intervention checklist as well as a videorecording coding chart. Case notes and a reflection journal were used to understand the course of each session as well as the therapist's decisionmaking during each session. The Outcome Questionnaire 45.2 was administered to each couple during

every session. The Revised Dyadic Adjustment Scale was administered before the initial session and after the fourth session. In the third couple's case, the RDAS was administered before the initial session and after the second session.

The results of this study suggest that the therapist applied interventions consistent with her integrated model of therapy using emotionally-focused therapy as her base theory, adding interventions from cognitive behavioral therapy and Gottman couple therapy. She found that she also used interventions from solution-focused therapy. This application of therapy was shown to be beneficial to every couple in certain ways. Sessions were found to inform subsequent sessions in a variety of ways. Unexpected findings, implications, and limitations are discussed.

(134 pages)

## ACKNOWLEDGMENTS

I would like to thank those who have supported me in my completion of this project and facilitated my development in becoming a better therapist and person.

A big thank you is necessary to my major advisor, Dr. Thorana Nelson, who pushed me to succeed. She taught me so much, from how to arrange and express my thoughts to developing my skills as a clinician. Thank you for all of your help!

Gratitude is also due to the members of my supervisory committee, Dr. Kathleen Piercy and Kevin Barlow, without whose knowledge and assistance this study would not have been successful.

I am indebted to the faculty in the Utah State University Marriage and Family Therapy program, who have supported me and taught me so much. Their guidance and humor helped me persevere in this program and complete this study.

Special thanks also to my cohort who have become like family to me. There is no way I could have survived this program without their help. I am a better person and clinician for having known you all.

I cannot end without thanking my parents, my brother, and my sisters on whose constant encouragement and love I have relied throughout my time in this program. You all amaze me and I could not have been luckier than to have you as my family.

McKenzie L. Christensen

## CONTENTS

	Page
ABSTRACT.....	ii
ACKNOWLEDGMENTS .....	iv
LIST OF TABLES .....	vii
CHAPTER	
I. INTRODUCTION .....	1
Problem .....	1
Purpose of Research.....	2
II. REVIEW OF LITERATURE .....	3
Emotionally Focused Therapy .....	4
Cognitive Behavioral Therapy .....	8
Gottman’s Couple Therapy.....	13
Theory Integration .....	18
Systems Concepts .....	20
Pre-Session Outlines .....	22
Purpose.....	22
III. METHOD .....	24
Design .....	24
Sample.....	25
Procedures.....	28
Instruments.....	29
Data Analysis .....	42
IV. RESULTS AND INTERPRETATIONS .....	46
Couple One .....	46
Couple Two.....	62
Couple Three.....	76

V. DISCUSSION .....88

    Results.....89

    Unexpected Findings .....95

    Integration of SFBT .....96

    Implications.....97

    Limitations .....98

    Conclusion .....100

REFERENCES .....101

APPENDICES .....105

    Appendix A. Informed Consents, Memo, IRB letter .....106

    Appendix B. Instruments .....113

    Appendix C. Pre-session Outline .....126

## LIST OF TABLES

Table		Page
1	Intervention Checklist: Inter-Rater Reliability .....	38
2	Interventions Observed for Couple One .....	48
3	Videorecording Coding Chart Results: Intervention Rating Frequencies, Couple One .....	51
4	OQ Scores, Couple One .....	53
5	Interventions Observed for Couple Two.....	64
6	Videorecording Coding Chart Results: Intervention Rating Frequencies, Couple Two.....	67
7	OQ Scores, Couple Two .....	68
8	Interventions Observed for Couple Three.....	78
9	Videorecording Coding Chart Results: Intervention Rating Frequencies, Couple Three.....	81
10	OQ Scores, Couple Three .....	83
11	Intervention Observations Across Couples.....	90

# CHAPTER I

## INTRODUCTION

### Problem

Every clinician is drawn to different models of therapy, and many times this includes multiple models, as in my case. When clinicians practice therapy without clear theoretical foundations, they lack direction and purpose. Patterson, Williams, Grauf-Grounds, and Chamow (1998) explained that to “intervene skillfully, you must be clear about what theoretical stance you are using and the skills associated with that stance” (p. 109). Nichols and Schwartz (2006) pointed out, “as family therapy enters the twenty-first century, integration is the dominant trend in the field” (p. 413). Lebow (1987) cautioned therapists who rely solely on their own personal characteristics to “overcome deficits in theory, conception, and technique” (p. 4) and called for any therapist practicing an integrated theory of therapy to “make a concerted effort to understand and explicate their theories of practice” (p. 4). Liddle (1982) described this as an “epistemological check-up” (p. 243) or an explanation of one’s personal paradigm. At this point in my practice of marriage and family therapy, I feel that understanding and clarifying my integrated theory and practice of therapy is essential. The plan for this study was to elucidate and apply my theory of therapy in order to identify fidelity to my model as well as understand the effects it has on clients.

My practice of therapy consists of an integration of cognitive behavioral therapy (CBT; Baucom, Epstein, LaTaillade, & Kirby, 2008; Dattilio, 1998; Epstein, Schlesinger, & Dryden, 1988; Hazlett-Stevens & Craske, 2002; Schlesinger & Epstein, 1986), emotionally focused therapy (EFT; Johnson, 2004, 2008), and Gottman’s model of



couple therapy (GCT; Gottman, 1999; Gottman & Gottman, 2006, 2008). These models are integrated through assimilating core concepts and interventions into a third, primary orientation (Lebow, 1987). The base theory from which I conceptualize cases is EFT with specific interventions or ideas from CBT and Gottman's couple therapy seen through that lens. The effectiveness of the integration and practice of my therapy is not yet established.

### Purpose of Research

The purpose of this research was to evaluate my application of and fidelity to my integrated model of therapy. I also investigated how my integrated approach influenced short- and longer-term change and how clients responded to interventions. In this paper, I elucidate my session progression and development by analyzing the results of specific interventions, re-evaluating sessions by watching recordings, and/or consulting with teammates. The goal for this study was to analyze my approach in a case study of application to three couples by identifying how accurately I practiced the theory I ascribe to, how each particular session influenced the next, and whether my theory brought about client progress and change.

## CHAPTER II

### REVIEW OF LITERATURE

Identifying a model of therapy to utilize in mental health professions is a highly personal process that influences the focal point and nature of one's practice of therapy. Many therapists find that their worldviews and foci of therapy are not fully encompassed in only one theory. This leads to integration of theories. Integration differs from eclecticism in that there is a method with which the different concepts are organized and applied together (Lebow, 1987). Integrated theories have many advantages: they are more easily tailored to specific cases, they provide the clinician with multiple interventions and strategies, and they are usually created because of the clinician's draw to and resonance with those theories. One important component of integration of theory of therapy is explicating how one does therapy and the reasoning behind one's actions. Understanding and explaining in depth one's view of integration and its application to cases can aid in solidifying proposed theories and fidelity to those models, and aid in the evolution of effective practice.

The following is an explanation of my theoretical integration and how it is applied in therapy. I have integrated emotionally focused therapy (Johnson, 2004, 2008), cognitive behavioral therapy (Baucom et al., 2008; Dattilio, 1998; Epstein et al., 1988; Hazlett-Stevens & Craske, 2002; Schlesinger & Epstein, 1986), and Gottman's theory of couple therapy (Gottman, 1999; Gottman & Gottman, 2006, 2008). Unless otherwise noted, I am drawing from Johnson (2008) when referring to EFT. I will define the basic assumptions and concepts, interventions, and research of each theory. I will end with a

brief integration of the assumptions, concepts, and interventions of all three models.

## Emotionally Focused Therapy

### *Emotionally Focused Therapy Basic Assumptions and Concepts*

Emotionally focused therapy (Johnson, 2004, 2008) is an experiential therapy rooted in attachment theory. Emotionally focused therapy is experiential in that it remains true to the following principles: (a) the therapeutic relationship is curative in and of itself, and should be as equal as possible among its members; (b) support and validation of client experience is a central tenet to therapy; (c) people will make inventive and functional choices when given the occasion; (d) subjective and objective perceptions influence one another; (e) relationships by their very nature are transformative; and (f) cultivating remedial experiences for clients in the present is important (Johnson, 2008).

Emotionally focused therapy is grounded in tenets of attachment theory, first illustrated by John Bowlby (1969) in his explanations of loss with children and then applied to adult love relationships by social psychologists and couple and family therapists (Johnson & Whiffen, 2003; Shaver & Mikulincer, 2002). There are ten central tenets of attachment theory: (a) attachment is an innate motivating force; (b) secure dependence complements autonomy; (c) attachment offers an essential safe haven; (d) attachment offers a secure base; (e) emotional accessibility and responsiveness build bonds; (f) fear and uncertainty activate attachment needs; (g) the process of separation distress is predictable; (h) a finite number of insecure forms of engagement can be identified; (i) attachment involves working models of self and other; and (j) isolation and

loss are inherently traumatizing (Johnson, 2004).

Emotionally focused therapy depicts a healthy relationship as “the ability to be autonomous and connected” (Johnson, 2008, p. 113). Distress in a relationship is described as a product of attachment insecurity and separation distress. The tasks of EFT include creating a collaborative alliance, accessing and expanding emotional responses and experience, and restructuring interactions to include accessibility and responsiveness of each partner to the other.

Emotionally focused therapy focuses on the presence and expression of primary and secondary emotions. Secondary emotions are the explicit acting out of primary emotions that underlie them; primary emotions are often implicit and may not be clearly expressed. For example, a husband may feel angry (secondary emotion) towards his wife; this anger is fueled by his feeling of hopelessness (primary emotion) for their relationship. Therapists utilizing this model strive to effect change by altering habituated negative interactions created by couples’ expression of dysfunctional secondary emotions. Identifying negative cycles and experiencing new emotional communication is seen to change patterns and strengthen attachment in the relationship.

In a study conducted by Greenberg, James, and Conry (1988), researchers recognized five prototypes of change characteristic of EFT: (a) expressing primary feelings, which leads to modifications in interpersonal perception; (b) communicating feelings and needs; (c) gaining insight; (d) taking accountability for experiences; and (e) receiving validation from the therapist. These categories were identified by analyzing significant events in therapy for commonalities across a variety of cases and continue to

form the basis of change in EFT.

*Emotionally Focused Therapy*  
*Basic Interventions*

*Reflection* is an intervention in which “the therapist tracks the client’s experience, processing the experience with the client and being aware of how this particular client constructs his or her experience moment to moment” (Johnson, 2004, p. 78). This assists the therapist and client in understanding the emotional experience and how each member of the couple interprets that experience. For instance, a wife may recount how she sees a recent argument. The therapist would then reflect what she or he had heard her say.

*Validation, reframing, and self disclosure* interventions are grouped together because each works toward the goal of normalizing and validating couple emotional reactions. The therapist seeks to validate clients’ experiences by explicitly accepting any responses from the clients as acceptable and expected in the clients’ contexts. The therapist validates each individual’s experience without blaming the other partner. Clients often frame their behaviors and interactions as defenses or blaming; therapists can validate clients’ experiences by interpreting them through an attachment lens (Johnson, 2008). This is called *reframing*. For example, a husband’s withdrawal from his wife after an argument can be framed as his need to protect himself from her accusations. The wife’s accusations can be framed as her fear of losing such an important attachment figure. *Self disclosure* is another form of validation where the therapist uses personal experience to support the clients’ responses or join more effectively with the clients.

*Evocative questioning* and *empathic interpretation* interventions are alike in premise. Each is used to crystallize the experience of the client through the use of

concrete metaphors or interpretations. These interpretations provide new ways of understanding emotion and are given tentatively for clients to decide whether or not they fit their experiences. An example of this intervention is found in a therapist's response presented by Johnson (2004): "So right now, the fear says, 'Just shut down – just stay away and numb out.' Is that it? The fear says, 'This is hopeless'" (p. 137). It is very important to tentatively offer these interpretations to clients instead of assuming it is what clients are experiencing.

*Heightening* and *enactment* both focus on identifying and altering negative patterns of interaction. *Heightening* highlights certain responses or experiences that may maintain existing negative interaction cycles or may be new experiences that break the old cycle. Therapists may ask clients to repeat what they have said or enact their inner experiences more explicitly so that the clients may identify their gridlock and more readily alter them. *Enactment* is guided experience used by the therapist to help clients experience their inner realities more overtly. For example, a husband has disclosed in therapy the fact that he has never "let anyone in" emotionally. The therapist then asks the husband to tell his wife at that moment in therapy that he will not let her in and he never has. This is an example of coaching clients in new experiences to create new ways of experiencing that can break negative patterns.

### *Emotionally Focused Therapy Research*

Emotionally focused therapy has gained reputability as an effective approach to couples therapy. Byrne, Carr, and Clark (2004) carried out a meta-analysis of 20 studies reporting efficacy of EFT. Compared to control groups, EFT was found to demonstrate a

greater improvement in relationship distress. The mean effect size was 1.27, which means that couples treated with EFT had higher marital quality scores than 89% of control couples (Byrne et al., p. 383). All 20 studies reported that EFT-treated couples maintained statistically significant improvement compared to control couples up to two years after therapy ended.

## Cognitive Behavioral Therapy

### *Cognitive Behavioral Therapy Basic Assumptions and Concepts*

Cognitive behavioral therapy views psychological and relational dysfunction as the products of inaccurate attributions of meaning and learned behaviors (Dattilio, 1998).

For example, biases toward attending to threatening information or toward interpreting ambiguous situations as threatening contribute to excessive or unnecessary anxiety. Similarly, memory biases for distressing events or negative details of events may contribute to depressed mood. Learning to shift appraisals, core beliefs, and associated biases in attention and memory forms the basis of cognitive therapies. (Hazlett-Stevens & Craske, 2002, p. 2)

Cognitive behavioral therapy also takes an experiential approach by restructuring false cognitions and encouraging clients to experience feared situations or behavioral habits differently. Change is believed to occur when maladaptive thoughts and behaviors are replaced with more helpful responses and clients develop better coping skills (Dattilio, 1998).

Cognitive behavioral couple therapy (CBCT; Baucom et al., 2008; Epstein et al., 1988; Schlesinger & Epstein, 1986) is a brief therapy based on managing behavioral, cognitive, and emotional interactions as well as skill acquisition in deficient areas.

Cognitive behavioral therapy and CBCT are seen as synonymous in the current study

because CBCT is CBT applied to a system (specifically, couple) framework. A main premise of CBCT is that “members of a family [or couple] in most instances actively interpret and evaluate each other’s behaviors, and that their emotional and behavioral responses to one another are influenced by these interpretations and evaluations” (Epstein et al., p. 5). A cognitive behavioral couples therapist balances many different roles in therapy, including director, collaborator, educator, and facilitator. Goals of assessment are (a) to identify the presenting problem as well as possible areas of improvement in the couple relationship; (b) to recognize the cognitive, behavioral, and affective issues related to the individuals, the couple as a unit, and their environment, which influence the presenting problem; and (c) to determine whether couples therapy is the most appropriate venue through which to address these concerns (Baucom et al.). Collaborative, explicit goal setting is a large part of CBCT.

*Schema* or *schemata* are an integral part of CBT (Dattilio, 1998). Schema are fundamental central beliefs that people develop about what to expect from the world around them.

Life events activate an individual’s schemata. . . . Once triggered, these schemata shape the content of the individual’s stream of consciousness thinking, which is comprised of automatic thoughts. The occurrence of automatic thoughts is often outside of a person’s conscious control (e.g., frequently they appear as if by reflex and seem to have a life of their own). Often a person is not fully aware of them, particularly because frequently they appear in “shorthand” form rather than as fully articulated logical expressions. Although they involve untested inferences, they seem plausible, even though they may not be accurate representations of life events. (Epstein et al., p. 13)

Schema can inhibit or facilitate therapeutic benefit. In some cases, clients’ schemas may need to be identified and altered, especially those negative schema about relationships



that have been created and maintained through continued dysfunctional interaction.

Schema are used in individual cognitive function as well as personal relationships.

Schlesinger and Epstein (1986) stated that

interpersonally, each spouse's emotional and behavioral responses simultaneously result from his or her own cognitive appraisals of the partner's responses and, in turn, serve as stimuli that will be appraised by the partner. Intrapersonally, each partner's emotions, behaviors, and cognitions interact. A person appraises his or her own emotions and behaviors as well as those of a partner; in this process, cognitions, emotions and behaviors can be altered independently of any interaction with the partner. (p. 138)

Thus, we see that individuals' behaviors are determined by a complex interaction of emotions and cognitions about their partners and the world around them.

Another concept of the CBT model is the idea of *cognitive distortions* (Epstein et al., 1988). Cognitive distortions are

errors in logical thinking which distort rational conclusions from either internal or external sources of data. This process changes an individual's perception of his or her immediate reality, and this changed perception then can become the object of further distortions. (Epstein et al., p. 14)

Usually, cognitive distortions are a dysfunctional interpretation of data that lead to unhealthy conclusions. There are eight traditionally recognized distortions: arbitrary inference, selective abstraction, overgeneralization, magnification and minimization, personalization, dichotomous thinking, labeling and mislabeling, and mind reading (Dattilio, 1998).

