

Pepperdine University
Graduate School of Education and Psychology

PROCESSES AND MECHANISMS OF CHANGE IN INTEGRATIVE BEHAVIORAL
COUPLE THERAPY: A CASE STUDY OF ONE COUPLE WITH DISTRESS OVER CHILD
REARING

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Jessica S. Schachter

July, 2015

Kathleen Eldridge, Ph.D. – Dissertation Chairperson

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This clinical dissertation, written by

Jessica S. Schachter

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Kathleen Eldridge Ph.D., Chairperson

Shelly Harrell, Ph.D.

Laura Wiedeman, Psy.D.

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VITA

JESSICA S. SCHACHTER (STEPHAN)

EDUCATION

Pepperdine University Graduate School of Education and Psychology, Los Angeles, CA
September 2011-present

Psy.D. Candidate, Clinical Psychology

GPA 3.96

Clinical Competency Exam: Passed, June 2013

Dissertation Final Defense: Scheduled for January 23, 2015

Title: *Processes and Mechanisms of Change in Integrative Behavioral Couple Therapy: A Case Study of One Couple with Distress over Child Rearing*

Pepperdine University Graduate School of Education & Psychology, Malibu, CA

May 2011 *Master of Arts in Clinical Psychology with an emphasis in Marriage & Family Therapy*

GPA 4.00

Emory University, Atlanta GA

May 2009

Bachelor of Arts in Psychology

GPA 3.55

SUPERVISED CLINICAL EXPERIENCE

Kaiser Permanente, Medical Center, Department of Psychiatry

Sept 2013-April 2014

Los Angeles, CA

Clinical Neuropsychology Doctoral Extern

Individual Supervisor: Karen Earnest, Ph.D., ABPP-CN

- Provided comprehensive adult outpatient neuropsychological assessment services for referrals from the Departments of Neurology, Neurosurgery, Geriatrics, and Psychiatry. Skills developed included selecting comprehensive assessment battery, conducting interview and completing testing, scoring test results, preparing summary sheet, and writing integrated assessment report.
- Received experience with regard to diagnosing dementia differentials, epilepsy, traumatic brain injury, multiple sclerosis, Parkinson's disease, aneurysm, stroke, brain tumor, subjective complaints of cognitive decline, and psychiatric disorders presenting with cognitive change.
- Directly observed WADA surgeries for patients with Epilepsy and seizure disorders and discussed results with supervising neuropsychologist, neurologist and neurosurgeon.
- Provided feedback to patients and their families including reviewing written assessment reports and discussing recommendations.
- Attended weekly neuropsychology didactic trainings and presented on assessment cases and articles of interest on a rotating schedule.
- Attended monthly movement disorder interdisciplinary team meetings to discuss patients with neurologists, neurosurgeons, neuropsychologists, nurses, and social works focusing on patients with Parkinson's disease
- Attended monthly Epilepsy interdisciplinary team meetings to discuss aspects of Epilepsy patient cases including reviewing video of seizures captured in the hospital, candidacy for treatment, implications of neuropsychology assessment on surgical outcome, and assignment to WADA surgery.

Kaiser Permanente, Medical Center, Department of Pediatrics
Los Angeles, CA

July 2012-April 2014

Clinical Psychology Doctoral Extern

Individual Supervisor: Juliet Warner, Ph.D.

- Conducted neuropsychological and psychoeducational assessments, using cognitive, achievement, and emotional measures with children and adolescents who presented to the *ADHD School Clinic* and *Oncology Late Effects Clinic* with cognitive and learning difficulties, psychological, attentional, and behavioral problems.
- Assessed data over time and wrote comprehensive reports for patients in the oncology late effects clinic who received treatment with chemotherapy, radiation, and/or bone marrow transplants and who receive annual neuropsychological assessments to track cognitive functioning as the child develops.
- Collaborated with patients' teachers when gathering information and/or providing detailed recommendations and participated in IEP meetings.
- Provided families with verbal and written report feedback regarding assessment outcomes and recommendations.
- Conducted weekly therapy with children diagnosed with ADHD and Sensory Integration Disorder focusing on social skills, behavioral, and sensory difficulties.

Juan de Anza Elementary School, Wiseburn School District

Jan 2013 – June 2013

Los Angeles, CA

Clinical Psychology Doctoral Extern

Individual Supervisor: Meredith Merchant, Ph.D.

- Provided school-based individual therapy to children grades K-5 with emotional, behavioral, academic, and family difficulties including adjustment, anxiety, and depressive disorders.
- Worked in partnership with teachers and school faculty to gather information and support students with various academic, behavioral, social, and emotional needs.
- Conducted initial intakes and sessions as needed with children's parents to gather information and provide feedback concerning the child's participation in counseling in order to further treatment progress.

Pepperdine Psychological and Educational Clinic

Sept 2011- April 2014

Los Angeles, CA

Clinical Psychology Doctoral Extern

Individual and Group Supervisors: Aaron Aviera, Ph.D. & Edward Shafranske, Ph.D.

- Provided individual therapy to adults experiencing various conditions and challenges including depression, anxiety, relational and occupational problems, and substance abuse
- Conducted individual therapy with children struggling with academic and family difficulties
- Provided couples therapy from an integrative behavioral couples therapy model
- Completed initial intake assessments and administered psychodiagnostic and outcome measures to inform diagnosis and treatment planning.
- Participated in weekly case conferences and presented clients with a selected treatment video segment and intake summary on a rotating basis focusing on diagnostic conceptualization and treatment planning.
- Provided emergency psychological interventions as the on-call therapist on a rotating basis assisting patients in crisis
- Maintained clinical charts for clients including intake assessments, chart notes, psychodiagnostic measures, and payment logs.

The Maple Counseling Center, Adolescent and Child Track (ACT)

Sept 2010-June 2011 Beverly Hills, CA

Marriage and Family Therapist Trainee

Individual and Group Supervisor: Susan Spiegel, Ph.D.

- Provided school-based individual and group therapy to adolescents, children, and families in the Beverly Hills school system
- Staffed center's HELP-LINE on a rotating basis, assisting callers in crisis
- Participated in weekly trainings on topics such as working with suicidal clients, domestic violence, and law and ethics

Plaza Community Services

January 2010-June 2010 Los Angeles, CA

Marriage and Family Therapist Trainee

Individual and Group Supervisor: Rachel Shimoni, M.A., LMFT

- Provided individual therapy for children and adults with varying challenges including behavioral difficulties, methamphetamine addiction, and domestic violence
- Co-led weekly group therapy for women focusing on self-esteem in relation to maintaining sobriety and improving self-confidence
- Completed Los Angeles Department of Mental Health (DMH) paperwork, progress notes, and created treatment plans for clients with several diagnoses ranging from generalized anxiety disorder to disruptive behavior disorder
- Collaborated with multidisciplinary treatment team including social workers, in home counselors, and substance abuse counselors.

RESEARCH EXPERIENCE & PROFESSIONAL PRESENTATIONS

Warner, J., Gindlesperger, M.F., Wells, V.A., Peaerlstein, R., Yang, A., Kohlman, S., Jackson, K., Fried, R., & Stephan, J. (2013).

Neurocognitive Late-Effects of Pediatric Oncology: Annual Screening as Standard of Care with the KP-NCLE Brief Assessment Battery Kaiser Permanente, Los Angeles Medical Center (Presented at the International Neuropsychology Conference)

Falender, C.A., Shafranske, E., Anderson, T., Miller, M., & Stephan, J. (2013). *Through the Mirror on Clinical Supervision* (Presented at the California Psychology Association Convention)

Stone, S. & Stephan, J. (2013). *Kids Club* (Presented at California State University Long Beach)

Stephan, J. (2012). *Caregiver Burnout in Foster and Adoptive Parents* (Presented at Westside Children's Center)

Semel Institute for Neuroscience and Human Behavior at UCLA **May 2008-Aug 2008; Sept 2009-Jan 2010**
Westwood, CA

Staff Research Assistant, Supervised by Robert Bilder

- Promoted from volunteer to staff research assistant that facilitated in the creation of an online collaborative database for phenotype annotation concerning various cognitive aspects of, and tests used to asses ADHD, Schizophrenia and Bipolar Disorder
- Investigated neuropsychological phenotypes and mechanisms on a genome-wide scale
- Conducted literature searches and examined quantitative data specific to cognitive tests and concepts of interest (e.g., response inhibition, Stroop test)

Emory University Laboratory of Interpersonal Processes

Sept 2007-May 2009

Atlanta, GA

Lab Member, Supervised by Stephen Nowicki

- Assisted clinical psychology graduate students in various projects concerning social skills and nonverbal behavior
- Co-authored poster concerning teacher and parent ratings of nonverbal communication deficits as related to behavior problems in children
- Participated in seminars and criticisms of masters theses and dissertations of clinical graduate students

Emory Psychology in the United Kingdom Program

May 2007-July 2007

Dundee, Scotland & London, England

Study Abroad Research Student, Supervised by Robin Fivush and Laura Namy

- Collaborated with program faculty to investigate cross-cultural differences in development of gender roles and gender stereotypes
- Conducted interviews with elementary school students in classroom and playground settings in Scottish educational system
- Assisted in management of elementary school classroom while maintaining journal of behavioral observations

TEACHING & SUPERVISION EXPERIENCE

Pepperdine University

September 2013-April 2014

Los Angeles, CA

Pre-Doctoral Therapy Peer Supervisor, Supervised by Aaron Aviera, Ph.D.

- Provided peer supervision of clinical work for one first year and one-second year doctoral student working at the Pepperdine University Psychological and Educational Clinic including weekly 1-hour of face-to-face supervision, review of clinical chart notes and intake reports, and of video taped therapy sessions.
- Co-lead various case conference meetings for first year psychology students including the assessment of urgent presenting issues, diagnostic questions, and client treatment and conceptualization supported by video observation of a student's selected therapy session
- Provide support to first year doctoral students carrying the clinic's emergency pager by guiding them through emergency procedures and assisting them in any on-call emergencies.
- Attend didactic training and intensive coursework in clinical supervision.

Kaiser Permanente

Sept 2013-April 2014

Los Angeles, CA

Pre-Doctoral Assessment Peer Supervisor, Supervised by Juliet Warner, Ph.D.

- Provided peer supervision of psychoeducational and neuropsychological assessment reports completed by new externs
- Reviewed assessments and edited for interpretation of patient's performance on assessment measures, grammar and punctuation, and appropriate recommendations
- Directly observed assessments conducted by new externs and provided feedback in administration of particular assessment measures.

Pepperdine University

Sept 2011-Dec 2012

Malibu, CA

Teaching Assistant, Charlene Underhill-Miller, Ph.D.

Pepperdine University

- Reviewed taped class exercises with students in PSY 612, Techniques and Theories in Psychotherapy providing theoretical and technical feedback
- Assisted students with preliminary case conceptualization and application of theory to various presenting problems
- Provided summaries of "consultations" with students regarding their taped video assignments

Pepperdine University

Sept 2011- Dec 2012

Malibu, CA

Teaching Assistant, Katherine Eldridge, Ph.D

- Assist in grading of class assignments and exams for PSY 640, Marriage and Family Therapy II
- Collaborate with the professor regarding textbooks and adjunctive course materials
- Maintain excel spreadsheets regarding assignment grades and class attendance

Pepperdine University

Jan 2011-May 2011

Malibu, CA

Teaching Assistant, Dennis Lowe, Ph.D.

- Assist in grading of papers, quizzes, and exams for PSY 600, Clinical Management of Psychopathology
- Conduct group meetings with students preparing for PSY 639, Marriage and Family Therapy I presentation

- Update information and corrects mistakes regarding APA style

ADDITIONAL RELATED EXPERIENCE

Compsych

Jan 2009-May2009; April 2010-June 2010, June 2014-Present

Atlanta, GA; London, United Kingdom

Guidance Resources Employee; Onsite Program

- Conducted international research from the company's London office on the most distressing work-life, mental health, and health problems for employees in numerous European countries and summarized current government and/or company implemented programs and resources.
- Provided trainings to employees of various companies in central London on pertinent work and health issues such as 'Managing Emotions in the Workplace' and 'Stress: A Way of Life or a Fact of Life'
- Guided trainings for companies, which rely on Compsych as their employee assistance program on topics such as anxiety and work stress.
- Worked for Chicago-based company creating directories of child-care, shelters, elder-care, housing, and more
- Examined resources and guidance provided by national and international employee assistance providers
- Recruited onsite guidance specialists to perform social work and assistance with providing immediate resources for behavioral and emotional health
- Evaluated candidates through a phone screening processes and searched for candidates using various provider networks

Emory University Help Line

Spring 2008-Spring 2009

Atlanta, GA

Peer Counselor/Public Relations Chair

- Provided confidential support to Emory University students and faculty for a variety of issues (e.g., sexual assault, suicidal ideation, anxiety, etc.)
- Participated in weekly intensive training administered by experts in various areas who focus on topics relevant to callers seeking support
- Disseminated information about the organization to the Emory University public in order to increase awareness of the Help Line as a dependable and anonymous resource

Beyond Words Center for Social Skills Training

Sept 2007-May 2009

Atlanta, GA

Group Assistant and Researcher

- Co-led weekly social skills training group of 7th grade boys focusing on social and nonverbal communication
- Became familiar with assessment measures commonly used with children (Teacher Report Form, Child Behavior Checklist, Emory Dyssemia Index Revised)
- Entered pre- and post-assessment data of children into an SPSS database and assisted in statistical analysis of data
- Co-authored poster on the validity of the Emory Dyssemia Index Revised as a predictive test for internalizing and externalizing problems in children

Emory Reads

Sept 2007-Dec 2007

Atlanta, GA

Tutor

- Tutored elementary children in public school districts in math and reading
- Interacted with children and provided academic support through games and reading activities

PROFESSIONAL & UNIVERSITY AFFILIATIONS

Student Government Association, 2 nd year class representative	June 2012-June 2013
Psi Chi: The National Honor Society in Psychology, member	June 2010-Present
APA, Graduate student affiliate of American Psychological Association	Sept 2009-Present
Research and Practice Team (RAPT), Pepperdine University, member	Sept 2009-May2011
APA, undergraduate student affiliate of American Psychology Association	Sept 2008-Jan 2009

ABSTRACT

Marital distress is common and can have a tremendous influence on an entire family. Spousal conflict related to children is known to have a particularly negative impact on both the parenting and marital relationship. A number of evidence-based therapies exist to support couples in need including integrative behavioral couple therapy (IBCT; Jacobson & Christensen, 1998), which focuses on emotional acceptance and behavior change as mechanisms that improve marital satisfaction. While IBCT is well documented as an effective treatment with lasting outcomes (Christensen, et al., 2004), how and why IBCT works remains less clear. The current study used qualitative methodology to increase understanding of IBCT and expand upon literature related to marital conflict and child rearing. Recommended case study methods were combined with the spirit and steps of discovery-oriented research to provide a rich description of change processes and mechanisms associated with therapeutic progress. The research questions posed in this study were designed to mirror the components and phases of the Doss (2004) framework for studying change in psychotherapy, and were addressed in the context of a selected course of IBCT for a couple who presented with conflicts about child rearing. Results included detailed reports of the client and therapy change processes, change mechanisms, and treatment outcomes for the selected couple. These results revealed that acceptance growth and behavior change taking place over the course of therapy lead to increased marital satisfaction and a reduction of conflict related to child rearing. Important findings about how and why IBCT works were discussed. Future research might examine change processes in *unsuccessful* treatments so as to continue to refine therapies and expand upon knowledge of how and why therapies work.

INTRODUCTION

Marital distress is one of the most commonly experienced difficulties in today's adult population. Specifically, divorce rates continue to remain near 50% and at any given time, 20% of those who are currently married report relationship distress (Lebow, Chambers, Christensen, & Johnson, 2012). A number of factors have been associated with an increased likelihood of marital distress such as a partner in the relationship with a mental or physical difficulty, infidelity, financial problems, and physical abuse (Cano, Christian-Herman, O'Leary, & Avery-Leaf, 2002; Lebow et al., 2012). Specific to the current study, there is also evidence that suggests the presence of children may exacerbate marital discord (Schermerhorn et al., 2007). Essentially, child-related conflict has been identified as a phenomenon that can negatively impact both the parenting relationship and the marital relationship (Lebow et al., 2012; Snyder & Halford, 2012). Likewise, the potential for decline in marital satisfaction during the transition to parenthood is well documented (Mitnick, Heyman, & Smith, 2009). While children are often sources of extreme joy, the challenges of raising a family can exert significant stress on the marital relationship. The prevalence of such challenges and the survival of marriages has significant implications for the emotional health of families and children (Gattis, Simpson, & Christensen, 2008).

The statements above highlight the relevance of couple therapy, as marital discord and parenting conflict will likely impact the entire family (Lebow et al., 2012; Schermerhorn, Cummings, DeCarlo, & Davies, 2007). While the effects of parenting conflict are well documented with regard to its impact on child rearing and parenting style, little is known from empirical literature about the ways in which couple therapy can support couples experiencing this specific type of challenge in their relationship. With the efficacy of couple therapy well-

documented (Lebow et al., 2012), researchers are shifting to increasingly qualitative and case-intensive formats of research to understand the underlying processes and mechanisms of change in couple therapy for specific sources of distress (Carlson, Ross, & Stark 2012; Doss, 2004; McLeod & Elliot, 2011). This dissertation seeks to utilize recommended case study methodologies to examine psychotherapy change processes and mechanisms specific to one couple whose marital distress is exacerbated by parenting conflict, thereby contributing to greater understanding of couple therapy and how therapists can effectively assist couples with co-occurring marital and parenting distress. The approach to therapy examined in this study is integrative behavioral couple therapy (IBCT; Christensen, Doss, & Jacobson, 2014; Christensen & Jacobson, 2002; Jacobson & Christensen, 1998), a third-wave behavioral approach integrating behavioral change and emotional acceptance. An in-depth analysis of a given couple and the treatment delivered provides valuable insight into the recovery of marriages and the ways in which therapists successfully guide couples through marital difficulties related to raising children.

Literature Overview

Parenting conflict. As previously mentioned, it is generally accepted that the nature of family members' influence on one another is reciprocal. The entire family is affected by separate subsystems (e.g., marital, child) with each influencing and being influenced by the other. Evidence that children influence their parents' relationship is found in the numerous studies that document the stress of a couple's transition to parenthood (Pinquart & Teubert, 2010). There are several interventions focused on supporting couples as they prepare for the challenges of parenthood. In their meta-analysis of couple-focused interventions with new and expectant parents Pinquart and Teubert (2010) examine intervention topics such as "prevention of marital

breakdown after childbirth” (p.225) and “promotion of couple adjustment and parenting” (p. 226). Such topics highlight the inherent stress of parenting and its effects on the marital relationship. Marriages are at an even greater risk when couples are parenting children with specific challenges. For example, couples that have a child diagnosed with a chronic illness are at risk for relationship difficulties as a result of the adverse circumstances they face as parents (da Silva, Eufemia, & Nascimento, 2010). Additionally, parents with children that have disorders such as attention deficit hyperactivity disorder (ADHD) experience increased stress as a result of their child’s behavioral and emotional symptoms and are more likely to divorce (Theule, Wiener, Rogers, & Marton, 2010; Wymbs, et al., 2008).

Not surprisingly, the direction of effects between parents and children is bi-directional. To date, there exists a wide body of research documenting parenting conflict as a source of marital distress that has the potential to negatively impact child development. More specifically, marital arguments about child rearing are believed to have especially significant effects on child development, even more than global marital dissatisfaction (Morawska & Thompson, 2009). For example, a number of studies have revealed the relationship between marital satisfaction and positive or negative parenting practices. Specifically, studies repeatedly show that positive marital relationships yield warm, nurturing parenting while marital distress results in more damaging parenting practices (Shelton & Harold, 2008). Ultimately, children may withdraw, exhibiting an increase in internalizing behaviors in response to their parent’s marital conflict, or they may act-out in an attempt to re-engage their parents in the parenting relationship (Shelton & Harold, 2008). Regardless of the initial internalizing or externalizing response to parenting conflict, children are at risk for future adjustment problems. Pedro, Ribeiro, and Shelton (2012) expand on this literature in their examination of collaborative parenting behavior as influencing

the relationship between marital satisfaction and parenting practice. They found that marital satisfaction inspired agreement around raising children and resulted in less triangulation of children and fewer instances of undermining the spouse's parenting abilities and authority. Other research describes that conflict over child rearing and child adjustment are related to marital satisfaction such that as parents become more satisfied in their marriage, they encounter less distress around parenting and their children demonstrate functional improvement related to behavior dysfunction, disrupted interpersonal relationships, emotional distress and somatic complaints (Gattis, Simpson, & Christensen, 2008). Aside from interventions designed for the transition to parenthood, there is a gap in the literature when it comes to understanding how couples experiencing conflict related to parenting beyond this transition are best supported. Research focused on treatment of marital conflict specific to parenting may support efforts in creating useful interventions targeting family functioning (Morawska & Thompson, 2009).

Couple therapy and IBCT. Generally speaking, mental health professionals know that couple therapy is helpful for both relational problems and psychological disorders such as depression or substance abuse. Recent reviews indicate 70% of couples who participate in couple therapy report positive change yet 25-30% indicate no benefit from therapy (Lebow et al., 2012; Snyder & Halford, 2012). This is similar to studies of individual therapy, which report that two-thirds of patients indicate successful treatment (Shadish & Baldwin, 2003). Today, the efficacy of couple therapy is well documented, and there are several evidence-based couple therapies such as traditional behavioral couple therapy (TBCT; Jacobson & Margolin, 1979), cognitive behavioral couple therapy (CBCT; Epstein & Baucom, 2002), and emotion focused couple therapy (EFCT; Greenberg & Johnson, 1988). Historically, TBCT has focused on skill building in communication and problem solving to increase positive behaviors and decrease negative

behaviors. Traditionally, CBCT attempts to alter the cognitions of the individuals in the couple related to their expectancies and attributions concerning their partner. Finally, EFCT focuses on decreasing hostility and increasing emotional vulnerability related to attachment needs.

Integrative behavioral couple therapy (IBCT) is another empirically supported couple therapy (Christensen et al., 2004; Lebow et al., 2012). Specifically, IBCT has proven to be a successful treatment for those who experience marital distress. As many as 71% of couples demonstrate clinically significant relational improvement in their marriage by the end of this specific form of treatment (Christensen, et al., 2004). Considered a *third wave* behavioral treatment, IBCT focuses on behavior change and acceptance (Jacobson & Christensen, 1998). This is in contrast to other therapies centered on behavioral change or problematic emotional states. Born out of TBCT, which utilizes accommodation, compromise, and collaboration as tenets of treatment, IBCT includes *acceptance* as a “missing link” (Jacobson & Christensen, 1998). Central to IBCT is the belief that honest incompatibility does exist in marriages. Not to be confused with defeat, acceptance is therefore defined as the release of the belief that differences are intolerable and the acknowledgment that an individual does not have the power to fundamentally change their partner. Essentially, there are three mechanisms by which acceptance can support couples in marital distress. The first involves the creation of intimacy by using conflict as a way of generating closeness (e.g., turn differences into sources of strength, develop love and appreciation for the ways in which partners are different from each other). The second is the creation of tolerance of the partner’s aversive behaviors. And finally, change that is maintained by natural contingencies rather than by the governance of rules. Put simply, in IBCT the job of the therapist is to “simply create conditions in therapy that allow couples to have experiences fostering both acceptance and change” (Jacobson & Christensen, 1998, p.15).

Interventions intended to bring about acceptance include empathic joining, unified detachment, and tolerance building (Jacobson et al., 2000). Empathic joining and unified detachment are designed to create acceptance that will enhance the couple's experience of intimacy. More specifically, empathic joining entails the re-formulation of the conflict as a natural difference between partners that is not only common, but also, in fact, inevitable. This is paired with acknowledgment of the pain experienced by each individual as they try, unsuccessfully and with significant effort, to find relief from their struggle. Therapists attempt to encourage empathic joining through a variety of interventions (e.g., communication skills training, promotion of soft responses from the speaker, and reformulation by the therapist). Unified detachment engages the couple in an objective analysis of the problem, free from blame and evaluation. To foster unified detachment, the therapist supports couples in describing problematic events without evaluating their partner or the incident of concern. Finally, building tolerance allows partners to refrain from changing the spouse's behavior, making it easier to "let go" and ultimately reduce their experience of pain. There are four main strategies by which therapists promote tolerance: identifying positive aspects of frustrating behavior, roleplaying negative behavior during a therapy session, acting out negative behavior between sessions, and self-care. These interventions serve to reduce the effects of conflict and promote speedier recovery from conflict.

Integrative behavioral couple therapy also incorporates a number of change techniques that are central to TCBT (Jacobson & Margolin, 1979). For example, behavior exchange strategies are interventions that are specifically intended to alter problematic behavior occurring in a relationship. More specifically, behavior exchange strategies serve to increase the ratio of positive to negative behaviors occurring in the relationship. Therapists hope to increase the

amount of positive behavior outside of the therapy session by directly assigning behavioral tasks. Additionally, communication training has been found to complement the acceptance work to be addressed in IBCT in such a way that emotions can be freely expressed without fear, blame, accusation, and defensiveness. Communication training provides the couple with the skills to support and understand each other while also providing them with the ability to deal with conflict. Being a better listener serves to decrease defensiveness while using “I” statements decreases blame. Finally, problem-solving skills help couples successfully resolve problems by clearly defining the problem, brainstorming possible solutions, reviewing pros/cons of solutions, and jointly deciding upon a solution.

Research on psychotherapy change processes and mechanisms. Creating opportunities for change and acceptance are identified as central tenets of IBCT, yet how and why these change mechanisms come about and translate into increased marital satisfaction is less clear. A number of professionals point out a lack of literature focusing on mechanisms of change and change processes across many forms of psychotherapy (Blow et al., 2009; Doss, 2004; Doss et al., 2005; Heatherington, Friedlander, & Greenberg, 2005; Kazdin, 2001). To date, efficacy and effectiveness research have allowed psychologists to establish that various treatments do work (Blow, Morrison, Tamaren, Wright, Schaafsma, & Nadaud, 2009). However, the complexities of therapy cases, which contain crucial information for understanding the therapeutic process, are neglected (McCleod & Elliot, 2011). It is thought that a deeper understanding of change processes can help therapists modify current therapies and make various treatments even more effective (Doss, 2004). Without question, change in psychotherapy is a complex and multilayered phenomenon that is not easily mapped into organized frameworks (Blow, 2009). For research purposes, it is important to identify and define the components of

change in psychotherapy; historically, such distinctions of the key ingredients of change in therapy have been ignored (Doss 2004; Kazdin, 2001).

As the general field of individual therapy research attempts to understand mechanisms of change, couple therapy researchers are also beginning to apply models of change to dyadic treatments (Doss, Thum, Sevier, Atkins, & Christensen, 2005). As presented in Figure 1, fundamental elements of change in psychotherapy include change processes, change mechanisms, and ultimate outcomes (Doss, 2004).

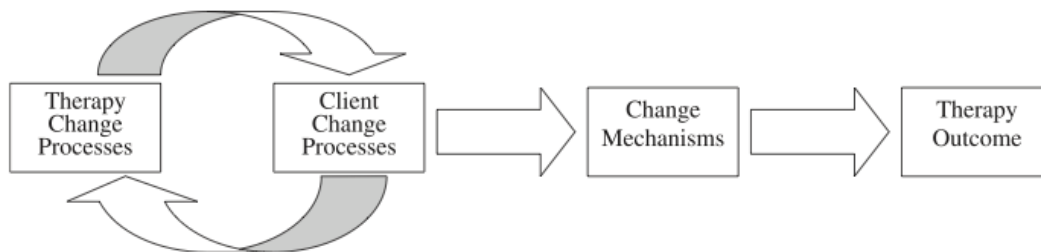


Figure 1. Components of change in psychotherapy. From “Changing the Way We Study Change in Psychotherapy,” by B. D. Doss, 2004, *Clinical Psychology: Science and Practice*, 11(4), p. 369. Copyright 2004 by Brian D. Doss. Reprinted with permission by author.

There are two types of change processes, therapy change processes and client change processes. Therapy change processes occur during the therapy session and include direct interventions and directives. For example, in TBCT therapy change processes might include teaching problem solving and communication skills and IBCT therapy change processes would include unified detachment and empathic joining interventions. Client change processes are experiences and behaviors that are the direct result of therapy change processes. The use of new communication skills correctly both in session and during homework is an example of TBCT client change processes while the use of empathy in place of blame is a client change process specific to IBCT. Therapy and client change processes interact to consequently produce improvements in the mechanisms of change. Change mechanisms lie between change processes

and ultimate outcomes and may be defined as the changes that have translated into the couple's life and are no longer the direct result of therapy. In TBCT the mechanism of change is viewed as the decrease in frequency of negative interactions and the increase in frequency of positive interactions. The change mechanism specific to IBCT is emotional acceptance.

Historically, the difference between change processes and change mechanisms has been essentially disregarded (Doss, 2004). Fundamentally, change mechanisms are those changes that have been adopted naturally into the couple's life while change processes are the "active ingredients" in therapy that lead to the aforementioned generalization of change (Doss, 2004, p.369).

Specifically, change mechanisms are alterations in client character or abilities that are byproducts of the therapy process. For example, a therapist engages a couple in unified detachment (therapy change process) to promote the externalization of the conflict (client change process). As a result, the couple experiences increased emotional acceptance (change mechanism). Finally, due to the increased emotional acceptance, the couple experiences increased marital satisfaction (treatment outcome).

Examination of the measures used to assess each of these components of the psychotherapy change process further clarifies the distinction between them. Specifically, therapy change processes can be assessed using the Behavioral Couple Therapy Rating Manual (Jacobson et al., 2000), which has been used to measure therapist adherence to IBCT and TBCT. Client change processes have been assessed using various coding systems of couple behaviors in session (Cordova, Jacobson, & Christensen 1998; Sevier, Eldridge, Jones, Doss, & Christensen, 2008; Wiedeman, 2012). Change mechanisms have been understood by examination of the Frequency and Acceptability of Partner Behavior Inventory (FAPBI; Christensen & Jacobson,

1997), which was developed as a self- and partner-report measure of behavior change and emotional acceptance. Treatment outcomes have been represented by the Dyadic Adjustment Scale (DAS; Spanier, 1976) and the Global Distress Scale of the Marital Satisfaction Inventory-Revised (GDS; MSI-R; Snyder, 1997). Another relevant outcome measure specific to the topic of this study is the Conflict over Child Rearing Scale of the MSI-R (CCR; Snyder, 1997).

Doss's (2004) framework also organizes the study of psychotherapy change components into specific phases. Phase one calls for the establishment of a treatment as effective. Prior to examining the process of change, it must first be known that IBCT can in fact help couples. Research shows IBCT to be an empirically supported treatment with the majority of couples demonstrating clinically significant relationship improvement by the end of therapy (Christensen et al., 2004). Such improvements remain in studies conducted 2 years and 5 years past initial treatment (Christensen et al., 2006; Christensen et al., 2010). The second phase of research concerns the identification of change mechanisms. Doss et al.'s (2005) study on change mechanisms in couple therapy indicates that emotional acceptance is an important mechanism of change for IBCT. The study further demonstrates that alterations in emotional acceptance are associated with increases in marital satisfaction and lead to lasting relational change. The third phase is an examination into therapy and client change processes. Client change process research has identified client changes in communication, particularly engaging in non-blaming problem-discussions, increasing frequency of positive behaviors, problem-solving skills, and vulnerability in combination with validation as delivering meaningful change in marital relationships during IBCT (Cordova, Jacobson, & Christensen, 1998; Sevier et al., 2008; Wiedeman, 2012). In the fourth and final phase of psychotherapy change research, the understanding of the mechanism of

change and processes that promote improvement is applied in such a way that treatments can be modified to be more effective and disseminated more broadly (Doss, 2004).

Although the Doss (2004) framework is helpful for guiding psychotherapy change research, it is important to acknowledge the complexity of this endeavor. For example, Blow et al. (2009) suggest that while identifying and defining the components of change supports therapists' ability to understand the process, change is not as clear and linear as one might hope. The same authors propose that the best approach is one that examines therapeutic moments and is sensitive to the possibility that change is a complex and dynamic phenomenon. Also bearing relevance to a discussion of couple change processes is the notion that couples have described change in therapy as gradual. Essentially, in couple therapy research, "Change was perceived as incremental rather than instantaneous or sudden; events identified as turning points were described not as earth-shattering revelations but as small, yet significant, experiences" (Christensen, Russell, Miller, & Peterson, 1998, p.184). Third, while change process research, and specifically the Doss (2004) model is largely focused on processes that enhance and promote desired therapeutic change, there are instances of unsuccessful therapeutic treatment. Doss (2004) suggests that the study of ineffective treatment can allow therapists to modify their treatments and ultimately increase the likelihood of the desired treatment outcome. Should outcome measures indicate a lack of desired change or a decrease in satisfaction, examination of change-interfering elements will be especially relevant. However, given that the current study aims to understand effective change processes and mechanisms for couples navigating conflict over child rearing, the study of ineffective treatment or treatment-interfering processes will not occur within the present study.

Put simply, studies that only focus on efficacy and effectiveness fail to contribute to therapists' knowledge of why or how treatment models help people (Blow et al., 2009). Understanding the complexities of psychological research focused on couples and families requires acknowledgement that various types of evidence contribute to a therapy being known as an evidence-based practice (Carlson, Ross, & Stark, 2012). As psychology places increasing emphasis on evidence-based practice and highlights the value of bridging research and practice in clinical training, understanding how a therapy works is an especially important contribution.

Case study research. Case study research is thought to be a valuable method of examining important mechanisms of change in psychotherapy (Carlson, Ross, & Stark, 2012). McLeod and Elliot (2011) purport that case studies are a “methodologically pluralistic” way of examining processes and outcomes in psychotherapy research by conducting comprehensive and in-depth analyses of forms of therapy using a variety of data formats (e.g., video-taped material, transcripts, questionnaires, etc.). Specifically, previous research has largely focused on randomized control studies to examine therapeutic work. Incorporation of other research methods (e.g., case studies) will allow for pluralistic methodology wherein multiple types of research support a particular research question (McCleod & Elliot, 2011). Of note are researchers who acknowledge that case study research has been largely neglected in the field of psychology because historically case studies have consisted of therapist's reports on what they were doing to support their clients and how this contributed to the therapeutic outcome (Carlson, Ross, & Stark, 2012; McCleod, 2010). Such criticisms make case study research easily dismissible. However, a number of sources exist for designing methodologically sound case studies (Creswell, 2013; McCleod, 2010; McCleod, 2011; Mertens, 2010; Yin, 2008). Each of them emphasizes case study research as the in-depth analysis of a single case through detailed

collection and analysis of multiple data sources. Especially appropriate for *how* and *why* research questions, the defining feature of a case study is the extensive understanding of the case (Creswell, 2013; Mertens, 2010). Such comprehensive analysis of a single case is obtained through creating a strong data set comprised of multiple sources of information including interviews with the therapist, client's responses to standardized questionnaires, transcripts of therapy sessions, archival records, and audiovisual material (Creswell, 2013; McLeod, 2011; Mertens, 2010). The strongest case studies utilize both quantitative and qualitative data to determine if treatment was effective and expose the pathways to change (Blow et al., 2009). Once all the data has been obtained, McLeod (2011) encourages readers to be critical in their analyses so as to avoid appearing to "sell" an approach to therapy. It is also important to explain how the data collected will serve to answer the research questions (Mertens 2010; Yin, 2009).

With the increasing emphasis on evidence-based practice, attention to methodologically sound case study research has also captured the attention of the American Psychological Association (APA). A case study that is respectful of APA guidelines for evidence-based research integrates literal clinical material and standardized measures of process and outcome (Carlson, Ross & Stark, 2012). Specifically, according to an APA website, "The goal of *Evidenced-Based Case Studies* will be to integrate verbatim clinical case material with standardized measures of process and outcome evaluated at different times across treatment" ("Evidence-based case study", 2013). They offer four minimal criteria in case study research: assessment of two standardized outcome measures and one process measure, presentation of outcome data using an effect size and discussing clinical significance, verbatim clinical vignettes, and informed consent. Careful examination of all available resources and the meticulous assessment of a selected case will yield relevant findings and information for the

following questions: How did the couple change as a result of therapy? What did the therapist do to facilitate change (Blow et al., 2009)?

The *how* and *why* nature of the present study is consistent with the explorative spirit of discovery-oriented research. The integration of multiple data sources (e.g., questionnaires, video) in combination with theory and clinical expertise guided the researcher in examining *how* IBCT works and *what* leads to change. Consistent with discovery-oriented research, the present study exercised rigorous observation from multiple sources of information of the couple and therapist participating in the therapy (Greenberg, 1991). Maher & Boulet (1999) provide a number of steps that guide discovery-oriented research: study tapes to determine if there are any impressive changes, study the tape to flag where the impressive changes seem to be, describe the impressive change and what qualifies it as impressive, study what the therapist and patient seemed to do to bring about the impressive change, study how the therapist uses the impressive change once it has occurred, continuously re-define and develop processes of impressive change in the therapy. Ultimately, the present study has a similar purpose to discovery-oriented research, that is, “to take a closer, in-depth look at psychotherapy and to discover what is there to be discovered” (Maher, 1999, p.697).

Current study. This dissertation attempted to use methodologically sound and recommended case study methods combined with the spirit and steps of discovery-oriented research methods to develop a deeper understanding of the change processes and mechanisms associated with therapeutic progress. The research questions posed in this study were designed to mirror the components and phases of the Doss (2004) framework for studying change in psychotherapy, and are addressed in the context of a selected course of IBCT for a couple who presents with conflicts about child rearing.

To summarize, the components of the Doss (2004) framework applied to IBCT would suggest that therapy change processes (unified detachment and empathic joining) and client change processes (shared vulnerability and nonblaming discussion of conflict) interact and lead to increased emotional acceptance, which results in increased marital satisfaction, the intended treatment outcome. The proposed phases for studying these components progress in the opposite direction, from the establishment of effective treatment, to examination of change mechanisms and finally examination of change processes. The research questions for the present study follow these components and phases accordingly. Also consistent with the Doss (2004) model of change processes, attention was paid to both holistic descriptions of processes that occur over the course of therapy and descriptions of processes that occur during moments of impressive change (Mahrer, 1999). Therefore, the following questions were asked concerning the course of treatment for a selected couple with distress over child rearing:

1. What was the treatment progress and outcome for the selected couple treated with IBCT whose marital distress was related to child rearing?
2. What were the change mechanisms experienced by the selected couple?
3. (a) What were the therapy change processes over time? (b) What were the client change processes over time?
4. (a) What were the IBCT therapy change processes utilized by the therapist during moments of impressive change and discussions of childrearing? (b) What were the client change processes displayed by the couple during moments of impressive change and discussions of childrearing?
5. What was the interaction between therapy change process, client change process, change mechanisms, and treatment outcome?

METHODS

Participants

The selected case in this study comes from an archive of data from a clinical trial of couple therapy (Christensen et al., 2004; Christensen et al. 2006; Christensen et al., 2010). Couples participating in the original study included 134 married couples that were seeking therapy and experiencing severe and chronic marital distress. Participation in the study required that the couple be married, cohabiting, requesting therapy, and experiencing ongoing distress (based on specific criteria). Additional requirements were a high school education (or its equivalent), age between 18-65, and the ability to speak English fluently. To avoid treatment interference, individuals with various co-occurring Axis I disorders (e.g., schizophrenia, bipolar disorder, and current substance disorders) and Axis II disorders (e.g., borderline, schizotypal, and antisocial personality disorders) were excluded. Additionally, the individuals in the couple could not be participating in other forms of treatment so as to avoid multiple treatment effects. Marriages with a history of domestic violence meeting criteria for battery were also excluded. The wives had a mean age of 41.62 years ($SD = 8.59$) and the husbands' mean age was 43.49 years ($SD = 8.74$). The mean amount of education was 16.97 years for wives ($SD = 3.23$) and 17.03 for husbands ($SD = 3.17$). On average, the couples were married for 10 years ($SD = 7.60$). Couples had an average of 1.10 children ($SD = 1.03$). The majority of the individuals in the study self-identified as Caucasian (husbands: 79.1%, wives 76.1%). Some participants self-identified as African American (husbands: 6.7%, wives: 8.2%), Asian or Pacific Islander (husbands: 6.0%, wives: 4.5%), Latino or Latina (husbands: 5.2%, wives: 5.2%), and Native American or Alaskan Native (husbands: 0.7%).

There were seven therapists delivering treatment to the couples in the study. All were licensed and practicing therapy actively in their communities. Four were located in Los Angeles and three were located in Seattle. Their clinical experience post-licensure ranged between 7 and 15 years. With regard to training, the therapists were required to read the treatment manual (Jacobson & Christensen, 1998) and attend a workshop conducted by either Andrew Christensen or Neil Jacobson.

For the purposes of this dissertation, one couple of interest was selected from the archival dataset described above by using specific inclusion and exclusion criteria. Only couples with children were considered in the selection process. In addition to evidence of marital distress before treatment (pre-treatment T-score ≥ 50 on the Global Distress Scale of the Marital Satisfaction Inventory-Revised; Snyder, 1997), the current study also required the selected couple to indicate distress related to child rearing (pre-treatment T-score ≥ 50 on the Conflict over Child Rearing Subscale of the MSI-R; Snyder 1997). The couple selected for the current study was randomly assigned to the IBCT treatment group. Finally, the couple had to have completed treatment and demonstrated improvement on self-reports of marital satisfaction, acceptance, and conflict over child rearing. The couple selected was from among those classified as “recovered” in the original outcome study based on clinically significant improvement and no longer meeting criteria for marital distress by the end of treatment (Christensen et al., 2004; Jacobson & Traux, 1991). Specific characteristics of the selected couple are presented in the Results section. Permission to conduct the current study was obtained from Pepperdine University’s Institutional Review Board and the principal investigator of the original study prior to couple selection.

Procedures

Original study. Following pre-treatment screening and data collection procedures, eligible couples were randomly assigned to either TBCT or IBCT treatment groups, and participated in up to 26 free therapy sessions. Couples who *completed* treatment participated in 10 or more sessions with their therapist. In addition to the pre-treatment assessment, couples completed assessments after the feedback session, 13 weeks after pre-treatment, 26 weeks after pre-treatment, at the final session, and at several post-treatment follow-ups. Assessments consisted of self-report and observational data collection procedures. Areas of assessment included marital satisfaction and status, conflict and supportive communication, emotional acceptance, personality, individual functioning, and others (see Christensen et al., 2004 for details on the design and procedures of the original study). Therapists also completed a post-session measure after each session and therapists and consultants completed a post-treatment summary at the end of treatment.

IBCT. Prior to the commencement of treatment, each couple participated in a four-session assessment and feedback process. During the first session the therapist gathered a detailed relationship history. The following two sessions were conducted with the husband and wife individually in order to gain more information about the presenting problem and to gather an individual history for each member of the couple. In the fourth session, any missing information was obtained and the therapist offered feedback (specific to treatment condition) around their presenting problems and upcoming treatment. For IBCT couples, feedback consisted of broad problematic themes rather than particular issues. Specifically, the therapist discussed the couple's difficulties in terms of the natural differences between them and their unproductive and emotionally taxing attempts at resolution, and their strengths as a couple that may support them in their journey toward greater understanding and closeness. The sessions that

followed were centered on treatment. Integrative behavioral couple therapy treatment was centered on emotional reactions of the couple to relationship problems rather than problem solving. Sessions usually focused on a current incident or anticipated incident (e.g., recent argument, a visit from in-laws). Empathic joining, unified detachment, and tolerance building were all used to foster emotional acceptance. Acceptance interventions were balanced with change strategies such as structured communication and problem resolution. The course of treatment was guided by the manual for IBCT written by Jacobson and Christensen (1998). Couples also utilized the self-help component for IBCT (Christensen & Jacobson, 2000). Each session was videotaped and therapists received weekly individual supervision in addition to occasional group supervision. Observation of sessions demonstrated that therapists were highly adherent to the therapy approach and delivered therapy competently (Christensen et al., 2004).

Measures

Measures of treatment outcome.

Marital Satisfaction Inventory (MSI-R; Appendix B; Snyder, 1997). The MSI-R is a widely-used self report measure consisting of 150 true-false items concerning marital satisfaction. The MSI-R was administered by research staff as a measure of treatment progress and outcome during the pre-treatment assessment and at weeks 13, 26, the final session, and at follow-ups. The MSI-R has adequate levels of internal consistency (Cronbach's alpha of .70 to .93) and test-retest reliability (.74 to .88; Snyder, 1997). The measure includes a Global Distress Scale (GDS), Conflict Over Child Rearing Scale (CCR) and 9 other scales that examine various areas of the marital relationship (e.g. Time Together, Affective Communication). The 43-item Global Distress Scale (GDS) is an indication of general marital distress and unhappiness. Items on the GDS include "At times I have very much wanted to leave my partner," and "I get pretty

discouraged about our relationship sometimes.” According to the MSI-R manual the GDS has strong internal consistency (Cronbach’s alpha of .93) and discriminant validity distinguishing between couples in therapy and non-distressed couples (Snyder, 1997). The 10-item CCR is a subscale of the MSI-R designed to represent marital distress surrounding parenting. True false items on the subscale make statements about child rearing (e.g., “Our children often manage to drive a wedge between my partner and me”). This scale is associated strongly with the GDS ($r > .50$; Snyder, 1997). The MSI-R total score and both of these subscale scores were used as indications of progress and treatment outcome for the selected couple (Research Question 1).

Dyadic Adjustment Scale (DAS; Appendix C; Spanier, 1976). The DAS is another extensively used self-report measure of marital satisfaction. The 34-item scale examines the quality of marital adjustment and is comprised of four subscales: Dyadic Satisfaction, Dyadic Cohesion, Dyadic Consensus, and Affective Expression. It was administered during the pre-treatment assessment, at week 13, at week 26, at the final session, and at follow-ups. For the purposes of this study the DAS contributed to the understanding of the outcomes of treatment as well as changes in marital satisfaction throughout the course of treatment for the selected couple (Research Question 1). The DAS is known to have very strong reliability with Cronbach’s alpha typically near .90 (Spanier, 1976). The construct validity is also strong and ranges from .86-.88 (Spanier, 1976).

Measures of change mechanisms.

Frequency and Acceptability of Partner Behavior Inventory (FAPBI; Appendix D; Christensen & Jacobson, 1997). The FAPBI consists of 20 items capturing the frequency and acceptability of positive and negative behaviors and was developed for the original study to measure the change mechanisms of behavior change and acceptance. It was administered during

the pretreatment assessment, 13 weeks after the pretreatment assessment, 26 weeks after the pretreatment assessment, immediately after the final therapy session, and at a 52-week assessment after pretreatment assessment. Each behavior is rated for frequency (e.g., “In the past month how often did your partner (behavior)” and acceptability (e.g., “How acceptable is it that your partner did (behavior) at that frequency”) which is rated on a 10-point scale. Examples of positive behaviors include “responded when I needed affection” or “hugged me.” Negative behaviors include items such as “my partner was critical of me” or “my partner was not responsive to me.” In this sample the Cronbach’s alpha for reports of acceptability of partner’s positive behaviors was high (husband, $\alpha = .85$; wife $\alpha = .79$) as were the reports of frequency of partner’s positive behaviors (husband $\alpha = .83$; wife, $\alpha = .80$). Alphas for reports of acceptance of negative behaviors (husband $\alpha = .65$; wife $\alpha = .69$) and frequency of negative behaviors (husband $\alpha = .73$; wife $\alpha = .71$) were somewhat lower (Doss et al., 2005). For the purposes of this study the FAPBI will serve as our measure of change mechanisms (Research Question 2).

Measures of change processes.

Behavioral Couple Therapy Rating Manual (Jacobson et al., 2000; Appendix E). This system served to accurately identify therapist behaviors and interventions or therapy change processes (e.g., initiation of specific format for solving interpersonal conflicts) during sessions of couple therapy. The manual was originally developed and used as a therapist adherence coding system (Christensen et al., 2004; Jacobson et al., 2000). An observer watches a therapy session and afterward completes ratings of therapist behaviors. Ratings occur on a Likert scale ranging from 1 (*not at all*) to 5 (*extensively*) on the extent to which therapists engage in 28 behaviors relevant to change processes in IBCT and TBCT (e.g., Therapist reformulated the problem either as deriving from a difference between the partners, OR as a vicious cycle resulting from each

partner's attempt to solve the problem that their differences create). Coding of both TBCT and IBCT therapist behaviors took place as TBCT interventions are integrated into IBCT and may therefore account for important therapy change processes. The coding was applied to earmarked impressive moments of change and discussions of childrearing (Research Question 3(a); Research Question 4(a)).

Acceptance Promoting and Interfering Interactions Rating System (APIIRS; Wiedeman, 2012; Appendix F). This coding system was developed to examine couple behaviors that either support or inhibit acceptance in IBCT treatment. In particular, ratings focus on interactions between spouses and not the therapist interventions or behaviors. It served to identify couple change processes that promote acceptance (e.g., wife vulnerability \leftrightarrow husband validation). Specific categories of client change processes include vulnerability, non-blaming intellectual problem discussion, and validation. The system has 5 categories of acceptance promoting and interfering behaviors that can be rated on a scale from 1 (*none*) to 9 (*a lot*) regarding the frequency and intensity of various behaviors. The manual suggests reviewing the entire therapy session using a notational system to make the large amount of data more manageable when attempting to code. The coding was applied impressive moments of change and discussions of childrearing (Research Question 3(b); Research Question 4(b)).

Other measures and materials.

Therapist and Consultant Post Treatment Questionnaire. The therapist and consultant post treatment questionnaire was developed for the original study to summarize themes and communication issues that created problems for the couple. It was completed at the end of each course of therapy by the therapist and the consultant. For example, therapists rate on a scale from 1 (*not at all*) to 10 (*major issue*) the extent to which certain themes were problematic for the

couple (e.g., trust, infidelity, responsibility and control). In this study this questionnaire served to inform the researcher of the therapist's and consultant's perspective on the course of therapy and foci of therapeutic attention for the selected couple (Appendix G).

Client Post-Feedback Questionnaire. The client post-feedback questionnaire was created for the original study. Clients completed this following the feedback session during which the therapist provided the couple with an individualized IBCT conceptualization of their problems and outlined a treatment plan. Couples responded to statements designed to assess the couple's impression of the feedback (e.g., My therapist is friendly and warm. My therapist seems optimistic.). This questionnaire provided the researcher with an understanding of the client's experience of the assessment phase and their understanding of the IBCT conceptualization (Appendix H).

Therapist Post-Feedback Questionnaire. The therapist post-feedback questionnaire was developed for the original study and is a measure of expectancy completed immediately after the feedback session. Items assess therapists' beliefs that change mechanisms and outcomes will take place in therapy (e.g., To what extent will the couple benefit from their therapy? To what extent will the husband come to accept his wife's problematic behavior? To what extent will the wife change her behavior to accommodate her husband's desires?). This questionnaire supported the researcher in obtaining an understanding of the therapist's expectancies for the selected couple (Appendix I).

Client Post Therapy Questionnaire. This questionnaire was developed for the original study and asks clients to answer questions about the services they received during their course of therapy (e.g., To what extent has our program met your needs? Have the services you received helped you to deal more effectively with your problems? What were the most helpful and least

helpful things about the therapy?). Clients respond to each question with ratings of “No definitely not”, “No, not really”, “Yes, generally”, and “Yes, definitely.” The post therapy questionnaires provided the couple’s perspective on the course of treatment (Appendix J).

Video Data. Video recordings of each therapy session of the selected couple in DVD format were viewed in a confidential location on the investigator’s laptop.

RESULTS

After the selection of the couple for the current study, the following steps for data analysis were taken. First, the researcher evaluated all client-report, therapist-report, and video data to summarize the couple and the course of treatment. This oriented the researcher to the couple and allowed her to obtain familiarity with demographics, length of marriage, nature of the marital problems, conceptualization of the couple from an IBCT orientation, and nature and course of treatment. The researcher then re-viewed the entire course of therapy recordings, earmarking moments that appeared to be impressive or where childrearing was the content being discussed. Once the data had been considered holistically (the entire course of treatment) and discrete moments of interest were identified, the researcher began addressing research questions in a systematic order.

Characteristics of Selected Couple

The selected couple participants were a male in his early 60s and a female in her early 40s who had been married for just over a decade. The couple had a school-aged son together and reportedly learned of the study from a radio advertisement.

Husband. The husband of the selected couple identified with the majority of participants as Caucasian/Not Latino. He reported that his mother and father maintained an intact marriage.

The husband reported that he had one previous marriage and one adult child from this marriage. The husband obtained his Ph.D. and was employed in academia.

Wife. The wife of the selected couple identified with the majority of the study participants as Caucasian/Not Latina. She indicated that her parents were divorced. The wife reported that this was her first marriage. The wife earned a M.A. and worked as a homemaker and occasionally as a writer.

Summary of couple's conflict. The selected couple presented to therapy in general marital distress and identified "communication, sex issues, and child issues" as areas of particular conflict. The wife was particularly distressed around the husband and son not "getting along" while the husband expressed feeling "rejected by his wife and son." The therapist summarized the couple's conflict as being rooted in the triangulation of the couple's son. He stated specifically that the couple was focused on a lack of closeness between the husband and son rather than a lack of closeness between husband and wife. The therapist ultimately identified isolating the marital relationship from the couple's relationship with their son as one of the goals of therapy. Bearing mention, throughout the course of therapy the wife identifies the husband's drinking habits as an additional area of conflict that has a particularly negative impact on their evening routine and communication.

IBCT conceptualization. Conceptualization of the couple's marital conflict from an IBCT perspective is centered on partner differences, emotional sensitivities, external stressors, and interaction patterns. For the selected couple in this study the therapist identifies sex and the role of the son in the couple's relationship as primary areas of distress. The underlying difference between the spouses that causes these two problem areas is in how the husband and wife seek closeness and intimacy. For example, the husband makes sexual advances toward his wife as a

way to be both intimate and emotionally close. While the husband desires physical closeness the wife prefers emotional closeness. She describes an emotional distance that prevents her from really *talking* with her husband. The wife experiences the husband's advances as "pressure" and ultimately retreats into her relationship with her son for emotional closeness. External stressors such as career changes and loss of friends has exacerbated the couple's conflict at times.

Emotionally, the husband feels rejected by his wife and son. The husband is particularly sensitive to feeling rejected as he grew up in a family that lacked greatly in emotional closeness, which also indicates the absence of a learning history of how to be emotionally close. The wife feels belittled by her husband and is sensitive to criticism and condescending remarks from him although the roots of this sensitivity are unclear. Early in the couple's relationship sex was an expression of their love for one another. As time went on the couple became fixed in a demand/withdraw pattern of interaction. Specifically, while the husband desires sex to obtain physical intimacy with his wife (demand) she desires emotional closeness and turns away from her husband and toward her son for emotional closeness (withdraw). As the husband continues to make physical advances the wife feels increasingly pressured, continues to turn to her son and the husband's feeling of rejection is exacerbated. A pattern of criticism/defense is also apparent. As the wife criticizes her husband for the way he interacts with their son he becomes defensive of his behavior. As the wife continues to be critical of the husband's relationship with their son he becomes increasingly self-justifying which causes the wife to be even more critical and perpetuates the cycle of criticism and defense. Of note, the therapist also suggests that while the husband has always "indulged" in alcohol, over time drinking had become a way to cope with rejection, making him even more distant from his family.

Treatment. The couple had a total of 25 sessions throughout their course of treatment. By week 13 they had completed 10 sessions and by week 26 they had completed 21 sessions. They attended 4 more therapy sessions before concluding treatment. Any amount of change in the measures between week 26 and the final assessment should be understood in the context of the short amount of time that occurred between week 26 and the final session (4 sessions).

Research Question 1: What is the treatment progress and outcome for the selected couple treated with IBCT whose marital distress was related to child rearing?

To assess change experienced over the course of treatment, measures of marital satisfaction and distress over time were examined. More specifically, the current study documents scores from pre-treatment, 13-week, 26-week, final session, and follow-up measures of satisfaction.

Measures of interest include the Global Distress Scale (GDS), Dyadic Adjustment Scale (DAS), and the Conflict Over Child Rearing Scale (CCR).

Wife. The wife's completion of pre-treatment measures indicated general marital distress (GDS pre-treatment $T = 66$). There was little reduction in her reported level of marital distress at 13 weeks (GDS 13 weeks $T = 65$). Scores of marital distress according to the GDS were somewhat lower at 26 weeks and at the conclusion of treatment (GDS 26 weeks $T = 61$; GDS final session $T = 59$; see Figure 2). The marital satisfaction score appeared to steadily increase throughout the course of treatment (DAS pre-treatment = 77, 13 weeks = 80, 26 weeks = 91, final = 92; see Figure 3). Conflict over child rearing indicated distress pre-treatment (CCR pre-treatment $T = 74$) and improvement but still in the distressed range at 13 weeks (CCR 13 weeks $T = 66$). At 26 weeks she again indicated distress in conflict over child rearing, returning to pre-treatment levels (CCR 26 weeks $T = 74$; see Figure 4). In contrast to the GDS and DAS, conflict over child rearing was not administered at the final session in the study.

Husband. The husband's completion of pre-treatment measures indicated general marital distress (GDS pre-treatment $T = 68$). His reported level of distress decreased at 13 weeks (GDS 13 weeks $T = 63$) and 26 weeks before remaining stable (GDS 26 weeks $T = 58$; GDS final session $T = 58$; see Figure 2). The marital satisfaction score improved significantly from pre-treatment completion of measures to 13 weeks (DAS pre-treatment = 88, 13 weeks = 104). His marital satisfaction score at week 26 and at the final session was relatively stable (DAS 26 weeks = 110, final session = 111; see Figure 3). The husband indicated initial distress concerning conflict over child rearing (CCR pre-treatment $T = 60$) which decreased significantly at 13 weeks and then remained stable (CCR 13 weeks $T = 49$; CCR 26 weeks $T = 49$; see Figure 4).