### *Cognitive Behavioral Therapy Basic Interventions*

Interventions of CBT typically focus on one of three intrapersonal and interpersonal domains: cognitive, behavioral, or affective. Behavioral interventions

include behavior modification and skills training. Cognitive interventions consist of *Socratic questioning* and *guided discovery*, which are questioning techniques used to guide the client to discover information that may be used to identify alternate meanings and understandings to those to which they originally ascribe. An example of this may be asking a wife to hypothesize alternative reasons for her husband's withdrawal from high conflict situations in addition to her hypothesis that he does not care about what she has to say. This gives her the opportunity to identify options in addition to the ones she has always assumed, thus introducing her to a new way of thinking about the situation. Important aspects of each individual's cognitions include selective attention, attributions, expectancies, assumptions, and standards (Baucom et al., 2008). Behavioral or affective interventions focus on changing the experience and expression of emotions within the relationship. Each domain of intervention includes and influences the others, further evidencing the systemic nature of this theory.

*Homework assignments* are an important part of CBT because they provide opportunities to change behavioral patterns and experience new ways of interacting. Using behavioral assignments can help clients behave, think, and feel differently (Dattilio, 1998). This can help them identify new relational or personal skills that will help them function better within their contexts. Change does not necessarily have to be large; according to systems theory, a small perturbation in a system can lead to greater change (Becvar & Becvar, 2006). A behavioral change may lead to cognitive change, emotional change, or even more behavioral changes. This is similarly true for cognitive change and emotional change.

*Enactments* in session are another intervention that may be helpful to both clients and therapists. Sometimes, a CB therapist will ask a couple to reenact a recent argument so that the therapist can see how the couple interacts. This helps the therapist identify areas where the clients may lack skills or application of those skills. After these areas needing improvement are identified, the therapist can then prescribe behavioral assignments or coach enactments in subsequent sessions utilizing skills taught in therapy. Enactments can also reveal cognitive misattributions or extreme emotional reactivity that may also be addressed in therapy.

#### *Cognitive Behavioral Therapy Research*

Cognitive behavioral therapy has been empirically validated as an efficacious and effective therapy for many problems such as anxiety disorders, depression, eating disorders, couple problems, alcohol use, and pain management (Hazlett-Stevens & Craske, 2002). Butler, Chapman, Forman, and Beck (2006) conducted a literature review of 16 methodologically sound meta-analyses of CBT. They found large and moderate effect sizes for a number of different presenting problems; CBT was somewhat superior to antidepressants in treating adult depression. These cited studies support the efficacy of CBT in treating a wide range of individual disorders. CBCT is the most extensively evaluated approach for couples work. Baucom et al. (2008) reported that CBCT was the focal point for study in roughly “two-dozen well-controlled treatment outcome studies” (p. 61) and each concluded it is an efficacious treatment for couples in distress.

## Gottman's Couple Therapy

### *Gottman's Couple Therapy* *Basic Assumptions*

Gottman's couple therapy (Gottman, 1999; Gottman & Gottman, 2006, 2008) is a research-based approach that has identified negative interactions that lead to divorce and positive interactions that strengthen marriages. Gottman's famous "love lab" research provided evidence for the theory that

marriages that are headed for divorce or unhappy stability are characterized by greater negativity than positivity in interactive behavior and perception and by chronic levels of diffuse physiological activation and the inability to self-soothe or be soothed by one's partner. (Gottman, p. 85)

This theory posits that small behavioral changes repeated frequently over time lead to large changes in the relationship.

Through research and experience, Gottman has identified negative behaviors that, if acted out too frequently, lead to divorce. Gottman terms these behaviors the *Four Horsemen of the Apocalypse*. The first horseman is *criticism*, which often "appears as a complaint or episode of blaming that is coupled with a global attack on [the] partner's personality or character" (Gottman & Gottman, 2006, p. 5). It is the personalizing of the behavior to the other partner's persona that makes this conduct especially deadly. The second horseman is *defensiveness*, which manifests as retaliation made by individuals when they feel vulnerable or as though they are being attacked. Defensiveness is also a way to evade accountability in the relationship or situation. *Contempt* is the third identified negative behavior and is defined as "criticism bolstered by hostility or disgust. . . . Contempt often involves sarcasm, mocking, name-calling, or belligerence" (Gottman

& Gottman, p. 5). Contempt is often evident in one partner when the other is in a vulnerable position. The final horseman is *stonewalling*, which is characterized by one partner's shutting down and withdrawing from the interaction. This person does not react physically or verbally to anything being said, but acts as if she or he is unaffected by the situation at hand.

Gottman and Gottman (2006) also identified positive interactions that lead to stronger marital relationships. *Softened startup* is starting a conversation "softly" without blame or criticism of the partner. An example of a blaming startup is a wife's starting a conversation with her husband about their financial difficulties with the statement, "You are an impulsive buyer. You've never had self control." A softened startup version of the same topic could be, "I believe we need to budget our finances. What do you think?" Starting a discussion this way makes the partner more open to things being said and less defensive. The next two positive behaviors are usually found occurring together: *turning toward* the partner and *repairing* the conversation. A *repair attempt* is an effort made by one partner to deescalate enmity or anxiety in an interaction. This can come in the form of a smile, a joke, or an apology. When a repair attempt is offered, the other partner can either "1. turn away, ignoring the bid, 2. turn against, reacting with anger or hostility, or 3. turn toward, showing you're open, listening, and engaged" (Gottman & Gottman, p. 6). *Accepting influence* is the final positive behavior found to strengthen relationships by Gottman's research. Being stubborn or controlling in a relationship weakens that relationship; being "open to persuasion from each other" (p. 6) does the opposite.

### *Theory of Therapy*

Gottman's theory of therapy (Gottman & Gottman, 2006, 2008) assumes that therapy is, for the most part, dyadic. The focus is on improving the interaction of the couple as a skilled facilitator or coach so that when the therapist is no longer there, the couple can function on their own with the skills they have honed. According to Gottman (1999), the most effective time to teach these skills and positive responses in therapy is when the couple is in the same emotional state they are in at home. During highly emotional situations, the therapist's goal is not to calm the couple, but instead, give them the tools they need to carry on the interaction in a more functional way. This gives rise to another assumption of Gottman's therapy: it is not the therapist's job to soothe either partner; partners must learn how to soothe themselves and each other. This feeds into the idea that the therapist should not be made irreplaceable to the couple. Other premises of this therapy are that interventions should seem simple and undemanding and that interventions should be tailored to the clients' stage of relational development. For example, directing partners not to be offended when the other swears at them is a large task compared to asking them to not swear back (Gottman).

The basic goals of Gottman's therapy are the following: (a) decrease negative affect during conflict, (b) increase positive affect during conflict, (c) build positive affect during nonconflict, (d) bridge meta-emotion mismatches, and (e) create and nurture a shared meaning system (Gottman & Gottman, 2008). These goals are carried out using a variety of interventions established by Gottman. Emotionally focused therapy is embraced by Gottman. He believes that EFT's focus on emotion is an integral part of the

therapy process, but is lacking in certain areas (Gottman & Gottman). For instance, Gottman believes the areas of meta-emotions (the rules governing the experiencing and disclosure of emotions in one's family of origin) and relating emotionally in sessions is important, but that a sole focus on emotion is unhelpful.

Gottman (1999) also hypothesized that there are both solvable and perpetual problems in the marital relationship. Perpetual problems may be content based, but inevitably also include "1) basic differences in partners' personalities, and 2) basic differences in needs that are central to their concepts of who they are as people" (Gottman, p. 96). Solving problems is not as important as the processes used to discuss them. Gottman believed that the key to discussing important differences is each partner's letting the other know she or he will be accepted as she or he is. The "marital paradox" is that people will only change when they feel they do not have to change (Gottman).

### *Gottman's Couple Therapy Basic Interventions*

Gottman (1999) posited that interventions must be tailored to each couple's situation specifically, but that a general organization should be followed in each case. Gottman's process for therapy is to start with a swift, drastic change followed by structured changes and relapse prevention. The initial dramatic change is created by identifying the gridlocked problem and changing the affect around which that problem is discussed. The key is to identify the dreams that underlie the gridlock and help each partner to respect the other's dream to some extent. The next goal of therapy is to structure lasting change. The therapist does this by first helping the couple complete the following steps: (a) processing the argument in session after it has transpired; (b)

expressing their feelings without the presence of the four horsemen; and (c) fostering the ability to mend negative interactions during the argument (Gottman). After the couple experiences the initial change, the therapist focuses on important content issues, helping the couple practice the skills they have learned in an isomorphic fashion. When the couple can implement learned conflict resolution skills with one content issue, it is assumed that they can apply them to others (Gottman).

An intervention that is a large part of Gottman's theory of therapy is identifying and stopping the couple's use of the four horsemen. After these behaviors are distinguished, the therapist works to enhance the marital friendship through various interventions that seek to strengthen the couple's friendship and increase their understanding of one another (Gottman, 1999).

After negative interactions are discontinued and the couple's friendship is strengthened, the therapist then teaches the couple the four positive interactions: softened startup, turning toward one's partner, repair attempts, and accepting influence. These skills are then practiced in session while the therapist guides the resolution of a solvable problem (Gottman, 1999).

There are many interventions to improve interactions around unsolvable problems. One is helping the couple recognize ways they have already adapted to things they cannot change in their marriage and how they can use those skills in a particular situation. Recognizing and honoring each other's dreams is a large part of learning to deal with perpetual problems. Having each partner identify the other partner's view of the conflict and defend that view may provide insight into and understanding for the other



partner's conflict (Gottman & Gottman, 2008).

### *Gottman's Couple Therapy Research*

Gottman's therapy is well-known from the research conducted in his "love lab." The research included behavioral observation, structured relational interviews, in-depth assessment tools, and physiological measures (Gottman & Gottman, 2006). These evaluations resulted in the assumptions and interventions described above. Gottman's theory of *sentiment override* in wives has been empirically supported (Hawkins, Carrere, & Gottman, 2002). Sentiment override refers to the positive or negative feelings that color the perceptions couples have of each other, whether negative or positive. Carrere, Buehlman, Gottman, Coan, and Ruckstuhl (2000) conducted a longitudinal study of 95 newlywed couples investigating the ability of Gottman's oral history interview (Gottman, 1993) to predict stability or divorce within the first five years of marriage. The oral history data predicted marriage stability or divorce with 81% accuracy (p. 52).

### Theory Integration

Emotionally focused therapy is the central model to my integrated theory of therapy from which I conceptualize and understand couple interactions. Cognitive behavioral therapy and Gottman's couple therapy are then seen through this lens of EFT and are mostly used for specific concepts or interventions.

### *Assumptions and Concepts*

Although EFT, CBT, and GCT offer differing assumptions, concepts, and interventions, the ideas behind them integrate quite well. For instance, affect or emotion

is an integral part of all three models and each is experiential in nature (Epstein et al., 1988; Gottman & Gottman, 2008; Johnson, 2004). The focus of therapy for each model is on the present and future, but ventures into past experience where necessary to understand present beliefs or behavior.

Proponents of each model believe the therapist should act as a facilitator of new experience in therapy, behaviorally, cognitively, or emotionally. The avenue of change in each of these models of therapy is the couple's experiencing new ways of relating to each other and continuing to utilize learned skills. These new skills and ways of relating are solidified as each partner finds them satisfying. Each model works to make the therapist unnecessary to healthy dyadic functioning by teaching necessary skills and assisting in experiencing more helpful ways of relating. Emotionally focused therapy research fits well with Gottman therapy in that one can view ideas from each model in the context of the other model. The four horsemen cited in Gottman's work can be seen through an EFT lens as defense mechanisms using secondary emotions when what really underlies them is the primary sadness at the thought of being abandoned or fear that the security of the most important relationship is being threatened. Cognitive distortions can also be seen through an EFT lens because they are evolutionary, self-protective reactions to repetitive attachment injuries to fulfill the need for security.

### *Interventions*

The array of interventions used in these models overlaps in many ways. Each model includes some form of enactment. Emotionally focused therapy's version of enactment focuses on guiding new emotional experiences, while CBT and GCT

approaches center on directing new behavioral experiences and expanding cognitive comprehension. Observing couple interaction and intervening to stop negative cycles is also a part of each theory. Cognitive behavioral therapy identifies and alters dysfunctional thought patterns and seeks to provide understanding for both partners. Emotionally focused therapy's intervention of reflecting and reframing the couple's interaction helps solidify new experiences and, with the guidance of the therapist, the couple can create a new way of experiencing and understanding each other from an attachment perspective. Gottman's approach includes an initial observation of the couple's communication, followed by an explanation of potential behavioral modifications. The couple is then asked to reenact their previous interaction using the skills the therapist has helped them develop. In each of these versions of observation and intervention, the therapist explicitly and implicitly teaches relational skills. Each approach allows partners to identify the roles they play in maintaining negative interactions and the changes they can make to develop healthier outcomes.

### Systems Concepts

System feedback (Becvar & Becvar, 2006) plays a large role in each model. In CBT, the responses individuals or couples receive from situations, which are interpreted and explained through the individual or couple's schema, feed back into the system, which either strengthens or weakens original schema. For example, "automatic thoughts, whether accurate or not, elicit emotions and behaviors that are consistent with them. These emotions and behaviors themselves are stimuli that can serve as the life events that trigger another cycle of cognitive processing" (Epstein et al., 1988, p. 14). This feedback

also serves another important CBT concept: *reinforcement*. Reinforcement occurs when an experience or event increases the likelihood of a particular response's occurrence in a similar situation in the future. This is true in EFT as well as Gottman's model of therapy. When interventions are effective toward changes the couple wishes to make, new ways of interacting emotionally (EFT) or behaviorally (Gottman) introduce positive feedback into the dyadic system, strengthening new ways of relating that are more functional.

The influence of communication and information processing (Becvar & Becvar, 2006) is also a salient systems concept found in each of these models. Gottman and Gottman (2006) stress the importance of healthy partner communication and conflict styles. Cognitive behavioral therapy focuses on the schemas used to interpret information (information processing), whether they are erroneous, and if so, altering and challenging those thinking errors. Emotionally focused therapy seeks to create more open experiences of emotional communication.

Each of the models also takes into account system rules and boundaries (Becvar & Becvar, 2006). Every system has its own implicit rules about what behavior, thought processes, or emotional expressions are appropriate within the system. Each of the three theories in my integrated approach works to alter system rules that may impede healthy couple functioning. System boundaries are important in these models in terms of how much the couple system receives or rejects influence or suggestion from others, the therapist, and each other. In Gottman's theory of therapy, partners' accepting influence from one another plays a large role in marital happiness and stability (Gottman & Gottman, 2006).

## Pre-session Outlines

A basic initial session outline (see Appendix C) was created and applied to each couple's first session. This outline consists of the goals I have for an initial session including data collection, introduction of the clinic, and assessment of the couple, applicable interventions, and so forth. It contains the interventions or concepts that I deem most important to cover in a first session of couple therapy. It acts as a guide for the session, with digressions in response to each session's events. In subsequent sessions, this outline was modified and applied depending on my analysis of the previous session. It was informed by the couple's assessed strengths and skill deficits, and which model would be most appropriate for use in each case. These were used as guides for me to refer to throughout the session.

## Purpose

The purpose of this study was to examine the function and effectiveness of my integrated model of therapy. This was accomplished by applying my approach to three cases of couple therapy. This study elucidated and solidified my assessment and decision-making trends in the therapy process. I utilized an integration of three different theories of therapy because of the holistic approach it provides and because it fits my way of thinking. Each specific client or case presented with different problems that influenced which approach was most salient. Understanding my reasoning in the choice to apply certain models or interventions in certain situations may help me more easily recognize what interventions will be helpful in future situations. Charting the short-term and longer-

term outcomes of these approaches and specific interventions may also help me to understand which are most effective for couples in certain situations or with particular conflict styles or interaction patterns.

This study is like most case studies in that it applied a therapy approach to specific cases describing application and measuring outcome. The main goal was not generalizability to other therapists or to teach more about treating a specific presenting problem, but to help me as a therapist validate and understand my own practice. This makes it a unique and original contribution to therapy literature as a whole as well as my personal research.

The following research questions acted as directives for this study:

1. To what extent did I follow my integrated theory of therapy: EFT as my framework, with CBT and Gottman as contributors of specific interventions or concepts?
2. Did my theory and practice of therapy produce short-term change in session as well as longer-term change through the course of therapy?
3. How did each session inform my plan for others?

## CHAPTER III

### METHOD

#### Design

In this study, a recursive gathering and analysis of qualitative and quantitative data through case study was carried out to identify salient themes, patterns, and outcomes of intervention in a therapy setting. Systematic data collection and analysis guided the developing process of theory construction and intervention in therapy. This study was informed by Greenberg and Pinsof's (1986) research on process and its relationship to short-term outcome by focusing on the little "o's" or outcomes taking place within and between sessions and how they affect long-term results.

This research consisted of a qualitative, multiple-case study design. Skate (2000) described triangulation as the process of utilizing multiple perceptions to illuminate significance and verify the repeatability of an observation or analysis. According to the idea of triangulation, multiple sources of data increase the validity of the findings (Stake). This theory informed the current research endeavors. Thus, I gathered data through use of the Outcome Questionnaire 45.2 (OQ; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994), the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995), case notes, a reflection journal, teammate consultation, an intervention checklist, coding charts, and observations of video recordings.

## Sample

### *Participants*

All three couples that participated in this study presented of their own volition to Utah State University's marriage and family therapy clinic with marital concerns. They were asked to fill out the OQ as well as the RDAS on presenting to the clinic. The OQ was then administered during the consultation break of every session throughout treatment. The RDAS was administered a second time after the fourth session or, in the case of couple three, after the second session. More in-depth description of the clients, including their demographics and specific presenting problems is provided below.

*Couple one.* To maintain confidentiality for this study, all of the participants' names have been changed. Chris (25) and Ally (25) had been married for 3 years when they presented for therapy. They had an 18-month-old daughter. Chris completed high school and worked in production at the time of therapy. Ally completed some college and worked part-time. Neither partner reported taking psychotropic medications. The couple reported being members of the Latter-day Saint religion.

This couple presented with trust issues due to a "text affair" that Chris had had a few months before therapy. They reported that they were fighting much more often and did not feel as close as they had before the affair occurred. Chris said he thought he had ruined the relationship and turned out like his father, who cheated on his mother and whom he never wanted to be like. Ally seemed timid in the first session and, when asked to explain things, seemed to shy away from responding. Chris and Ally attended four sessions of 50-minute duration each. Each session was videorecorded and analyzed for



recurrent themes and patterns.

A pattern presented early in which the couple seemed to be caught in a pursuer/withdrawer cycle, Chris as the pursuer (trying to fix things) and Ally as the withdrawer (saying that nothing was wrong and not talking about it). Ally seemed to show signs of reserve and distrust toward me in the first session. Stonewalling in the form of retreating from Chris and ceasing communication seemed to play a central role in their conflict resolution or lack thereof as seen in an assessment enactment conducted in the first session.

*Couple two.* Zane (20) and Roxanne (19) had been married for about a year when they came to therapy. They married after they found out Roxanne was pregnant with their year-old son. Both explained that being married with a child at their young ages was not what they had wanted or planned on. Both were students at USU. Neither reported taking any psychotropic medications. The couple reported adhering to the Latter-day Saint religion.

Zane and Roxanne presented with complaints of trust, communication, and commitment problems. Roxanne reported previous experience with individual therapy at the MFT clinic in 2006. Zane reported no previous therapy experience. They were stressed by relational concerns as well as financial and child-rearing obligations. Roxanne reported pushing Zane away until he finally left. She thought that she did this to people to see whether they really loved her. At the time of therapy, Zane was living with his girlfriend with whom he had begun an affair a few months earlier.

Zane and Roxanne attended four sessions of 50-minute duration, which were

recorded. Each session was videorecorded and analyzed for recurrent themes and patterns. They attended additional sessions, but only the first four were used for data for this study. A pattern presented early in sessions where Roxanne would bring up something such as her feelings about their situation or something Zane could improve, and Zane would become overcome with guilt and disengage. Roxanne joined with the therapist quickly through validation of her experience. Zane was slower to join because of the shame and embarrassment from his situation, but warmed up when he realized the therapist empathized with him and was not judging him.

*Couple three.* Rich (28) and Alicia (23) had been married for 8 months and living together for 3 years when they came to therapy. They had a 4-year-old son and Rich had a 7-year-old daughter from a previous marriage who stayed with them for the weekend every 2 weeks. Rich worked in a warehouse and the couple also cleaned an office to make ends meet. Neither partner reported taking psychotropic medications. The couple reported adhering to the Latter-day Saint religion. Alicia's father committed suicide in 2001 for which she had previous therapy that she did not like. Their families lived nearby. The couple met when Rich was separated from his previous wife. His divorce took two and a half years to complete.

The couple presented with parenting disagreements. Alicia thought Rich disciplined their biological son more harshly than his daughter from his previous marriage. Alicia saw a lot of herself when she was young in Rich's daughter and warned him that if he did not intervene, bad things would happen. The couple was stressed by relational concerns as well as financial and child-rearing obligations. They seemed to be

caught in a pursuer (Alicia's trying to make Rich parent a certain way)/withdrawer (Rich's not talking about it because Alicia nagged too much) pattern.

The couple attended two sessions, the first of which was only 30 minutes because they took longer to fill out their paperwork than the allotted half hour. The second session was the traditional length of 50 minutes. They did not return for a third session. These two sessions were used for data collection for this couple. The couple seemed to join with the therapist quickly and was open with their concerns. Ten sessions with these three couples were used for the current study.

*Site.,*

Therapy sessions took place at a Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE)-accredited university marriage and family therapy master's program clinic. On contacting the clinic to set up an appointment, clients were notified that master's level students conducted the therapy under supervision and that the session might be recorded. Clients gave written permission for their information and data to be used in research.

#### Procedures

Ten sessions with three couples seeking marital therapy at the Utah State University Marriage and Family Therapy Clinic were the sources of data for this study. Each case was followed for up to four sessions of therapy; cases overlapped each other. Participants were recruited through advertisement of the MFT clinic, but came in for therapy of their own accord. No couples approached to take part in this study declined

participation. They were asked to sign separate informed consents for therapy and to participate in research (Appendix A). The form for research participation was explained by and signed in front of clinic personnel other than the therapist as to not influence the decision of clients to participate. Anonymity of subjects was preserved by assigning case numbers to data. A memo from the program director was received, approving the use of existing clinic data in this study (Appendix A). USU's Institutional Review Board for the protection of Human Subjects approved this study (Appendix A).

The couples involved in the study were selected using convenience sampling. These were assigned to me and each couple consented to participate in the research. Because of the qualitative nature of the study, the in-depth recursive analyses, and the focus on process and outcome, a sample size of three cases was considered adequate. Each couple was asked to commit to four sessions. For the purposes of this research, data were collected up to and including the fourth session of each case. The minimum number of sessions that could be used per couple was two. A minimum of eight to twelve sessions across three different cases was deemed appropriate to effectively answer the research questions. Ten sessions occurred and were analyzed.

## Instruments

### *Outcome Questionnaire*

The OQ was administered upon entering therapy and during the consultation break of every session up to four sessions. This instrument assesses for symptoms indicative of a wide range of disorders and is used to measure client progress throughout therapy. Clients responded to OQ questions using a 5-point Likert scale ranging from 0 to

4 (0 = never, 1 = rarely, 2 = sometimes, 3 = frequently, and 4 = always). The OQ provides a total score ranging from 0 to 180 as well as scores on three subscales: (a) symptom distress, (b) interpersonal relations, and (c) social role performance. The OQ is scored by adding the numbers reported for each question according to subscale and then adding those scores together to create the total score. Higher scores suggest increased distress with the clinical cutoff falling at 63 points for the total score.

Lambert et al. (1994) reported an internal consistency of .93 as well as concurrent validity coefficients with the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villaseñor, 1988), the Social Adjustment Scale (Weissman & Bothwell, 1976), and the Taylor Manifest Anxiety Scale (Taylor, 1953) ranging from .55 to .88 (p. 63). Amelioration of symptoms as reported by the OQ as well as by the couple is interpreted as successful change in this study. All subscales were used to assess client complaint as well as changes made throughout therapy to answer research question two.

#### *Revised Dyadic Adjustment Scale*

The RDAS was administered in order to understand the relational dynamics of each couple and give me a better understanding of the presenting problem. The RDAS is a 14-item instrument used to evaluate dyadic adjustment of distressed couples. Clients responded to RDAS questions using a 6-point Likert scale. It is scored on three different subscales: (a) consensus, (b) satisfaction, and (c) cohesion. These subscale scores are then added together to create a total score. Lower scores suggest increased marital conflict with the overall clinical cutoff score falling at 48. Busby and colleagues

described this instrument as reliable and valid, reporting an internal consistency score of .90 as well as a correlation coefficient of .68 ( $p < .01$ ) with the Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1959). The RDAS was used to answer research question two.

### *Therapist*

I provided therapy to all three couples. I have a bachelor of science degree in psychology and am a master's student in a COAMFTE-accredited marriage and family therapy program. I had one and a half years of clinical experience at the time of the study and employed a systems theory approach of therapy to these cases, consisting of an integration of emotionally focused therapy, Gottman's couples therapy, and cognitive behavioral therapy.

The nature of this study immersed me in every aspect of data collection and analysis. In this way, I can be seen as a type of instrument. Thus, my theory base and biases not only inform and influence the research, but are the basis and precedent for the research. This decreases generalizability to other therapists, but because the research is being conducted to inform my theory of therapy and change, that is not a concern in this study.

Biases that may be apparent in this study include my preference for the models in my approach. This preference influences the interventions I deem most appropriate and helpful. This may result in my overlooking or downplaying aspects of other theories or approaches that might be helpful.

My beliefs about marriage also influence my practice. I believe that marriage is a

divine institution, but also practical and the most functional and ideal relationship in which to organize society into manageable units. I believe that people should attempt their best efforts at preserving and enriching their marriages no matter what befalls them. I believe divorce can be appropriate but should be reserved for situations that merit its use, such as violence, infidelity, severe substance abuse, and other oppressive harms that keep either partner from happiness and self-progression.

Also, my perception of what creates a functional marriage is based on my life experiences. This influences my observation of couple interaction and my assumption of what change or progress looks like in therapy. I believe that a functional marriage is one in which partners are interdependent. Both are complete, happy, functioning persons on their own, but see their relationship as fulfilling and realize that together they can learn and progress in ways that they could not on their own. The relationship is somewhat of a catalyst in their progression to self actualization. Differences between each partner are embraced and seen as complementary instead of threats to the relationship. I perceive good communication as low in intensity, with each partner's attempting to understand and take into account the other's opinions and needs. This informs my practice in that I attune to and perceive events according to this preconceived notion of functionality.

Also influencing my practice of therapy are specific events that can be seen as my "hot buttons." For example, one "hot button" that I am aware of is when partners constantly blame, criticize, or belittle the other without taking responsibility for any role they may play in the problem. This usually results in my taking a more directive approach to therapy, resulting in more structured sessions as well as direct confrontation of clients'

actions in session. There are other issues of my own that affect my therapy and one hope I had for this study was that I would learn more about them.

I created my integrated theory of therapy as well as its implementation and means of data collection and data analysis, thus researcher bias (e.g., lack of objectivity) is inherent throughout this study. These biases will be taken into account in reporting the results and in the discussion section of this study.

### *Intervention Checklist*

An interventions checklist (see Appendix B for checklist and coding manual) was created to identify my fidelity to the models as well as interventions that may have induced change. The checklist consists of basic interventions from each model of therapy that I ascribe to. It consists of three separate lists according to the model. Each list contains three columns: the first identifies the intervention, the second is a box reserved for tally marks whenever the intervention was used, and the last column is the total number of times the intervention was observed from video observation written in number form to make it easier to analyze data. This was used to compare the proportion of times EFT interventions were used in comparison to both CBT and GCT interventions. A number of empty rows at the bottom of each checklist provided room for listing interventions from these three models not otherwise listed that the observer or I believed I used in the session. Also, a fourth, empty checklist was provided for concepts or interventions applied that were judged as not belonging to any of the three models included in the integrated theory. Each concept/intervention is described below with detailed operational definitions.



*Emotionally focused therapy.* The EFT portion of the intervention checklist was used to record my use of the following interventions or concepts: reflection, heightening, primary/secondary emotions, reframe, introduction to negative cycle, tracking negative cycle, and enactment. A description of the operational definitions of these concepts and interventions is required in order to help establish inter-rater reliability of observations using the checklists. These descriptions are found below. A number of the concepts/interventions from the approach-specific portions of the checklist overlap. The differences between these interventions are their focus. For instance, an enactment in EFT focuses on each partner's altering his or her experience specific to emotions, while CBT enactment is specific to thought processes and GCT enactment is specific to the four horsemen, repair attempts, and so on.

Reflection is my tracking and processing the clients' experiences with them in the sessions. For identification purposes, reflection was operationalized as any time I repeated the clients' descriptions of their experiences either in the client's words or in my own words, without adding any speculations of my own as to what the client was experiencing.

Heightening is used to highlight certain responses or experience that may be maintaining current negative interaction patterns. Operationalized, heightening was seen when I asked clients to repeat a specific phrase or reaction in order to make the negative cycle more obvious and to show that person's role in that cycle.

Primary/secondary emotions can be operationalized in many ways. Introducing and educating the clients on primary and secondary emotions as well as applying them to

the clients' current situation and helping them identify when they are utilizing them are ways in which primary and secondary emotions are operationalized in this study.

A reframe can be identified as my educating the couple on attachment theory or interpreting client experiences and reactions through an attachment lens. This is done by emphasizing the human need for security. Many times, this can overlap with the use of primary and secondary emotions in therapy.

Tracking the negative interaction cycle can be seen as any time I seek to elucidate the clients' emotional experience of their negative cycle that is identified in the first session. This can be done by asking them questions such as, "What usually happens now?," introducing them to the cycle the therapist has observed, or educating them on typical negative cycles that are experienced by couples. Reframing partners' reactions in term of the negative interaction cycle (e.g., pursuer/withdrawer) is also an important part of tracking the cycle.

I also used enactment, which was characterized by my asking clients to enact their emotional experiences, usually their negative interaction cycles, in different ways. Enactments also arose spontaneously and were guided by me.

*Cognitive behavioral therapy.* The CBT portion of the intervention checklist was used to identify my use of the following concepts and interventions: guided discovery, homework assignment, enactment, cognitive distortions, and tracking negative cycle.

Guided discovery can be defined as the therapist's use of logical questioning to help clients identify alternate ways of viewing their current situations or experiences. When observing therapy, guided discovery was seen as my asking leading questions with

the goal of client insight.

Homework assignments are very easy to identify in therapy. I introduced them as needing to be completed before the next session.

Enactments were observed in therapy as reenactments of recent arguments or conflict. They also were used as in-session experiments with different behavioral or cognitive techniques. A CBT enactment was distinguished from an EFT enactment when I prescribed experiences focusing on behavioral or cognitive processes instead of emotional processes.

I introduced and educated the clients on the concept of cognitive distortions. Interventions utilizing the idea of cognitive distortions were also identified when I applied the concept to the clients' current situation.

Tracking the negative cycle in CBT is similar as in EFT except that with CBT, the focus was on the specific cognitions or behaviors behind the cycle instead of emotions. Obviously, many of these ideas overlapped and the context of the situation or couple distinguished them from one another.

*Gottman's couple therapy.* The GCT portion of the intervention checklist was used to identify my use of the following concepts and interventions: four horsemen, couple friendship, softened startup, repair attempt, accepting influence, solvable versus perpetual problems, enactment, positive sentiment override, and dream recognition.

Each concept listed in the GCT portion of the checklist is an explicit psychoeducational and observably behavioral intervention utilized in session. Each can be used by educating clients on its effects on the couple's relational functioning as well

as applied to their current situation, whether it is by observation of the therapist or use in an intervention specific to the couple.

Each concept was identified when I introduced the concept or educated the clients on its importance in couple relations. Each also was recognized when I tracked its use in the couple's interaction or applied it to a homework assignment.

Enactments may be the one intervention listed that is not as easily recognized as the others in terms of specific approach. Enactments can be observed in therapy as reenactments of recent arguments or conflict. Usually this consists of an assessment enactment, where I asked the couple to discuss a topic and observed their interaction; or a structured enactment, where I restructured the interaction, asking the partners to experiment with different approaches instead of their usual behavioral patterns. A GCT enactment is distinguished from EFT or CBT enactments in that the focus is on identification or application of concepts particular to this model only.

### *Second Coder*

A second coder was a source of triangulation for data collection. This coder has a bachelors of science in psychology and was also a master's student in the same marriage and family therapy program as myself. He has one and a half years of clinical experience and also employs a systems theory approach of therapy, consisting of an integration of emotionally focused, solution-focused, and experiential therapy.

The second coder was asked to observe my sessions, either live or recorded, and to fill out the interventions checklist according to what he saw and inter-rater reliability was computed (see Table 1). Prior to this, he was provided with a manual that defines

Table 1

*Intervention Checklist: Inter-Rater Reliability*

	Session 1	Session 2	Session 3	Session 4
EFT				
Reflection	.83	.86	.50	.90
Heightening	.50	.86	.80	.87
Primary emotions	1.00	.67	1.00	.67
Reframe	1.00	.67	1.00	.67
Introducing negative cycle	.50	.00	.00	1.00
Tracking negative cycle	1.00	.76	1.00	1.00
Enactment	1.00	.50	1.00	1.00
Validation	.00	1.00	1.00	1.00
CBT				
Guided discovery	.00	1.00	1.00	1.00
Homework assignment	1.00	.00	1.00	1.00
Enactment	1.00	1.00	1.00	1.00
Cognitive distortions	.00	1.00	1.00	1.00
Introducing negative cycle	1.00	.00	1.00	1.00
Tracking negative cycle	1.00	.86	1.00	1.00
GCT				
Four horsemen	1.00	1.00	1.00	1.00
Couple friendship	.50	1.00	.50	1.00

*(table continues)*

	Session 1	Session 2	Session 3	Session 4
Softened startup	1.00	1.00	1.00	1.00
Repair attempt	1.00	1.00	1.00	1.00
Accepting influence	1.00	1.00	1.00	1.00
Solvable/unsolvable problems	1.00	1.00	.50	1.00
Enactment	1.00	1.00	1.00	1.00
Positive sentiment override	1.00	1.00	1.00	1.00
Dream recognition	.00	1.00	1.00	1.00
Relationship history	1.00	1.00	.00	1.00

each intervention on the list and provides its operationalized definitions (see Appendix B).