Clinical interpretation of scores. The widely-used cut-offs indicating clinical levels of marital distress on these measures are T-scores above 59 on the GDS and a raw scores at least one standard deviation below the population mean on the DAS (<98) (Christensen et al., 2004). Distress concerning the CCR is generally indicated by a T-score greater than 50 (Snyder, 1997). Initially both the husband and the wife indicated clinical levels of distress as their pre-treatment scores fell beyond cut-offs on the GDS, DAS, and CCR. At 13 weeks both members of the couple showed improvement in their GDS score although they remained in the distressed range. This improvement continued to 26 weeks where the husband's score no longer indicates a clinical level of marital distress. At the final session both members of the couple were below the clinical cutoff, indicating non-distressed status. With regard to the DAS at 13 weeks the husband no longer met criteria for clinical distress as indicated by the cutoff and he continued to remain above the cutoff. While the wife showed steady improvement in her DAS score she remained in the distressed range throughout the entire course of treatment. Concerning the CCR scale, the wife initially showed improvement in her score although she returns to pre-treatment levels of

distress at week 26. The husband appeared to experience significant improvement in this area of distress, and he remained below the distressed range through to the end of treatment.

In the clinical trial (Christensen et al., 2004), couples were also categorized as either moderately or severely distressed at pre-treatment based on average scores on the DAS and GDS for both the husband and the wife. DAS scores were translated into T scores and combined with the GDS so that higher scores represented more distress. A median T score ($T = 66$) was the cut-off between moderately and severely distressed groups. Based on their combined T-score of 69, this couple was considered to be in severe distress pre-treatment. This is very close to the mean T-score of 70.6 ($n = 68$) for all severely distressed couples in the clinical trial, and significantly higher than the mean T-score of 62.7 ($n = 66$) for all moderately distressed couples.

The clinical significance of couples' progress in therapy was also categorized as deteriorated, no change, improvement, and recovered. Deteriorated referred to couples who demonstrated change in a negative direction, separated, or dropped out of treatment because they were doing poorly. Couples categorized as *no change* failed to show reliable improvement in any direction. Those who were *improved* showed reliable improvement but did not achieve scores in a normal (non-distressed) range. Couples who were categorized as 'recovered' demonstrated reliable change in a positive direction and ended treatment in the non-distressed range for scores (Christensen et al., 2004). Based on their combined scores on these measures, this couple was considered recovered by the end of treatment, which means they showed reliable improvement and scores that were in a non-distressed range (i.e., $DAS > 98$).

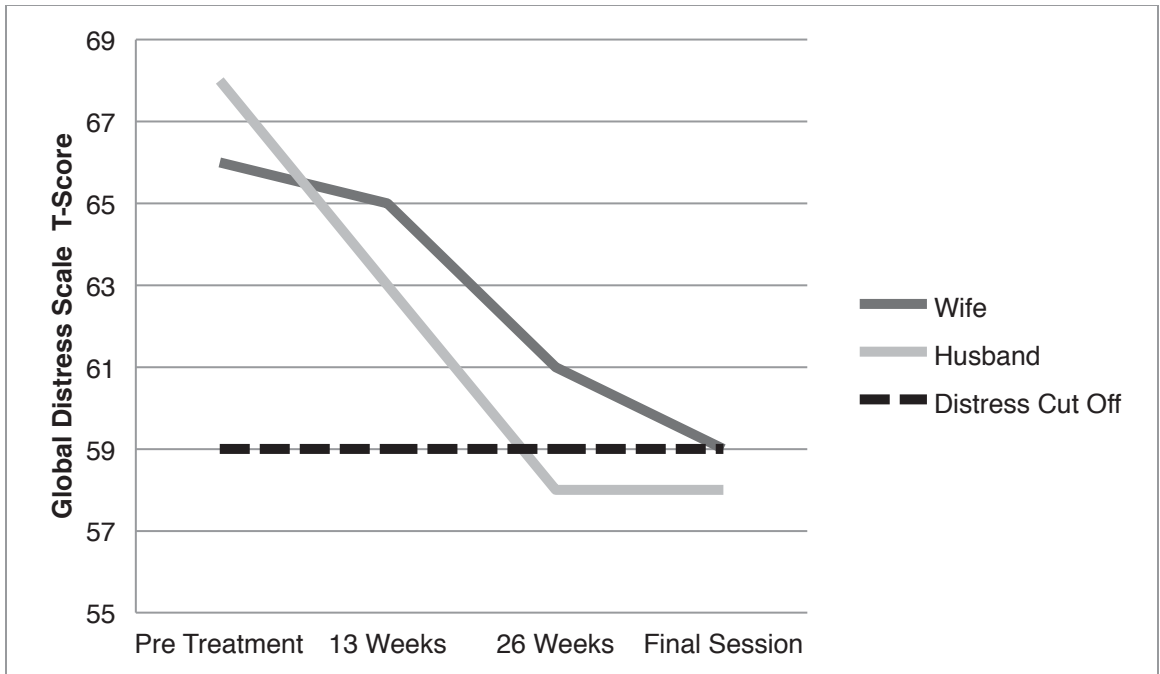


Figure 2. Global distress scale T-scores over time

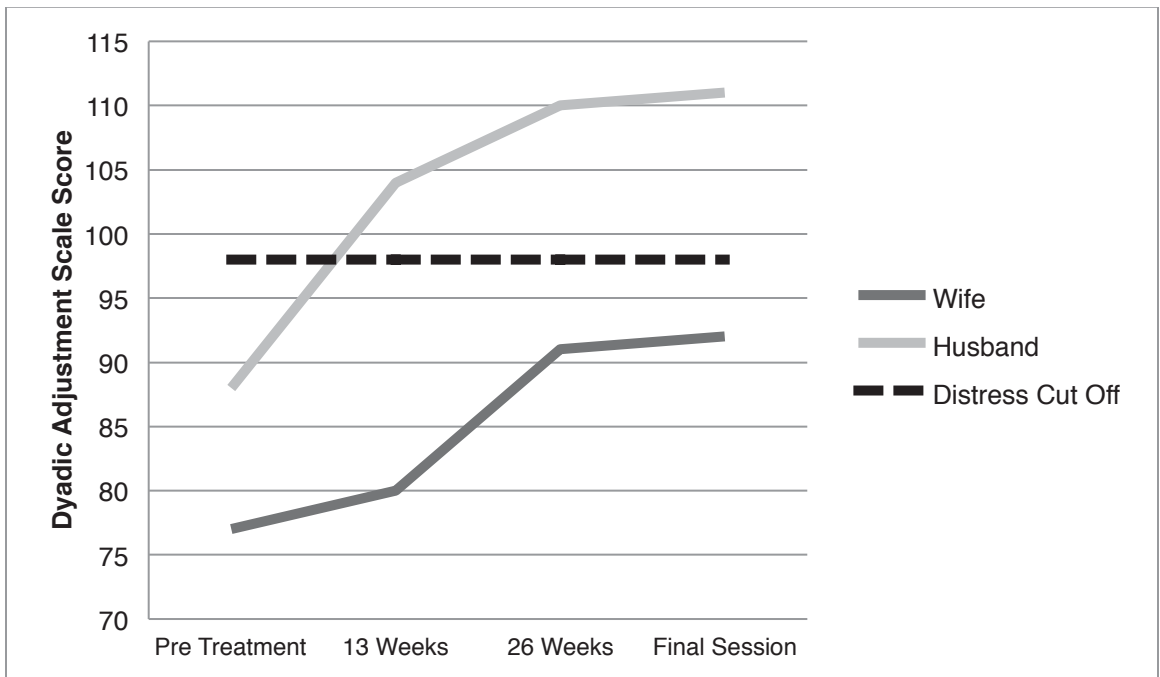


Figure 3. Dyadic adjustment scale scores over time

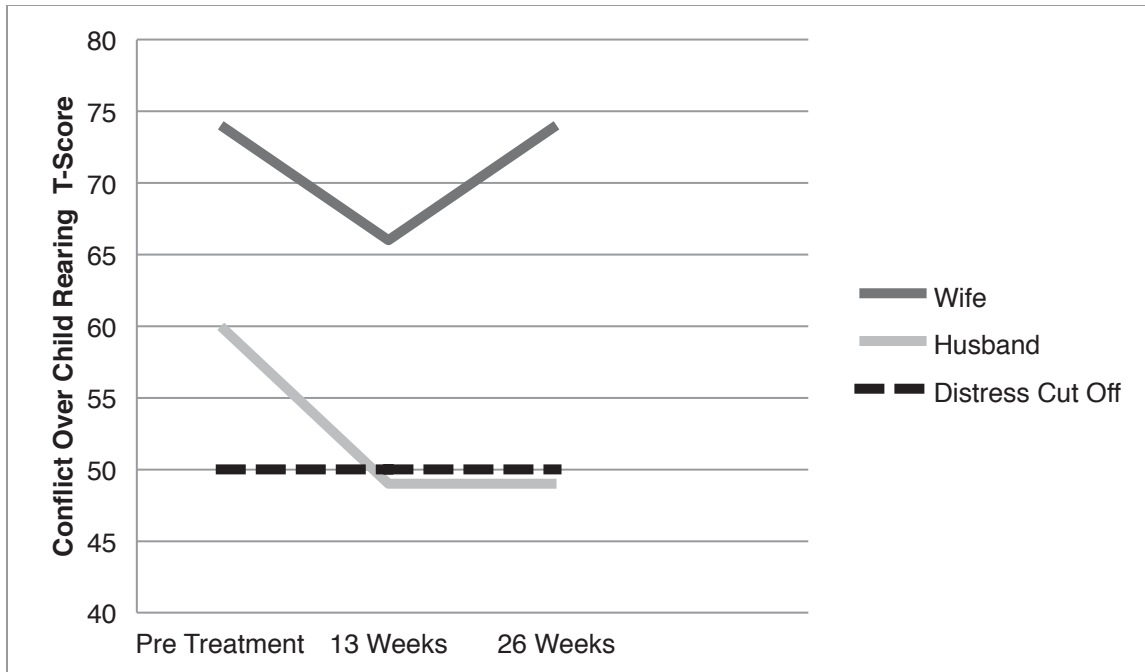


Figure 4. Conflict over child rearing scale T-scores over time

Research Question 2: What were the change mechanisms experienced by the selected couple? To describe the change mechanisms the Frequency and Acceptability of Partner Behavior (FAPBI) questionnaire was utilized. The scores on the FAPBI were examined for levels of behavior change and emotional acceptance reported over time, from pre-treatment to 13 weeks later, and from the 13-week to 26- week assessments.

Wife. The wife's completion of the FAPBI at pre-treatment, 13 weeks, and 26 weeks indicated a general increase in acceptance of husband's behavior over the course of treatment, with a particularly large increase between pre-treatment and 13 weeks (Total Acceptance pre-treatment = 16.24; 13 weeks = 21.21, 26 week = 23.4; see Figure 5). Behaviorally, she reported a steady increase in the frequency of positive behaviors of her husband (e.g., husband did housework) throughout the course of treatment (Frequency of Positive behaviors pre-treatment = 9.60; 13 weeks = 16.80; 26 weeks = 22.34; see Figure 6). The frequency of reported negative behaviors demonstrated by her husband (e.g., husband was verbally abusive) appeared to

decrease over time, with dramatic change in the latter half of treatment (Frequency of negative behaviors pre-treatment = 12.93; 13 weeks = 12.65; 26 weeks = 7.23; see Figure 7).

Husband. The husband's level of acceptance of his wife's behaviors appeared to steadily increase throughout the course of treatment (Total Acceptance pre-treatment = 19.25; 13 weeks = 23.62; 26 weeks = 25.33; see Figure 5). Behaviorally, he reported an increase in the frequency of positive behaviors demonstrated by his wife (e.g., wife was verbally affectionate), which occurred during the latter half of treatment (Frequency of Positive behaviors pre-treatment = 30.56; 13 weeks = 30.13; 26 weeks = 38.96; see Figure 6). There was a dramatic decrease in the reported frequency of negative behaviors demonstrated by his wife (e.g., wife was critical of him) between pre-treatment and 13 week assessments (Frequency of negative behaviors pre-treatment = 7.17; 13 weeks = 2.76). At 26 weeks, there was an increase in the reported frequency of negative behaviors, however the frequency remained lower than what was initially reported (Frequency of negative behaviors 26 weeks = 5.02; see Figure 7).

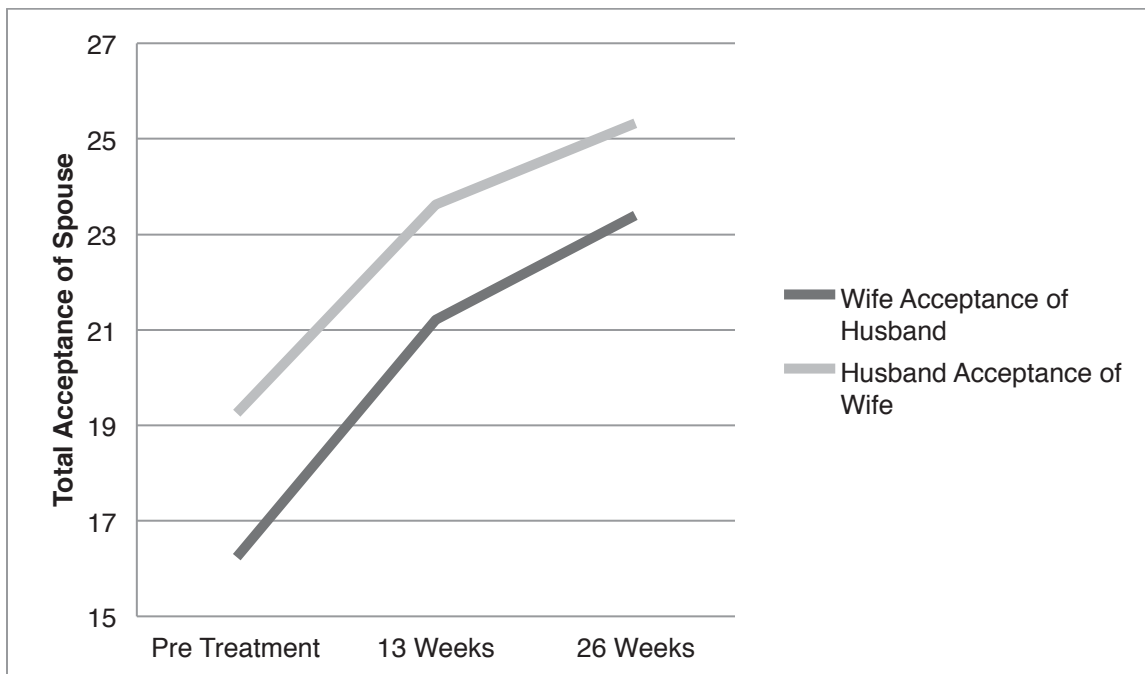


Figure 5. Total acceptance scores over time

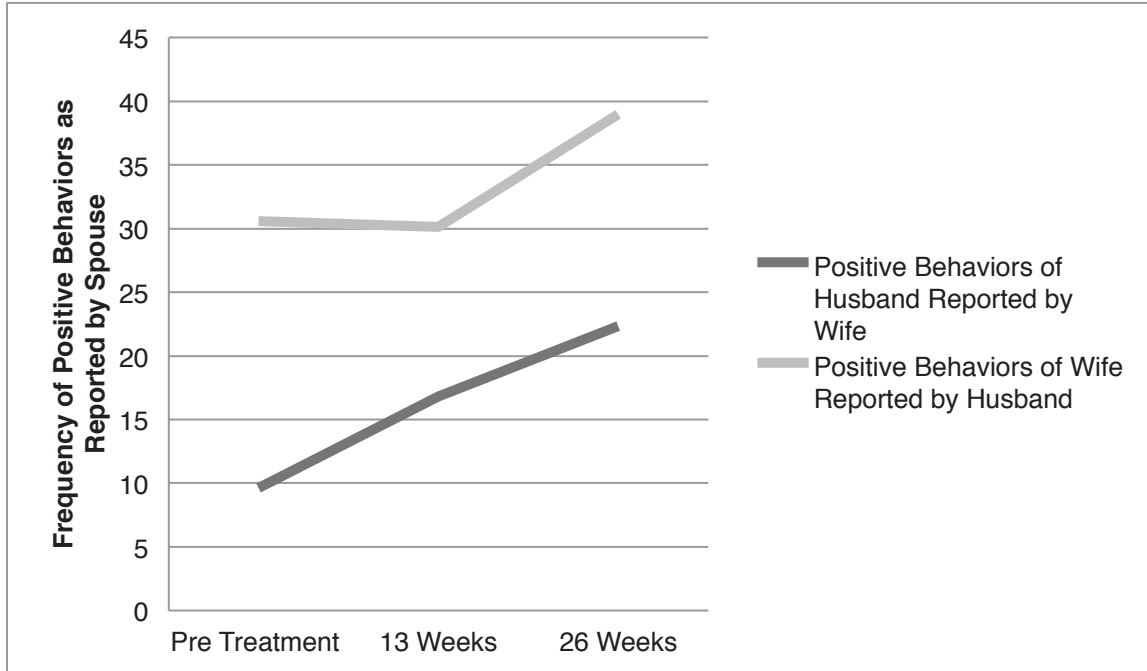


Figure 6. Frequency of positive behaviors over time

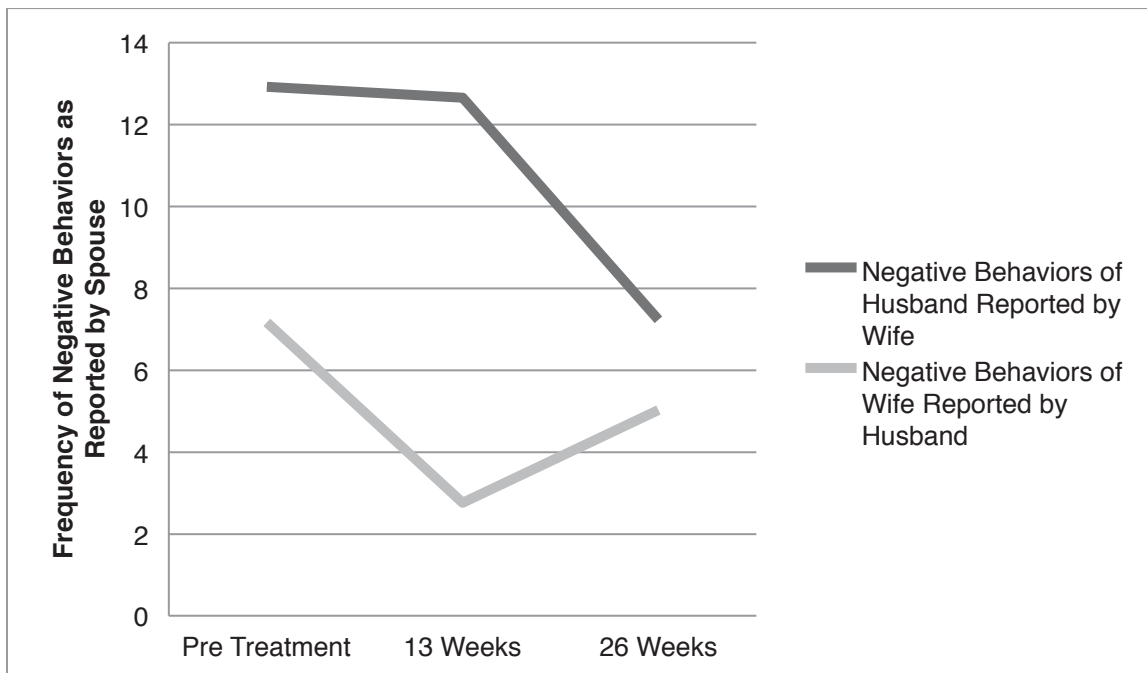


Figure 7. Frequency of negative behaviors over time

Clinical interpretation of scores.

Patterns of acceptance growth. Acceptance for each spouse grew more in first half of treatment than the second half of treatment, but continued to grow throughout. As would be predicted, with acceptance increasing over time marital distress and dyadic adjustment for the couple also improved (Doss et al, 2005). The fact that the change mechanism of acceptance and the outcome variable of satisfaction appear to follow similar trajectories supports the notion that acceptance was likely an effective change mechanism for this couple, leading to improvements in satisfaction, consistent with the framework guiding this case study (Doss, 2004). However, concerning specific conflict over child rearing, the wife returns to pre-treatment levels of distress despite her continued overall improvements in marital satisfaction and acceptance. This suggests that overall marital satisfaction and acceptance can improve despite continued conflict in particular problem areas.

Patterns of behavior change. In contrast to spousal similarities in trajectories of acceptance, the spouses showed diverse patterns in the second change mechanism, behavioral change. Specifically, while the wife's report of increasing positive behaviors of her husband continued steadily throughout treatment, it is not until the second half of treatment that the husband reported an increase in his wife's positive behavior. Negative behaviors of each spouse decreased for both the husband and wife over the course of treatment. However, the husband reported a dramatic reduction of his wife's negative behavior in the first half of treatment followed by an increase in negative behavior before the end of treatment, while the wife reported a dramatic reduction of her husband's negative behavior in the second half of treatment. Bearing mention, both spouses increased positive behaviors over time and decreased negative behaviors over time. The amount of positive and negative behavior in relationships has been examined

through the lens of social exchange theory (Nakonezny & Denton, 2008). This research has indicated specific ratios of positive to negative behavior, with satisfied couples having a ratio of 5:1 and unsatisfied couples 1:1 or less (Gottman & Levenson, 1992). It is noteworthy that the couple's overall trend of increasing positive behaviors and reducing negative behaviors was moving towards the desired ratio for satisfied marriage. As with acceptance, the change mechanism of behavior change also appeared to have been an effective component of the psychotherapy change process for this couple, moving in the expected direction and associated with improvements in the outcome variables of distress and satisfaction.

Relationships between change mechanisms of acceptance growth and behavior change. Examining the patterns of the two change mechanisms of acceptance and behavior change alongside one another was also quite interesting, since IBCT posits that each one fosters the other. It is noteworthy that although the wife reported greater reduction in negative behavior of husband, her acceptance continued to remain lower than his. Her greatest gains in acceptance and marital satisfaction were in the first half of therapy, although negative behaviors of the husband (reported by wife) decline most in the second half of therapy. Perhaps for the wife, increase in husband's positive behaviors was sufficient for acceptance to grow, and her growth in acceptance then prompted reductions in his negative behaviors. Just the opposite may have been true for the husband, whose acceptance grew in the context of reduction in wife's negative behaviors, which was then followed by increases in her positive behaviors in the latter half of therapy. For these spouses, the bidirectional relationship between behavior change and acceptance appears unique, yet both demonstrated concurrent improvements in each change mechanism over time.

Relationship between change mechanisms and treatment outcomes. A final notable

pattern in the change mechanisms is that the husband reported increases in his wife's negative behaviors in the second half of therapy. Interestingly, his overall satisfaction and acceptance continued to grow in the context of this apparent relapse in his wife's negative behavior. It is reasonable to wonder if initial success in therapy, particularly growth in acceptance, provides some protection or inoculation against behavioral relapses that later occur. However, if treatment solely focuses on behavior change, without concurrent efforts toward acceptance, behavioral relapses such as this may leave a couple more vulnerable.

Differences in amount of acceptance and behavior change. There are also noteworthy differences in amount of acceptance and behavior change reported by each spouse throughout treatment, as lines never intersect but remain higher or lower throughout. Specifically, although both spouses reported increases in acceptance, the husband's acceptance scores began and remained above his wife's throughout the entire course of treatment. Similarly, although both spouses ultimately reported increases in positive behavior demonstrated by their partner by the end of treatment, the husband consistently reported more positive behaviors of his wife than his wife reported of him. Finally, the wife consistently reported more negative behaviors of her husband than he reports of her, despite a dramatic reduction in his negative behavior during the second half of treatment. Given that the wife consistently reported lower positive and higher negative behaviors of her husband than he reported of her, it is not surprising that her level of acceptance was also lower throughout treatment. Despite exhibiting the same trends over time, the rate at which individuals perceive changes in their partner's positive and negative behaviors may ultimately affect the level of total acceptance they can achieve.

FAPBI subscale score comparisons. It is also helpful to consider where the couple stands in relation to other couples who have completed the FAPBI. In their original study of the

FAPBI, Doss and Christensen (2006) calculated mean subscale scores for acceptance of partner behaviors for distressed men and women in couple therapy (pre-treatment scores) and non-distressed men and women (not seeking therapy). These numbers provide a meaningful context to understand the FAPBI scores of the husband and wife in the current study. Subscales were developed based on factor analysis of behavioral items, which fell into four types of behaviors: Affection (e.g. physical affection; sexual activity), Closeness (e.g., discussed problems; social activities), Demand (e.g., controlling and bossy; verbally abusive), and Violation (e.g., did not keep agreements; flirting and affairs) (Doss & Christensen, 2006). Higher scores on each subscale indicate greater levels of acceptance of those partner behaviors. See Figures 8 and 9 for graphic presentation of FAPBI subscale score comparisons.

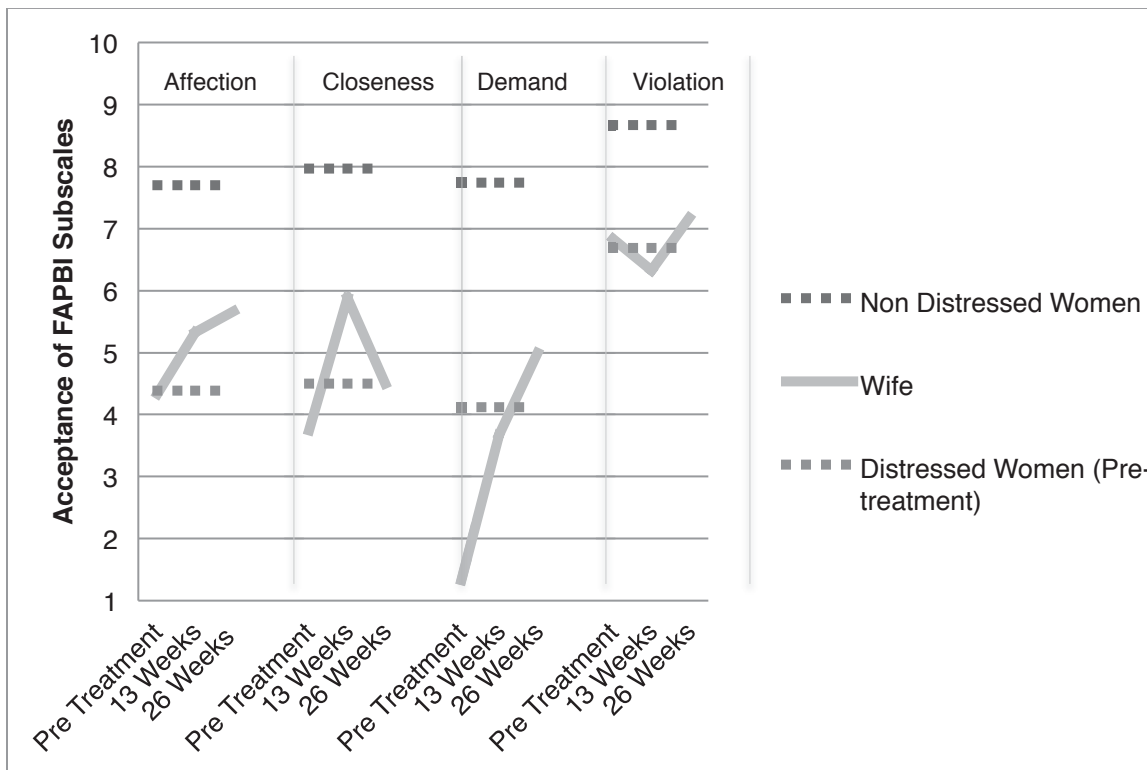


Figure 8. Comparison of wife’s FAPBI subscale scores to distressed (pre-treatment) and non-distressed women

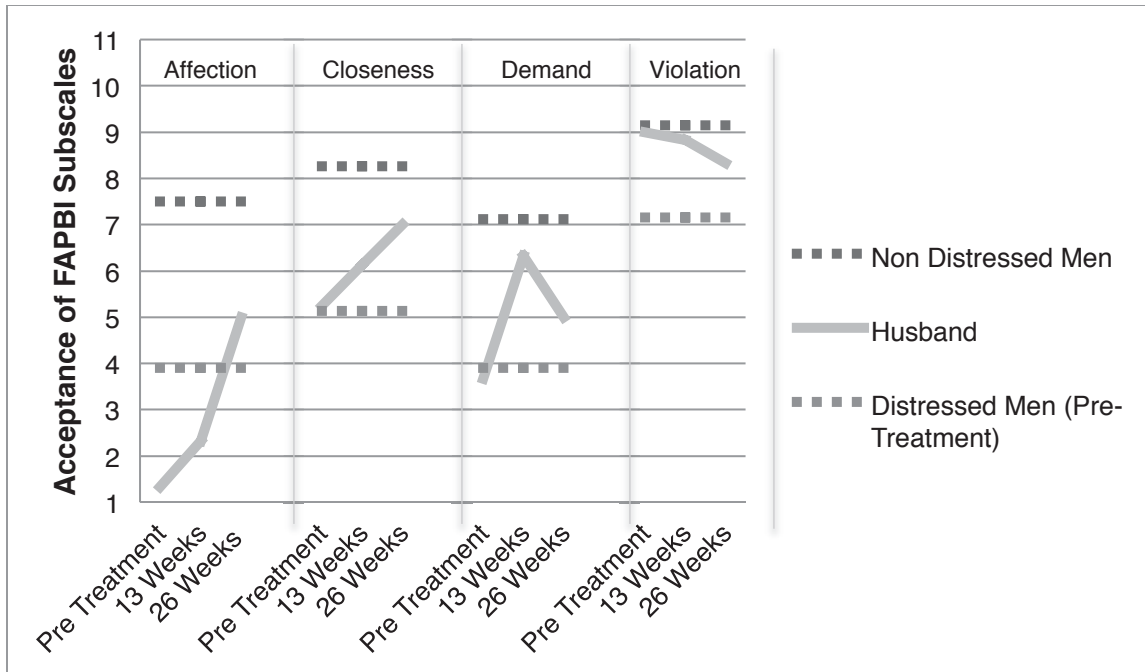


Figure 9. Comparison of husband's FAPBI subscale scores to distressed (pre-treatment) and non-distressed men

As you see in Figure 8, the wife's scores typically fall closer to distressed wives than non-distressed wives, and in fact consistently indicate levels of acceptance that are lower than non-distressed wives, even after 26 weeks of treatment. However, during the course of treatment, her scores did reach levels of acceptance that are higher than the pre-treatment mean of distressed wives. Specifically, the wife initially had an affection score pre-treatment of 4.33, which is similar to other women seeking marital therapy ($M = 4.39$). At the end of treatment her affection score had increased to 5.67 but was still below non-distressed women ($M = 7.70$). Pre-treatment the wife had a closeness score of 3.75, below distressed women ($M = 4.50$). At week 26 her score had increased to 4.50, matching the mean of distressed women and significantly below the average for non-distressed women ($M = 7.97$). The demand score for the wife was initially lower than distressed women (pre-treatment wife score = 1.33, distressed women $M = 4.12$) and improved throughout the treatment yet never surpassed the average for non-distressed women (13 weeks = 3.67; 26 weeks = 5.00; non-distressed women $M = 7.74$). The wife's

acceptance of violation scores initially decreased before increasing somewhat although the change in scores over time was minimal (pre-treatment = 6.83; 13 weeks = 6.33; 26 weeks = 7.17). Her score remained close to the average for distressed women ($M = 6.69$) during the first two times the FAPBI was completed and she never surpassed the average of non-distressed women ($M = 8.67$).