Inter-rater reliability between the therapist and the second coder was computed upon completion of their first intervention checklist filled out after the first session. It was computed using simple percentage of agreement. Each coder watched the DVD recording or observed the live session, filled out the checklists independently, and met to compare notes and resolve differences. This was repeated for the next three research sessions. Table 1 reports the inter-rater reliabilities for each intervention observed.

The second coder also was a source of consultation on each case. Descriptions of consultations and how they influenced my plan for subsequent sessions were included in the reflection journal.

### *Videorecording Coding Chart*

I created a videorecording coding chart in which I rated myself on my application of each intervention and described client responses. The coding chart contains five categories of very poorly, somewhat poorly, somewhat well, very well, and no opportunity to indicate whether I used an intervention in session and, if I did, how well I thought I used it. I did not supply a rating for every single time an intervention was used or observed. Ratings represent how I felt I applied the intervention generally throughout the session. I included reasons for my evaluations. I then described the clients' responses in detail. This coding chart was used to identify my judgment of the effectiveness of the intervention as well as the outcome according to client response. After every session, I evaluated my approach, identified positive and negative outcomes within the session, and used this information to construct my approach to the next session or case. A separate coding chart was created for each session using the pre-session outline.

### *Case Notes*

Case notes laid out the course of each session: what I did, how the clients responded, and so forth. The context of the therapy session was explained; for example, I recorded information about reports of fights right before sessions, attachment injuries occurring during the week, or significant insights that were experienced outside of therapy. Any changes that I observed in session or compared to the previous session were explained. Client reports of change since the previous session were also recorded. This information helped to identify the circumstances and contexts influencing my application of interventions and the direction the session took. This information also

helped me construct my plan for the next session.

### *Reflection Journal*

The reflection journal contains immediate reflections after I watched session recordings and consulted with the second coder or thought about following sessions. Impressions from therapy and decision-making rationale were explained. This journal contains notes that describe how decisions were made to use certain interventions such as what happened in session, what data influenced the use of which intervention, and how reviewing that decision process altered the plan for the next session. My experience of client reactions and how that influenced my use of specific interventions was also included. Within-session changes that were noticed were identified and explained. The journal also includes clients' OQ scores and their implications for short-term or between-session changes. The reflection journal contains the following tabs: (a) post-session reflections, (b) DVD reflections, and (c) teammate consultations.

Therapy-session data were recorded using observations of DVDs, case notes, and my personal observations in the reflection journal. Confidentiality of data was maintained by storing the data in a locked cabinet behind two locked doors in the Family Life Center. DVDs were destroyed after sessions were viewed and coded. There is no identifying information on the coding sheets. Confidentiality of case notes is preserved via state and federal regulations that do not allow the clinic or the therapist to identify clients outside the clinic. Similarly, I kept confidential notes that were not part of the official client record, which is current practice at the USU MFT clinic. These notes do not include identifying information, and charts or other data reduction instruments similarly do not



include personal identifying information.

## Data Analysis

### *Recursivity of Analysis*

Data were collected and analyzed in recursive waves after each therapy session. The initial pre-session outline and videorecording coding chart were utilized in the first session of each case. Following the first session, case notes were recorded as well as post-session reflections in the reflection journal to help me remember the context and layout of the session. The journal was also used to record data that influenced my use of certain interventions and how those decisions were made. The second coder and I then observed the DVD recording of the session and tracked use of interventions with the intervention checklist. My insight or reflections of the DVD recording were added to the reflection journal under DVD reflections. Feedback from the second coder and its influence on my plan for the next session were also included in the reflection journal in the teammate consultation section. The effectiveness of each intervention and client responses were then recorded and analyzed using the coding chart. Insight gained from this process or realized before the next therapy session was also included in the post-session reflections section of the journal.

Following each session of each case, I examined the pre-session outlines and altered them, resulting in coding charts adapted from that outline. Outlines were created through analysis of the data collected from the previous session. This cycle of application, collection, analysis, and revision of plans continued until data collection was complete.

*Research Question One*

To what extent did I follow my integrated theory of therapy: EFT as my framework, with CBT and GCT as contributors of specific interventions or concepts? Research question number one was answered in terms of how I followed my integrated theory in the following domains: (a) in general, (b) in proportion of use of EFT as opposed to the others, and (c) my use of interventions of other models outside of the three I have specified. Part A of this question was answered using coding charts to (a) identify how I thought I applied each intervention, especially as it applied to the pre-session outline, and (b) whether my application of each intervention was utilized within an EFT framework. Part B was answered using the intervention checklist filled out while watching the DVD recordings of each session. After totals were taken of my implementation of different interventions, they were examined to identify whether the majority were related to EFT in proportion to the other models. To answer part C of this question, I looked at the intervention checklist for interventions used that do not belong to EFT, CBT, or GCT. This process was supplemented by observations I made in my reflection journal, in which I asked myself whether my approach to each session was grounded in EFT while utilizing CBT and GCT principles. I also identified and explained times when I used interventions from models outside of my integrated theory.

*Research Question Two*

Did my theory and practice of therapy produce short-term change in session as well as longer-term change through the course of therapy? The OQ was filled out before or during every session and the results were used to track changes made between

sessions. The RDAS was completed prior to the first session and after the fourth session, or in the case of couple three, the second session, to identify longer-term changes. The client-response section of the coding chart was used to identify changes I saw in session. Case notes also played a large role in identifying within-session change as well as longer-term progress. Relevant notations that I made in the reflection journal were used to assess client progress. In the journal, I noted client reports of change as well as changes I observed as the results of specific interventions or of the therapy process in general.

### *Research Question Three*

How did each session inform my plan for others? This research question was answered using every source of data collection. The case notes laid out the course of each session, what I did, how the clients responded, and so forth. The intervention checklist identified specific interventions used and their frequency. The videorecording coding chart reported client responses to interventions. The reflection journal identified the process of my decision-making, illuminating the influential information taken into account when I created goals for therapy as well as interventions used to meet them. The OQ and RDAS helped by elucidating certain problem areas of the couple relationship which were addressed in therapy. I used this information to reflect on and describe how what happened in each session affected my decision for planning each ensuing session.

### *Within-Case Analysis*

Findings are reported in the results section of this document according to each case. The couples are introduced and their presenting problems explained. A brief synopsis of their therapy treatment is described. Each research question is answered

within the context of that couple and their case. Emergent themes or patterns are identified and explained, such as specific interventions that one couple found especially helpful throughout therapy or the applicability of one specific model and its interventions to a specific presenting problem.

## CHAPTER IV

### RESULTS AND INTERPRETATIONS

Findings are reported according to each case. The couples are introduced and their presenting problems explained. A brief synopsis of their therapy treatment is described. Research questions are answered within the context of each case. Emergent themes and patterns are identified and explained, such as specific interventions that one couple found especially helpful throughout therapy or the applicability of one specific model and its interventions to a specific presenting problem. Note the title of this section is “results and interpretations”. For the purposes of this study, interpretations specific to each couple are included in this chapter and discussed further in the next chapter.

#### Couple One

##### *Couple Description*

Chris (25) and Ally (25) had been married for 3 years when they came for therapy. This couple presented with trust issues due to a “text affair” that Chris had had a few months before therapy. They reported that they were fighting much more often and did not feel as close as they had before the affair occurred. Chris and Ally attended four sessions of 50-minute duration each. They attended additional sessions, but only the first four were used for data for this study. A pattern presented early in which the couple seemed to be caught in a pursuer/withdrawer cycle, Chris’s being the pursuer (trying to fix things) and Ally’s being the withdrawer (saying that nothing was wrong and not talking about it).

*Research Question One*

To what extent did I follow my integrated theory of therapy: EFT as my framework, with CBT and GCT as contributors of specific interventions or concepts? Research question number one is answered in terms of how I followed my integrated theory in the following domains: (a) in general, (b) in proportion of use of EFT to the others, and (c) my use of interventions of other models outside of the three that were specified. Coding charts and intervention checklists filled out following each session were used to answer this research question.

*Intervention checklist.* Totals were computed of my implementation of different interventions using the intervention checklist used during observation of therapy by the second coder or of my observation of videorecordings. Data were examined to identify whether the majority of interventions were EFT in proportion to the other models. The tallies of interventions utilized from EFT, CBT, and GCT were totaled and compared. From an examination of these tallies across all four sessions, EFT was found to be used 122 times compared to 13 times that CBT interventions were used and 7 times that GCT interventions were used in this therapy case.

Table 2 shows the frequency of interventions observed across every model used in each session with couple one. An examination of this table shows that the use of interventions from CBT and GCT decreased as sessions progressed. For EFT, instances of reflection, heightening, and reframing increased as the sessions progressed. This is consistent with EFT theory in that the therapist must create an alliance with the couple and prove therapy as a safe place to be able to experience emotions in a new way as

Table 2

*Interventions Observed for Couple One*

	Session 1	Session 2	Session 3	Session 4	Totals
EFT					
Reflection	5	7	10	8	30
Heightening	2	6	15	10	33
Primary emotions	1	3	2	1	7
Reframe	3	3	3	4	13
Enactment	1	2	4	0	7
Introducing negative cycle	2	1	0	0	3
Tracking negative cycle	5	14	1	9	29
EFT totals	19	36	35	32	122
CBT					
Guided discovery	1	0	0	0	1
Homework assignment	1	0	1	0	2
Enactment	1	0	0	0	1
Cognitive distortions	0	0	0	0	0
Tracking negative cycle	0	1	0	0	1
Introducing negative cycle	1	7	0	0	8
CBT totals	4	8	1	0	13

*(table continues)*

	Session 1	Session 2	Session 3	Session 4	Totals
<b>GCT</b>					
Four horsemen	1	2	0	0	3
Couple friendship	1	1	0	0	2
Softened startup	0	0	0	0	0
Repair attempt	0	0	0	0	0
Accepting influence	0	0	0	0	0
Solvable/unsolvable problems	0	0	0	0	0
Enactment	1	0	0	0	1
Positive sentiment override	0	0	0	0	0
Dream recognition	0	1	0	0	1
GCT totals	3	4	0	0	7
<b>SFBT</b>					
“What would it look like?”	0	1	2	0	3
“What would be different?”	0	1	0	1	2
Miracle question	0	1	1	0	2
SFBT totals	0	3	3	1	7

sessions progress. These interventions also played an important role in tracking the couple’s negative interaction cycle. Introducing the negative cycle was the intervention used the most from the CBT model, while interventions involving the four horsemen



were used the most from GCT model.

The intervention checklist contains a section to identify interventions that do not belong to EFT, CBT, or GCT. According to my observations noted on the intervention checklists, the only interventions utilized with this couple that were outside of the chosen integrated theory were from solution-focused brief therapy (SFBT; de Shazer, 1985), which were used seven times. They included the following interventions: (a) “What would that look like?,” (b) “What is different?,” and (c) the Miracle Question. These were used to identify behavioral changes that were made or could be made to improve the couple’s relationship. Use of SFBT interventions increased as sessions progressed. Discussion of this approach is included in Chapter V.

*Coding charts.* Data from the videorecording coding charts indicate that in the majority, I applied my interventions somewhat well to very well by my own evaluation (see Table 3). I did not supply a rating for every single time an intervention was used or observed. Ratings represent how I felt I applied the intervention generally throughout the session. These data indicate that I applied interventions that were consistent with the pre-session outline. I did, however, deviate a few times due to client responses to emotionally charged interventions. Chris and Ally seemed very uncomfortable disclosing their emotional experiences or making themselves vulnerable, especially Ally. For instance, on numerous occasions, Ally responded to interventions such as heightening or enactments by saying, “I don’t know.” I also thought there were many times I became just as stuck in their situation as they were. This prompted me to utilize interventions outside of my own

Table 3

*Videorecording Coding Chart Results: Intervention Rating Frequencies, Couple One*

	Session 1	Session 2	Session 3	Session 4	Totals
No opportunity	2	1	0	0	3
Very poorly	0	0	0	0	0
Somewhat poorly	2	1	0	0	3
Somewhat well	3	7	3	4	17
Very well	3	1	4	4	12

theory because the couple was so uncomfortable.

My perception of the ease with which concepts from each model integrated together made it easy to apply them within an EFT framework. The negative interaction cycle, primary and secondary emotions, and the four horsemen were introduced in the first session. Each was explained in terms of the others. For example, I reframed Ally's stonewalling as the withdrawer portion of the pursuer/withdrawer pattern. I also reframed her stonewalling as a secondary emotion being expressed while her primary emotion was hopelessness that talking about things could not fix anything.

*Reflection journal.* According to my reflection journal for Chris and Ally's therapy, my approach changed throughout the four sessions. In the first two sessions, I utilized an EFT framework as well as interventions from CBT and GCT, but when I did not receive the desired client response, I deserted my theories for interventions associated with solution-focused therapy (de Shazer, 1985). I did this partially because I wanted to

understand what kind of concrete changes the couple wanted as well as to increase hope in the session. The other reason I did this was because my earliest training was in SFBT and it seems to be what I revert to when I feel stuck in my usual approach.

In the third session, I decided that whether or not the couple felt comfortable with emotions, I was going to try my best to implement the concepts and interventions of my theory. I believed that what I saw as resistance in this case was even more reason to continue using my theory, because it was probably what was keeping the couple from improving their relationship. Instead of avoiding the stuckness I felt and using an approach I am less comfortable with in terms of effecting change, I embraced and heightened the stuckness so the couple would realize that something different was necessary for change.

I continued this approach in the fourth session. I stressed EFT concepts and interventions and continued to heighten the stuckness of their situation. Chris and Ally responded well, expanding on their emotional experiences and framing them in terms of the couple's negative cycle. However, both continued to use their former responses to need enactments, Chris's saying that no needs were met by his prior texting relationship and Ally's saying that there was nothing Chris could do to undo the effects of the affair.

### *Research Question Two*

Did my theory and practice of therapy produce short-term change in session as well as longer-term change through the course of therapy? The OQ was filled out every session and the results were used to track changes made between sessions as well as over time (see Table 4 for overall and subscale scores across the sessions of therapy). Chris

Table 4

*OQ Scores, Couple One*

	Session 1		Session2		Session 3		Session 4	
	C	A	C	A	C	A	C	A
Symptom distress	41	50	34	44	33	31	30	33
Interpersonal relations	16	17	12	17	17	18	19	17
Social role performance	12	10	8	7	6	6	10	8
Overall	69	77	54	68	56	55	59	58

*Note.* C = Chris and A = Ally.

scored 69 points overall in the first session, while Ally scored 77 points overall. Each partner's overall score dropped in the next session to 54 and 68 points respectively. Ally's score continued to drop in the third session to 55 points, while Chris's score increased to 56 points. In the fourth session, both partners' scores increased three more points. Cutoff scores for the OQ are (a) overall: 63 points, (b) symptom distress: 36 points, (c) interpersonal relations: 15 points, and (d) social role performance: 12 points. Thus, we see that both partners' overall scores dropped from the clinical range to the nonclinical.

OQ subscales provide more details about these changes. Both partners' subscale scores, higher on symptom distress and interpersonal relations, seemed congruent with the couple's presenting problem, which was a text affair. Chris's subscales dropped 11 points on symptom distress, but increased 3 points on interpersonal relations over the four sessions. Ally reported a 17-point drop in symptom distress, but her scores stayed the

same on the interpersonal relations subscale. According to these scores, both partners reported continued distress in the area of interpersonal relations in the clinical range, but decreased their symptom distress to the nonclinical range by the fourth session.

Chris and Ally completed the RDAS prior to the first session and after the fourth session to identify longer-term changes in perception of couple conflict. Ally scored 50 points overall at the first session followed by a report of 51 points overall in the fourth. According to the RDAS, lower scores indicate less consensus, satisfaction, and cohesion. Chris scored 54 points on the first RDAS administration and 56 on the second in the fourth session. The clinical cutoff score for the RDAS is 41. This lack of change in RDAS scores seem to reflect a similar trend on the interpersonal relations subscale of the OQ.

*Summary of change.* According to case notes, coding charts, and my reflection journal, the couple seemed uncomfortable and resistant to the therapeutic interventions in the first session, but seemed more comfortable and cooperative as therapy went on. In the first session, the couple seemed to experience difficulty understanding the concepts I introduced and answered, “I don’t know” to many of my questions about their emotional experiences.

The second session showed progress in that they seemed to understand concepts better, apply them to their situation, and disclose more about their experiences. For instance, Ally was able to identify her primary emotion of hopelessness when she thought of her current situation. The couple did, however, struggle with identifying needs that were not being met in the relationship previously or at the time of therapy, and how they

could be met. Chris, especially, struggled, saying that no needs were being met by his affair earlier and that his wife met all his needs currently and in the past. This caused more confusion for Ally because she did not understand: if nothing was missing, why would he cheat on her?

In the third session, the clients were still somewhat inhibited in disclosing their emotional experiences, but after I explained to them that I would not stop pushing them, they were more open. They participated in enactments when I directed them to ask one another questions they previously had not or broach topics they previously had not been able to discuss. The couple's ability to identify and track their negative cycle also improved and Chris commented that learning this had been one of the most helpful things he had gained from therapy to that point. The couple also was much more open in expressing needs not being met currently and at the time of the affair. Ally expressed that Chris was like a different person; he ignored her and even treated their child differently around the time the affair started.

By the fourth session, the clients seemed to have mastered the concepts and interventions used in therapy. They were much more open than in their first session and seemed to view their problem in terms of primary and secondary emotions, their negative cycle, and attachment theory. Although the clients made progress in understanding the constructs from the models and in their behaviors, it did not seem to do much for Ally's feelings of hopelessness about the relationship. She still did not seem willing to make herself vulnerable enough to give Chris another chance. The fourth session ended on the same note as the third. Ally could not understand why Chris had cheated and she felt that

nothing could change until he told her why. Chris could not give a reason.

### *Research Question Three*

How did each session inform my plan for others? This research question was answered using every source of data collection. Case notes laid out the course of each session: what I did, how the clients responded, and so forth. The first session consisted mostly of assessment. From the assessment, I observed that the couple was exhibiting a pursuer/withdrawer cycle and that stonewalling (GCT) played a large role in the relationship. Because of this observation, I decided to introduce them to and educate them on the concept and application of the four horsemen (GCT) as well as their negative interaction cycle (EFT). I wanted to stress the importance of identifying and changing these behaviors, so I gave them a homework assignment to identify their use of the four horsemen. I also wanted to increase positive interactions, so I told them to take part in an activity they both enjoyed together. The plan for the second session involved processing instances in which they saw themselves exhibiting the four horsemen or their negative cycle.

The second session occurred over a month later, so the plan was altered to include changes they had experienced during the previous month and what had kept them from coming back earlier. The couple reported no changes and that they had gone mattress shopping for their homework assignment. They explained they had not returned earlier because of the fee. I asked whether they had used the four horsemen in any of their interactions over the previous month. Chris said that he saw Ally stonewalling during conflict. This led me to process the negative cycle in detail as it pertained to the

concepts introduced as well as expounding on each partner's experience of that cycle.

Chris expressed that he felt helpless in the cycle, while Ally expressed hopelessness that anything could be done to save the relationship. Neither partner was very forthcoming in elaborating on their experience and "I don't know" was Ally's repetitive response to my questions.

At this point, I was struggling with where to go in the session because of what I perceived as a lack of participation from the clients, so I decided to ask the Miracle Question (SFBT) to identify goals the couple wanted to accomplish and to increase hope. The couple reverted to more "I don't know" responses and adopted suggestions I made without thinking much about them. For instance, when I asked what would be different if the problem was gone, neither partner could think of anything. I suggested that maybe they would be smiling more or touching, which the husband agreed to right away. When I asked details about what the smiling looked like, he could not think of any. I decided to give them homework for the next week to go on a real date (not mattress shopping) alone together (not with other couples or with their baby present).

The third session was influenced by the previous session in that much more education was used. I did not know whether EFT and the elaboration of personal, emotional experiences would be helpful for this couple. I thought perhaps it was too early for the partners to express such personal emotions to one another; perhaps they did not feel safe enough in therapy to do so. I introduced concepts of attachment theory and primary and secondary emotions, and applied them to the couple's current situation. The negative cycle was also elaborated upon. The couple, yet again, had difficulty responding



to questions about their experiences. I felt stuck and opted to ask more solution-focused questions to get an idea of where the couple wanted to go, such as what things would look like if they were improving. The couple reverted to their responses of, “I don’t know,” which exacerbated my frustrations. The homework assignment for the couple was to identify when they were being caught up in their negative cycle within the next week.

The fourth session was influenced by my view of the couple as resistant. I decided to explain to the couple that the relentless focus on emotions was necessary for progress in therapy and that I would continue to push them. This seemed to make the couple try a little harder to elaborate on their emotional experiences. When asked about their homework assignment, they reported they had not fought at all during the previous week. Ally explained that she thought it was because of the hopelessness she felt that even bringing up the texting affair was pointless and would not fix anything. We tracked and processed their negative interaction cycle in much more detail due to the increase in what I saw as their willingness to do so. Processing the cycle showed that the couple would get stuck when Ally would ask Chris why he had even started texting the other woman and he said he did not know. I thought that facilitating a needs enactment might help identify what needs might not have been met in the past and currently in the relationship without blaming either partner for the affair. Chris again responded that all his needs were met by his wife in the past and at the time of therapy. Ally responded that she did not know what she needed. I then asked what small things they could do for one another to meet their needs when they were feeling unsafe in the relationship. Ally came up with the idea of Chris’s telling her he loved her as a way to help meet her needs. When asked what Ally

could do to make Chris feel better, he said she could refrain from telling him, “You don’t have to do that” when he tells her he loves her.

The couple’s homework assignment for the next week was to identify their use of primary and secondary emotions during the next week and to try to meet one another’s needs using the ideas we had generated in session. I thought this homework assignment would be helpful so that each partner could start to understand how he or she expressed primary emotions in the form of secondary emotions with one another, so that later they could try to share the primary emotions with each other. I thought the second part of the homework would be helpful because it started the application of small changes in relating that would interrupt the couple’s negative interaction cycle.

In addition to case notes, the intervention checklist identified specific interventions used as well as their frequency. The three interventions utilized the most throughout each session with this couple were reflection, heightening, and tracking the negative cycle (see Table 2).

An example of reflection was when Ally explained that she could not think of anything Chris could do to help their situation and I stated, “So, you feel like there is nothing he can do to fix the current situation?” I also heightened Ally’s experience by following my reflection with the following statement: “So, nothing can be fixed? You’re hopeless? There is no point in working on this relationship if Chris doesn’t know what was missing in the first place?” The goal of this statement was to heighten Ally’s emotional experience and identify the primary emotion underlying her response. This would then lead to tracking the negative cycle, where I could ask what listening to his

wife's response was like for Chris, how he typically could respond, and how both partners' responses fit into this negative cycle. The frequency with which these interventions were used was influenced each session by client response, which either led to an increase or decrease of their use in subsequent sessions.

The videorecording coding chart also allowed me to record client responses to each intervention. This couple's responses to interventions played a large role in altering my plans for subsequent sessions. The coding chart data show that the couple's responses to interventions vacillated from uncomfortable and even resistant to accepting and willing to work with me throughout therapy. This challenged my use of the interventions because I sometimes found it difficult to influence the clients to participate and was not sure whether the interventions actually fit the clients.

The reflection journal identified the process of my decision-making, illuminating the influential information taken into account when creating goals for therapy as well as interventions used to meet them across sessions. The goals from this couple's treatment plan included (a) promoting alternate emotional experience, (b) helping the clients identify their use of the four horsemen, and (c) identifying the negative interaction cycle and intervene in it. These goals were influenced by the patterns I observed in early sessions as well as the general goals for EFT. For example, Ally's use of what I identified as stonewalling influenced my plan to educate the couple about the four horsemen. I framed the horsemen in terms of attachment theory in that stonewalling was a way of expressing that Ally felt too hopeless about the situation to even try to fix things, so she withdrew.

The goals of promoting alternative emotional experiences and identifying and altering negative interaction cycles are general to EFT and applicable to the couple's situation. From notes in my journal I deduced that the couple seemed to be exhibiting a classic pursuer/withdrawer cycle, which both the couple and therapist came to understand in more detail in subsequent sessions through tracking that cycle. Promoting alternative, safer emotional experiences in therapy for this couple was important because of the precarious state of their relationship. It was obvious by the withdrawn body language and the lack of emotional disclosure that neither person felt safe in the relationship in the first session and even in subsequent sessions.

Reading through my reflection journal each session with this couple helped me decide where I wanted to go in terms of goals for the next session and creating a pre-session outline. For example, after the second session with this couple I felt stuck. Thus, I looked to the goals I had identified for therapy with this couple, one of which was to create new emotional experiences in session. For the next session I decided to focus on that and use heightening and reframing to do so using primary and secondary emotions that I had educated them on earlier. Prior to this session, I also consulted with my second coder, whose suggestions I recorded in my journal. He recommended that to help the couple understand primary and secondary emotions more clearly and thus understand each other's emotional experience better, I use an imagery technique he had used to help clients understand and experience in session, first and secondary emotions. That influenced my plan for the third session in that I utilized that technique, which I felt helped the couple to conceptualize emotions better.

The partners' responses to the RDAS influenced therapy in many ways. Both partners reported that they discussed and considered divorce or separation. Ally also reported occasionally regretting having married Chris. These responses influenced my decision to assess commitment in the first session, which I did by having each partner scale their commitment to the relationship on a 1-to-10 scale. I also helped them emphasize that both Ally and Chris were committed to the relationship and how therapy was evidence of this commitment to the relationship.

*Summary.* Overall with this couple, each session informed my plan for the next session in many ways. The progress made by the clients, whether self-reported, gained from the instruments, or observed by the therapist, influenced my plan for following sessions. Client response played a particularly large role in my plans with this couple. Their responses to specific interventions influenced which interventions were used, or in this case, not used, subsequently with this couple.

## Couple Two

### *Couple Description*

Zane (20) and Roxanne (19) had been married for about a year when they came to therapy. Zane and Roxanne presented with complaints of trust, communication, and commitment problems. At the time of therapy, Zane was living with his girlfriend with whom he had begun an affair a few months earlier. Zane and Roxanne attended four sessions of 50-minute duration, which were recorded. Each session was videorecorded and analyzed for recurrent themes and patterns. They attended additional sessions, but only the first four were used for data for this study.

*Research Question One*

To what extent did I follow my integrated theory of therapy: EFT as my framework, with CBT and GCT as contributors of specific interventions or concepts? Research question number one is answered in terms of how I followed my integrated theory in the following domains: (a) in general, (b) in proportion of use of EFT to the others, and (c) my use of interventions of other models outside of the three that were specified. Videorecording coding charts and intervention checklists filled out following each session were used to answer this research question.

Totals of each type of intervention were computed using the intervention checklist. Totals were examined to identify whether the majority could be identified as EFT in proportion to the other models. The tallies of interventions utilized from EFT, CBT, and GCT were totaled and compared (see Table 5). From a review of tallies across all four sessions with Zane and Roxanne, EFT was found to be used 103 times compared to 16 times that CBT interventions were used and 7 times that GCT interventions were used.

An examination of the tables displaying the use of each model's interventions in each session shows that the use of interventions from GCT and SFBT decreased as sessions progressed, while use of CBT interventions stayed quite constant. For EFT, instances of reflection, heightening, and reframing increased as the sessions progressed. This is consistent with EFT theory in that the therapist must create an alliance with the couple and prove therapy as a safe place to be able to experience emotions in a new way as sessions progress.

Table 5

*Interventions Observed for Couple Two*

	Session 1	Session 2	Session 3	Session 4	Totals
EFT					
Reflection	1	7	4	12	24
Heightening	5	6	11	15	37
Primary emotions	1	3	1	0	5
Reframe	2	0	8	3	13
Enactment	1	0	0	3	4
Introducing negative cycle	1	0	0	0	1
Tracking negative cycle	4	3	4	8	19
EFT totals	15	19	28	41	103
CBT					
Guided discovery	0	5	0	0	5
Homework assignment	1	3	2	3	9
Enactment	0	0	0	0	0
Cognitive distortions	0	1	1	0	2
Tracking negative cycle	0	0	0	0	0
Introducing negative cycle	0	0	0	0	0
CBT totals	1	9	3	3	16

*(table continues)*

	Session 1	Session 2	Session 3	Session 4	Totals
<b>GCT</b>					
Four horsemen	1	0	0	0	1
Couple friendship	2	1	0	0	3
Softened startup	0	0	0	0	0
Repair attempt	1	0	0	1	2
Accepting influence	0	0	0	0	0
Solvable/unsolvable problems	0	0	0	0	0
Enactment	0	0	0	0	0
Positive sentiment override	0	0	0	0	0
Dream recognition	0	0	0	0	0
Relationship history	1	0	0	0	1
GCT totals	5	1	0	1	7
<b>SFBT</b>					
“What would it look like?”	0	1	1	0	2
“What would be different?”	1	0	1	0	2
Miracle Question	0	0	0	0	0
“What have you tried?”	1	0	0	0	1
“How did that happen?”	0	0	1	1	2
SFBT totals	2	1	3	1	7



*Intervention checklist.* The intervention checklist contains a portion to identify interventions used that do not belong to EFT, CBT, or GCT. According to the intervention checklists completed by the therapist, the only interventions utilized with this couple that were outside of the chosen integrated theory were solution-focused, which were used seven times. These interventions included the following questions: (a) “What would it look like?,” (b) “What would be different?,” (c) “What have you tried?,” and (d) “How did that happen?” These were used to identify behavioral changes that were made or could be made to improve the couple’s relationship.

*Coding charts.* Data from the videorecording coding charts indicate that in the majority, I applied my interventions somewhat well to very well (see Table 6). These data indicate that I applied interventions that were consistent with the pre-session outline. I did, however, deviate a few times due to the nature of therapy when the focus needed to go in a different direction with this couple.

For instance, I had planned to educate this couple on the basics of attachment theory in the second session, but felt that it would be more helpful for the couple to track their negative interaction cycle and heighten their emotional experiences. I did this because the couple spontaneously started to reenact their negative interaction cycle in session, and it seemed like an optimal opportunity to track and heighten each partner’s experience. There were a few times when I did not execute pre-planned interventions even when opportunities presented. For example, there were moments when opportunities to facilitate enactments presented themselves and I did not take advantage of them.

Table 6

*Videorecording Coding Chart Results: Intervention Rating Frequencies, Couple Two*

	Session 1	Session 2	Session 3	Session 4	Totals
No opportunity	0	1	0	0	1
Very poorly	0	0	0	0	0
Somewhat poorly	0	0	1	1	2
Somewhat well	4	2	2	0	8
Very well	4	5	4	6	19

*Research Question Two*

Did my theory and practice of therapy produce short-term change in session as well as longer-term change through the course of therapy? The OQ was filled out every session and the results were used to track changes in scores between sessions as well as over the course of therapy (see Table 7 for overall and subscale scores across the sessions of therapy). Zane scored 105 points overall in the first session, while Roxanne scored 87 points overall. Each partner's overall score dropped consistently across the next three sessions. This steady decline in scores shows change between sessions. It also shows a large drop: Zane reported scores 42 points lower and Roxanne reported scores 32 points lower from the first session to the fourth. Roxanne's overall score dropped from clinical to nonclinical, while Zane's dropped from above to right at the overall clinical cutoff score.

OQ subscale scores provide more details about these changes. Zane's scores were consistent with the presenting problem, scoring highest in symptom distress and

Table 7

*OQ Scores, Couple Two*

	<u>Session 1</u>		<u>Session 2</u>		<u>Session 3</u>		<u>Session 4</u>	
	Z	R	Z	R	Z	R	Z	R
Symptom distress	57	47	44	37	41	37	31	28
Interpersonal relations	29	24	22	20	18	17	19	15
Social role performance	16	19	17	12	20	13	13	12
Overall	105	87	82	69	79	67	63	55

*Note.* Z = Zane and R = Roxanne.

interpersonal relations, both of which can be affected by continued stress from having had an affair. The largest drop in subscale scores for Zane occurred on the symptom distress and interpersonal relations scales, dropping from 57 and 29 on the first administration to 31 and 19 respectively on the fourth administration. Roxanne's scores were also consistent with the presenting problem, scoring highest in symptom distress and interpersonal relations. Scores on both of these scales dropped considerably from 47 and 24 on the first administration to 28 and 15, respectively, on the fourth administration. Roxanne's scores dropped from clinical to nonclinical levels on every subscale. Zane's scores dropped from clinical to nonclinical only on the symptom distress subscale.

The RDAS was also completed prior to the first session and after the fourth session to identify longer-term changes in perception of couple conflict. Roxanne scored 51 points overall at the first session followed by a report of 45 points overall in the fourth. According to the RDAS, lower scores indicate less consensus, satisfaction, and

cohesion. Zane scored 52 points on the first RDAS administration and 51 on the second in the fourth session. The clinical cutoff score for the RDAS is 41. These scores stayed at nonclinical levels throughout the course of therapy.

*Summary of change.* The client response section of the videorecording coding chart was assessed to identify changes I saw between and across sessions. By the second session, I identified the clients as being less inhibited in disclosing their emotional experience due to their openness in answering my questions, which heightened those experiences. I also determined from the more personal and detailed nature of their disclosures that they felt more comfortable and safe in session and with one another.