As shown in Figure 9, the husband's scores never reached levels typical of non-distressed men with the exception of violation, which was initially on the edge of non-distressed levels. The husband had a pre-treatment acceptance of affection score of 1.33, significantly below the average for non-distressed men ($M = 3.90$). At the conclusion of treatment his acceptance of affection had grown to 5.00 but was still below the mean for non-distressed men ($M = 7.50$). Pre-treatment, the husband's acceptance of closeness score was 5.25, very close to the average of distressed men ($M = 5.14$). Throughout treatment his acceptance of closeness score rose to 7.00, still below that of non-distressed men ($M = 8.26$). The husband had a pre-treatment acceptance of demand score of 3.67, slightly below the average for distressed men ($M = 3.90$). At the end of treatment his score increased to 5.00 but was still below the average for non-distressed men ($M = 7.12$). The husband's acceptance of violation score of 9.00 pre-treatment is above the average for distressed men ($M = 7.15$) and closer to the average of non-distressed men ($M = 9.15$). His acceptance of violation scores decrease slightly over time (13 weeks = 8.83; 26 weeks = 8.33) never dropping below the average for distressed men.

It is noteworthy that neither the husband or wife's acceptance scores reach the non-distressed averages for men and women. However, the wife's subscale scores remained much closer to distressed women while the husband's acceptance of violation, demand, and closeness scores appeared to approach non-distressed levels.

A particularly interesting difference between the husband and wife was the closeness subscale. While the husband's acceptance of closeness score consistently improved, the wife's acceptance of closeness score initially improved before taking a sharp decrease after week 13, ultimately returning close to pre-treatment levels. This pattern mirrored the wife's conflict over child rearing score, where despite initial improvements, she ultimately returned to pre-treatment levels of dissatisfaction in that area. Such similar trends could suggest that for the wife, her acceptance of closeness with her husband was particularly tied to conflict over their child.

Additionally, while the wife's acceptance of demand score consistently increased over the course of treatment, the husband's acceptance of demand score sharply decreased after week 13. Interestingly, the husband's acceptance of demand score may also reflect the wife's conflict over child rearing pattern. As her conflict over child rearing score relapsed her husband's acceptance of demand score also relapsed. Concurrently the wife's acceptance of closeness decreased while her demand score increased. Her increase in demand and decrease in closeness may have been associated with relapses in acceptance in these two areas despite increases in acceptance overall. It is noteworthy that overall acceptance increased throughout the entire course of therapy for both individuals in the couple despite reductions in acceptance subscales mentioned above. This suggests that specific areas of acceptance may have more influence than others on the overall level of acceptance. To further this idea, the husband's acceptance of violation score steadily decreased over the course of therapy, yet his overall acceptance continuously improves.

Research Question 3a: What were the therapy change processes over time?

Review of the entire course of therapy coupled with examination of post-session questionnaires completed by the therapist revealed specific therapy change processes. Two post-

session questionnaires were not completed, after sessions 5 and 16. According to the 24 post-session questionnaires completed, the IBCT therapy change process employed most frequently was unified detachment, which he indicated during 19 sessions. Tolerance was reportedly used in 7 sessions. During the vast majority of sessions (17) empathic joining was used. The therapist also indicated communication training in one session. Generally speaking the therapist rated himself as adherent to extremely adherent to the IBCT treatment procedures.

Acceptance based interventions.

Empathic joining. Close observation of therapy sessions by the researcher revealed frequent utilization of empathic joining, particularly in the form of reformulation of the conflict by the therapist. For example, the couple frequently focused on incidents of conflict related to the husband's interaction style with the son, which subsequently upset the wife and frustrated the husband. In these instances the therapist often described the couple's struggle with their son as one defined by the husband's experience of rejection from both his wife and son and refocused the couple on isolating the relationship with their son from the marital relationship. Essentially the therapist attempted to re-join the husband and wife as a parental subsystem, uniting them in their frustrations concerning momentary parenting incidences while shifting attention to the painful soft emotions coming up in the marital relationship for both individuals (e.g., rejection, sadness, fear). While the reformulation of the couple's conflict was explicitly described in the feedback session, the therapist frequently referred back to his reformulation throughout the course of therapy. The second half of the course of therapy contained frequent interventions where the therapist fostered empathic joining around the idea that both the husband and wife found it challenging to talk about deep emotional states. The therapist encouraged the couple to describe the problematic events they discussed in therapy by focusing on their own emotional

experience rather than evaluating their partner's actions. There is a shift to more emotionally heightened therapy sessions where the therapist frequently attempted to elicit soft emotions, particularly from the wife. For example, the wife frequently responded that she felt "annoyed" at her husband and the therapist encouraged her to share a deeper, softer feeling gently stating for example, "I wonder if you are feeling anything else."

Unified detachment. After hearing a specific conflict described, the therapist frequently summarized and fed the conflict back to the couple highlighting the frustration that both individuals were experiencing while noting, in a non-blaming way, the differences in each person's interactional styles (e.g., the husband who understood things concretely and avoided emotional conversation, while the wife craved more emotional conversation and appeared to understand family interactions on a deeper level). Although challenging, the therapist made many attempts to foster unified detachment between the husband and wife concerning interactions involving their son. He appeared to do this by encouraging the husband to explain his thought process or rationale for approaching his son in a particular way, and emphasizing moments in therapy when the husband expressed a desire for closeness with his son. However, although the husband and wife appeared to agree with the therapists' non-blaming conceptualization, many times the final response from the wife indicated that she was still fixated on a particular incident.

Tolerance. The most obvious tolerance-focused intervention occurs near the middle of the therapy course when the therapist instructs the husband to exaggerate frustrating behaviors at home (e.g., being inquisitive). The rationale for faking a negative behavior outside of session is that it gives the couple an opportunity to observe the effects of the identified negative behavior on their partner, and can also desensitize them to the behavior particularly if it is done in an

exaggerated, playful or humorous way. Additionally, since the therapist is instructing that a negative behavior be faked the partner may have a decreased negative reaction or more tolerant response at home knowing that the *bad behavior* is an act. While the husband followed through with the assignment and noted that his wife appeared more tolerant, the wife stated she was unaware that he was exaggerating his behavior and that he continued to frustrate her. The therapist also noted positive features of the couple's negative behavior and interaction style, pointing out that what creates distance between them currently once connected the couple. Specifically he noted that while the wife is now upset by her husband's interpersonal style, she was once attracted to this and admired his knowledge and professional style. Both the husband and wife appeared open to the therapist's statements typically nodding in agreement after this particular tolerance intervention.

Behavior change focused interventions.

Homework and sex therapy. Homework was used to compliment therapy sessions although on two occasions the husband and wife failed to complete the assignment. One particularly successful homework intervention took place when the therapist asked the couple to engage in "random acts of affection" and refrain from sexual intercourse. Sex was focused on for a portion of the first half of the course of therapy and sex therapy interventions around caressing and relaxation were utilized by the therapist. The couple reported that caressing and physical warmth without fear of sexual progression was a relief and allowed both of them to feel more relaxed.

Praise. Throughout the course of therapy there were also instances, particularly in the middle of therapy, when the couple was impressed with the changes in their relationship. In these

moments the therapist would praise the changes the couple made. An example of praise includes, “Wow! You’re not falling into the same traps that you used to.”

Communication training. As indicated in the post-session questionnaire, the therapist also used communication training in session 10. Review of this particular session reveals the therapist instructing the couple how to make ‘I statements’ after the husband becomes upset at the wife frequently stating what she *feels* her husband is doing or *should do*.

Nonspecific therapy factors. Also bearing mention, ordinary conversation and humor were used throughout the course of therapy seemingly to maintain rapport. For example, in one session the husband joked, “We are cured!” when describing positive changes he had noticed in his marriage. The therapist then responded in an equally playful and humorous tone, “Lets throw a party!” At other times the therapist would comment on current sports with the husband, knowing it was an interest of his. Finally, knowing the literary backgrounds of both the husband and wife, the therapist fostered rapport on one occasion by sharing a quote by a famous author he found relevant to the couple.

Research Question 3b:What were the client change processes over time? Client change processes were examined and described after review of the entire course of therapy. Particular patterns of couple interactions that either promote or hinder acceptance were described.

Acceptance hindering interactions. Initially, sessions were saturated with descriptions of recent conflict potent with blaming descriptions of aversive partner behaviors and other acceptance hindering behavior such as pressuring the other person to change. Pressure to change is most frequently expressed by the wife and directed at the husband (husband aversive behavior \leftrightarrow wife pressure to change). The husband’s interactions with their son were particularly aversive to the wife and when discussing them the wife frequently expressed annoyance

(husband aversive behavior + wife annoyance). Occasionally the wife's desire for her husband to change appeared more vulnerable as she seemed to express a desire for a more united and connected family. However, this was most often followed with the husband explaining his reason for responding to their son in a particular way (wife vulnerability \leftrightarrow husband defensiveness). Additionally, the husband had vulnerable moments where he expressed a desire to be closer to his son and sadness around feeling excluded and rejected by the rest of this family. This was typically followed by the wife failing to attend to her husband's feelings or criticizing him (husband vulnerability \leftrightarrow wife invalidation or criticism). A particularly significant interaction occurred during a session when the wife was crying as she expressed her pain around a friend's death. The husband did not respond to his wife with words or with any change in body language (wife vulnerability \leftrightarrow husband no response). Generally speaking, throughout the entire course of therapy there was little if any change in body language. The couple never sat side by side on the same couch, they never touched each other, and they rarely looked at each other unless to be directly critical (no response and withdrawal). Similarly, a marital problem identified by the couple at the onset of therapy was the lack of physical intimacy in their marriage. Consistent with their report of this problem area, acceptance-hindering interactions concerning sex and affection were apparent near the start of therapy. The wife stated that physical advances by her husband were undesired and uncomfortable (husband vulnerability \leftrightarrow wife negative response).

Acceptance promoting interactions. Overwhelmingly, vulnerability appeared to be the most salient client change process to promote acceptance for the couple over the course of therapy. Acceptance promoting interactions frequently took the shape of nervous humor (e.g, the husband referring to himself as the "tyrant" followed by nervous laughter), which is generally

met with laughter from the other individual or a neutral response (husband vulnerability \leftrightarrow wife nonverbal affection).

There was a shift in the second half of therapy where vulnerability takes on the form of more frequent expressions of hurt, fear, needs, and sadness. Specifically the wife was occasionally tearful in the sessions and the husband expressed fear and guilt over the quality of his relationship with his wife and son. When deeper emotions were expressed by an individual in the couple, the other individual would reinforce this by responding with an equally vulnerable emotional statement (vulnerability \leftrightarrow reciprocal vulnerability). In one particular instance, the husband acknowledged that it was easier for him to deal with intense emotions when he is reading, and not from other people, while the wife shared that she was afraid to open up to her husband for fear that she would be ignored or told the way she is feeling is wrong. In this instance, the husband's self-disclosure was met with reciprocal vulnerability as she shared a fear. The couple appeared to become increasingly comfortable discussing their emotional experiences in session and took increasing ownership over their desire to remain married. For example, during a later therapy session the husband stated that upon reflection he entered therapy feeling he "ought" to be closer with his wife. He notes that the difference is that now he "want[s]" to be closer with my wife and son "because it feels good." With more emotions being expressed, and with increased understanding of each other the couple seemed more open to accepting their differences.

Vulnerability in the form of self-disclosure also appeared to be a central client change process that promoted acceptance for the couple over the course of therapy. For example, the husband described parts of his childhood he feels influenced his way of being as an adult and the wife agreed (husband vulnerability \leftrightarrow emotional understanding/empathy). Other times,

speaking intellectually about the husband's interactions with his son was met with sharing impactful childhood experiences (e.g., nonblaming intellectual problem discussion \leftrightarrow sharing of personal information).

As previously mentioned, at the outset of therapy the wife expressed that physical advances by her husband were undesired and uncomfortable. However, over the course of therapy the husband was eventually able to cuddle and caress his wife, or hug her and the wife stated in therapy that she would welcome the affection stating that she "liked" it (husband vulnerability \leftrightarrow wife validation).

Behavior change. Behavior change is most apparent near the middle of the course of treatment where the couple described a decrease in the amount of conflict and arguments surrounding their son and an increase in acts of affection and physical intimacy between them. The behavior change most noted in sessions was related to communication, particularly the utilization of 'I statements'. Other behavior change took place outside of sessions, was related to the aforementioned therapy homework assignments, and is best understood as a change mechanism.

Research Question 4: (a) What were the IBCT change processes utilized by the therapist during moments of impressive change and discussions of childrearing? (b) What were the client change processes displayed by the couple during moments of impressive change and discussions of childrearing? During the researcher's review of the entire course of therapy for research questions 3a-b, she ear-marked what appeared to be moments of impressive change and discussions of childrearing. She also reviewed the Therapist and Consultant Post-Treatment Questionnaire, and Post-Session Questionnaires, to determine if there were particularly important sessions or moments described by the couple or therapist to closely review. The researcher

utilized multiple ways of determining moments of impressive change. First, consistent with Mahrer & Boulet (1999), impressive moments were selected along the basis of the moments which *touched* the researcher as something impressive happening. Additionally, moments were selected on the basis that they contained theorized change processes in IBCT and/or were about childrearing. She then returned to these particular moments and studied them in detail, starting with a description of the significant moment. Next, the Behavioral Couple Therapy Rating Manual (Jacobsen et al., 2012) and The Acceptance Promoting and Interfering Interaction Rating System (APIIRS; Wiedeman, 2012) were utilized to further examine the change processes, providing the researcher with helpful language and codes to further describe change. Ultimately selection and description of impressive moments occurred in three phases: (a) study of tapes to determine if the session contained impressive in-session events; (b) locate where the impressive event appears to start and end; (c) study the impressive event to allow for a detailed description of the change process (Maher & Boulet, 1999). To provide rich descriptions of change processes within the context and scope of this study, it was determined that among the many moments of impressive change, three would be selected for description in the current research question.

Of note, although the researcher had initially endeavored to answer questions 4a and 4b separately, review of impressive moments revealed that client and therapy change processes are numerous and closely intertwined, especially in moments of impressive change. A similar process is described by Maher and Boulet (1999) who state that “some impressive changes are relatively short and some are rather long, involving a fair number of both patient and therapist interchanges” (p.1484). In an effort to accurately depict the change processes in these impressive moments it was decided that therapy and client change processes would be examined and described together during the impressive moments, rather than presenting all therapy processes

followed by all client processes. Selected moments of change will be described first on the basis of their selection as impressive followed by a detailed account of the client and therapy change process, and finally the therapist's use of the impressive change once it occurs (Maher & Boulet, 1999).

Impressive moment 1.

Identification as impressive. An impressive moment of change occurred during session 6. The husband and wife began the session arguing about an evening intended for family bonding that instead resulted in tension and arguing, and the husband ultimately withdrawing to watch television before falling asleep. The impressive therapeutic shift is one that moved the couple from blaming and criticism into non-blaming stances where they were both making vulnerable statements regarding how they felt that evening and speaking objectively about their conflict.

Client and therapist change processes prior to the shift.

Client change processes.

- Wife criticism \leftrightarrow husband defensiveness
- Husband criticism \leftrightarrow wife defensiveness
- Wife criticism \leftrightarrow husband inappropriate humor

Therapist Change Processes.

- Homework reviewed
- Clarifying
- Reflection
- Therapist humor (to reduce tension)

Initial client change processes which characterized the arguing and defensiveness that took place before the shift are: wife criticism \leftrightarrow husband defensiveness and husband criticism

↔ wife defensiveness. Therapist interventions included homework review, clarifying, reflection, and humor. As the details of the family night gone wrong are discussed each partner refuted the other's recollection and became defensive. For example, the wife described that she and her son were making pretzels together before the family sat down to watch a movie for Halloween, and her husband "was basically watching a football game and yelling at the T.V." In retaliation the husband used humor defensively stating, "It was a risky game, they deserved it!" As the details of the night unfolded, the therapist mostly intervened by clarifying the events, reflecting feelings, and using humor to reduce tension. For example, after hearing a listing of the negative feelings and sequence of events afflicting the couple on the given night, the therapist stated, "Sounds like you were both having a bad day." Of note, although he attempted to review homework assigned in the previous session, which was a tolerance intervention to fake negative behavior at home, the couple had failed to complete it.

Client and therapist change processes as shift occurs.

Client change processes.

- Husband vulnerability ↔ therapist response
- Wife vulnerability ↔ therapist response
- Wife non-blaming intellectual problem discussion ↔ husband validation
- Wife vulnerability ↔ husband nonverbal affection
- Wife objective problem discussion ↔ therapist response
- Therapist reflection of husband's emotions ↔ wife validation/empathy

Therapist change processes.

- Reflection of soft emotions

- Empathic joining
- Unified detachment

Notable client change processes during the shift included: husband vulnerability \leftrightarrow therapist response, wife vulnerability \leftrightarrow therapist response, wife non-blaming, intellectual problem discussion \leftrightarrow husband validation, wife vulnerability \leftrightarrow husband nonverbal affection, and wife objective problem discussion \leftrightarrow therapist response. Therapist change processes were consistent with IBCT and included: reflection of soft emotions, empathic joining by promotion of soft disclosures, and unified detachment. The catalyst to the impressive change appeared to be the therapist's promotion of soft disclosures, an empathic joining intervention. For example, he asked the husband what he is "feeling emotionally" and suggested that the husband might be feeling "ignored or not as valued" during evening routines. The wife was inspired to respond with empathy stating, she "feels bad for [her husband] that he's always [made to feel like] the bad guy." In addition to the soft emotions being expressed during this shift, the therapist also worked to support the couple in having a non-blaming discussion of their problem, free from fault and evaluation as was previously occurring. He did this by clarifying the events and pointing out to the couple when they had responded with their opinion on what happened rather than the actual events. Not only was the couple able to describe the events of the evening without evaluating them, but also there was a shift from blaming to non-blaming language as evidenced by the wife's statement, "We often have a problem where we don't understand each other." And, approaching what happened with humor, the wife jokes the "family evening was a bust," which is met by smiling and laughter by the husband.

Client and therapist change processes after the shift.

Client change processes.

- Wife and husband positive response

Therapist Change Processes.

- Tolerance building
- Ordinary conversation

The moment appeared to end as the therapy session was concluding and the therapist described the homework assignment that the couple did not complete in the previous session, asking them to attempt it again. He emphasized that there was a lot to benefit from faking negative behavior. The couple appeared invested in carrying out the assignment as the wife asked for clarification and examples of how to carry out the homework. The change process appeared to officially conclude as the couple and the therapist engage in conversation around upcoming holidays and stand up before leaving the session.

Impressive moment 2.

Identification as impressive. Another particularly impressive moment of change concerning discussions of raising their son occurred in session 17. It began with the couple's typical acceptance hindering interactional style with the wife criticizing the husband's difficulty interacting with their son while he defended himself or withdrew, and shifted to a vulnerable conversation as the husband shared deep concerns and the wife provided compassion and reassurance.

Client and therapist change processes prior to the shift.

Client Change Processes.

- Wife criticism \leftrightarrow husband defensiveness
- Wife criticism \leftrightarrow husband withdrawal

Therapist Change Processes.

- Reflection
- Empathic joining

Prior to the shift from criticism to more vulnerable conversation, couple change processes included; wife criticism \leftrightarrow husband defensiveness, wife criticism \leftrightarrow husband withdrawal. Therapist interventions were non-specific such as reflection, and IBCT-specific empathic joining through encouraging soft disclosures. As the therapist reflected the negative feelings of frustration and anger expressed by the wife her criticism continued as did her husband's defensiveness and withdrawn behavior. It was not until the therapist began to emphasize the softer emotions behind the wife's criticism (e.g., hopelessness and sadness) and the husband's defensiveness (e.g., hurt and sadness) that the therapy shifted toward vulnerability.

Couple and therapist change process as shift occurs.

Client change processes.

- Wife aversive behavior \leftrightarrow husband lack of typical response
- Husband vulnerability \leftrightarrow wife positive response
- Husband vulnerability \leftrightarrow wife compassion and reassurance
- Wife vulnerability \leftrightarrow therapist response

Therapist change processes.

- Empathic joining

The shift from criticism to vulnerability was characterized by client change processes which indicated a shift from the couple's typical response style to each other: wife aversive behavior \leftrightarrow husband lack of typical response, husband vulnerability \leftrightarrow wife positive response, husband vulnerability \leftrightarrow wife compassion and reassurance, wife vulnerability \leftrightarrow therapist response. The process appeared to begin with the husband asking a genuine vulnerable

question to his wife, exposing his sincere confusion about family connection, stating, “Well what do you do [with our son]? That’s what I am asking! What do you do?” Rather than criticize him the wife responded with suggested activities. The therapist deepened vulnerability by rephrasing the husband’s question as a difficulty just *being* with other people, including his wife and child. Specifically, the therapist suggested to the husband, “Maybe the question is how do you *be*?” The husband’s acknowledgment of his challenge being with others ultimately elicited a supportive statement from his wife where she suggested that her husband was not alone in his challenges as many dads have a similar struggle. The therapist’s empathic joining interventions, such as encouraging soft disclosures by reflecting soft feelings, successfully softened the husband and wife. The wife expressed hurt feelings that she perceived her husband to prefer watching television alone rather than being with her in the evenings.

Client and therapist change processes after the shift.

Client change processes.

- None

Therapist change processes.

- Therapist behavior exchange \leftrightarrow wife vulnerability
- Therapist behavior exchange \leftrightarrow couple rejection of activity

The shift toward vulnerability appeared to conclude as the session draws to a close when the therapist suggested a behavior exchange where the couple read to each other to connect at night. Although initially successful in extending the vulnerable change process as the wife reflected on times in their distant past when they would read romantic material to each other, the couple ultimately rejects the therapist’s suggestion. Client and therapist change processes after the shift were: therapist behavior exchange \leftrightarrow wife vulnerability, therapist behavior exchange

↔ couple rejection of activity. Time had run out for the session, which concluded the moment of change and prohibited the therapist from more vulnerable exploration.

Impressive Moment 3.

Identification as impressive. Another impressive moment of change occurred in session 20. The moment began with an extremely blaming and tense conversation as the wife described her annoyances with her husband and the husband was exceedingly defensive. The therapist utilized interventions that are both general and specific to IBCT to move the couple from blaming to non-blaming problem discussion characterized by an increase in soft emotions. This moment was selected on the basis of the impressive reduction of negative intensity and movement to a non-blaming and supportive stance by the couple. It is also interesting that the therapist change processes were intended to encourage soft disclosures yet the client change processes were non-blaming intellectual discussion instead of vulnerable soft feelings. However, the therapist focused on positive intent as well and that does support non-blaming intellectual problem discussion.

Client and therapist change processes prior to the shift.

Client change processes.

- Wife aversive behavior ↔ husband defensiveness

Therapist Change Processes.

- Empathic joining
- Clarifying
- Reflecting

Prior to the positive shift that occurs in this moment, notable client processes that generally hindered acceptance included: wife aversive behavior (criticism/attack) ↔ husband

defensiveness. Therapist interventions were generalist in nature (e.g., clarifying, reflecting) with the exception of one instance of encouraging a soft disclosure when he stated to the wife, “I wonder if you’re also hurt or feeling put aside.” In summary, leading up to the shift towards non-blaming the wife was listing her irritations with her husband which lead him to feel blamed and become defensive. As the therapist summarized what each individual was saying there was significant back-and-forth about behaviors the husband and wife found annoying about each other.

Client and therapist change processes as shift occurs.

Client Change Processes.

- Wife non-blaming intellectual problem discussion \leftrightarrow husband increase in vulnerability
- Wife non-blaming intellectual problem discussion \leftrightarrow husband non-blaming response
- Husband vulnerability \leftrightarrow wife reciprocal vulnerability
- Wife non-blaming intellectual problem discussion \leftrightarrow husband sharing of personal information
- Husband validation \leftrightarrow therapist response

Therapist Change Processes.

- Therapist reflection of soft feelings \leftrightarrow wife sharing of softer feelings
- Wife non-blaming intellectual problem discussion \leftrightarrow therapist response
- Unified detachment

The shift appeared to begin once the therapist became aware of the wife’s softer implied feelings of hopelessness for change and as he reflected her softer emotions stating, “And that

makes you retreat into feeling as though nothing is changing, it's the same thing over and over again." For an extended period of time the therapist was focused solely on the wife with interactions best captured by the following processes: therapist reflection of soft feelings ↔ wife sharing of softer feelings, wife non-blaming intellectual problem discussion ↔ therapist response. The therapist change processes occurring during this shift included multiple instances of encouraging soft disclosures by reflecting soft feelings, particularly from the wife, and unified detachment by emphasizing positive intent of both the husband and wife. Bearing mention, there was a brief instance where the conversation regresses to a critical tone with the wife making a sarcastic joke in response to her husband's vulnerability. Once the therapist re-focused the wife back to her own feelings the movement toward vulnerability and non-blaming continued. Essentially, the couple moved away from criticizing each other and with the therapist reflecting soft emotions of each individual, and particularly the wife, they were able to speak objectively about patterns of behavior that are contributing to their conflict and taking responsibility for their own unhelpful attitudes or actions. Notable content included discussion of the wife's disappointment that her husband and son do not appear to have a meaningful relationship and the couple's joining around their mutually generated idea that they appear to both be "negative" people at times. The shift toward non-blaming was especially obvious in the language. Toward the end of the moment there is an obvious change from 'I/you' blaming language to 'we' non-blaming language between the husband and the wife. For example, the wife stated, "I guess we just accept [our negative patterns] and it just keeps happening." And the husband stated, "We certainly let [old patterns] continue. But I don't think it's genetically fated. I think that we can change the patterns. I think she can talk to me and I think I can myself try to break that pattern of getting so easily irritated and withdrawing."

Client and therapist change processes after the shift.

Client Change Processes.

- None

Therapist Change Processes.

- Therapist behavior exchange \leftrightarrow husband and wife positive response

The shift concluded as the therapy session ran out of time. The therapist encouraged the couple to suggest what each spouse could do for the other to be helpful. It is possible that behavior change might happen more readily once non-blaming is achieved because the context is no longer pushing for change but supporting change.

Research Question 5: What was the interaction between therapy change process, client change process, change mechanisms, and treatment outcomes?

To examine the interaction between therapy change processes, client change processes, change mechanisms, and treatment outcomes, two clear and complete examples of the psychotherapy change process consistent with the Doss (2004) framework represented in Figure 1 above are presented. Specifically, the sequential relationship among therapy change processes, client change processes, change mechanisms, and eventual treatment outcome was mapped out using specific moments of therapy and client change processes interacting with one another.

Description of how the change processes relate to change mechanisms was supported by observation of sessions in combination with the measures of acceptance and change (FAPBI) described above. Further, viewing scores from the GDS and MSI-R alongside the FAPBI scores will highlight the relationship between change mechanisms and therapy outcomes concurrently and longitudinally.

Example 1. Session 6 has been recognized as containing impressive change wherein the couple moved from blaming and criticism (wife) to non-blaming problem discussion and vulnerability (wife and husband). Session 6 took place during the first half of the therapy between the pre-treatment and 13 week assessments.

Therapy change processes. Therapy change processes that took place in session 6 included reflection of soft emotions, empathic joining by promotion of soft disclosures, unified detachment by supporting discussion of problem without evaluation, and tolerance building (assigns couple to act out negative behavior at home).

Client change processes. Client change processes included a move from wife criticism \leftrightarrow husband defensiveness, husband criticism \leftrightarrow wife defensiveness, and wife criticism \leftrightarrow husband inappropriate humor to: husband vulnerability \leftrightarrow therapist response, wife vulnerability \leftrightarrow therapist response, wife non-blaming, intellectual problem discussion \leftrightarrow husband validation, wife vulnerability \leftrightarrow husband nonverbal affection, wife objective problem discussion \leftrightarrow therapist response.