As the sessions progressed, the clients also exhibited the ability to understand and personally apply EFT concepts. They identified ways in which they utilized secondary emotions and the primary emotions underlying them. For instance, Roxanne explained that she used anger to cover her fear of losing Zane. Zane and Roxanne also reported times during the previous week when they saw their negative interaction cycle being displayed. Throughout subsequent sessions, improvements were maintained and even increased in terms of being vulnerable and disclosing their emotional experiences. Zane initially had said he had no idea why he could not return to live with Roxanne, but in the third session he explained that he was scared that even if he went back to her, he would not be able to make Roxanne happy. The couple also became more open in expressing their needs to one another.

I made notations in my reflection journal to track the clients' progress. In this journal, I noted client reports of change as well as changes I observed as the results of

specific interventions or of the therapy process in general. In the second session, Roxanne and Zane reported less conflict and showed an enhanced ability to expound on their emotional experiences in session. In the third session, their ability to understand and explain their emotional experiences continued to show improvement. The couple also increased the time they spent together outside of therapy. Each partner showed an ability to identify and alter the course of the negative interaction cycle in session. Zane explained that he felt safer discussing the problem in session and that broaching such topics in therapy kept him from shutting down as much outside of therapy. By the fourth session, the couple was able to recognize and expound on their negative interaction cycle during the session. Zane and Roxanne reported that they even identified the cycle outside of session and chose to react differently rather than get caught up in the cycle. They also identified and expressed their needs to one another.

Case notes were also used to identify within-session change as well as longer-term progress. The case notes supplemented the notations made in the reflection journal. In the second session, the couple demonstrated their ability to understand primary and secondary emotions and apply the concept to their current situation. Zane, especially, improved in his capacity to identify and disclose his emotional experience of their situation. In the third session, Zane and Roxanne reported that they had been fighting less in the previous week and spending more time together. Their homework assignment was to have a date and they spent time together two additional days after that. They each continued to disclose more to the other and to elaborate upon their emotional experiences. Zane and Roxanne also identified small ways in which each could make the other feel

safe at times when they were caught in the frightening primary emotions of their negative interaction cycle. For instance, Roxanne expressed that Zane could comfort her by saying, "I love you." Zane said that Roxanne could, in turn, comfort him by holding his hand or being closer physically, such as a hug or sitting closer.

By the fourth session, Zane and Roxanne maintained the improvements noticed in the third session: continuing to spend time together, fighting less, and increasing their ability to expand their emotional experiences and disclose them to each other. They also identified, processed, and externalized their negative cycle in this session. Across the first four sessions, the major changes noted in the case notes were the increase in spending time with one another, enhancement in understanding each other's and their own emotional experiences, and growth in ability to be vulnerable to one another and express needs.

### *Research Question Three*

How did each session inform my plan for others? This research question is answered using every source of data collection. Actions and plans carried out in each session were created through a combination of overall goals for therapy as well as specific situations that came up in session. Case notes and videorecording coding charts laid out the course of each session: what I did, how the clients responded, and so forth. The OQ and RDAS helped inform me of progress made, areas of distress, and sources of conflict or cohesion.

The first session consisted mostly of assessment. From the assessment, I learned that the couple was exhibiting a pursuer/withdrawer cycle and that criticism and

stonewalling played a large role in the relationship. This sparked the idea of introducing and educating the couple about the cycle as well as the four horsemen in the next session. Zane and Roxanne reported that they observed the four horsemen, thus I decided that education on the secondary and primary emotions underlying the use of those horsemen should be included in the plan for the next session.

In the second session, the negative cycle was processed in more detail as it pertained to the concepts of emotion and the horsemen. Through processing this cycle, I found that the couple became stuck after someone introduced the fact that Zane was living with his girlfriend. This observation made me speculate about which needs were being met by this relationship that were not being met in Zane's current relationship with Roxanne. I then facilitated a needs enactment to identify needs that may not have been met in the past and currently in the relationship. Neither partner could identify any needs. Zane reported that he had no idea why he was staying with his girlfriend and could not move back to be with his wife.

This influenced the third session in that I continued to heighten each person's emotional experience in the negative cycle. I did this by processing in detail each partner's past and current experiences in the relationship and by providing them with more concrete ways in which to understand their emotions. For example, when processing Roxanne's experience of Zane's stonewalling, she explained that he shut down. I asked her whether it was as if she was standing at the door knocking and asking him to let her in and he locked it. I did this because I thought that heightening the stuckness of their current situation might stimulate change in Zane's response to the idea

of moving back in with his wife. I again facilitated a needs enactment in which each partner went into more detail about his or her unmet needs. I asked what small things each partner could do for one another to meet those needs when they were feeling unsafe in the relationship. They identified behavioral ideas such as saying, “I love you” or holding hands, which I gave as homework for the next week.

The fourth session consisted of continuing to externalize and process the negative cycle. I did this to stay true to the goals and interventions of EFT. I was hoping that continuing to process the cycle would help the couple identify their emotional experiences and understand the other’s better. I think this also helped to identify the points in that cycle during which they could utilize new behaviors they learned that met each other’s needs the week before.

In addition to the case notes, the intervention checklist identified specific interventions used as well as their frequency. The three interventions utilized the most throughout each session were reflection, heightening, and tracking the negative cycle (see Table 5).

The videorecording coding chart also allowed me to record client responses to each intervention. The chart showed that the couple responded favorably to the interventions used. Reflecting each partner’s experience seemed to make them feel understood and validated. For example, Roxanne reported that heightening during the third session and reframing the couple’s responses to each other made her behaviors sound “less scary” and more acceptable. She was referring to my attempt to reframe reactions in terms of primary emotions, attachment theory, and the negative interaction



cycle. The fact that the clients showed improvement in their ability to express emotional experiences and identify negative cycles early in therapy made me gravitate to those interventions more in later sessions.

The reflection journal identified the process of my decision-making, illuminating the influential information taken into account when creating goals for therapy as well as interventions used to meet them. The goals from this couple's treatment plan included (a) promoting alternate emotional experience, (b) helping clients identify their use of the four horsemen, and (c) identifying the negative interaction cycle and intervening in it. These goals were influenced by the patterns that I observed in early sessions as well as the general goals for EFT. For example, the husband's use of stonewalling influenced my plan to educate the couple about the four horsemen. I framed the horsemen in terms of attachment theory in that stonewalling was a way of expressing that something was terrifying or overwhelming for him.

The other two goals are general to EFT and were applicable to the couple's current situation. They seemed to be exhibiting a pursuer/withdrawer cycle, which the couple and I came to understand in more detail in subsequent sessions through tracking that cycle. Promoting alternative, safer emotional experiences in therapy for this couple was important because of the immediate, dangerous state of their relationship. It was obvious by the withdrawn body language and the lack of emotional disclosure that neither person felt safe in the relationship in the first session.

Reading through my reflection journal before each session with this couple helped me decide where I wanted to go in terms of goals for the next session and creating a pre-

session outline. For example, after the second session with this couple I thought that they seemed uncomfortable disclosing their emotions and making themselves vulnerable in session. In my reflection journal I discussed possible reasons for their discomfort such as their fear of being emotionally vulnerable, as well as the effect their discomfort and mine may be having on therapy. I decided to commit fully to my emotionally focused interventions. In the next session I addressed their discomfort, informed them that I noticed it, and that it was normal, but that I would continue my focus on emotions because I believed it would be the most helpful approach for them. This led to what I saw as a more commitment from them in their willingness to take part in emotionally focused interventions.

The OQ and RDAS elucidated certain problem areas of the relationship that influenced therapy. Zane's overall high score on the OQ before the first session showed that he was experiencing problems in each subscale area, particularly symptom distress and interpersonal relations. Zane reported the largest deviations from the cutoff scores in these subscale areas, with 21 points above the clinical cutoff score for symptom distress and 14 points above for interpersonal relations. This indicated to me that Zane was experiencing a number of symptoms that may have been related to the problems he was experiencing in interpersonal relations, especially his marriage. Roxanne's scores corresponded with Zane's in the specific subscales of most concern, but were closer to the cutoff scores and her symptom distress score was not as high as Zane's. The improvements in OQ scores every session resulted in my complimenting the couple on their progress.

The partners' responses on the RDAS influenced the therapy in many ways. Both partners reported that they more often than not discussed and considered divorce or separation. This influenced my decision to assess commitment to the marriage and to each other in the first and second sessions and to emphasize that each was committed and how important that would be for therapy. I assessed each partner's commitment to the marriage by having them scale that commitment on a 1-to-10 scale. I then asked each what he or she saw as signs of commitment from her or his spouse. They also each reported occasionally engaging in outside interests together on the RDAS. This influenced my idea to give a homework assignment of a date at least once a week for the couple. I thought that since they lived apart, increasing positive interactions outside of therapy could benefit them in therapy. I facilitated the couple's brainstorming of activities they enjoyed doing together to utilize in their dates.

*Summary.* Overall with this couple, each session informed my plan for the next session in many ways. My initial assessment influenced the interventions I chose to utilize throughout the course of therapy. The progress made by the clients, whether self-reported, gained from the instruments, or observed by me, influenced my plan for subsequent sessions. Client responses to specific interventions influenced which interventions were used subsequently with this couple.

### Couple Three

#### *Couple Description*

Rich (28) and Alicia (23) had been married for 8 months and living together for 3 years when they came to therapy. They had a 4-year-old son and Rich had a 7-year-old

daughter from a previous marriage who stayed with them for the weekend every 2 weeks. The couple presented with parenting disagreements. They seemed to be caught in a pursuer (Alicia's trying to make Rich parent a certain way)/withdrawer (Rich's not talking about it because Alicia nagged too much) pattern. The couple attended two sessions, the first of which was only thirty minutes because they took longer to fill out their paperwork than the allotted half hour. The second session was the traditional length of fifty minutes.

#### *Research Question One*

To what extent did I follow my integrated theory of therapy: EFT as my framework, with CBT and GCT as contributors of specific interventions or concepts? Research question number one is answered in terms of how I followed my integrated theory in the following domains: (a) in general, (b) in proportion of use of EFT to the others, and (c) my use of interventions of other models outside of the three that were specified. Videorecording coding charts and intervention checklists filled out following each session were used to answer this research question.

Totals were computed of my implementation of different interventions using the intervention checklist. They were examined to identify whether the majority fell under EFT in proportion to the other models. The tallies of interventions utilized from EFT, CBT, and GCT were totaled and compared. A review of these tallies across the two sessions with this couple shows that EFT was found to be used 40 times and CBT and GCT not at all. Table 8 shows the frequency of interventions observed across every model with couple three.

Table 8

*Interventions Observed for Couple Three*

	Session 1	Session 2	Totals
<b>EFT</b>			
Reflection	6	13	19
Heightening	3	6	9
Primary emotions	0	0	0
Reframe	2	6	8
Enactment	0	0	0
Introducing negative cycle	1	0	1
Tracking negative cycle	0	3	3
EFT totals	12	28	40
<b>CBT</b>			
Guided discovery	0	0	0
Homework assignment	0	0	0
Enactment	0	0	0
Cognitive distortions	0	0	0
Tracking negative cycle	0	0	0
Introducing negative cycle	0	0	0
CBT totals	0	0	0
<b>GCT</b>			
Four horsemen	0	0	0

*(table continues)*

	Session 1	Session 2	Totals
Couple friendship	0	0	0
Softened startup	0	0	0
Repair attempt	0	0	0
Accepting influence	0	0	0
Solvable/unsolvable problems	0	0	0
Enactment	0	0	0
Positive sentiment override	0	0	0
Dream recognition	0	0	0
Relationship history	0	0	0
GCT totals	0	0	0
<b>SFBT</b>			
“What would it look like?”	0	1	1
“What would be different?”	0	2	2
Miracle Question	0	0	0
“What have you tried so far?”	0	0	0
“How did that happen?”	0	0	0
Exceptions	0	1	1
SFBT totals	0	4	4

An examination of the table displaying the use of each model’s interventions in each session shows that no interventions were utilized from CBT or GCT with couple

three. For EFT, instances of reflection, heightening, reframing, and tracking the negative cycle increased as the sessions progressed. This is consistent with EFT theory in that the therapist must create an alliance with the couple and prove therapy as a safe place to be able to experience emotions in a new way as sessions progress.

The intervention checklist contains a section set apart to identify interventions used that do not belong to EFT, CBT, or GCT. According to the intervention checklists completed by the therapist, the only interventions utilized with this couple that were outside of the chosen integrated theory were solution-focused, which were used four times and increased as sessions progressed. Solution-focused interventions included the following questions: (a) “What would it look like?,” (b) “What would be different?,” and (c) identifying exceptions. These were used to identify behavioral changes that were made or could be made to improve the couple’s relationship. They also were utilized to increase the couple’s hope that change was possible. Solution-focused interventions were used in the second session.

*Coding charts.* Data from the videorecording coding charts indicate that in the majority, I applied my interventions somewhat well to very well (see Table 9). These data indicate that I applied the majority of my interventions consistent with the pre-session outline. I did, however, deviate a few times. Partially, this was because the first session was so short that I could not introduce a few of the ideas I had planned to address. Also, I strayed from the pre-session outline due to the presenting problem reported by this couple and the fact that instead of just the couple being present, they also brought along their young son, Harry. For instance, heightening was utilized, but only to a certain extent

Table 9

*Videorecording Coding Chart Results: Intervention Rating Frequencies, Couple Three*

	Session 1	Session 2	Totals
No opportunity	2	0	2
Very poorly	0	0	0
Somewhat poorly	0	0	0
Somewhat well	2	3	5
Very well	2	2	4

because I was not comfortable increasing the emotional intensity very much with the child present. In the second session, I tended to use solution-focused interventions to find out what they specifically wanted when it came to easing their parenting conflict. I thought that my theory fit their problem, but wondered whether they would rather simply be educated on parenting techniques or change the way they interact emotionally, which are two very different goals.

According to observations made in the reflection journal, the vast majority of my interventions with this couple were applied within an EFT framework. Those falling outside of my integrated theory of therapy were solution-focused interventions that I used to assess details about the couple's goals for parenting.

*Research Question Two*

Did my theory and practice of therapy produce short-term change in session as well as longer-term change through the course of therapy? Data from the OQ, the RDAS,



the videorecording coding chart, the reflection journal, and case notes were used to answer research question number two. The OQ was filled out both sessions and the results were used to track changes in scores between sessions. This couple attended only two sessions; therefore, short-term changes only can be reported.

*OQ.* Rich reported an overall score of 66 on the OQ in the first session, while Alicia scored a 48 overall (see Table 10). Each partner's overall score dropped by the next session to 53 for Rich (11 points) and 29.5 for Alicia (18.5 points). The clinical cutoff overall score on the OQ is 63. Although Rich's overall score dropped from the clinical to the nonclinical range, Alicia's started off in the nonclinical range and stayed there. This decline in scores demonstrates change between sessions. Alicia's subscale scores seemed consistent with the presenting complaint in that her highest subscale score was 17 on interpersonal relations which is above the clinical cutoff score for that subscale. Rich, on the other hand, scored highest on the symptom distress subscale with 40 points, which is 4 points above the clinical cutoff score for that subscale. The greatest changes were observed in Alicia's symptom distress and interpersonal relations subscales dropping 12.5 and 7 points, respectively. Changes were observed in all three of Rich's subscale scores dropping 7, 2, and 4 points, respectively.

*RDAS.* The RDAS was also completed prior to the first session and after the second session to identify longer-term changes in perceptions of couple conflict. I administered the RDAS the second session because I had reached 10 sessions in my data collection, which fell within the target area of 8 to 12 sessions. This second session also helped me fulfill the research requirement of at least two sessions per couple. Rich

Table 10

*OQ Scores, Couple Three*

	Session 1		Session 2	
	R	A	R	A
Symptom distress	40	28	33	15.5
Interpersonal relations	15	17	13	10
Social role performance	11	3	7	4
Overall	66	48	53	29.5

*Note.* R = Rich and A = Alicia.

scored 38 points overall at the first session followed by 47 points overall in the second.

According to the RDAS, lower scores are worse, indicating less consensus, satisfaction, and cohesion. Alicia scored 42 points on the first RDAS administration and 36.5 in the second session. The couple did not return for a third session.

*Summary of change.* According to case notes, videorecording coding charts, and my reflection journal, the couple was open to the therapeutic interventions and were cooperative with my suggestions in the first session. The couple seemed to understand the concepts introduced and answered my questions about their emotional experiences openly and in detail.

The second session showed progress in that they seemed to understand concepts better, apply them to their situation, and disclose more about their experiences. For instance, Rich explained that when they fought, he thought that Alicia did not even hear what he had to say and that it felt “crappy.” They also reported less fighting. When asked

how that had happened, they said they had both been more willing to step back and consider the other person's point of view during conflict. They seemed to be able to frame their responses in terms of their negative cycle. However, when assessing the couple's goals for therapy, Alicia indicated that she was not going to "wait around while [Rich's daughter] turns into a spoiled brat." I assumed that was a threat of divorce, but decided not to address it because it seemed too early in therapy to do so and might have no real intention behind it.