Change mechanisms. The client and therapy change processes that took place during this moment can be considered within the context of the overall shifts in change mechanisms that took place between pre-treatment and 13 week assessments. Changes in FAPBI scores between these two assessments indicated significant increases in acceptance during the first half of therapy. Similarly, both partners indicated a reduction of their spouse's negative behaviors during this time. Although the wife indicated an increase in her husband's positive behavior during this time, the husband indicated a minor reduction in the frequency of his wife's positive behaviors. Ultimately, the client and therapy change processes that are examined in-depth in session 6 are likely among those that contributed to significant improvements in the change

mechanisms of acceptance that take place in the first half of therapy. As a reduction in the frequency of negative behaviors is also evident, it is likely that shifts in acceptance and behavior change support each other and are facilitated by the change processes occurring during this time.

Therapy outcome. As change processes interacted and change mechanisms shifted over the first part of treatment, indicators of marital distress and conflict over child rearing also reflect significant change. Specifically, both the husband and wife indicated a reduction in global distress, improvement in dyadic adjustment, and a reduction in conflict over child rearing between pre-treatment and 13 week assessments.

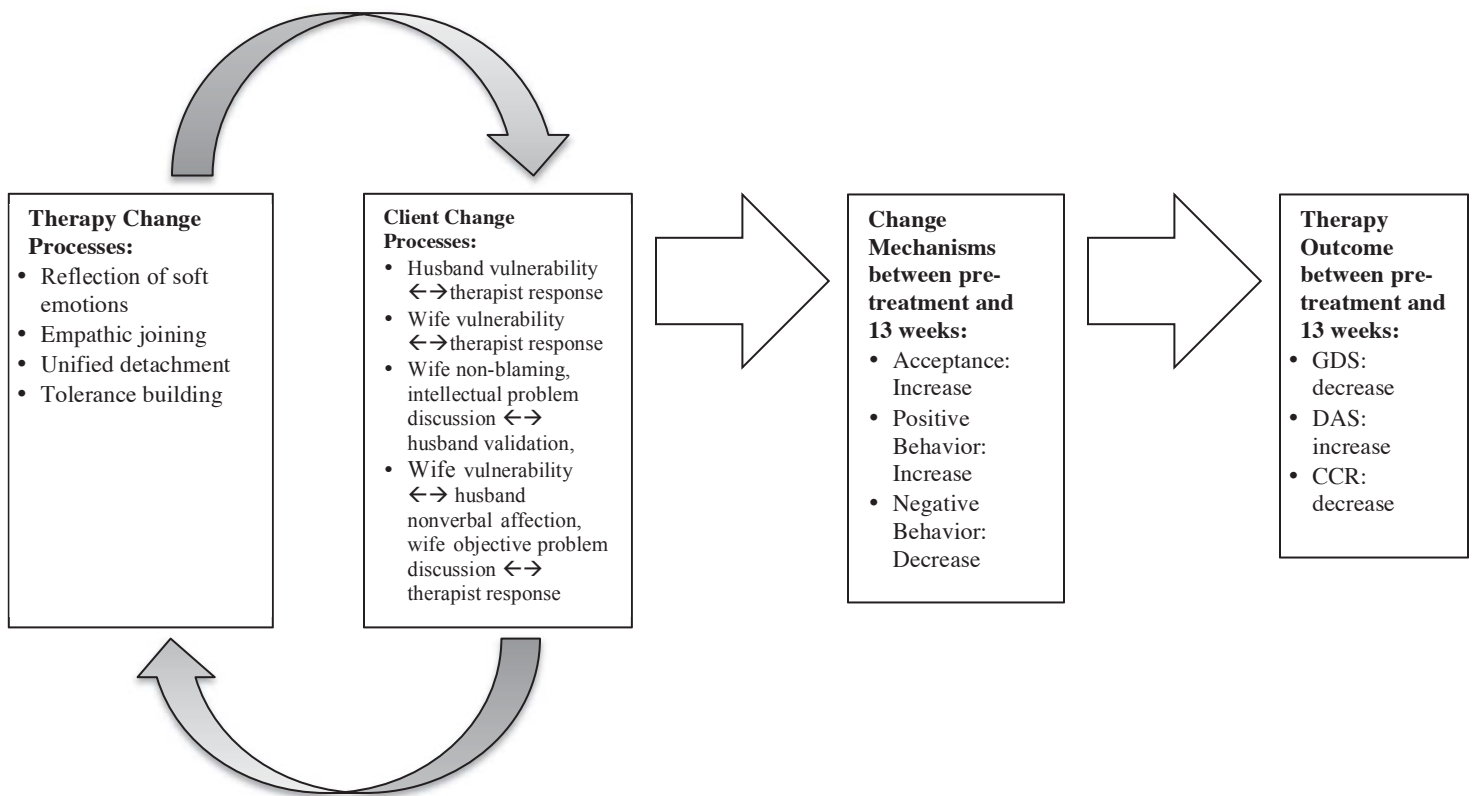


Figure 10. Example 1 inserted into Doss (2004) model

Example 2. Session 17 has been identified as a moment containing impressive change wherein the couple moves from criticism (wife) and defensiveness (husband) to vulnerability

(husband) that is met with compassion and reassurance (wife). Session 17 took place during the second half of the therapy between the 13 week and 26 week assessments.

Therapy change processes. Therapy change processes that took place in session 17 included reflection and empathic joining by encouraging soft disclosures.

Client change processes. Client change processes included a move from criticism (wife) and defensiveness and withdrawal (husband) to vulnerable processes including: Wife aversive behavior \leftrightarrow husband lack of typical response, husband vulnerability \leftrightarrow wife positive response, husband vulnerability \leftrightarrow wife compassion and reassurance, Wife vulnerability \leftrightarrow therapist response

Change mechanisms. The client and therapy change processes that took place during this moment were likely associated with the overall shifts in change mechanisms that occurred between the 13 week and 26 week assessments. Specifically, changes in FAPBI scores between these two assessments indicated increases in both acceptance and frequency of positive behaviors for the husband and wife. With regard to the frequency of negative behaviors, the wife reported a decrease in the frequency her husband's negative behaviors while the husband reported an increase in his wife's negative behaviors. As increases in acceptance and frequency of positive behaviors were evident earlier in the couple's participation in therapy (the trends become obvious between pre-treatment and 13 week assessments) it is likely that shifts in acceptance and behavior change occurring earlier in treatment were also supporting the change processes occurring in the latter half of treatment including session 17.

Therapy outcome. As change processes interacted and change mechanisms shifted over the course of treatment, indicators of marital distress and satisfaction also reflected significant change. Specifically, both the husband and wife indicated a dramatic reduction in global distress

and an improvement in dyadic adjustment between weeks 13 and 26. Interestingly, the wife indicated an increase in conflict over child rearing. The husband's score, although lower than pre-treatment levels, remained stable between weeks 13 and 26.

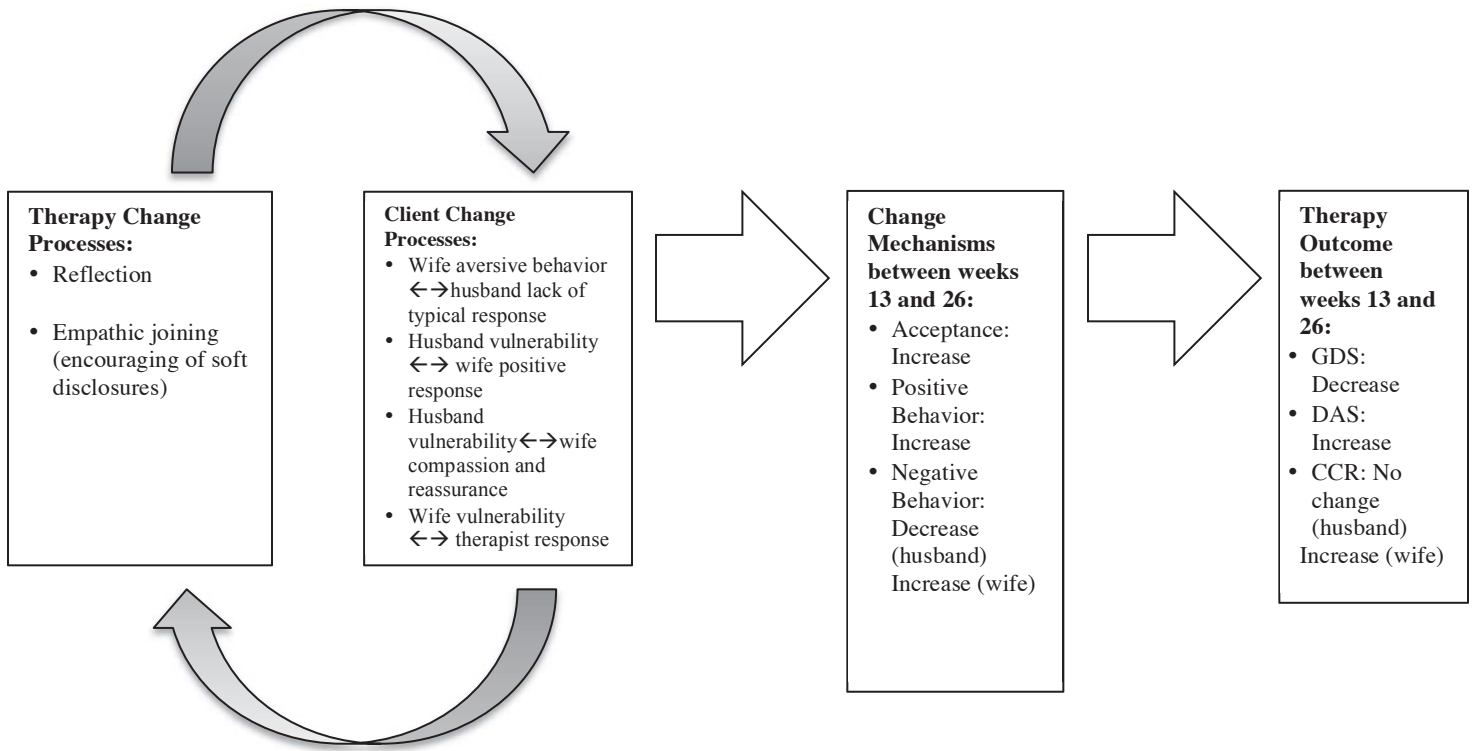


Figure 11. Example 2 inserted into Doss (2004) model

DISCUSSION

This study utilized recommended case study methods combined with discovery-oriented research methods to develop a deeper understanding of the change processes and mechanisms associated with therapeutic progress in IBCT. This is the first study to examine the entire IBCT psychotherapy change process through qualitative examination of a specific case, filling much-needed gaps in both the IBCT and psychotherapy process research literatures. The research questions posed in this study were designed to mirror the components and phases of the Doss (2004) framework for studying change in psychotherapy, and were addressed in the context of a

selected course of IBCT for a couple who presented with conflicts about child rearing. This study speaks directly to the need for greater understanding of how and why therapies work by examining change processes. It is also responding to the demand for research to move from “endless comparisons of treatments to focus on principles of change” (Christensen, 2010, p.35). This section will begin by describing the important findings in the current study and addressing the question of how and why IBCT works. Implications for clinicians and future research will be discussed. Finally, methodological limitations will be reviewed.

Important Findings

How and why IBCT works. Examining the psychotherapy process research questions of how and why therapies work was of central inspiration to the current study. A suggested way of answering these questions is looking at processes that create desired therapeutic change (Doss, 2004). Behavior change and acceptance, the hypothesized mechanisms of change for IBCT, were studied in an effort to shed light on how this evidence based practice works. Over the course of therapy for the selected couple acceptance grew consistently. Positive behaviors also increased for both the husband and wife. Negative behaviors decreased for both the husband and wife, however the husband reported an increase in the wife’s negative behavior in the second half of therapy. Ultimately, the couple ended therapy with dramatic improvements in their marital satisfaction. These patterns support the notion that IBCT works to reduce couple distress by increasing both acceptance and positive behaviors. Although decreasing negative behaviors may also be important, it may not be as significant or necessary to reducing marital distress in IBCT, particularly since this treatment is designed to increase acceptance of negative behaviors as a route to marital satisfaction. The therapy and client change processes that took place with this couple also support the understanding of how IBCT works. Essentially, unified detachment and

empathic joining, the most common IBCT interventions used by the therapist, interacted with the client change processes, namely vulnerability, to create opportunities for acceptance growth and positive behavior change.

For clinicians, this study of how and why IBCT works bridges the gap between research, practice, and clinical training. It provides some specific examples of these interventions, and of the beneficial shifts couples can make during therapy sessions while IBCT interventions are being effectively utilized. As with all approaches to the therapy, doing IBCT well is both a science and an art. Reading about artful examples of eliciting soft responses or engaging a couple in non-blaming problem discussion can contribute to therapists' ability to do so in their own work with couples. Clinicians can rely on detailed case study examples such as those presented in this study as one facet of their training.

Skillful integration of acceptance and change. An additional value in qualitative studies like this that closely examine psychotherapy is the opportunity to observe not just what works, but what doesn't work, or what works but in a way that is contrary to expectations. Noting some examples of this from the current study will be equally helpful to clinicians in learning the art of therapy, and also provide ideas for the refinement of IBCT. For example, in the current study, moving into behavior change interventions prematurely on the heels of acceptance-based work appeared to result in rejection of the intervention. The art of integrating traditional behavioral strategies into IBCT is nuanced, as the couple was receptive to behavioral interventions at other times. This suggests that the within-session timing of interventions had significant implications for their impact with the current couple and suggests that timing of acceptance and behavior change is an important detail to refine in IBCT. This begs the question of 'how are therapists to know when a couple will be receptive to a behavioral intervention?' and

also tasks them with skillfully balancing the integration of behavior change and acceptance. This particular couple appeared most receptive to behavioral interventions towards the end of therapy sessions when they were responding positively to each other and were both demonstrating a willingness to exercise vulnerability. Premature movement to behavior change was ultimately less effective. Of note, they were especially averse to behavioral interventions that took up significant time or felt too similar to ‘work’ (e.g. reading aloud to each other in bed before going to sleep). The need for skillful integration of interventions with appropriate timing is echoed by Christensen (2010) who suggests that clinicians should practice careful timing of discussions in therapy and possess the clinical skills to manage them with finesse.

Doss et al. (2005) increased our understanding of timing across the course of therapy by examining change and acceptance during the first versus second half of therapy rather than within-session timing. The current dissertation continued to examine change and acceptance at increasingly micro levels within individual therapy sessions. In many instances the couple’s therapy sessions initiated with a tense tone as conflicts from the previous week were described, and these descriptions were accompanied by negative emotions and behaviors such as anger and defensiveness. Acceptance interventions appeared especially impactful at the beginning of therapy sessions and seemed to make the couple more open to behavioral interventions or homework assignments at the end of therapy. Of course, therapy appointments are time-limited and often the change processes occurring in session concluded as time ran out. Had there been more time in the appointment there were ways that the therapist could have extended the change process. This raises the question of whether an integrative approach such as IBCT that works best by attending to both acceptance and change would be delivered most effectively in a lengthier session format than the typical 50 minutes, allowing sufficient time for both types of

change processes to occur and build upon one another. Homework assignments that are part of IBCT (Christensen, Doss, & Jacobson, 2014) and numerous other therapy approaches are another way to continue further positive therapeutic change that begins in therapy but might be prematurely stopped due to session time constraints.

Intervention and expected outcome. A reasonable assumption when observing a particular therapeutic intervention might be that if it is successful, it will lead to a *specific* and *expected* outcome. For example in the current study, if the therapist encourages soft disclosures we might expect the clients to ultimately express more vulnerable feelings with each other. However, sometimes therapist and client change processes were seemingly mismatched in terms of the immediate goals of an intervention and the immediate impacts. For example, in session 20 the therapist encourages soft disclosures and the couple engages in non-blaming intellectual problem discussion rather than emotional expression. This finding is important because it suggests that the impact of a particular intervention may not be immediate or expected, and highlights that outcomes are multilayered. In the example above the therapist's encouragement of soft disclosures occurred in a session that also contained one instance of unified detachment by emphasizing positive intent. Instead of working in isolation, the interventions in the session may have had the combined impact of moving the couple into non-blaming problem discussion. For this particular couple, problem discussion was typically a tense and blame ridden activity that included criticism and attacks suggesting that even venturing into problem discussion was a vulnerable act for the husband and wife. Ultimately, the delayed impact and combined influence of interventions in therapy sessions possibly results in unexpected therapy outcomes. This finding serves as a reminder that change and the impact of therapeutic interventions is rarely

instantaneous and is often the combined effect of “small, yet significant, experiences” (Christensen, Russell, Miller, & Peterson, 1998, p.184).

Nonspecific therapy interventions. There is value in understanding the impact of common or overlapping treatment elements. As suggested by Christensen (2010) once generally effective treatment elements are identified, clinicians can tailor them to the nuances of the couples they treat. For example, Christensen (2010) proposes that providing a contextualized dyadic objective conceptualization of the couple’s presenting problem as a common principle of change. As an overlapping feature of change processes and a common element of treatment, an objective conceptualization can be adjusted to the particulars of a specific couple. Concerning the couple in this dissertation, nonspecific therapy interventions such as reflection, summary, and clarification occurred frequently during therapy sessions. Interestingly, these interventions appeared to occasionally operate differently than in individual therapy, at times escalating conflict or prohibiting the couple from moving out of a nonblaming stance. For example, the therapist might reflect the wife’s frustrations and hopelessness regarding her husband’s relationship with their son only to have her feel righteous in her aggravation and the husband’s defensiveness would increase. At other times reflecting or summarizing the couple’s conflict in a nonblaming, balanced way, such as in the couple’s feedback session, appeared to make them feel understood by their therapist. This suggests that the timing and nature of such nonspecific interventions is important as they can have varying impacts on the therapy process. It may be that in couple therapy, reflection, summarization, and clarification should be indicated in instances where the experience of *both* individuals is addressed rather than solely the husband or wife so as not to invalidate or increase the negative emotions of one individual.

Refining IBCT. The fourth and final phase of the Doss (2004) psychotherapy change research model involves understanding the mechanisms of change and processes that promote improvement. It is suggested that therapies can be refined based on studies examining change processes similar to the current study. The current study has a number of findings that may support the refinement and efficiency of IBCT. As previously mentioned, the timing of interventions is significant and should not be underestimated as a detail which largely determines the success of an intervention. Acceptance interventions appear most impactful toward the beginning of a session when a couple is likely to be describing negative events from the previous week. They may also be most receptive to behavioral interventions in the second half of a therapy session when tension has eased and the couple is more open to behavior change. The occasional mismatch between intervention and outcome is also significant. To be specific, IBCT therapists might be mindful that interventions can have unexpected immediate results while still contributing to a positive ultimate outcome. Further, future descriptions of IBCT could include descriptions and recommendations around the use of nonspecific therapy strategies (e.g. limited use of one-sided empathic reflections in favor of dyadic nonblaming reflections) so that they are most effective in preparing couples for acceptance and change interventions. Finally, the examination of acceptance, behavior change, and outcome measures in this dissertation is identified as a significant tool for discussion and treatment planning. Couple therapists practicing from an IBCT perspective could engage their clients in productive assessments and conversations about acceptance, change, and progress supported by graphs that display specific therapeutic components. Sharing such visual representations with couples could not only contribute to therapy discussions but also easily highlight differences and display changes over the course of therapy.

Acceptance growth. Another important discussion point is the observation of acceptance growth despite acceptance-hindering interactions taking place. Specifically, the progression of research questions 1-5 highlights that the wife was able to make steady gains in acceptance, despite inconsistent improvements in behavior change, ultimately resulting in a successful treatment. From a clinical perspective, these results highlight the potential for acceptance to continue to grow even with limited or inconsistent behavior change. Additionally, the husband and wife displayed different patterns of behavior change yet similar trends in acceptance. As such, it can be inferred that for certain individuals behavior change is more related to acceptance than others. For couple therapists, this finding might encourage the use and analysis of measures of acceptance and behavior change throughout therapy to understand each individual's ability to increase acceptance in the context of certain behavior changes. For example, a therapist may find that acceptance growth and frequency of negative behaviors in one individual have plateaued while positive behaviors continue to increase. This could encourage the therapist to focus his or her interventions on reducing negative behaviors in the couple so that acceptance growth may resume. Effectively, examination of acceptance growth in relation to frequencies of positive and negative behaviors during the course of therapy, such as in research question #2 using the FAPBI, may allow the therapist to tailor interventions to increase the effectiveness of the therapy change processes.

Research Implications

Discovery-oriented research. Rigorous in nature, intensive case study research combined with a discovery-oriented approach provided rich detail and uncovered opportunities to further our understandings of effective couple therapy and therapeutic change processes. Those who wish to engage in change process research may benefit from utilizing a discovery-

oriented approach. Examination of all data sources was complemented with frequent discussions concerning the best way to present data and to integrate available data with a model of change processes. Such open mindedness and patience provided for rich discussion during the research process, and multiple versions of research questions ultimately allowed data to truly unfold and take the shape of interesting and informative results. For example, being open to discover what there was to be uncovered allowed the researcher to ultimately identify the rate of perceived partner behavior change as significant and possibly related to changes in acceptance.

Specifically, in research question 2 it was noted that the husband and wife exhibit similar trends in mechanisms of change over time, yet their levels of acceptance differ. This allowed the researcher to consider rates of perceived partner change, an opportunity which could have been overlooked should there be a strict focus on amount of change rather than considering all there is to be discovered about change processes. Future research could continue to benefit from discovery-oriented models, which free researchers from being confined to specific response styles and instead allows for opportunities to realize best research practices during the research process. The presentation of research question 4 is another example of how the current study benefited from the discovery-oriented approach. Originally, the researcher's intent was to provide descriptions of impressive moments that separate out significant client and therapist change processes. Careful examination of the data, openness to best practices in presenting findings, and flexibility resulted in the ultimate decision to present the client and change processes together as moments are highly interactional. The willingness to experiment with multiple ways of synthesizing and presenting data in order to discover the best possible method was again the result of a discovery-oriented research spirit. This is similar to previous suggestions that researchers "embrace ambiguity" to focus on discovery (Wiedeman, 2011).

Future research.

Direction of change processes. An implication for future research concerns the Doss (2004) model for change processes as well as the APIIRS coding system utilized in this study. Crucial to understanding change processes is the ‘direction’ of change. As it stands, the Doss (2004) model implies unidirectional change between client and therapy change processes and change mechanisms (as indicated by the inclusion of a one-way arrow). Review of the therapy process as a whole in research question 5 suggests that shifts in acceptance and behavior change occurring early in treatment are *also* possibly supporting the change processes occurring later in treatment. Therefore, the Doss (2004) model may more accurately reflect the therapy change processes by changing to two-way arrows to emphasize the relatedness of many of the components of change in therapy including treatment outcome. Similarly in this study the APIIRS codes were expressed with two-way arrows rather than ‘+’ symbols included in the original coding manual. This decision was made out of a desire to again emphasize the interaction behaviors being observed were not uni-directional but rather influencing and influenced by partner responses.

Ineffective treatment. Another area for future potential research concerns the study of ineffective treatment. This is in contrast to Christensen’s (2010) call for research that identifies overlapping successful treatment elements, although both are in the interest of refining and improving therapies. Doss (2004) suggests that his model of studying therapy change processes might be helpful in determining unhelpful parts of therapy that are redundant or ineffective. Although the current study briefly describes what takes place once a moment of impressive change has concluded, it is ultimately focused on successful therapeutic processes. Understanding unproductive therapy processes as well might continue to refine therapists’ ability

to provide swift and effective treatment. For example, in the current study non-specific therapy skills such as summarizing and reflecting when couples are discussing a problematic incident appear to possibly maintain or intensify conflict until the therapist shifts into designated IBCT-specific interventions. Future research could investigate the utility of these non-specific interventions in the course of IBCT.

Acceptance and vulnerability. The discovery oriented research approach that guided this study allowed a number of intriguing hypotheses to emerge concerning acceptance and vulnerability. Although the current study was qualitative in nature, opportunities for quantitative studies revealed themselves. For example, vulnerability was a central change process for the couple and acceptance was a key mechanism of change. A future correlational study might examine the relationship between vulnerability and acceptance. Given that the couple's acceptance grew continuously and that vulnerability appeared to be a central change process over the course of therapy, more attention might be given to the relationship between vulnerability and acceptance. Specifically, a future study might examine the hypothesis that increases in vulnerability lead to increases in acceptance. Lastly, if vulnerability is a key couple process with a strong relationship to acceptance and ultimately marital satisfaction, more research regarding the concept of vulnerability itself is warranted. Uncovering vulnerable emotions is a highly valued aspect of couple therapy, especially when the vulnerable emotion is related to a focal point of the couple's conflict (Christensen, 2010). Given the apparent significance of vulnerability, researchers might ask the following questions: What couple characteristics can lead to mutual vulnerability? How do you assess one's capability for vulnerability? Are there couples for whom IBCT will or will not work (i.e. those for whom vulnerability and acceptance are exceedingly challenging, unattainable, or unsafe)? Are there opportunities to prepare couples

for the vulnerability required to propel them toward successful treatment outcomes in IBCT (e.g., pre-empathic joining exercises)? What qualities in a relationship or person make acceptance more attainable? Truly, research regarding acceptance-based interventions and the process of acceptance has “only just begun” giving power to the aforementioned research suggestions surrounding acceptance and vulnerability (Sullivan & Davila, 2014, p. 8). Acceptance interventions continue to be viable alternatives to behavior change interventions that might be met with resistance from a couple. Put simply, “there is very little research on the process of acceptance itself, and it is this issue that should be the primary focus of future research” (Sullivan & Davila, 2014, p. 9).

Acceptance and behavior change. In their study of mechanisms of change in couple therapy Doss et al. (2005) described that the frequency and acceptance of behaviors appeared particularly significant to levels of marital satisfaction during the first part of therapy. As acceptance continued to be important for marital satisfaction during the second half of therapy, the frequency of partner behavior appears to become less significant. While the authors suggest the examination of change processes early and late in the therapy process rather than over an entire course therapy is one of the largest contributions of their study, they call for further explorations of important change mechanisms. As of yet the relationship between positive and negative behaviors and acceptance has not been thoroughly studied in IBCT. Instead, the most thorough study of mechanisms of change in IBCT completed by Doss and colleagues (2005) largely focused on the relationship between these change mechanisms and marital satisfaction. According to IBCT both acceptance and behavior change determine marital satisfaction and future research might examine the relationship between these two mechanisms. This would

provide insight into the true power of decreasing negative behaviors and support deeper understanding of the complex nature of change in IBCT.

Varying lenses. This study intended to examine couple therapy change processes from an IBCT perspective. As such ‘how’ and ‘why’ questions were answered with specific reference to IBCT. As previously mentioned, IBCT is one of a number of evidence-based couple therapies. Should another lens (e.g., emotion-focused) have been applied to the change processes underwent by the current couple, the processes and conceptualization of change may have been different. Future research might examine one couple therapy case from multiple lenses as a way of clarifying similarities and differences for clinical and research purposes. In addition to varying therapy lenses, future research might examine cases from unified principles of change. This would serve to emphasize common elements of change across all couple therapies and highlight opportunities to tailor treatment according to a particular theory.

Case studies. Finally, case study research is one way to address the 4th phase of therapy change research described in this study (Doss, 2004). Future research might aim to assemble a collection of studies to make results increasingly generalizable and thus have implications that reach even more couples and therapists. According to McCleod (2013), once a sizeable amount of thorough case studies is available, researchers should attempt to glean knowledge from multiple cases in the form of ‘meta-synthesis’.

Triadic change and treatment mediators. A significant challenge posed to the current dissertation was how to study therapy and client change processes at the *same time*. The therapy and client change processes were viewed as inseparable, leading from the original focus on dyadic change process to the concept of ‘triadic change processes’. Combining data for therapist, husband, and wife change processes is consistent with the idea that “change processes

are linked, conceptually and empirically” (Heatherington et al., 2005, p.19). With three individuals undergoing change processes (husband, wife, and therapist) there was an abundance of data to examine links between individual change process and overall treatment outcome. The decision to combine data to answer research questions was decided based on the nature of the hypothesized change process. Ultimately, the current dissertation strived to describe specific reasons for analytic approaches to the data for all three individuals involved in the change processes and to interpret accordingly (Heatherington et al, 2005). Future research should be mindful of all individuals involved in therapeutic change processes and endeavor to use data to effectively describe multi-person concurrent change processes.

Marital conflict related to children. Examining marital conflict related to child rearing was also a principal aim of the current study. The therapist that treated the couple studied in this dissertation conceptualized the marital conflict around child rearing as one of triangulation. He appeared to largely understand the couple’s conflict related to their child as an avoidance of the true *marital* conflict that they had difficulty addressing. Although the therapists’ interventions attempted to shift the couple toward discussion of their marriage instead of criticisms about parenting, measures of the couple’s conflict over child rearing indicate significant improvement in the first half of therapy, with the wife’s ratings ultimately returning to pre-treatment levels. These findings indicate that without addressing child-rearing conflicts directly, individuals in a couple can experience a reduction in distress related to parenting as their marital quality improves. This is consistent with family systems theories which assume that couples will benefit from a therapeutic focus on their relationship rather than identified ‘problems’ such as raising children or finances, which, although may be topics of conflict, are actually symptoms of marital conflict rather than the source. Although it is unclear why the wife’s conflict over child rearing

ratings increased in the second half of therapy, the initial reduction in this conflict area is significant.

Throughout the course of therapy the couple described their child as “negative” and a “glass half-empty” type individual, who can often have behavioral challenges when asked to complete homework. Future case study research might focus on couples who are experiencing marital difficulties related to raising a child with particular emotional, behavioral or even medical diagnoses. This would expand upon existing quantitative research that highlights the marital difficulties of parents with children with medical or behavioral challenges (da Silva, Eufemia, & Nascimento, 2010; Theule, Wiener, Rogers, & Marton, 2010; Wymbs, et al., 2008). The couple in this study appeared to particularly benefit from “date nights” which might indicate that couples with challenges in parenting could benefit from ‘couple-care’ similar to the popular suggestion of ‘self-care.’

Methodological Limitations

The discoveries of this study should be considered within the context of its limitations. Due to the scarcity of research documenting change processes in any type of therapy, researchers have been tasked with matching best research practices to the most respected and thorough models of change that occurs in therapy. While there is a plethora of available data sources for this study (i.e. questionnaires, video tapes, etc.), use of data to provide detailed descriptions of the selected change model occurred in hindsight, as the study was not originally conducted to examine change processes in IBCT.

The qualitative nature of this study necessitates a discussion of potential validity threats inherent in this type of research. According to Lebow et al. (2012) the “primary problem that remains within research on treatment of couple distress is concerned with external validity”

(p.148). Moreover, transferability, the qualitative equivalent of external validity, concerns the ability to generalize findings based on the sample used in the study. By providing a “rich description” to readers, detailing the time, place, context and culture of a study, consumers are better able to use their own judgment in the applicability of the research findings to their work (Mertens, 2010). Also relevant to the discussion of validity is the notion that case study findings are unable to own the instinctive generalizability that is permitted by studies that examine hundreds of diverse cases (McLeod & Elliot, 2011). While one must approach the discussion of findings in case study research with caution, multiple data sources strengthens findings and allows for a rich description of the case. To accurately understand any case study, readers should approach external validity with caution and be mindful that case studies focus on one particular case and that any understandings gained from the study should be considered within the complex context in which the case occurred.

A potential limitation of this study was the impression that the researcher was biased and attempting to ‘sell’ IBCT as a therapeutic practice (McLeod, 2011). The purposeful use of tentative language and acknowledgment of limitations was deliberately used to indicate the balanced position of the researcher. Additionally, it was stated outright that the study was purposefully examining an example of effective therapy. This study did not identify IBCT as the *only* effective therapy. Other effective evidence-based therapies were mentioned and briefly described. Finally, IBCT was not investigated as the *best* approach to use when treating couples, but rather as an effective treatment method of which a greater understanding could improve its utility.

Despite these methodological challenges, the current researchers were committed to open discussion of best methodological practice with regard to case study research and were aware

that changes in methodology may occur during the research process as they began to have a deepened understanding of the ways that available data may speak to change processes.

In this study the identification and description of the components of change for the selected couple was thorough. While it can be said that the question of how IBCT works was studied in great detail, the change processes and the study of change in therapy remains not as clear or linear and one might prefer (Blow et al, 2009). As such, while the current study approached the questions of how and why IBCT works with a commitment to discovery and thoughtful methodology, true understanding of change remains multifaceted, dynamic, and somewhat intangible. However ‘intangible’ the study of change may be, it is hoped that the challenge of understanding change does not deter researchers from attempting to study the change process in macro- and micro-analytic ways and from multiple perspectives. As this dissertation is the first case study examining IBCT change processes born out of the original outcome study (Christensen et al., 2004), the were significant strides made toward best practices in studying change. It is believed that this dissertation serves as a valuable model for understanding change processes in couple therapy and could serve as a model for future case studies of change processes.

Conclusion

The purpose of this study was to conduct an in-depth examination of change processes within IBCT for a couple whose marital distress was related to raising their child. The current investigation utilized multiple data sources and coding systems to enrich the understanding of therapy outcomes and change processes. This study contributes to the articulated desire for studies to move beyond efficacy and effectiveness and instead examine how and why therapies succeed. Qualitative case study research that is discovery oriented in spirit afforded a rich

understanding of the transformative powers of acceptance and behavior change for a particular couple across their course of integrative behavioral couple therapy.

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APPENDIX A

Literature Review Table

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Literature Review Table

Parenting Conflict

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach	Major Findings
da Silva, F., Jacob, E., & Nascimento, L. (2010). Impact of childhood cancer on parents' relationships: An integrative review. <i>Journal Of Nursing Scholarship</i> , 42(3), 250- 261. doi:10.1111/j.1 547- 5069.2010.013 60.x	Purpose: to examine the effects of childhood cancer on parents' relationships.	Fourteen articles published from 1997- 2009	Search engines: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psychology Information (PsycINFO), PubMed, Scopus, CUIDEN, and Latin American and Caribbean Health Science Literature (LILACS)	Integrative literature review.	<ul style="list-style-type: none"> • Changes in the parents' relationship are related to the trajectory of the child's illness. • There is difficulty in communication between couples. • There are gender differences in parental stress and coping.
Gattis, K. S., Simpson, L. E., & Christensen, A. (2008). What about the kids? Parenting and child adjustment in the context of couple therapy. <i>Journal of Family Psychology</i> , 22(6), 833-42. doi:10.1037/a0 013713	Purpose: to examine parenting and child adjustment when couples engage in in therapy. Hypotheses: 1.) distressed couples with children would show fewer improvements in marital satisfaction that distressed couples without children 2.) parenting and child adjustment would improve over the course of treatment, particularly if couple therapy	<ul style="list-style-type: none"> • 134 married couples • 68 couples had at least one child (from current or previous marriage) under age 18 living with them at the time of treatment • Average age of children was 6.86 years 	<ul style="list-style-type: none"> • Dyadic Adjustment Scale (marital satisfaction) • Marital Satisfaction Inventory Revised, specifically dissatisfaction with children scale and conflict over child rearing scale (parenting) • Youth Outcome Questionnaire (child adjustment) 	Randomize d clinical trial	<ul style="list-style-type: none"> • Partial support for the hypothesis that couples without children would show greater gains than couples with children. • Suggest that longer married couples without children may be able to make more rapid and significant gains during therapy than couples with children or couples who have not been married as long. • Parenting and child adjustment, we found that couples' conflict over child rearing decreased over the course of therapy

	<p>succeeded in improving the marital relationship</p> <p>3.) gains in parenting and child adjustment would be maintained over time, particularly if the couple maintained their gains in relationship satisfaction</p> <p>4.) conflict over child rearing and dissatisfaction with children would serve as longitudinal mediators in the relationship between marital satisfaction and child adjustment</p>				<p>and stayed at this decreased level over the 2-year follow-up.</p> <ul style="list-style-type: none"> • Although statistically significant, the effect was small and most couples and children began and remained in the nonclinical range. • Found no improvements in dissatisfaction with children over time, but parents did view their children as becoming better adjusted over the course of therapy, though these gains were not maintained over the follow-up. • Parents of older children tended to report poorer child adjustment prior to treatment than parents of younger children. • Change in conflict over child rearing and child adjustment was associated with change in marital satisfaction, such that improvement in one area reflected improvement in another. • Change in conflict over child rearing mediated the relationship between change in marital satisfaction and change in child adjustment, such
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					that as parents became happier in their relationships, they experienced less conflict over their children, which was related to improvement in child functioning.
Mitnick, D. M., Heyman, R. E., & Smith Slep, A. M. (2009). Changes in relationship satisfaction across the transition to parenthood: a meta-analysis. <i>Journal of Family Psychology</i> , 23(6), 848-52. doi:10.1037/a0017004	Purpose: To examine changes in relationship satisfaction across the transition to parenthood.	37 studies tracking couples from pregnancy to after birth of their first child.	<ul style="list-style-type: none"> • Dyadic Adjustment Scale • MAT 	Meta Analysis	<ul style="list-style-type: none"> • Provides evidence for decline in marital satisfaction across transition to parenthood.
Morawska, A. & Thompson, E. (2009). Parent problem checklist: Measure of parent conflict. <i>Australian and New Zealand Journal of Psychiatry</i> 43, 260-269.	Purpose: To examine the contribution of conflict specific to child rearing to the prediction of childhood problems and to validate psychometric properties of the Parent Problem Checklist.	200 parents with children ages 2-16.	<ul style="list-style-type: none"> • Relationship Quality Index (RQI), this is correlated with the Dyadic Adjustment scale (DAS). • Dyadic Adjustment Scale-Consensus Subscale (DAS-CS) • Parent Problem Checklist (PPC) • Strengths and Difficulties Questionnaire (SDQ) 	Psychometric property evaluation.	<ul style="list-style-type: none"> • Parenting conflict influences children's outcomes more than either general marital conflict or marital satisfaction.
Pedro, M.F., Ribeiro, T., & Shelton, K.H.	Purpose: To examine relationship	519 married or living together	<ul style="list-style-type: none"> • Marital Life Areas Satisfaction 	Correlational study	<ul style="list-style-type: none"> • Coparenting behavior mediates the association

<p>(2012). Marital satisfaction and partners' parenting practices: The mediating role of coparenting behavior. <i>Journal of Family Psychology</i> 26(4), 509-522. doi: 10.1037/a0029121</p>	<p>between spouse's marital satisfaction and partner's parenting practices.</p> <p>To consider the role of coparenting behavior as a mediator.</p>	<p>couples, with 9- to 13-year-old children.</p>	<p>Evaluation Scale</p> <ul style="list-style-type: none"> • Coparenting Questionnaire • Egna Minnen Beträffande Uppfostran (EMBU-P) which has three subscales: Emotional Support, Rejection, and Control Attempts 		<p>between spousal marital satisfaction and partners' parenting practices.</p> <ul style="list-style-type: none"> • Child and parent gender moderated the pattern of associations. Relationships were stronger between maternal marital satisfaction and paternal parenting practices.
<p>Pinquart, M., & Teubert, D. (2010). A Meta-analytic Study of Couple Interventions During the Transition to Parenthood. <i>Family Relations</i>, 59(3), 221-231. doi:10.1111/j.1741-3729.2010.00597.x</p>	<p>Purpose: To review results of controlled studies looking at couple-focused interventions for new and expecting parents.</p>	<p>21 controlled studies are reviewed</p>	<p>N/A</p>	<p>Meta-Analysis</p>	<ul style="list-style-type: none"> • Transition to parenthood can be a difficult time for couples. • In general couple-focused interventions for stress during this transition had minimal effects on communication, psychological well-being and couple adjustment. • Pure couple-focused interventions do not affect parenting outcomes
<p>Shelton, K. H., & Harold, G. T. (2008). Interparental conflict, negative parenting, and children's adjustment: bridging links between parents' depression and children's psychological distress. <i>Journal of Family</i></p>	<p>Purpose: To assess relationships between parental depressive symptoms, adult relationship insecurity, interparental conflict, negative parenting, and children's psychological adjustment</p>	<p>352 two-parent families with 11 to 13-year-old children (179 boys, 173 girls)</p>		<p>3-wave longitudinal research design.</p>	<ul style="list-style-type: none"> • Maternal and paternal depressive symptoms were associated with insecurity in adult close relationships. This was concurrently related to heightened levels of interparental conflict. • Interparental conflict was related to child appraisals of father and mother rejection which were related

<p><i>Psychology</i>, 22(5), 712-24. doi:10.1037/a0013515</p>					<p>to children's internalizing symptoms and externalizing problems.</p>
<p>Theule, J., Wiener, J., Rogers, M. a., & Marton, I. (2010). Predicting Parenting Stress in Families of Children with ADHD: Parent and Contextual Factors. <i>Journal of Child and Family Studies</i>, 20(5), 640-647. doi:10.1007/s10826-010-9439-7</p>	<p>Purpose: To examine parental ADHD symptoms and contextual (parental education, social support, marital status) predictors of parent domain parenting stress (parental distress) as a function of child ADHD symptoms.</p>	<p>95 families. From each family, one child and one biological parent participated in the study</p>	<ul style="list-style-type: none"> • Parenting Stress Index — Short Form (PSI/SF) • Conners' Rating Scales— Revised: Long Version (CRS) • Conners' Adult ADHD Rating Scales (CAARS) • Family Support Scale • Wechsler Abbreviated Scale of Intelligence (WASI) and Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) 	<p>Intercorrelational study</p>	<ul style="list-style-type: none"> • Parental ADHD symptomatology was the strongest predictor of parental distress of the variables considered. • Parental ADHD symptomatology and parenting stress reduction should be considered in development of interventions for families of children with ADHD. • Child ADHD symptoms, as reported by parents or teachers, were correlated with parenting stress. Child ADHD symptoms were, however, non-significant predictors of parenting stress when parental ADHD was added to the analyses.
<p>Wymbs, B. T., Pelham, W. E., Molina, B. S. G., Gnagy, E. M., Wilson, T. K., & Greenhouse, J. B. (2008). Rate and predictors of divorce among parents of youths with ADHD. <i>Journal of Consulting and Clinical Psychology</i>,</p>	<p>Purpose: To examine if parents of youths with ADHD are more at risk for divorce than are parents of children without ADHD.</p>	<p>364 families participating in the Pittsburgh ADHD Longitudinal Study</p>	<ul style="list-style-type: none"> • Divorce history • Rating Scale for Disruptive Behavior Disorders (RS-DBD) • Structured Clinical Interview for DSM-IV Axis I Disorders, Nonpatient Edition (SCID-I) 	<p>Longitudinal study</p>	<ul style="list-style-type: none"> • In families of youths with ADHD, it was found that maternal and paternal education level; paternal antisocial behavior; and child age, race/ethnicity, and oppositional-defiant/conduct problems each uniquely predicted the timing of divorce between parents of youths with ADHD.

76(5), 735-44. doi:10.1037/a0012719			(given to parents)		
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Couple Therapy and IBCT

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach	Major Findings
Christensen, A. (2010). A unified protocol for couple therapy. In Hahlweg, K. Editor, Grawe-Gerber, K. Editor, & Baucom, D. H. Editor (Eds.), <i>Enhancing couple therapy: The shape of couple therapy to come</i> , (pp. 33-46). Cambridge, MA: Hogrefe Publishing.	Purpose: to outline an unified protocol for couple therapy.	N/A	N/A	Book Chapter	<ul style="list-style-type: none"> • Common treatment elements across couple therapy protocols can be identified to create a unified protocol for couple therapy. • Treatment from the protocol can then be tailored to the specific couple.

<p>Christensen, A., Atkins, D.C., Berns, S., Wheeler, J., Baucom, D.H., & Simpson, L.E. (2004). Traditional versus integrative behavioral couple therapy for significantly distressed married couples. <i>Journal of Consulting and Clinical Psychology</i> 72(2), 176-191. doi:10.1037/0022-006X.72.2.176</p>	<p>Purpose: To examine the overall and comparative efficacy of TBCT versus IBCT</p>	<p>134 seriously and chronically distressed married couples (</p>	<ul style="list-style-type: none"> • Marital Adjustment Test (MAT; Locke & Wallace, 1959) • Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1997) • GDS (Global Dissatisfaction Scale) • Dyadic Adjustment Scale (DAS; Spanier, 1976) • Conflicts Tactics Scale-Revised (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) • Structured Clinical Interview for DSM-IV (SCID; 	<p>Randomized clinical trial</p>	<ul style="list-style-type: none"> • Impact of marital therapy on this sample of couples: improved relationship satisfaction, stability, and communication. • Did not find evidence for second hypothesis, that satisfaction improves more rapidly early in treatment than later in treatment. • TBCT and IBCT performed similarly across measures, despite being demonstrably different treatments. • Differences between spouses occurred with AFC, in which wives started therapy more distressed than husbands, and with the therapeutic bond, in which wives rated their therapists more highly than did husbands. • Finding of comparable rates of change in severely and moderately distressed couples is encouraging. It means that IBCT and
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					<p>TBCT can be applied to even very severely distressed couples with a reasonable hope of improvement.</p> <ul style="list-style-type: none"> • Couple therapy can be effective, at least in the short term, for even very seriously distressed couples.
<p>Christensen, A., Atkins, D. C., Yi, J., Baucom, D. H., & George, W. H. (2006). Couple and individual adjustment for 2 years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. <i>Journal of Consulting and Clinical Psychology</i>, 74(6), 1180-91. doi:10.1037/0022-006X.74.6.1180</p>	<p>Purpose: To examine follow up data 2 years after couples participated in randomized clinical trial - comparing methods of couple therapy</p>	<p>130 of 134 couples who were part of the original study</p>	<ul style="list-style-type: none"> • Marital Satisfaction Inventory-R • Marital Activities Questionnaire • Mental Health Index 	<p>Randomized clinical trial (originally)</p>	<ul style="list-style-type: none"> • Both treatments showed a pattern of change in which satisfaction dropped immediately after treatment termination but then increased for most of follow-up. • The break point when couples reversed courses and gained in satisfaction occurred sooner for IBCT than TBCT couples, and those couples who stayed together generally fared better in IBCT than in TBCT. • There was evidence of greater stability

					<p>during follow-up in IBCT than in TBCT couples.</p> <ul style="list-style-type: none"> • There was little change in individual functioning over follow-up, but when change occurred it was strongly related to change in marital satisfaction.
<p>Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. <i>Journal of Consulting and Clinical Psychology</i>, 78(2), 225-35. doi:10.1037/a0018132</p>	<p>Purpose: To follow up on marital satisfaction and marital status in couples 5 years after their participation in randomized clinical trial</p>	<p>134 seriously and chronically distressed couples that had participated in the original outcome study</p>	<ul style="list-style-type: none"> • Dyadic Adjustment Scale • Marital Activities Questionnaire • Phone assessment via brief interview done over the phone 	<p>Distressed married couples were randomly assigned to approximately 8 months of either traditional behavioral couple therapy or integrative behavioral couple therapy.</p> <p>Marital status and satisfaction were assessed approximately every 3 months during treatment and every 6</p>	<ul style="list-style-type: none"> • Pre to Post treatment effect sizes were not significantly different for IBCT and TBCT • TBCT and IBCT both produced substantial effect sizes in even seriously and chronically distressed couples.

				months for 5 years after treatment	
Christensen, A., & Jacobson, N. S. (2002). <i>Reconcilable differences</i> . New York, NY: The Guilford Press.	Purpose: Book written for couples based on principles of IBCT to support couples in distress organized by sections (Anatomy of an Argument, From Argument to Acceptance, Deliberate Change through Acceptance, When Acceptance is Not Enough)	N/A	N/A	Book	<ul style="list-style-type: none"> Provides specific details including vignettes regarding development of acceptance and promotion of change
Epstein, N.B. & Baucom, D.H. (2002). <i>Enhanced cognitive-behavioral therapy for couples: A contextual approach</i> . Washington, DC, US: American Psychological Association.	N/A	N/A	N/A	Book	<ul style="list-style-type: none"> A book written for therapist detailing the modification of behaviors, cognitions, and emotional responses to strengthen relationships.
Gattis, K.S., Simpson, L.E., & Christensen, A. (2008). What about the kids? Parenting and child adjustment in the context of couple therapy. <i>Journal of Family Psychology</i> , 22(6), 833-842. doi:	Purpose: to examine parenting and child adjustment when couples engage in therapy.	134 married couples 68 couples had at least one child (from current or previous marriage) under age 18 living with them at the time of treatment	<ul style="list-style-type: none"> Dyadic Adjustment Scale (relationship satisfaction) Marital Satisfaction Inventory Revised, specifically dissatisfaction with children scale and 	Randomized clinical trial	<ul style="list-style-type: none"> Partial support for the hypothesis that couples without children would show greater gains than couples with children. Suggest that longer married couples without children may be able to make more rapid and

10.1037/a0013713		Average age of children was 6.86 years	<p>conflict over child rearing scale (parenting)</p> <ul style="list-style-type: none"> • Youth Outcome Questionnaire (child adjustment) 	<p>significant gains during therapy than couples with children or couples who have not been married as long.</p> <ul style="list-style-type: none"> • Parenting and child adjustment, we found that couples' conflict over child rearing decreased over the course of therapy and stayed at this decreased level over the 2-year follow-up. Although statistically significant, the effect was small and most couples and children began and remained in the nonclinical range. • Found no improvements in dissatisfaction with children over time, but parents did view their children as becoming better adjusted over the course of therapy, though these gains were not maintained over the follow-up. • Parents of older children tended to report poorer child adjustment prior to treatment than parents of younger children • Change in conflict over child rearing and
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					<p>child adjustment was associated with change in marital satisfaction, such that improvement in one area reflected improvement in another.</p> <ul style="list-style-type: none"> • Change in conflict over child rearing mediated the relationship between change in marital satisfaction and change in child adjustment, such that as parents became happier in their relationships, they experienced less conflict over their children, which was related to improvement in child functioning.
Greenberg, L.S. & Johnson, S.M. (1988). <i>Emotionally focused therapy for couples</i> . New York: The Guilford Press.	N/A	N/A	N/A	Book	<ul style="list-style-type: none"> • A book written for therapists detailing the use of emotionally focused therapy for couples focusing on the creation of new and more satisfying couple interactions.
Jacobson, N.S., Christensen, A., Prince, S.E., Cordova, J., & Eldridge, K. (2000). Integrative behavioral couple therapy: An acceptance-based,	Purpose: To provide preliminary data on a new approach to treating marital distress, integrative behavioral couple therapy (IBCT)	21 couples requesting therapy for marital distress Legally married and living together and both spouses	<ul style="list-style-type: none"> • Marital Satisfaction Inventory • Global Distress Scale • Dyadic Adjustment Scale 	Randomized clinical trial	<ul style="list-style-type: none"> • IBCT is distinct treatment from TBCT. • Evidence of differential processes occurring in the two treatments was found in an examination of couples' in-

promising new treatment for couple discord. <i>Journal of Consulting and Clinical Psychology</i> , 68(2), 351-355. doi: 10.1037//0022-006X.68.2.351		had to be between 21 and 60 years old Above 58 on GDS of MSI			session verbal behavior .
Jacobson, N. S., & Christensen, A. (1998). <i>Acceptance and change in couple therapy: A therapist's guide to transforming relationships</i> . New York: Norton.	Purpose: To serve as a guide for clinicians regarding the theory behind and practice of integrative behavioral couple therapy Focus is on IBCT conceptualization, traditional behavioral change strategies, and acceptance-based interventions.	N/A	N/A	Book	<ul style="list-style-type: none"> • Acceptance as a key mechanism of change in couple therapy.
Jacobson, N.S. & Margolin, G. (1979). <i>Marital Therapy: Strategies Based on Social Learning and Behavior Exchange Principles</i> . New York: Brunner/Mazel, Publishers.	N/A	N/A	N/A	N/A	<ul style="list-style-type: none"> • A book written for therapists detailing the process of marital therapy based on behavior exchange and social learning principles.
Lebow, J.L., Chambers, A.L., Christensen, A., & Johnson, S.M. (2011). Research on the treatment	Purpose: To summarize couples research 2000-2009 (lit review).	N/A	N/A	Literature review and summary of research findings from 2000-2009	<ul style="list-style-type: none"> • Addressing the fact that “couples” definition should be expanded beyond marriage (gay, lesbian, committed

<p>of couple distress. <i>Journal of Marital and Family Therapy</i>, 38 (1), 145-168. doi:10.1111/j.1752-0606.2011.00249.x</p>				<p>Review of other meta-analytic articles on effectiveness of couples therapy</p>	<p>relationships) .</p> <ul style="list-style-type: none"> • Primary problem in couples research of external validity • Both behavioral couples therapies make substantial improvements for both seriously and chronically distressed couples. • EFT, BCT, IOCT, IBCT are beyond the threshold for empirically supported treatments. • When couples present for therapy must assess for comorbid psychopathology . • Engagement and retention in couples therapy is a problem.
<p>Sevier, M., Eldridge, K., Jones, J., Doss, B. D., & Christensen, A. (2008). Observed communication and associations with satisfaction during traditional and integrative behavioral couple therapy. <i>Behavior Therapy</i>, 39(2), 137-50. doi:10.1016/j.beth.2007.06.001</p>	<p>Purpose: To investigate changes in couple communication and potential mechanisms of change during treatment in either IBCT or TBCT.</p>	<p>134 distressed, married couples</p>	<ul style="list-style-type: none"> • Dyadic Adjustment Scale and Global Distress scales of Marital Satisfaction Inventory Revised • Couple interaction rating system (as an observational interaction measure) • Social Support 	<p>Couples were observed in relationship and personal problem discussions prior to and near the end of treatment. Analyses were conducted using the Hierarchical Linear Modeling program.</p>	<ul style="list-style-type: none"> • Over the time in therapy, during relationship problem discussions, positivity and problem solving increased while negativity decreased. • Compared to IBCT, TBCT couples had the largest gains in positivity and reductions in negativity. • During personal problem discussions, negativity decreased, while

			Interaction Rating System (behavior ratings)		<p>withdrawal increased and positivity decreased.</p> <ul style="list-style-type: none"> • TBCT couples had larger declines in negativity. • In both discussion types increases in marital satisfaction were associated with increases in positivity and problem solving. • Declines in marital satisfaction were associated with increased negativity during relationship problem interactions and increased withdrawal during personal problem interactions. However, no treatment differences in these associations were found.
Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. <i>Journal of Marital and Family Therapy</i> , 29, 547–570.	Purpose: To examine efficacy of MFT interventions for distressed couples and for marital “enrichment.”	20 meta-analyses of marital and family therapy interventions.	N/A	Meta-Analysis	<ul style="list-style-type: none"> • Interventions are effective, although the effect-size is slightly reduced at follow-up.
Snyder, D. K., & Halford, W. (2012). Evidence-	Purpose: To discuss the history and future direction	N/A	N/A	Review/Discussion	<ul style="list-style-type: none"> • Identifies current evidence-based couple therapies

<p>based couple therapy: Current status and future directions. <i>Journal of Family Therapy</i>, 34(3), 229-249. doi:10.1111/j.1467-6427.2012.00599.</p>	<p>of evidence-based couple therapy.</p>				<p>and their utility in marital and individual distress.</p> <ul style="list-style-type: none"> • Suggests that future research examines mechanisms of change for couple-based interventions.
<p>Sullivan, K.T., & Davila, J. (2014). The problem is my partner: Treating couples when one partner wants the other to change. <i>Journal of Psychotherapy Integration</i>, 24(1), 1-12. doi: 10.1037/a0035969</p>	<p>Purpose: to review couple's capacity for change, the process of behavior and personality change, and role of attachment theory.</p>	N/A	N/A	Review	<ul style="list-style-type: none"> • Emotional acceptance is key when working change-demanding couples.
<p>Wiedeman, L. D. (2012). <i>Acceptance promoting and hindering interactions in integrative behavioral couple therapy</i> (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. 3461736)</p>	<p>Purpose: To develop a dyadic coding system and use it to examine change processes and treatment outcome in Integrative Behavioral Couple Therapy</p>	<p>7 couples were selected out of 134 moderately and severely distressed married couples who participated in the original outcome study.</p>	<ul style="list-style-type: none"> • The Acceptance and Promoting and Interfering Interaction Rating System. • Dyadic Adjustment Scale, and the Frequency and Acceptability of Partner Behavior Inventory 	<p>Dissertation, Qualitative Study</p>	<ul style="list-style-type: none"> • "Growth" couples with more positive outcome displayed openness and curiosity about their partner's perspective and utilized humor • "No growth/decline" couples made critical and disparaging remarks, and had one partner (at least) that was not open to changing perspectives.