Because this couple attended only two sessions, progress was difficult to observe and longer-term change could not be seen. I am assuming that had the couple attended four sessions, longer-term progress could have been made and observed.

### *Research Question Three*

How did each session inform my plan for others? This research question was answered using every source of data collection. Case notes laid out the course of each session: what I did, how the clients responded, and so forth, while coding charts reported the clients' responses to interventions.

The checklist identified specific interventions used and their frequency. The three interventions utilized the most throughout each session were reflection, heightening, and reframing (see Table 8). The coding chart allowed me to record client responses to each intervention.

The chart shows that the couple responded favorably to the interventions. Client responses were especially positive and led to more disclosure when reflection and reframing were used. When I reflected what either partner said, each would go into more

detail about their experience. Rich and Alicia seemed to feel validated by these interventions and better understood. This led me to increase reflection in the second session. Heightening was used frequently because one of the main goals of EFT is to promote alternative emotional experiences and to help partners understand one another's experiences better.

The reflection journal identified the process of the therapist's decision-making, illuminating the influential information taken into account when creating goals for therapy as well as interventions used to meet them. I was still in the process of identifying the couple's goals for therapy when the couple did not return to therapy. The first session was only a half hour and consisted mostly of assessment and some intervention. From the assessment, I observed that the couple was exhibiting a pursuer/withdrawer cycle and that stonewalling and criticism played a large role in the relationship. I reframed these actions in terms of attachment theory and their negative interaction cycle which seemed to leave each partner feeling validated and accepted.

The second session was two weeks later and I continued with assessment. Within the first few minutes, the couple was spontaneously reenacting a fight they had had the previous week. I focused on their differing perceptions of Rich's daughter's behavior and their reactions to it. I did this to identify their parenting styles and understand their experiences better. I then asked whether their fighting like that was limited to parenting issues. I did this to identify the isomorphic nature of their conflict. Rich and Alicia reported that they fought like that about many things. I tried to identify exceptions and get more details about times they had resolved things peaceably (SFBT) and how they did

that. Rich and Alicia explained that they would compromise and I introduced the idea of softening. I heightened their experience of the parenting conflict so that they would understand their own and their partner's experiences better. I then assessed their experiences of punishment and parenting in their families of origin. I did this to help each partner identify why they felt the way they did about parenting and to understand their partner's approach better. I assessed for goals of therapy for the rest of the session. I did this because the basic goals of EFT usually apply to every case, but with this couple, I was not sure what they wanted from therapy.

The tentative goals from this couple's treatment plan included (a) promoting alternate emotional experience, and (b) identifying negative interaction cycle and intervening. These goals were influenced by the patterns I observed in early sessions as well as the general goals for EFT. The couple seemed to exhibit a pursuer/withdrawer cycle, so I decided to educate them about that. For example, I reframed Rich's stonewalling and Alicia's criticism in terms of attachment theory and explained how stonewalling and criticism fit into their negative cycle. If I had seen this couple in therapy longer, I would have worked more towards the first EFT goal of promoting alternative, safer emotional experiences in therapy. Again, I was not sure whether the couple would rather focus on strengthening their relationship or simply focus on learning new parenting techniques.

Reading through my reflection journal each session with this couple helped me decide where I wanted to go in terms of goals for the next session and creating a pre-session outline. For example, after the first session I had noted in my reflection journal

that I thought focusing more on strengthening the marital dyad would improve the situation with this couple's entire family. At the same time, I was not sure whether the couple wanted to focus more on improving their relationship or learning new parenting approaches. I was still undecided on how to approach the next session when I consulted with my second coder. He suggested that I stay true to the goals of EFT and focus on promoting new emotional experiences in therapy. This influenced me in my plan for the next session in that I decided to heighten each partner's emotional experience as well as reframe partner responses more often than the first session.

The OQ and RDAS elucidated certain problem areas of the relationship that influenced therapy. Neither Alicia nor Rich had high scores on the OQ overall and were, at the highest, only two (Alicia) or three (Rich) points higher than the clinical cut off scores on any of the subscales. Rich seemed to be experiencing some symptom distress while Alicia was struggling with interpersonal relations. These scores did not influence therapy much because neither partner was reporting much distress in any subscale or in therapy, although their affect with each other suggested potential interpersonal relation problems.

Each partner's responses on the RDAS influenced the therapy in many ways. Both partners reported that they discussed and considered divorce or separation. This did not influence my plan for therapy very much, because the couple came in focusing on parenting concerns and less on the possibility of divorce. It was also a difficult topic for me to discuss because the couple brought their four-year-old son to every session. Looking back, I probably should have asked them to come to therapy by themselves.

## CHAPTER V

### DISCUSSION

The purpose of this study was to determine how an integrated model of couple's therapy was applied, progress made by clients during the course of therapy using this model, and how each session informed the next. Three couples who presented for therapeutic services participated. Ten therapy sessions were conducted across the three cases. Each session was videorecorded and coded with an intervention checklist as well as a videorecording coding chart. Case notes and a reflection journal were used to understand the course of each session as well as my decision-making process for each session. The OQ was administered to each couple during every session. The RDAS was administered before the initial session and after the fourth session. In the third couple's case, the RDAS was administered before the initial session and after the second. This was done because the target of ten sessions, at least two for every couple, had been reached and I did not want to chance the couple's dropping out before I could administer the RDAS again. It so happened that the couple did not return to therapy after the second session. The results of this study suggest that I applied interventions consistent with my integrated model of therapy, with the addition of SFBT interventions. This application of therapy was shown to be beneficial to every couple in certain ways. Sessions were found to inform others in a variety of ways.

The following sections discuss the results of this study as well as unexpected findings, implications, and limitations. The context of this sample must be considered when drawing conclusions from the data. All six participants were similar in spiritual

beliefs and city of residence. All of the participants were married and between the ages of 19 and 28. Two of the three couples presented with fidelity issues.

## Results

### *Research Question One*

To what extent did I follow my integrated theory of therapy: EFT as my framework, with CBT and GCT as contributors of specific interventions or concepts? Across all three cases, it seems that I applied the majority of my interventions within an EFT framework. Most of my sessions followed the pre-session outline, except when I felt the approach was not working or that it needed to go in an alternate direction. Most of my interventions were framed within the concept of primary emotions, the negative interaction cycle, and attachment theory. Emotionally focused therapy interventions and concepts were utilized 265 times in therapy, much more frequently in proportion to CBT interventions, which were used 29 times, or GCT interventions, which were used 14 times (see Table 11). I used solution-focused techniques four times more than GCT techniques. In two of the three cases, CBT interventions were used more frequently than solution-focused techniques.

These results indicate to me that I apply the integrated model of therapy I say I do with the addition of solution-focused techniques. Thus, I maintain fidelity to my model, plus selectively borrowing from solution-focused therapy. This tells me that my model may not promote hope or identify specific goals in therapy sufficiently and that solution-focused techniques may aid in those objectives.



Table 11

*Intervention Observations Across Couples*

	EFT	CBT	GCT	SFBT
Couple one	122	13	7	7
Couple two	103	16	7	7
Couple three	40	0	0	4
Total	265	29	14	18

The results also show that I apply interventions within the framework of my base model, which is emotionally focused therapy, and that the majority of interventions I utilized were from that model. This means to me that I conceptualize using emotionally focused theory and that it is the underlying adhesive, holding my array of concepts and interventions from other models together.

I have learned that I utilized CBT and solution-focused techniques more often than GCT techniques, which I did not realize before this study. I may need to increase my use of GCT concepts and interventions because of how helpful I perceive them as being to couple's therapy. I do believe that the reason GCT techniques were not used as frequently with these couples is because the couples were not highly conflictual and did not exhibit the four horsemen or highly destructive conflict styles in abundance.

*Research Question Two*

Did my theory and practice of therapy produce short-term change in session as well as longer-term change through the course of therapy? It seems that my theory and

practice of therapy produced short-term change between sessions as well as for longer periods of time, although each couple was tracked in therapy for four sessions at the most. OQ scores dropped across all couples except on one subscale of couple one.

RDAS scores changed, most times slightly and not for the better. This model of therapy did not necessarily seek to decrease conflict between couples, but to guide them to experience it in a different way emotionally, particularly in early sessions of therapy. Client responses in session exhibited change in every couple in terms of understanding their emotional experiences as well as their partners.

As for resolution of presenting problems, I do not believe my theory fully resolved any of the couples' presenting complaints. Small steps toward change were made, but each couple seemed to revert to their fear of being vulnerable and not willing to take steps necessary towards forgiveness and change. Yet, I cannot necessarily expect resolution with this model in four sessions. Clients reported change in terms of understanding their emotions better, and more easily and effectively expressing them to their partners. They also seemed to feel more secure in their emotions, fearing less that they were inappropriate or out of control. These may have been signs of impending changes and progress to be made by the couples in future sessions.

The small improvement in couple one's RDAS scores did not correspond with the lack of change in their interpersonal relations subscales. In couple two, although both partners' RDAS scores declined, showing a decrease in cohesion, consensus, and satisfaction, their OQ interpersonal relations subscale scores decreased also, which shows an improvement in interpersonal relations. In the case of couple three, neither partner's

IR subscale scores corresponded with the decrease in RDAS score. The discrepancy between the small change in RDAS scores and both OQ and self-report of greater change may be due to the fact that the conflict was still there, but instances of conflict were not as frequent. It also may have not been enough time in therapy to show change consistent across both instruments. The RDAS may not be as sensitive to short-term changes as the OQ subscales are.

These results inform my practice in that although changes were made and progress measured, this model probably takes longer than four sessions to fully resolve many clients' complaints. The large drop in symptom distress scores across all couples suggests that this integrated model decreases the stress couples may be experiencing due to conflict. This might be because of my model's inherent focus on normalizing and validating client experiences. This reduction in distress may serve as a starting point in therapy that may lead to more effective change as therapy progresses. This study did not test this hypothesis.

### *Research Question Three*

How did each session inform my plan for others? Each session informed my plan for the others in a variety of ways. Clients' responses to interventions and client feedback in general seemed to be especially important in my plans and execution of therapy in following sessions. Clients' responses to interventions also seemed to prompt further use of those interventions. Clients' understanding my interventions and working with me through applying therapy concepts to their situations and answering questions I asked resulted in my being much more comfortable in session. This was exhibited with

couple two, when Zane and Roxanne were open to sharing their emotional experiences and willingly applied EFT concepts to their situation. Unfortunately, this especially influenced my view of couple one as resistant because they did not respond as well to the interventions. I interpreted the partners' responses of "I don't know" as failure to try instead of reluctance to take part in an intervention that made them emotionally vulnerable to one another. I must be more careful in the future to focus less on my comfort in therapy and more on the clients' comfort and needs, or use my discomfort as a signal to pay more attention to the clients.

The context of each session influenced the plan for therapy, especially with couple three who brought their son to therapy, which I thought inhibited the progress we could make. For example, when Alicia threatened that she would not wait around while Rich negatively impacted his daughter with his parenting style, I may have responded differently if their son were not there. A different response may have changed the trajectory of therapy and convinced the couple to return after that second session. I must take context into account when planning what is appropriate for therapy. In this situation, I should have made the therapy context more conducive to my emotionally focused practice of therapy by asking the couple to attend on their own. Also, with couple two, interventions were tailored around the sensitive fact that Zane was still living with his girlfriend. This made certain topics such as commitment to the relationship a larger focus in therapy.

The OQ and RDAS instruments were helpful in corroborating the presenting problem and identifying other options for topics therapy could cover. For each couple,

the subscales of the OQ indicated in which areas partners were experiencing the most distress. Each couple reported distress in the symptom distress and interpersonal relations areas, which seemed consistent with the presenting problems reported. Also, the RDAS was especially influential in that every couple reported discussing divorce. This influenced me to assess commitment in both couple one and couple two. Because couple three brought their son with them, I did not think discussing divorce in their sessions would be appropriate. These findings indicate that the RDAS may be more useful as a clinical tool for initial assessment than for tracking longer-term change.

Sessions with couples seen earlier in this study influenced my plans with couples I saw later. My experience with couple one especially influenced my application of therapy with couple two. The responses I got from Ally and Chris made me uncomfortable in session and I hesitated to utilize emotionally focused interventions. After looking to the EFT research and understanding that heightening the couple's feelings of being stuck could motivate them to change, I refocused on my theory's interventions. Experiencing this made it easier for me to apply emotionally focused interventions with Zane and Roxanne because I knew the discomfort in session could be used in a proactive way to help them. Thus, I was more committed to my theory and practicing it in subsequent sessions and cases.

Consultation with my second coder/consultant also seemed to have influenced my practice of therapy in this study. Because he practiced emotionally focused therapy himself, he was more prone to suggest use of those interventions. Another model he drew from regularly was solution-focused, which may have influenced my use of those

interventions in many of the sessions.

### Unexpected Findings

There were many unexpected findings discovered through this study. One was that as an emotionally focused therapist, I find it difficult to press clients to disclose their emotions. I am willing enough to do so when the couple seems open and willing to disclose this information and work with me to discover new emotional experiences. However, when couples hesitate, misunderstand, or refuse to answer my questions, I hesitate to continue to press them. I dislike awkward situations and I especially loathe forcing people into uncomfortable situations and that was reflected in my practice in this study. This was especially evident with Couple one and with Ally, whose oft-repeated answer seemed to be, "I don't know." I felt completely at an impasse when neither partner seemed willing to focus on emotions. I thought about utilizing other models that might be more helpful, such as SFBT, but found that the couple was just as resistant when I used that model. Thus, I looked to the EFT literature and renewed my focus on emotions and, when coming to another impasse, continued to heighten the stuckness of the couple. It was not the couple's so-called resistance, but my discomfort that needed to change.

Another unexpected finding was alluded to in the previous paragraph. When my theory of therapy was not working or I felt stuck in therapy, I utilized SFBT interventions. I believe the reasons for this are twofold: First, when I am stuck, I try to reevaluate the goals and direction of therapy or find an alternate path to goals. Solution-focused techniques are very helpful in developing clear goals and using client resources

to reach them. Second, I received my earliest therapeutic training in SFBT and it was the first model I felt really comfortable utilizing in sessions. Therefore, I have a tendency to use it. Also, according to the intervention checklists, I utilized SFBT interventions just as frequently as CBT or GCT techniques. I see this as an evolution of my theory to encompass yet another helpful model that will expand my resources in therapy and my applicability to different couples' contexts. This unexpected finding encourages the need for an integration of SFBT into my theory of therapy.

A third unexpected finding was the modification of my utilization of pre-session outlines. At first, the outlines were used somewhat as to-do lists. I would attempt to accomplish everything planned prior to the session whether or not they were necessarily congruent with the flow of the session. As sessions progressed, my pre-session outlines turned into mere guidelines and instead I seemed to have an overarching goal for each session. For instance, with couple two, in the fourth session, my goal was to track and understand their negative interaction cycle in as much detail as possible.

### Integration of SFBT

The assumptions, concepts and interventions of SFBT lend themselves well to those of my initial integrated theory. For instance, the focus of therapy for each model is on the present and future, but ventures into past experience where necessary to understand present beliefs or behavior. All of the models view clients as being "stuck" in dysfunctional patterns rather than as pathological in some way (Dattilio, 1998; de Shazer 1985; Gottman, 1999; Johnson, 2004). The avenue of change in each of these models of therapy is the couple's experiencing new ways of relating to each other and continuing to

utilize learned skills as well as resources the clients already have.

The solution-focused approach also adds elements to my theory that may have been missing before. Solution-focused interventions can aid in enactments by generating details of what more ideal interactions would look like for the couple. Solution-focused interventions may be used in therapy to help clients identify new ways to meet one another's needs or help each other feel safe within their relationships, which utilize resources or skills the clients already have. Solution-focused interventions can be used to develop a treatment plan by helping to identify goals the clients have for therapy. They also can be used to assess progress throughout therapy.

### Implications

This study informs my practice in a variety of ways. First, I've realized my practice of therapy also includes SFBT techniques, which expands my ability to help clients. Also, it seems that my integration and application of theories does promote change in couple's therapy, especially for couples who are experiencing infidelity. I also think that from this study I have learned that this approach to therapy may work best with only the couple present, because the presence of a child made it more difficult for me to help heighten the emotional experience of the partners in session. For instance, with Couple three I did not think it appropriate to heighten Rich's experience of Alicia's threatening him that if he did not parent his daughter differently, she would not "wait around." This could have been a perfect opportunity to reframe each partner's response and process their experience of that statement, but I thought it might be too overwhelming for both the child and the parents with the child present, and thus



inappropriate.

This study also generated suggestions for therapist training and development. First, I believe it is important to track the progress of clients to demonstrate the effectiveness of one's theory and practice of therapy. I suggest that every therapist in training have the opportunity to do so and to continue this throughout his or her career. I also suggest that therapists in training give themselves an "epistemological checkup" to confirm that the theory of therapy they are practicing matches the theory they claim to be practicing. In my personal experience as well as my observations of others I have trained with, clinicians sometimes work from models outside of the ones they claim to work from.