Research Methods and Case Study Research

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach	Major Findings
<p>Carlson, C.I., Ross, S.G., & Stark, K.H. (2012). Bridging systemic research and practice: Evidence-based case study methods in couple and family psychology. <i>Couple and Family Psychology: Research and Practice, 1</i>(1), 48-60. Doi: 10.1037/a0027511</p>	<p>Purpose: To suggest guidelines for evidence-based case studies and single case designs</p>	<p>N/A</p>	<p>N/A</p>	<p>Review/Discussion</p>	<ul style="list-style-type: none"> • <i>Clinical case study</i>: detailed analysis of individual, couple, or family therapy that includes verbatim clinical case material and is instructive regarding the treatment, the problem, or population. • <i>Evidence-based case study</i>: the integration of verbatim clinical material with standardized measures of success and outcome evaluated at different times across treatment and with attention to clinical significance methodology • (From this perspective, single-case design is considered a type of evidence-based study) • Single-case designs address the efficacy question of “is this therapy effective?” Single- case research is based

					<p>on a number of methodological principles: (a) reliable and valid measurement of outcome variables, (b) accurate description of the intervention, (c) time-series analysis of patterns of change, and (d) the logic of replication (McLeod, 2010). Single-case research involves (a) a design to follow in systematically gathering evidence, (b) visual analysis of the data, and (c) more recently, determination of effect size.</p>
<p>Creswell, J.W. (2013). <i>Qualitative Inquiry and Research Design</i>. Thousand Oaks: SAGE.</p>	N/A	N/A	N/A	Book	<ul style="list-style-type: none"> • Outlines various types of qualitative research. • Includes discussion designing and implementing qualitative research.
<p>Evidence-based case study. (2013). Retrieved October 15, 2013, http://www.apa.org/pubs/journals/pst/evidence-based-case-study.aspx</p>	<p>Purpose: To suggest guidelines for evidence-based case studies and encourages case study research as a way to bridge the gap between research and practice</p>	N/A	N/A	Discussion of case study research practices.	<ul style="list-style-type: none"> • Integrate verbatim clinical case material with standardized measures of process and outcome evaluated at different times across treatment. • Describe clinical vignettes highlighting key interventions and mechanisms of change regarding

					their specific approach to treatment in the context of empirical scales
Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. <i>Journal of Consulting and Clinical Psychology</i> , 59, 12–19.	N/A	N/A	N/A	N/A	<ul style="list-style-type: none"> Provides cutoffs for determining clinical significance in psychotherapy change research.
McLeod, J. (2010). <i>Case Study Research in Counseling and Psychotherapy</i> . London: SAGE.	N/A	N/A	N/A	Book	<ul style="list-style-type: none"> Outlines best practices for conducting case-study research.
McLeod, J., & Elliott, R. (2011). Systematic case study research: A practice-oriented introduction to building an evidence base for counseling and psychotherapy. <i>Counseling & Psychotherapy Research</i> , 11(1), 1-10. doi:10.1080/14733145.2011.548954	Purpose: Provides an overview of the characteristics of rigorous case study research, introduces a set of studies that exemplify these principles, and reviews the relevance of systematic case study inquiry for policy, practice and training.	N/A	N/A	N/A	<ul style="list-style-type: none"> Describes benefits of case study research Complexity: in research that involves large numbers of participants, typically only a relatively small number of observations are made in relation to each person. By contrast, in case study research a large number of observations are made on each case, thus allowing for the identification and analysis of complex patterns

					<p>of interplay between different factors or processes;</p> <ul style="list-style-type: none"> • Longitudinal sensitivity: extensive or large N studies tend to provide either a snapshot of what is happening at one point in time, or at best a comparison of group data across two or three measurement points; case studies typically look in detail at how change unfolds over time, based on series of multiple observations; • Appreciation of context: a case study has the space to examine the influence of contextual factors, in ways that are not possible when large numbers of participants are being studied; • Narrative knowing: a good case study tells a story that is potentially highly memorable for readers, and offers knowledge that is readily assimilated into the pre-existing 'action schemas' that guide their practice with clients. As a form of knowledge, case studies are
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					<p>therefore of particular relevance for practitioners.</p> <ul style="list-style-type: none"> • Case study research is most relevant for practice (practical knowledge and theoretical sensitivity), policy, and training.
<p>Mertens, D. M. (2010). <i>Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods (3rd ed.)</i>. Los Angeles, CA: SAGE.</p>	N/A	N/A	N/A	Book	<ul style="list-style-type: none"> • The text provides an in-depth description and analysis of various research approaches in education and psychology.
<p>Sexton, T., Gordon, K. C., Gurman, A., Lebow, J., Holtzworth-Munroe, A., & Johnson, S. (2011). Guidelines for classifying evidence-based treatments in couple and family therapy. <i>Family Process, 50</i>(3), 377-92. doi:10.1111/j.1545-5300.2011.01363.x</p>	<p>Purpose: To provide identify effective intervention programs for clients who seek treatment.</p>	N/A	N/A	N/A	<ul style="list-style-type: none"> • Evidence informed → evidenced based → evidenced based and ready for dissemination and transportation within diverse community settings • Each level reflects an interaction between the specificity of the intervention, the strength and breadth of the outcomes, and the quality of the studies that form

<p>Stanton, M., & Welsh, R. (2012). Systemic thinking in couple and family psychology research and practice. <i>Couple and Family Psychology: Research and Practice, 1</i>(1), 14-30. doi:10.1037/a0027461</p>	<p>Purpose: The objective is to provide an overview of systemic thinking and to present ideas about how systemic thinking is applied to research and practice.</p>	<p>N/A</p>	<p>N/A</p>	<p>Eleven applications of systemic thinking (perceptual and cognitive structuring processes) are described to characterize the way couple and family psychologists think about research and practice</p>	<p>the evidence.</p> <ul style="list-style-type: none"> • The ability to conceptualize change is the foundation for psychological practice with individuals, couples, families, and larger social systems (p25) • Major tenets of systemic thinking in research and practice: challenge mental models, see the system, comprehend complexity, recognize reciprocity, conceptualize change, observe patterns and trends, consider unintended consequences, contemplate connections, accept ambiguity, shift perspective, factor in time. • In research: identify the collective variable of interest, characterize behavioral attractor states, describe the dynamic trajectory of dynamic variable, identify points of transition, recognize control parameters, manipulate the putative control parameters to experimentally
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					<p>generate phase transitions.</p> <ul style="list-style-type: none"> • In practice: requires systemic thinking about alliance, in assessment and conceptualization , about change, in treatment interventions. • Six steps that identify collective variables, characterize attractor states, describe dynamic trajectories, identify points of transition, recognize control parameters, and manipulate control parameters to identify core mechanisms of change is rehearsed and detailed.
<p>Yin, R.K. (2009). <i>Case study research: Design and methods</i> (4th ed.). Thousands Oaks, CA: Sage Publications, Inc.</p>	N/A	N/A	N/A	Book	<ul style="list-style-type: none"> • Book written for researchers conducting case studies. • Outlines best methodological practices for conducting case study research.

Change Process Research

Author/ Year	Research Questions/ Objectives	Sample	Instruments	Research Approach	Major Findings
Blow, A. J., Morrison, N. C., Tamaren,	Purpose: To describe a research study	One selected couple	• Dyadic Adjustment Scale	Discovery-oriented approach	• Much of the current research on couple

<p>K., Wright, K., Schaafsma, M., & Nadaud, A. (2009). Change processes in couple therapy: an intensive case analysis of one couple using a common factors lens. <i>Journal of Marital and Family Therapy</i>, 35(3), 350-68. doi:10.1111/j.1752-0606.2009.00122.x</p>	<p>that explored the process of how change occurred in for a distressed couple, using a common factor lens.</p>		<ul style="list-style-type: none"> • Life Events Questionnaire • Video recording of all sessions • Session rating form • Client and Therapist Interviews. 	<p>Independent viewing of therapy tapes (and come up with tentative ideas about how change occurred) then group discussion of sessions, consistent application to common factor lens</p>	<p>therapy tells us little about how change occurs in the therapy room, only that it does occur.</p> <ul style="list-style-type: none"> • Process of change is complex and multifaceted; as such, it is not easy to manualize in a regimented step-by-step fashion exactly what takes place • Combination of several events, many unrelated, had the additive effects of bringing about change. • Change is not a discrete variable but it is rather a concept that is more useful to think about in continuous terms.
<p>Cordova, J.V. (2001). Acceptance in behavior therapy: Understanding the process of change. <i>The Behavior Analyst</i>, 24(2), 213-226.</p>	<p>Purpose: To describe how acceptance is observed and measured. To describe how therapists promote acceptance. To describe when acceptance is indicated our contraindicated as a therapeutic goal</p>	<p>N/A</p>	<p>N/A</p>		
<p>Doss, B. D. (2004). Changing the way we study change in psychotherapy. <i>Clinical</i></p>	<p>Purpose: To provide a conceptual and methodological framework to study change in therapy.</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>	<ul style="list-style-type: none"> • <i>Change processes:</i> aspects of therapy, occurring during the treatment

<p><i>Psychology: Science and Practice</i>, 11(4), 368-386. doi:10.1093/clippsy/bph094</p>					<p>session or as direct result of therapy.</p> <ul style="list-style-type: none"> • <i>Therapy change processes</i>: interventions, directives, therapist-constructed therapy characteristics. • <i>Client change processes</i>: client behaviors or experiences that occur as a direct result of therapy change processes and are expected to lead to improvements in change mechanisms. • <i>Change Mechanisms</i>: intermediate changes in client characteristics or skills, not under direct therapist control, that are expected to lead to improvements in the ultimate outcomes of therapy.
<p>Doss, B.D., Thum, Y.M., Sevier, M., Atkins, D.C., & Christensen, A. (2005). Improving relationships: Mechanisms of</p>	<p>Purpose: To examine moderators of change in satisfaction, mechanisms, and their relation. (TCBT v ICBT)</p>	<p>134 married couples</p>	<ul style="list-style-type: none"> • DAS (Dyadic Adjustment Scale) • Frequency and Acceptability of Partner Behavior Inventory • Communication Patterns Questionnaire 	<p>Correlational</p>	<ul style="list-style-type: none"> • Differential amount of change early and late in therapy in frequency and acceptability of behaviors: first half of therapy → frequency of target behaviors significantly improved, with significantly more change in

<p>change in couple therapy. <i>Journal of Consulting and Clinical Psychology</i> 73(4), 624-633. doi: 10.1037/0022-006X73.4.624</p>					<p>the frequency of target behaviors in TBCT than in IBCT. Spouses reported significant decreases in the frequency of target behaviors in the second half of therapy. Although the frequency of positive behaviors significantly improved in the second half, the frequency of negative behaviors significantly increased during the second half of therapy.</p> <ul style="list-style-type: none"> • Results of the current study provide a cautionary warning to those treatments that focus on specific and immediate change, such as TBCT and solution-focused approaches. • Increases in acceptance were significantly related to increases in satisfaction for couples in both therapies; leaving open the possibility that emotional acceptance could be an important mechanism of change in the
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					second half of couple therapy.
Greenberg, L.S., & Newman, F.L. (1996). An approach to psychotherapy change process research: Introduction to the special section. <i>Journal of Consulting and Clinical Psychology</i> 64(3), 435-438.	Purpose: To examine how to study processes of change in psychotherapy	N/A	Decomposition, central to this task, is applied to delineate the stream of psychotherapeutic process into a series of phenomena or therapeutic tasks with an identifiable, recurring event structure, the resolution of which advances the course of therapy and leads to change	Discovery Verification (8 steps to model)	<ul style="list-style-type: none"> • 8 Steps: <ol style="list-style-type: none"> 1.) Explicate implicit map of expert clinician 2.) Select and describe the task and task Environment 3.) Verify the significance of the task 4.) Rational analysis of performance: Constructing Performance diagrams 5.) Empirical analysis of performance: Measurement of actual performance 6.) Comparison of actual and possible performances: Construct a specific model 7.) Validation of model 8.) Relating complex process to outcome
Heatherington, L., Friedlander, M. L., & Greenberg, L. (2005). Change process research in couple and family therapy: methodological challenges and opportunities. <i>Journal of Family Psychology</i> ,	Purpose: To present discussion of methodological challenges and opportunities in couple and family therapy research.	N/A	N/A	Review of steps made in the study of change processes for systemic therapeutic work	<ul style="list-style-type: none"> • Specification of the client behaviors that lead to therapeutic change has been relatively neglected. • Systematic research programs have focused on client behavior as it relates to hypothesized change mechanisms. • Argument that

<p>19(1), 18-27. doi:10.1037/0893-3200.19.1.18</p>					<p>systemic theory is incompatible with empirical research has been disconfirmed.</p>
<p>Kazdin, A. E. (2001). Progression of therapy research and clinical application of treatment require better understanding of the change process. <i>Clinical Psychology: Science And Practice</i>, 8(2), 143-151. doi:10.1093/clippsy/8.2.143</p>	<p>Purpose: To discuss developing effective treatments as depending heavily on investigations that address critical scientific questions; particularly, what are the mechanisms through which therapy operates and under what conditions is therapy likely to be effective and why.</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>	<ul style="list-style-type: none"> • A call for research that addresses a broader range of questions and encompasses more diverse methods of evaluating treatment.

APPENDIX B

Marital Satisfaction Inventory-Revised

APPENDIX B

Marital Satisfaction Inventory-Revised



Directions

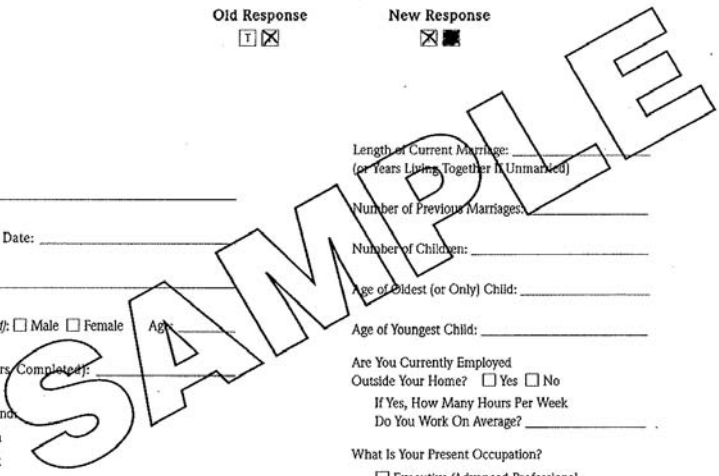
Please begin by filling in the information about your background. When that information has been completed, proceed to the first numbered inventory item.

This Inventory consists of statements about you and your relationship with your partner. Read each statement and decide if it is TRUE for you or FALSE for you. Then mark your answer in the place provided beside that statement. If the statement is true or mostly true for you, place an X in the box labeled T. If the statement is false or not usually true for you, place an X in the box labeled F. Mark only one response for each statement. If you want to change an answer, you must completely darken the box that contains your old answer, and then place an X in the box that shows your new answer.

Example:

Old Response New Response
T X X F

Start here: Couple ID: Administration Date: Individual ID: Gender (required): Education (Years Completed): Ethnic Background: Length of Current Marriage: Number of Previous Marriages: Number of Children: Age of Oldest (or Only) Child: Age of Youngest Child: Are You Currently Employed Outside Your Home? If Yes, How Many Hours Per Week Do You Work On Average? What Is Your Present Occupation?



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MSI-R

Douglas K. Snyder, Ph.D.

1. When my partner and I have differences of opinion, we sit down and discuss them. T F
2. I am fairly satisfied with the way my partner and I spend our available free time. T F
3. My partner almost always responds with understanding to my mood at a given moment. T F
4. My childhood was probably happier than most. T F
5. There are some things my partner and I just can't talk about. T F
6. It is sometimes easier to confide in a friend than in my partner. T F
7. My partner seems to enjoy sex as much as I do. T F
8. I wish my partner shared a few more of my interests. T F
9. During an argument with my partner, each of us airs our feelings completely. T F
10. I was very anxious as a young person to get away from my family. T F
11. I would prefer to have sexual relations more frequently than we do now. T F
12. Even when angry with me, my partner is able to appreciate my viewpoints. T F
13. My partner likes to share his or her leisure time with me. T F
14. There is a great deal of love and affection expressed in our relationship. T F
15. I am sometimes unhappy with our sexual relationship. T F
16. There are many things about our relationship that please me. T F
17. A lot of our arguments seem to end in depressing stalemates. T F
18. Even when I am with my partner, I feel lonely much of the time. T F
19. I trust my partner with our money completely. T F
20. There are some things about my partner that I do not like. T F
21. Our relationship has been very satisfying. T F
22. My partner has slapped me. T F
23. Some equality in marriage is a good thing but, by and large, the man ought to have the main say so in family matters. T F
24. The good things in our relationship far outweigh the bad. T F
25. My partner and I decide together the manner in which our income is to be spent. T F
26. There are times when my partner does things that make me unhappy. T F
27. Two people should be able to get along better than my partner and I do. T F
28. I have never worried that my partner might become angry enough to hurt me. T F
29. There should be more daycare centers and nursery schools so that more mothers of young children could work. T F
30. Our relationship is as successful as any that I know of. T F
31. Our relationship has never been in difficulty because of financial concerns. T F
32. My partner and I understand each other completely. T F
33. My partner has slammed things around or thrown things in anger. T F
34. Such things as laundry, cleaning, and child care are primarily a woman's responsibility. T F
35. I have often considered asking my partner to go with me for relationship counseling. T F
36. There are some things about our relationship that do not entirely please me. T F
37. If a child gets sick, and if both parents work, the father should be just as willing as the mother to stay home from work and take care of the child. T F
38. My partner and I need to improve the way we settle our differences. T F
39. My partner and I spend a good deal of time together in different kinds of play and recreation. T F
40. My partner doesn't take me seriously enough sometimes. T F
41. My parents' marriage was happier than most. T F
42. My partner is so touchy on some subjects that I can't even mention them. T F
43. Whenever I'm feeling sad, my partner makes me feel loved and happy again. T F
44. I am somewhat dissatisfied with how we discuss better ways of pleasing each other sexually. T F
45. My partner and I don't have much in common to talk about. T F
46. When we argue, my partner and I often seem to go over and over the same old things. T F
47. All the marriages on my side of the family appear to be quite successful. T F
48. One thing my partner and I don't fully discuss is our sexual relationship. T F
49. My partner's feelings are too easily hurt. T F
50. It seems that we used to have more fun than we do now. T F
51. Sometimes I feel as though my partner doesn't really need me. T F
52. My partner sometimes shows too little enthusiasm for sex. T F
53. Our relationship has been disappointing in several ways. T F
54. Minor disagreements with my partner often end up in big arguments. T F
55. My partner and I have never come close to ending our relationship. T F
56. Our financial future seems quite secure. T F
57. There are times when I wonder if I made the best of all possible choices in a partner. T F
58. I get pretty discouraged about our relationship sometimes. T F
59. I have worried about my partner losing control of his or her anger. T F
60. Earning the family income is primarily the responsibility of the man. T F
61. My partner and I seldom have major disagreements. T F
62. It is often hard for us to discuss our finances without getting upset with each other. T F
63. My partner occasionally makes me feel miserable. T F
64. I have never felt better in our relationship than I do now. T F
65. My partner has never thrown things at me in anger. T F
66. The man should be the head of the family. T F
67. The future of our relationship is too uncertain for us to make any serious plans. T F
68. My partner is forever checking up on how I spend my money. T F
69. I have never regretted our relationship even for a moment. T F
70. My partner sometimes screams or yells at me when he or she is angry. T F
71. A woman should take her husband's last name after marriage. T F
72. My partner and I are happier than most of the couples I know. T F
73. Trying to work out a budget causes more trouble with my partner than it is worth. T F
74. The most important thing for a woman is to be a good wife and mother. T F

75. When arguing, we manage quite well to restrict our focus to the important issues. T F
76. Our daily life is full of interesting things to do together. T F
77. Sometimes my partner just can't understand the way I feel. T F
78. My parents didn't communicate with each other as well as they should have. T F
79. My partner has no difficulty accepting criticism. T F
80. Just when I need it the most, my partner makes me feel important. T F
81. My partner has too little regard sometimes for my sexual satisfaction. T F
82. My partner doesn't take enough time to do some of the things I'd like to do. T F
83. My partner sometimes seems intent upon changing some aspect of my personality. T F
84. My parents never really understood me. T F
85. My partner and I nearly always agree on how frequently to have sexual relations. T F
86. My partner and I seem able to go for days sometimes without settling our differences. T F
87. I spend at least one hour each day in an activity with my partner. T F
88. My partner does many different things to show me that he or she loves me. T F
89. I have never seriously considered having an affair. T F
90. I have important needs in our relationship that are not being met. T F
91. Our arguments frequently end up with one of us feeling hurt or crying. T F
92. At times I have very much wanted to leave my partner. T F
93. My partner is a very good manager of finances. T F
94. My partner has all of the qualities I've always wanted in a companion. T F
95. There are some serious difficulties in our relationship. T F
96. My partner has never pushed me or grabbed me in anger. T F
97. Where a family lives should depend mostly on the man's job. T F
98. I might be happier if I weren't in the relationship. T F
99. My partner and I rarely argue about money. T F
100. There are times when I do not feel a great deal of love and affection for my partner. T F
101. I have often wondered whether our relationship may end in separation or divorce. T F
102. My partner has left bruises or welts on my body. T F
103. In a relationship the woman's career is of equal importance to the man's. T F
104. I believe that our relationship is as pleasant as that of most of the people I know. T F
105. I feel as though we live beyond our financial means. T F
106. I don't think any couple could live together with greater harmony than my partner and I. T F
107. My partner has never threatened to hurt me. T F
108. In a relationship, a major role of a woman should be that of housekeeper. T F
109. I have known very little unhappiness in our relationship. T F
110. My partner buys too many things without consulting with me first. T F
111. If a mother of young children works, it should be only while the family needs the money. T F
112. My partner has never injured me physically. T F
113. When we disagree, my partner helps us to find alternatives acceptable to both of us. T F
114. Our recreational and leisure activities appear to be meeting both our needs quite well. T F
115. I feel free to express openly strong feelings of sadness to my partner. T F
116. I had a very happy home life. T F
117. My partner and I rarely have sexual relations. T F
118. Sometimes I wonder just how much my partner really does love me. T F
119. I would like my partner to express a little more tenderness during intercourse. T F
120. The members of my family were always very close to each other. T F
121. My partner and I are often unable to disagree with one another without losing our tempers. T F
122. I often wondered whether my parents' marriage would end in divorce. T F
123. There are some things I would like us to do, sexually, that my partner doesn't seem to enjoy. T F
124. My partner often fails to understand my point of view on things. T F
125. Whenever he or she is feeling down, my partner comes to me for support. T F
126. My partner keeps most of his or her feelings inside. T F
127. Our sexual relationship is entirely satisfactory. T F
128. I believe our relationship is reasonably happy. T F
129. My partner often complains that I don't understand him or her. T F
- Couples WITHOUT children STOP here. Couples WITH children answer the following:**
130. For the most part, our children are well behaved. T F
131. My partner and I rarely argue about the children. T F
132. My children's value systems are very much the same as my own. T F
133. My partner doesn't spend enough time with the children. T F
134. Our relationship might have been happier if we had not had children. T F
135. My partner and I rarely disagree on when or how to discipline the children. T F
136. I wish my children would show a little more concern for me. T F
137. Our children often manage to drive a wedge between my partner and me. T F
138. My children and I don't have very much in common to talk about. T F
139. My partner doesn't display enough affection toward the children. T F
140. Our children do not show adequate respect for their parents. T F
141. My partner and I decide together what rules to set for our children. T F
142. Our children don't seem as happy and carefree as other children their age. T F
143. My partner doesn't assume his or her fair share of taking care of the children. T F
144. Having children has not brought all of the satisfactions I had hoped it would. T F
145. My partner and I nearly always agree on how to respond to our children's requests for money or privileges. T F
146. Our children rarely fail to meet their responsibilities at home. T F
147. Our relationship has never been in difficulty because of the children. T F
148. Rearing children is a nerve-wracking job. T F
149. My partner and I assume equal responsibility for rearing the children. T F
150. I frequently get together with one or more of the children for fun or recreation at home. T F

Item Number	Coded Response	Corresponding Inconsistency Item (Coded Response Comparison)	Full Text of Item
Role Orientation (ROR)			
23	F		Some equality in marriage is a good thing but, by and large, the man ought to have the main say-so in family matters.
29	T		There should be more daycare centers and nursery schools so that more mothers of young children could work.
34	F	108 (Different)	Such things as laundry, cleaning, and child care are primarily a woman's responsibility.
37	T		If a child gets sick, and if both parents work, the father should be just as willing as the mother to stay home from work and take care of the child.
60	F	97 (Different)	Earning the family income is primarily the responsibility of the man.
66	F		The man should be the head of the family.
71	F		A woman should take her husband's last name after marriage.
74	F		The most important thing for a woman is to be a good wife and mother.
97	F	60 (Different)	Where a family lives should depend mostly on the man's job.
103	T		In a relationship the woman's career is of equal importance to the man's.
108	F	34 (Different)	In a relationship, a major role of a woman should be that of housekeeper.
111	F		If a mother of young children works, it should be only while the family needs the money.
Family History of Distress (FAM)			
4	F	116 (Different)	My childhood was probably happier than most.
10	T		I was very anxious as a young person to get away from my family.
41	F	78 (Same)	My parents' marriage was happier than most.
47	F		All the marriages on my side of the family appear to be quite successful.
78	T	41 (Same)	My parents didn't communicate with each other as well as they should have.
84	T		My parents never really understood me.
116	F	4 (Different)	I had a very happy home life.
120	F		The members of my family were always very close to each other.
122	T		I often wondered whether my parents' marriage would end in divorce.
Dissatisfaction With Children (DSC)			
130	F		For the most part, our children are well behaved.
132	F		My children's value systems are very much the same as my own.
134	T		Our relationship might have been happier if we had not had children.
136	T		I wish my children would show a little more concern for me.
138	T		My children and I don't have very much in common to talk about.
140	T		Our children do not show adequate respect for their parents.
142	T		Our children don't seem as happy and carefree as other children their age.
144	T		Having children has not brought all of the satisfactions I had hoped it would.
146	F		Our children rarely fail to meet their responsibilities at home.
148	T		Rearing children is a nerve-wracking job.
150	F		I frequently get together with one or more of the children for fun or recreation at home.

continued on next page...

Item Number	Coded Response	Corresponding Inconsistency Item (Coded Response Comparison)	Full Text of Item
Conflict Over Child Rearing (CCR)			
131	F		My partner and I rarely argue about the children.
133	T		My partner doesn't spend enough time with the children.
135	F		My partner and I rarely disagree on when or how to discipline the children.
137	T		Our children often manage to drive a wedge between my partner and me.
139	T		My partner doesn't display enough affection toward the children.
141	F		My partner and I decide together what rules to set for our children.
143	T		My partner doesn't assume his or her fair share of taking care of the children.
145	F		My partner and I nearly always agree on how to respond to our children's requests for money or privileges.
147	F		Our relationship has never been in difficulty because of the children.
149	F		My partner and I assume equal responsibility for rearing the children.

APPENDIX C

Dyadic Adjustment Scale

APPENDIX C

Dyadic Adjustment Scale

Couple ID _____
 Husband / Wife (circle one)

Date: _____

Assessment: Pre 13week Final Session# _____

26week F1 F2 F3 F4

Dyadic Adjustment Scale¹

Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Matters of recreation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Religious matters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Demonstration of affection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Sex relations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Conventionality (correct or proper behavior)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Philosophy of life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Ways of dealing with parents or in-laws	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Aims, goals, and things believed important	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Amount of time spent together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Making major decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Household tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Leisure time interests and activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Career decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

¹ Reproduced with permission from Multi-Health Systems Inc., 908 Niagara Falls Blvd., North Tonawanda, NY, 14120-2060 (800) 456-3003.

	All The Time	Most Of The Time	More Often Than Not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or termination of your relationship?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often do you or your mate leave the house after a fight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. In general, how often do you think that things between you and your partner are going well?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Do you confide in your mate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Do you ever regret that you married (or lived together)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often do you and your partner quarrel?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often do you and your mate get on each others' nerves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Every Day	Almost Every Day	Occasionally	Rarely	Never
23. Do you kiss your mate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	All of Them	Most Of Them	Some of Them	Very Few Of Them	None Of Them
24. Do you and your mate engage in outside interests together?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How often do the following occur between you and your mate?

	Never	Less Than Once a Month	Once/Twice a Month	Once/Twice a Week	Once a Day	More Often
25. Have a stimulating exchange of ideas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Laugh together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Calmly discuss something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Work together on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These are some things about which couples sometimes agree or disagree. Indicate if either item below caused differences of opinions or were problems in the past few weeks (fill in yes or no).

	Yes	No
29. Being too tired for sex	<input type="radio"/>	<input type="radio"/>
30. Not showing love	<input type="radio"/>	<input type="radio"/>

31. The bubbles on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please fill in the bubble which best describes the degree of happiness, all things considered, of your relationship.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?
Fill in the one circle for the most accurate statement.

- I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
- I want very much for my relationship to succeed, and will do all I can to see that it does.
- I want very much for my relationship to succeed, and will do my fair share to see that it does.
- It would be nice if my relationship succeeded, but I can't do much more than I am doing now to keep the relationship going.
- It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
- My relationship can never succeed, and there is no more that I can do to keep the relationship going.

APPENDIX D

Frequency and Acceptability of Partner Behavior

APPENDIX D

Frequency and Acceptability of Partner Behavior

Couple ID _____
 Husband / Wife (circle one)

Date _____
 Assessment: Pre 13-week 26-week
 FU1 FU2 FU3 FU4

Frequency and Acceptability of Partner Behavior

Andrew Christensen, Ph.D. and Neil S. Jacobson, Ph.D.

Instructions:

In every relationship there are positive behaviors that individuals like their partner to do, and negative behaviors that individuals don't like their partner to do. The following pages list typical behaviors that can cause relationship satisfaction or dissatisfaction. For each behavior listed below:

A) Give an estimate of the frequency of that behavior in the **past month**. Estimate the number of times (0-9) that behavior has occurred this past month either per day, week, or month by bubbling in the appropriate number and time frame you are referring to. For instance, if a behavior occurred twice a week, you can either estimate it as 2 times per week or 8 times per month. In the example below, the spouse indicated that his/her partner initiated physical affection about 2 times per week in the last month. If a behavior occurred at least once in the past month, do NOT estimate it as zero times per day or zero times per week.

B) After you have estimated the frequency of the behavior in the past month, then rate how acceptable it is to you that this behavior has occurred at the specified frequency in the past month. Use the low end of the scale to rate behaviors whose frequency in the last month is unacceptable, intolerable, and unbearable. Use the high end of the scale to rate behaviors whose frequency in the last month is acceptable, even desirable. **If the behavior has not happened in the last month, respond with zero times per month then rate how acceptable it is to you that the behavior has not happened in the past month.** In the example below, the spouse feels that the frequency of her spouse initiating affection one time per day in the last month is moderately acceptable. The spouse could have also said that her spouse initiated affection seven times per week; this is the same thing as one time per day.