This study also produced implications for research in marriage and family therapy. My findings suggest that my therapeutic approach, which is grounded in EFT, may be especially helpful when working with couples who have experienced infidelity or a betrayal of some kind. Further, more controlled research on this topic is needed. Also, identifying alternative ways of heightening in session that may be more comfortable for emotionally reserved couples would be a worthy research endeavor. Similarly, it might be useful to identify ways of heightening that are more conducive for couples who bring their children to therapy. Further research on the long-term effects of the application of my integrated theory is also needed.

### Limitations

There are many limitations to this study. First, I decided which interventions would be most helpful during the course of therapy as well as developed many of the

tools to track specific interventions. This may have limited the effectiveness of therapy to only those interventions that I deemed appropriate although there may have been others more applicable to the clients or their presenting problems. Also, I created the data-collection tools, analyzed data from those tools, wrote the case notes and the reflection journal, and provided the therapy. My subjective report of what happened in therapy likely resulted in a biased interpretation of the course of the sessions as well as client feedback and progress even though I attempted to watch for alternate hypotheses or explanations. I did watch for negative instances of interventions, which led to the discovery that I use SFBT interventions. Regardless, for my purposes, this was a valuable experience.

The generalizability of this study to other therapists is not possible because it consists of a specific integration and my own application of multiple theories. Also, the sample was small, consisting of only three couples.

Inter-rater reliability was computed with the intervention checklist between myself and the second coder, but the checklist has not been used in studies outside of this one to establish its validity or reliability. Additional research utilizing this instrument may aid in altering the checklist or its training manual for more reliable use. The training manual may not have been adequate enough for the second coder to identify interventions from every model, especially in the case of emotionally focused interventions, which are difficult to track numerically because of their progressive nature. For instance, as shown in Table 1, which reports the inter-rater reliability of each intervention, percentages of agreement for heightening, primary emotions, and reframe are all below .9. I believe this

is due to the difficulty that the second coder may have had in identifying where an instance of reframing or heightening may have stopped or started. This also is a limitation to the current study.

There was a potential for second coder bias in that the second coder wanted my research to turn out positively. This may have influenced his observation of interventions. Much of the data was gained through client self-report as well as therapist observation, which may be biased. This may reduce the validity of the findings; however, triangulation of data from multiple sources was used in an effort to increase validity.

### Conclusion

This study contributes to my understanding of the application of my integrated theory of therapy. I maintained fidelity to my model with the addition of SFBT techniques. My integrated model of therapy produced objective short-term change as well as client report of change. My theory may, however, be more successful in producing longer-term change in couple relationships with more sessions. My sessions of therapy influence subsequent sessions in a variety of ways, such as client response to interventions, client report of change, OQ score changes, and context of therapy.

The sample and design included specific limitations; however, this study informed my theory application and understanding of myself as a therapist in many ways. The implications of this study are to use the information presented in this work in my subsequent practice of therapy and for other clinicians to conduct an “epistemological checkup” on their own theory and practice.

## REFERENCES

- Baucom, D. H., Epstein, N. B., LaTaillade, J. J., & Kirby, J. S. (2008). Cognitive-behavioral couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4<sup>th</sup> ed; pp. 31-72). New York: Guilford.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.
- Becvar, D. S., & Becvar, R. J. (2006). *Family therapy: A systemic integration* (6<sup>th</sup> ed.). Boston: Allyn & Bacon.
- Bowlby, J. (1969). *Attachment and loss: Vol. I. Attachment*. New York: Basic Books.
- Busby, D. M., Christensen, C., Crane, D. R., & Larson, J. H. (1995). A revision of the dyadic adjustment scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy, 21*, 289-308.
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17-31.
- Byrne, M., Carr, A., & Clark, M. (2004). The efficacy of behavioral couples therapy and emotionally focused therapy for couple distress. *Contemporary Family Therapy, 26*, 361-387.
- Carrere, S., Buehlman, K. T., Gottman, J. M., Coan, J. A., & Ruckstuhl, L. (2000). Predicting marital stability and divorce in newlywed couples. *Journal of Family Psychology, 14*, 42-58.

- Dattilio, F. M. (Ed.). (1998). *Case studies in couple and family therapy: Systemic and cognitive perspectives*. New York: Guilford Press.
- de Shazer, S. (1985). *Keys to solution in brief therapy*. New York: W.W. Norton.
- Epstein, N., Schlesinger S., & Dryden W. (1988). *Cognitive-Behavioral Therapy with families*. New York: Brunner.
- Gottman, J. M. (1993). *What predicts divorce?: The relationship between marital processes and marital outcomes*. Mahwah, NJ: Erlbaum.
- Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy*. New York: W.W. Norton.
- Gottman, J. M., & Gottman, J. S. (2006). *Ten lessons to transform your marriage*. New York: Three Rivers Press.
- Gottman, J. M., & Gottmann, J. S. (2008). Gottman method couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4<sup>th</sup> ed.; pp.138-164). New York: Guilford.
- Greenberg, L. S., & Pinsof, W. M. (1986). *The psychotherapeutic process: A research handbook*. New York: Guilford.
- Greenberg, L. S., James, P. S., & Conry, R. F (1988). Perceived change processes in emotionally focused couples therapy. *Journal of Family Psychology*, 2, 5-23.
- Hawkins, M. W., Carrere, S., & Gottman, J. M. (2002). Marital sentiment override: Does it influence couples' perceptions? *Journal of Marriage and the Family*, 64, 193-201.
- Hazlett-Stevens, H., & Craske, M. G. (2002). Brief cognitive-behavioral therapy:

- Definition and scientific foundations. In F. W. Bond & W. Dryden (Eds.), *Handbook of brief cognitive behaviour therapy* (pp. 1-20). New York: Guilford.
- Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*, 885-892.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy* (2<sup>nd</sup> ed.). New York: Brunner-Routledge.
- Johnson, S. M. (2008). Emotionally focused couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4<sup>th</sup> ed.; pp. 107-137). New York: Guilford.
- Johnson, S. M., & Whiffen, V. (2003). *Attachment processes in couple and family therapy*. New York: Guilford Press.
- Lambert, M. J., Lunnen, K., Umphress, V., Hansen, N. B., & Burlingame, G. (1994). *Administration and scoring manual for the Outcome Questionnaire (OQ-45.1)*. Salt Lake City, UT: IHC Center for Behavioral Healthcare Efficacy.
- Lebow, H. (1987). Developing a personal integration in family therapy: Principles for model construction and practice. *Journal of Marital and Family Therapy, 13*, 1-14.
- Liddle, H. (1982). On the problems of eclecticism: A call for epistemological clarification and human scale theories. *Family Process, 21*, 243-250.
- Locke, H. J., & Wallace, K. M. (1959). Short marital-adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living, 21*, 251-255.
- Nichols, M., & Schwartz, R. (2006). *Family therapy: Concepts and methods* (7<sup>th</sup> ed.).

Needham Heights, MA: Allyn & Bacon.

Patterson, J., Williams, L., Grauf-Grounds, C., & Chamow, L. (1998). *Essential skills in family therapy*. New York: Guilford Press.

Schlesinger, S., & Epstein, N. (1986). Cognitive-behavioral techniques in marital therapy. In P. Keller & L. Ritt (Eds.), *Innovations in clinical practice: A source book* (Vol. 5; pp. 137-155). Sarasota, FL: Professional Resource Exchange.

Shaver, P. R., & Mikulincer, M. (2002). Attachment-related psychodynamics. *Attachment and Human Development, 4*, 133-161.

Skate, R. E. (2000). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3<sup>rd</sup> ed.; pp. 435-454). Thousand Oaks, CA: Sage.

Taylor, J. A. (1953). A personality scale of manifest anxiety. *Journal of Abnormal and Social Psychology, 48*, 285-290.

Weissman, M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry, 33*, 1111-1115.

APPENDICES



Appendix A. Informed Consents, Memo, IRB 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

# 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 2 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

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](mailto: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.



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  
Document IRB Password Protected per IRB Administrator

**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

20 March 2009

I give permission for McKenzie Christensen to use data collected from the Family Life Center Marriage and Family Therapy clinic for her thesis project.



Scot Allgood, Ph.D.  
Director, Marriage and Family Therapy Program



# Utah State UNIVERSITY

INSTITUTIONAL REVIEW BOARD OFFICE  
9530 Old Main Hill, Suite 214a  
Logan, UT 84322-9530  
Telephone: (435) 797-1821  
FAX: (435) 797-3769

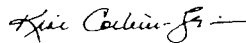

USU Assurance: FWA#00003308  
Protocol # 2312

SPO #:  
AES #: UTA00

4/6/2009

## MEMORANDUM

TO: Thorana Nelson  
McKenzie Christensen

FROM: Kim Corbin-Lewis, IRB Chair   
True M. Fox, IRB Administrator 

SUBJECT: An Epistemological Checkup: The Explication, Application, and Evolution of  
an Integrated Theory of Couples Therapy

Your proposal has been reviewed by the Institutional Review Board and is approved under exemption #4.

- X There is no more than minimal risk to the subjects.  
There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file. **Any change in the methods/objectives of the research affecting human subjects must be approved by the IRB prior to implementation.** Injuries or any unanticipated problems involving risk to subjects or to others must be reported immediately to the IRB Office (797-1821).

The research activities listed below are exempt based on the Department of Health and Human Services (DHHS) regulations for the protection of human research subjects, 45 CFR Part 46, as amended to include provisions of the Federal Policy for the Protection of Human Subjects, June 18, 1991.

4. Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Appendix B. Instruments



## Intervention Checklist

Client ID:

Session #:

Date of Session:

Date of Review:

Reviewer:

<b>Intervention</b>	<b>EFT</b>	<b>TOTAL</b>
Reflection		
Heightening		
Primary Emotions		
Reframe		
Enactment		
Tracking Negative Cycle		

<b>Intervention</b>	<b>CBT</b>	<b>TOTAL</b>
Guided Discovery		
Homework		

Assignment		
Enactment		
Cognitive Distortions		
Tracking Negative Cycle		

<b>Intervention</b>	<b>GCT</b>	<b>TOTAL</b>
Four Horsemen		
Couple Friendship		
Softened Startup		
Repair Attempt		
Accepting Influence		
Solvable vs. Perpetual Problems		



### Videorecording Coding Chart (1<sup>st</sup> Session)

Client ID:

Session #:

Date of Session:

Date of Review:

Reviewer:

#### **EFT**

##### 1. Application of **Heightening**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:**

**Client Response:**

2. Introduction to **Primary & Secondary Emotions:**

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:**

**Client Response:**

3. Application of **Reframing:**

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:**

**Client Response:**

4. Introduction of **Negative Interaction Cycle**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:****Client Response:****GCT**5. Introduction of **Assessment Enactment**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:****Client Response:**

6. Introduction of **Four Horsemen**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:**

**Client Response:**

7. Application of **Four Horsemen**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:**

**Client Response:**

**CBT**8. Introduction of **Homework Assignment**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:****Client Response:**9. Application of **Homework Assignment**:

Very Poorly	Somewhat Poorly	Neutral	Somewhat Well	Very Well

**Explain Rating:****Client Response:**



## Manual of Operational Definitions

*Emotionally focused checklist.* The EFT intervention checklist is used to record my use of the following interventions or concepts: reflection, heightening, primary/secondary emotions, reframe, introduction to negative cycle, tracking negative cycle, and enactment. Descriptions of the operational definitions of these concepts are found below. A number of the concepts/interventions from these checklists overlap. The differences between these interventions are their focus. For instance, enactment in EFT will focus on each partner altering their experience specific to emotions, while CBT would be specific to thought processes and Gottman would be specific to four horsemen, repair attempts, and so on.

**Reflection** is my tracking and processing the client's experience with them in the session. For identification purposes, reflection was operationalized as any time I repeated the clients' descriptions of their experiences either in the clients' words or in my own words, without adding any speculations of my own as to what the client is experiencing.

**Heightening** is used to highlight certain responses or experiences that may be maintaining current negative interaction patterns. Operationalized, heightening was seen when I asked clients to repeat a specific phrase or reaction in order to make the negative cycle more obvious and to show a person's role in that cycle.

**Primary/secondary emotions** can be operationalized in many ways. Introducing and educating the clients on primary and secondary emotions as well as applying them to the client's current situation and helping them identify when they are utilizing them are ways in which primary and secondary emotions are operationalized in this study.

A **reframe** can be identified as my educating the couple on the evolutionary aspect of attachment theory or interpreting client experiences and reactions through an attachment lens. This is done by emphasizing the human need for security. Many times, this can overlap with the use of primary and secondary emotions in therapy.

**Tracking the negative interaction cycle** can be seen as any time I seek to elucidate the clients' emotional experience of their negative cycle that is identified in the first session. This can be done by asking them questions such as, "What usually happens now?," introducing the couple to the cycle the therapist has observed, or educating them on typical negative cycles that are experienced by couples. Reframing partners' reactions in term of the negative interaction cycle (e.g., pursuer/withdrawer) is also an important part of tracking the cycle. **Introducing the negative interaction cycle** is observed as when I initially introduce or educate the couple on the negative interaction cycle.

I may also use **enactment**, which is characterized by my asking client's to enact their emotional experience, usually their negative interaction cycle, in a different way. Enactments may also arise spontaneously and can then be guided by the therapist.

*Cognitive-behavioral checklist.* The CBT intervention checklist is used to identify the therapist's use of the following concepts and interventions: guided discovery, homework assignment, enactment, cognitive distortions, and tracking the negative cycle.

**Guided discovery** can be defined as the therapist's use of logical questioning to help clients identify alternate ways of viewing their current situations or experiences. When observing therapy, guided discovery can be seen as my asking leading questions with the end goal being client insight.

**Homework assignments** are very easy to identify in therapy. There are assignments that I will introduce as needing to be completed in the week before the next session.

**CBT enactments** can be observed in therapy as reenactments of recent arguments or conflict. They can also be used as in-session experiments to experiment with different behavioral or cognitive techniques. A CBT enactment is distinguished from an EFT enactment in that the therapist is prescribing experiences focusing on behavioral or cognitive processes instead of emotional processes.

**Cognitive distortions** are identified by my introducing and educating the clients on the concept. It also is identified when I apply the concept to their current situation. There are eight traditionally recognized distortions: arbitrary inference, selective abstraction, overgeneralization, magnification and minimization, personalization, dichotomous thinking, labeling and mislabeling, and mind reading.

**Tracking the negative cycle** in CBT is similar as in EFT except that with CBT, the focus is on the specific cognitions or behaviors behind the cycle instead of emotions.

Obviously, many of these ideas overlap and the context of the situation or couple distinguish them from one another. For example, if we had been discussing primary or secondary emotions, an enactment would be identified with EFT. If we had been discussing minimizing or mind reading it would be identified with CBT. **Introducing the negative interaction cycle** is observed as when I initially introduce or educate the couple on the negative interaction cycle.

*Gottman checklist.* The Gottman intervention checklist will be used to identify the

therapist's use of the following concepts and interventions: **four horsemen, couple friendship, softened startup, repair attempt, accepting influence, solvable vs. perpetual problems, enactment, positive sentiment override, and dream recognition.**

Each concept listed in the Gottman checklist is an explicit psychoeducational and observably behavioral intervention utilized by the therapist in session. Each can be used by educating clients on the concept's effects on the couple's relational functioning as well as applied to their current situation, whether by observation of the therapist or use in an intervention specific to the couple.

Each concept can be identified when the therapist introduces the concept or educates the clients on their importance in couple relations. They can also be recognized when the therapist tracks their use in the couple interaction or applies them to a homework assignment.

**Enactments** may be the one intervention listed that is not as easily recognized as the others. Enactments can be observed in therapy as reenactments of recent arguments or conflict. Usually this consists of an assessment enactment, where the therapist asks the couple to discuss a topic and observes the interaction; or a structured enactment, where the therapist restructures the interaction, asking the partners to experiment with different approaches instead of their usual behavioral patterns. A GCT enactment is distinguished from EFT or CBT enactments in that the focus is on identification or application of concepts particular to this model only.

Appendix C. Pre-Session Outline

## Pre-session Outline

1. Guiding Outline- 1<sup>st</sup> Session
  - a. Assessment and introduction
    - i. Administer couple intake paperwork
      - i. OQ
      - ii. RDAS
    - ii. Introduce clinic
  - b. Identify negative cycle
  - c. Asses for behavioral, cognitive, or emotional deficits
  - d. Heighten and solidify emotional experience (addressing behavioral cues of emotion)
  - e. Reflection
  - f. Introduce primary emotions
    - i. Formulate hypotheses about vulnerabilities and attachment injuries
  - g. Reframe partner reactions in attachment terms
  - h. Assessment enactment during break
  - i. Introduce negative cycle to clients
    - i. Track and reflect negative cycle
  - j. Introduce 4 horsemen
    - i. Definitions
    - ii. Frame in attachment theory
  - k. Summarize high points, themes and developments of the session.
  - l. End with homework to strengthen friendship and decrease 4 horsemen