Example:

i. <u>In the past month</u> , my partner was physically affectionate (e.g., held my hand, kissed me, hugged me, put arm around me, responded when I initiated affection)											
Frequency:	0	1	2	3	4	5	6	7	8	9	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Times per:	Day			Week			Month				
		<input type="radio"/>			<input type="radio"/>				<input type="radio"/>		
How acceptable is it to you that your partner was physically affectionate <u>at this frequency in the past month</u> ?											
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Totally Unacceptable										Totally Acceptable

Partner Positive Behaviors

1. In the past month, my partner was physically affectionate (e.g., held my hand, kissed me, hugged me, put arm around me, responded when I initiated affection)

Frequency:	0	1	2	3	4	5	6	7	8	9
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Times per:		Day			Week			Month		
		<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		

How acceptable is it to you that your partner was physically affectionate at this frequency in the past month?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Totally Unacceptable									Totally Acceptable

2. In the past month, my partner was verbally affectionate (e.g., complimented me, told me he/she loves me, said nice things to me)

Frequency:	0	1	2	3	4	5	6	7	8	9
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Times per:		Day			Week			Month		
		<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		

How acceptable is it to you that your partner was verbally affectionate at this frequency in the past month?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Totally Unacceptable									Totally Acceptable

3. In the past month, my partner did housework (include times when partner initiated the housework as well as when you suggested it and partner did it—e.g., cooked, did the dishes, cleaned the house, did the laundry, went grocery shopping, washed car, took out the trash)

Frequency:	0	1	2	3	4	5	6	7	8	9
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Times per:		Day			Week			Month		
		<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		

How acceptable is it to you that your partner did housework at this frequency in the past month?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Totally Unacceptable									Totally Acceptable

13. Positive behavior(s) not included that you found important in the last month
 Behavior: _____

Frequency:	0	1	2	3	4	5	6	7	8	9
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Times per:	Day	Week	Month
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How acceptable is it to you that your partner _____ at this frequency in the past month?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Totally Unacceptable					Totally Acceptable				

Partner Negative Behaviors

14. In the past month, my partner was critical of me (e.g., blamed me for problems, put down what I did, made accusations about me)

Frequency:	0	1	2	3	4	5	6	7	8	9
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Times per:	Day	Week	Month
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How acceptable is it to you that your partner was critical of you at this frequency in the past month?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Totally Unacceptable					Totally Acceptable				

15. In the past month, my partner was not responsive to me (e.g., didn't listen when I tried to tell him/her something, ignored my needs for attention, spent too much time by him/her self or with his/her friends)

Frequency:	0	1	2	3	4	5	6	7	8	9
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Times per:	Day	Week	Month
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How acceptable is it to you that your partner was not responsive to you at this frequency in the past month?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Totally Unacceptable					Totally Acceptable				

22. In the past month, my partner invaded my privacy (e.g., opened my mail, listened in on my conversations with friends or family)

Frequency: 0 1 2 3 4 5 6 7 8 9

Times per: Day Week Month

How acceptable is it to you that your partner invaded your privacy at this frequency in the past month?

 Totally Totally
 Unacceptable Acceptable

23. In the past month, my partner engaged in addictive behavior (such as smoking, using drugs, drinking alcohol, etc.) that bothered me. NOTE: Please include what the behavior was _____.

Frequency: 0 1 2 3 4 5 6 7 8 9

Times per: Day Week Month

How acceptable is it to you that your partner engaged in this addictive behavior at this frequency in the past month?

 Totally Totally
 Unacceptable Acceptable

24. Negative behavior(s) not included that you found important in the last month.
Behavior: _____

Frequency: 0 1 2 3 4 5 6 7 8 9

Times per: Day Week Month

How acceptable is it to you that your partner _____ at this frequency in the past month?

 Totally Totally
 Unacceptable Acceptable

Items of Most Concern to You:

Out of the behaviors you rated on this questionnaire, what are the 5 behaviors (positive or negative) that were of most concern to you that troubled you the most in the last month? For your convenience, all the behaviors included in this questionnaire are listed below. For example, if item 14 was of most concern, you would write the number 14, then indicate the issue was criticism (see example below). PLEASE DO NOT put more than one item on each line, and please do your best to chose 5 items as requested

EXAMPLE:

Item of Most Concern: Item # on this questionnaire 14 Item Topic critical of me

WHAT IS YOUR:

Item of Most Concern: Item # on this questionnaire _____ Item Topic _____

Item of 2nd Most Concern: Item # on this questionnaire _____ Item Topic _____

Item of 3rd Most Concern: Item # on this questionnaire _____ Item Topic _____

Item of 4th Most Concern: Item # on this questionnaire _____ Item Topic _____

Item of 5th Most Concern: Item # on this questionnaire _____ Item Topic _____

POSITIVE BEHAVIORS:

- Item #1. Physical affection
- Item #2 Verbal affection
- Item #3 Housework
- Item #4 Child care
- Item #5 Confided in me
- Item #6 Sexual activity
- Item #7 Supportive of me
- Item #8 Did social activities with me
- Item #9 Socialized with my family or friends
- Item #10 Discussed problems in our relationship
- Item #11 Showed consideration for me
- Item #12 Participated in financial responsibilities
- Item #13 Other positive behavior not listed
(Note: to include this here, you must have rated frequency and acceptability of this item.)

NEGATIVE BEHAVIORS:

- Item #14 Critical of me
- Item #15 Not responsive to me
- Item #16 Dishonest with me
- Item #17 Inappropriate with members of the opposite sex
- Item #18 Did not follow through with agreements
- Item #19 Verbally abusive
- Item #20 Physically abusive
- Item #21 Controlling and bossy
- Item #22 Invaded my privacy
- Item #23 Addictive behavior
- Item #24 Other positive behavior not listed
(Note: to include this here, you must have rated frequency and acceptability of this item.)

APPENDIX E

Behavioral Couple Therapy Manual

APPENDIX E

Behavioral Couple Therapy Manual

Behavioral Couple Therapy Rating Manual

4/4/94

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Introduction to Raters

The purpose of this study is to describe as accurately as possible what the therapist does during the sessions of couple therapy you will be coding. Because many of the interventions described in this manual could be used in both the therapies being compared, it is important that you listen and code each item carefully, based on what you actually hear rather than based on your guess about the type of therapy. Here are a few guidelines (adapted from the CSPRS Raters Manual) to help you rate the sessions.

Rate Therapist Behavior

All items are designed to measure therapist behavior. It is important to distinguish the therapist's behavior from the client's behavior in response to the therapist. The rater should attempt to rate the therapist behavior, not the client response to that behavior. In rating therapist behavior, the rater should consider what the therapist attempted to do, not whether those attempts met with success or failure.

Rate Extensiveness, Not Quality

The items are designed to measure the extent to which the therapists' engage in the behaviors being measured, rather than the quality with which those behaviors are performed. Although extensiveness is not totally independent of the quality of therapist behavior, the rater should not consider the quality of the therapist behavior per se when rating the items.

Frequency versus Intensity

Most of the items require the rater to rate how extensively (or thoroughly) the therapist behavior occurred. In order to determine the extent to which a therapist behavior occurred the rater must consider BOTH the frequency with which that behavior occurred during the session and the intensity with which that behavior was engaged in when it did occur. (Intensity means the therapist's concentration of effort or focus on the intervention.)

Items vary with regard to how relevant frequency and intensity are in determining how that item should be rated and there are no fixed rules for determining the importance of each concept. The relative weighing of these two concepts depends not only on which item is being rated, but also on which specific techniques the therapist uses to accomplish the strategy or goal stated in the item. For example, Instructing to Fake Negative Behavior at Home is an item for which intensity is more relevant than frequency.

This intervention may take comparatively little time within the session; however, as long as it is discussed directly with the couple it should receive a high rating. The less directly it is discussed the lower the rating it should be. On the other hand, Ordinary Conversation is an example of an item whose rating is based entirely on frequency. The more the therapist engages in ordinary conversation, the higher the rating should be.

There are no fixed rules for determining the equivalence of doing something intensively for a short period of time versus doing something not very intensively for a long period of time. Because the rules for combining frequency and intensity would be very complex and might not always lead to valid ratings, we have left it up to the rater to appropriately weight these concepts when rating items.

Avoid Haloed Ratings

These items were designed for the purpose of describing therapist's behavior in the session. In order to use the scale correctly, it is essential that the rater rates what she/he hears, NOT what she/he thinks OUGHT to have occurred. The rater must be sure to apply the same standards for rating an item regardless of:

- 1) what type of therapy the rater thinks she/he is rating;
- 2) what other behaviors the therapist engaged in during the session;
- 3) what ratings were given to other items;
- 4) how skilled the rater believes the therapist to be in a particular modality;
- 5) how much the rater likes the therapist;
- 6) whether the rater thinks the behavior being rated is a good thing to do or a bad thing to do.

Rating Conjunctive Relationships

Instances of AND and OR which are particularly important to note have been capitalized. When two aspects of a behavior specified in an item are joined by AND, both must be present in order for the item to be rated highly. When two aspects are joined by OR, the item can be rated highly if either aspect is present.

Use of Guidelines

The descriptions and definitions of items in this manual are intended to be guidelines for use in rating. In some cases, there are specific rules, which the rater should use in assigning a particular rating to an item. These rules are referenced in the scale as “/ /” and are clearly noted in the Rater's Manual as NOTES. In most cases, however, this manual contains only guidelines. We expect the rater to exercise her/his judgement in applying these guidelines as well as in rating situations for which the guidelines do not apply.

Use of Examples

Whenever possible, examples have been included to illustrate how to rate therapist behavior. These examples, however, are only guidelines for how to rate an item. Often the example will only state that therapist behavior similar to the example merits a rating greater than a “1”. This is because the examples are of brief interchanges whereas the rater must consider the entire session when rating an item. The examples are a better guide to the kinds of behaviors and the intensity with which they should occur, than they are to the frequency with which behaviors should occur.

The manual includes reference to “low”, “medium” and “high” ratings in discussions of how examples should be rated. Because the rater must consider the entire session and not just a discrete incident or period of time in deciding the exact rating, these suggested ratings should not be considered fixed. In general, however, a low rating corresponds to 2,

medium rating to 3 or 4, and high rating to 5. The manual explicitly states when the rater should assign a rating of 1. A low rating does not refer to a 1.

Making Distinctions

Because the items vary in terms of breadth of coverage, the same therapist behaviors which are appropriately rated in one item, may also be rated in another item.

Conversely, the rater is often required to make fine distinctions between therapist behaviors which are similar yet should be rated distinctly. Some items measure therapist behaviors which are similar and which may covary, but yet are distinct. The rater should be careful to rate them distinctly (i.e., in rating each item, the rater should consider the extent to which the behavior specified in that item occurred and should not consider other similar behaviors).

When possible, similar items have been placed near one another to help the rater make these distinctions. The rater should bear in mind the subtle differences between some items, and not use the same exact behavior to substantiate ratings given to different items unless it is appropriate to do so.

The Raters Manual also contains an “Important Distinctions” section within the entry for some items. This section contains information regarding how the item is similar to and different from other items. These “Important Distinctions” are not the only important similarities or differences that need to be attended to- don’t rely on “Important Distinction” sections to point out all of the important similarities and differences which exist.

Specific Instances Required for Rating

In order to give a rating greater than a “1”, the rater must hear a specific example of the therapist behavior being rated. The rater should be careful not to rate behavior as having occurred if she/he thinks it probably occurred but cannot think of a specific example.

Substantiating Ratings

The starting point for rating each item in the scale is 1, “not at all”. Give a rating higher than a 1 only if there is an example of the therapist behavior specified in the item. This is particularly difficult to do when rating the facilitative conditions items where the rater may be tempted to assign an average rating unless the therapist’s behavior was remarkable either by its absence or abundance. DO NOT DO THIS. The rater must be able to substantiate the rating she/he assigns to every item.

In particular, a high rating for facilitative items should be reserved for instances in which the therapist makes verbal statements that communicate rapport, warmth, etc. For example, a session characterized by frequent therapist statements such as, *“I really appreciate the risks you both have been willing to take to talk about such a sensitive topic with me,”* would receive a higher rating of rapport than a session in which the rapport is evidenced only through non-verbal actions such as the session seeming to flow smoothly without any obvious rifts. In other words, raters should substantiate ratings for facilitative items with verbal statements rather than solely non-verbal indications of facilitative conditions.

Overlap between Current versus Prior Sessions

Often an issue that was discussed in an earlier session is implicitly or explicitly referred to in the session being rated. For example, the client may seem to know what the therapist means when referring to communication training (because the couple must have learned it in a previous session). However, if communication training is mentioned only passing without the therapist conducting communication training in the current session, communication training should not be rated. Discussions, which took place in an earlier session, should not be considered in determining a rating given to the current session.

Instructions to Raters

1. RATE EVERY ITEM.
2. READ CRITERIA FOR ITEMS EACH TIME THAT THEY ARE RATED.
3. ATTEND TO MANUAL NOTES.
4. LISTEN BEFORE RATING.
5. TAKE NOTES.
6. FILL OUT CODE SHEETS CLEARLY AND CORRECTLY.

NOTE: There will be some therapist behavior that is not described by any item in this manual. One common example of this are seeking questions by the therapist: If the couple came in having had a fight during the week and the therapist simply asked, "*What happened?*" that statement need not be coded. Typically, the therapist will follow-up information seeking questions with interventions that you will be able to code under items in the manual.

1. Setting and Following Agenda.

Therapist worked with the clients to formulate and follow a specific agenda for the session.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Setting an agenda may include generating items to be discussed, choosing which of the items will be discussed, determining the order in which items are discussed, and allotting time to be spent on discussing each item.

Following the agenda includes therapist comments that remind the couple of the agenda and keep the discussion focused in order to cover items on the agenda. Sometimes the agenda must be revised and such therapist comments should also be rated here.

There are two aspects to consider when rating this item: 1) did the therapist work with the clients to set a specific agenda for the session? 2) did the therapist work with the clients to follow the agenda during the session?

2. Ordinary Conversation.

The therapist talked with the client about topics that seemed more likely ordinary conversation than therapy AND that cannot be classified under any other item.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

For example, the client and therapist may have talked about the weather, some recent news event, movies or a book, some place that they all have visited, etc., but in no way does the therapist tie the discussion topic to the client’s feelings, thoughts, or actions, currently or in the past. This item should not be rated higher than 1 unless the therapist in no way uses the conversation for assessment or intervention. Before rating this item, the rater should thoroughly check to rule out other items that might better describe the client and therapist’s interactions.

3. Assessing Collaborative Set.

Therapist asked questions in order to determine the extent to which each partner viewed himself or herself as the cause of some of the problems in the relationship and was willing to assume responsibility to make changes in his or her behavior to improve the relationship.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Important Distinction. This item differs from Item #4 Inducing Collaborative Set. In Inducing Collaborative Set, the therapist tries to get partners to act collaboratively despite how they feel. In Assessing Collaborative Set, the therapist simply asks questions to determine how each person views his or her role in causing problems.

4. Inducing Collaborative Set.

Therapist actively encouraged partners to work together collaboratively (i.e., changing his/her own behavior to improve the relationship without waiting for the other to change first), and/or reinforced positive client behavior which reflects an effort to behave collaboratively.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Inducing collaborative set can include the therapist presenting a model in which both partners accept responsibility for their own actions that contribute to marital distress, and the therapist persuading the couple to act collaboratively regardless of how they feel. Induction of collaborative set may sometimes have a “preachy” or “hard sell” tone as the therapist strongly tries to persuade each partner to make changes.

Important Distinction. Item #4 Induce Collaborative Set differs from Item #3 Assess Collaborative Set. The crucial aspect of Induce Collaborative Set is that the therapist actively asks the couple to adopt a particular orientation to therapy (focus on own role in creating problems and on changes he or she can independently make to improve the relationship). Whereas for Assess Collaborative Set, the therapist does not ask the couple

to adopt a collaborative set but rather determines the extent to which the couple is or is not already collaborative.

Note: A rating of 4 or 5 should be reserved for when the therapist is actively persuading the couple to adopt a collaborative set, rather than solely presenting the model.

5. Behavior Exchange.

Therapist initiated and/or facilitated discussion of things each partner could independently do to improve spouse's satisfaction with the relationship.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

The therapist encouraged partners to make changes in order to increase marital satisfaction by:

- 1) generating lists of behaviors likely to please the spouse, OR
- 2) discussing hypothetical attempts to increase partners' marital satisfaction, OR
- 3) discussing past efforts to promote marital satisfaction through increases in pleasing behavior, OR
- 4) giving direct advice or suggestions about changes either partner should make to increase the other's satisfaction, OR
- 5) teaching parenting skills (e.g., how to get your kid to go to bed, or time out procedures).

Important Distinctions. When the therapist suggests or advises one or both partners to make changes in order to increase marital satisfaction AND the therapist does not make these suggestions in the context of formal problem solving, the therapist's behaviors should be rated as Item # Behavior Exchange. In other words, when the therapist helped the couple resolve some problem or difficulty by asking questions, proposing alternatives, etc., without using a specific format, this is rated as Item #5 Behavior Exchange rather than Item #9 Problem Solving.

6. Praising Change.

Therapist praised the couple's efforts at making changes by summarizing what worked, commenting on how hard they are working, how differently the interaction went because of their hard work, etc.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

7. Sex Therapy.

Therapist helped the couple improve sexual dysfunctions or dissatisfactions (e.g., used techniques such as sensate focus).

1	2	3	4	5
---	---	---	---	---

not at all some moderately considerably extensively

Therapist helped the couple work on sexual problems: sexual dysfunctions (i.e., impotence, premature ejaculation, orgasmic dysfunction) and/or sexual dissatisfaction (e.g., different preferences regarding sexual activity or frequency, sexual boredom). The therapist may have developed activities designed to reduce fear of failure or pressure to engage in sexual activity. For example, the therapist may have used specific sex therapy techniques such as sensate focus (mutual, non-goal-oriented sensual interaction between the partners).

Companionship.

Therapist initiated/facilitated discussion of enjoyable activities that the couple could or has participated in together.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

8. Problem Solving.

Therapist taught or initiated practice in using a specific format for solving interpersonal conflicts.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

The problem solving format includes defining the problem, brainstorming possible solutions, discussing the costs and benefits of various solutions, and coming to an explicit agreement. The therapist's teaching role involves didactic instruction, behavior rehearsal, and providing feedback.

9. Problems as Differences.

Therapist reformulated the problem either as deriving from a difference between the partners, OR as a vicious cycle resulting from each partner's attempt to solve the problem that their differences create.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

The therapist pointed out how each one's behavior is reasonable and understandable given its place in the vicious cycle. A session could receive a rating of up to 5 if the therapist discussed problems either in terms of deriving from a difference between the couple, or as a vicious cycle that results from efforts to solve the problem; the therapist does not have to do both in order to receive a high rating.

Important Distinction. Item #10 Problems as Differences may occur with Item #11 Reasons for Partner Differences. The important aspect for Item #10 Problems as Differences is that the therapist emphasizes that the couple's problem is a result of how they ineffectively handle their differences as opposed to emphasizing the reasons for those differences. Item #11 Reasons for Partner Differences, however, should be rated when the therapist helps the couple understand the reasons for the differences, not the reasons for the problem.

10. Reasons for Partner Differences.

Therapist explored reasons why partners might differ regarding preferences for intimacy, time alone, need for reassurance, ways of showing affection, etc.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

These reasons should involve family history, factors in the current environment, or culture (sex roles, ethnic differences, or religious differences).

11. Cognitive Interventions.

The therapist led the couple to examine evidence for interpretations of or attributions about each other's behavior or to examine whether expectations about each other or marriage were reasonable.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

The therapist challenged, through Socratic questioning, the logic or reasonableness of the client's interpretations, attributions, or expectations of each other. In the following example, the wife was complaining that the husband had not taken initiative nor followed through with helping one of their children with a school assignment. She attributes his inaction to a lack of interest in the children.

T: Mike, if it isn't just a lack of interest, as she is interpreting it, what is it?

H: No, I am interested. For example, I've been appalled at how little they know about what is happening in the world and I've been trying to read them some things from the newspaper or talk over things I hear on the news. It's just that assignment that he had to do was just not something I felt, I just felt incompetent.

T: So Gloria, I want to go back to your initial mis-guess about what's going on with him about why he doesn't get engaged more. Your original thought was, "He just doesn't care about the kids. He doesn't care about what is going on with them in school." And Mike just said that no I am interested and I have evidence that I am interested: I've been trying to think about how to increase their exposure to current events. If you had that different understanding, how would that make things different for you? How might this feel different to you?

13. Genogram.

Therapist asked each partner about their families of origin to create a structural diagram showing how patterns are transmitted intergenerationally and how past events such as death, illness, great success or immigration have influenced current patterns.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

14. **Reframing.**

The therapist reinterpreted one partner's negative behavior in a more positive light.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

For example (J & M, 1979, p. 144), "In the following excerpt, the couple is discussing the husband's tendency to conceal certain things from his wife; here they are discussing a bounced check which the husband intercepted before the wife discovered it.

W: You can't accept responsibility for your behavior. Whenever you do something wrong, you lie, deceive me. I can't stand your dishonesty.

T: It seems like her approval is very important to you (to husband). You care so much about what she thinks that you can't get yourself to tell her when you screw something up.

Here the therapist chooses to interpret the husband's behavior as indicating that he cares very much about his wife's opinion of him, a much more positive, and not any less accurate, outlook than the wife's perspective which attributes the husband's behavior to the trait of "dishonesty".

Important Distinction. Reframing should be rated only when the therapist reinterprets behavior, not emotions. If the therapist relabels emotions in a more positive light, that should be rated under Item #15 Soft Disclosures.

15. **Soft Disclosures.**

When clients were blaming, hostile, contemptuous (or expressing other strongly negative emotion), the therapist solicited partner disclosure of "soft" feelings and thoughts (e.g., fear, sadness, insecurity) and/or reinterpreted hard emotions in terms of their underlying softer emotions.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

The therapist attempted to heighten the client's expression of her/his softer emotions or thoughts instead of the harder emotions expressed when attacking or blaming. To do this, the therapist may have solicited partner disclosure by helping the client to recognize and express softer thoughts or feelings that:

- 1) the client is unaware of; OR
- 2) the client is aware of but not expressing; OR
- 3) the client is expressing nonverbally but not verbally.

The therapist may either say what the client is feeling for the client or encourage the client to voice the softer emotions him or herself; either therapist behavior should be coded here.

NOTE: This item should not be rated higher than a 3 unless the therapist paid particular attention to helping the client express "soft" emotions. To give a rating higher than a 3 the therapist must not only help the client express thoughts and feelings, but, in particular,

help the spouse express vulnerability, sadness, disappointment, etc., likely to draw the couple together.

Important Distinction.

Soft Disclosure can be confused with two other items, Item #14 Reframing and Item #16 Communication Training. The important distinction between reframing and soft disclosure is the targeted behavior that is relabeled in a more positive light. Rate soft disclosure when the therapist relabels hard emotions in terms of their more primary softer emotions. Rate Item # 14 reframing when the therapist relabels overt behavior in a more positive light.

Soft disclosure should also be discriminated from Item #16 Communication Training. Although the therapist using communication training may ask the couple to talk about feelings, the therapist uses a specific format in order to increase the couple’s skill in communicating; whereas in soft disclosure the therapist does not use a specific format, but instead seeks to articulate the softer emotions likely to draw the couple together.

16. Communication Training.

Therapist taught or initiated practice of active listening or expressive communication skills.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Communication training involves didactic instruction (e.g., modeling use of a specific format), behavior, rehearsal, and feedback from the therapist. Feedback is the provision of information to a couple regarding some aspect of their interaction; modeling (coaching) is instructing or demonstrating alternative responses; behavioral rehearsal is practice of new communication skills. Communication training may target any of the following: helping partners to listen more effectively and demonstrate understanding of each other; validating each other; teaching how to express positive and negative feelings; teaching how to express caring, appreciation, affection, and how to give compliments and praise; or teaching assertiveness skills. The essential element of communication training is that it is done in a teaching, didactic manner. The therapist’s intervention need not be formal, but should definitely include feedback and rehearsal in order to be coded as communication training.

Communication training can occur in conjunction with other interventions. For example, while having the couple discuss the outcome of BE homework, the therapist may instruct and give feedback about the way partners describe their feelings about what the other did to please them. Or the therapist may comment during problem-solving training, *“Joe, when you repeatedly interrupt Mary as she tries to paraphrase what she heard your issue to be, it seems to be de-railing her. Try to wait until she is completely finished before you tell her what she isn’t understanding about what you said.”* In these examples, communication training should be rated in addition to the other interventions (BE, Homework review, Problem-Solving Training). If the therapist asked the couple to practice

communication skills at home, this should be rated both as communication training and as homework assigned.

17. Talking about an Interaction Theme as an “It”.

Therapist engaged partners in a general discussion of an interaction theme or issue without a focus on what could be done to change it, and without explicitly trying to teach expressive communication skills.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Therapist helped partners talk about the problem as something they share, rather than something that one does to the other. Said differently, the therapist tries to develop a descriptive rather than blaming account of the couple’s troubling interaction pattern. The therapist may do this in a variety of ways. The therapist may have helped each partner elaborate and articulate his/her particular feelings, thoughts, and actions in the theme. The therapist may have helped the couple identify the mutual traps. Humor or “short hand” labels to describe an interaction sequence may be used in order to help the couple gain a different perspective. These discussions could, but do not necessarily, involve:

- a) upcoming events, where the event is relevant to the interaction theme; or
- b) recent incidents, where a recent positive or negative incident was relevant to an interaction theme.

Important Distinction. When an interaction pattern is defined as the problem to be solved within the problem solving format, the therapist’s behavior should be rated under Item #9 Problem Solving rather than Item #17 Talking about an Interaction Theme as an “It”.

Similarly, when the therapist focuses on “reciprocal causation”, that is how what each does is in part caused by the other, but also focuses discussion on what partners can do to change this interaction pattern, this should not be coded as Interaction Theme as an “It”. Instead, when the therapist identifies reciprocal causation and asks the couple to consider changing, you should consider whether the therapist’s intervention is more appropriately rated as items Inducing Collaborative Set, Behavior Exchange, or Communication Training. For example, if the therapist said, “*when he does x, you do y. As soon as you do y, he does more of x. I want you both to take a minute to think about what you should do to make this go differently*”, and then the therapist went on to help each identify ways to change, this would be coded as Inducing Collaborative Set (focus on each changing own behavior in a slightly preachy “should” way) and as Behavior Exchange (changes to improve the other’s satisfaction).

18. Circular Questioning.

Therapist invited client(s) to describe the partner’s relationship with a third family member.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Rather than (or in addition to) asking the client directly about a conflict he or she experiences with a family member, the therapist invited the spouse to describe what he or she has observed. For example, the therapist might ask the husband, *“How does your mother-in-law see this conflict between your wife and your son? When your wife disciplines your son, what does her mother do? How does your son then respond to his grandmother?”*

19. Preparing for Slip-ups and Lapses.

Even during success with change efforts, therapist alerted the couple to the likelihood that “slip-ups” or “lapses” will occur.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

For this item to be rated highly, the therapist must have communicated that the couple cannot count on change by, for example, helping the couple prepare for the lack of change or discussing how the couple can have a good relationship while the problem occurs and as they try to recover from a slip-up. In other words, high ratings should be reserved for therapist interventions that clearly propose acceptance of lack of change and coping with lack of change.

It’s important to note that preparing for slip-ups and lapses should only be rated when the therapist intervention is future oriented or is a reminder of having predicted some problem would occur, rather than solely providing a rationale for change/progress being unsteady as a way to control damage after a slip-up.

20. Positive Features of Negative Behavior.

Therapist discussed or engaged couple in a discussion of the positive features of one or both partner’s negative behavior.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Therapist highlighted how what one or both partner’s view as negative actually serves an important use in the relationship. For example, the therapist might say, *“You, Mr. Brown, like to spend money and you, Mrs. Brown, like to save money. Even though this gives rise to a lot of conflict, your problems would be even worse if you were both the same; in your old age you would either be in debt from spending beyond your means or have savings but not have enjoyed yourselves. There is a real benefit of having both qualities in a marriage.”*

21. Restraint of Change (and Other Strategic Interventions).

Therapist suggested that couple should NOT change because change might be harmful or have a negative impact. Therapist may appear to be arguing against what is a “positive” change or to be playing devil’s advocate.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Strategic interventions are sometimes used in the context of client resistance to change: the therapist intervenes to create some contrasting position that pushes the client toward change. The therapist may instruct the couple not to change some troubling behavior with the intention of freeing the couple TO change.

22. In-session Rehearsal of Negative Behavior.

Therapist attempted to increase one or both spouse’s ability to tolerate the other’s upsetting behavior.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Therapist requested one member of the couple to role-play negative behavior in the session as a means of discovering feelings, thoughts, and actions as well as partner’s reactions.

23. Instructing Couple to Fake Negative Behavior at Home.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Therapist asked one member of the couple to fake some negative behavior during the coming week by doing the negative behavior when they don’t really feel it. Therapist explained the purpose of such faking to both partners.

24. Self-care.

Therapist encouraged couple to explore self-care possibilities, particularly, but not exclusively, those he or she can use when the partner does engage in negative behavior.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

25. Explicit Guidance.

The therapist directed or guided the session in an explicit way

1	2	3	4	5
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not at all some moderately considerably extensively

The rater should not rate how explicit the guidance was on any particular occasion. Raters should consider the extent to which the therapist explicitly controlled the direction of the session. The therapist might accomplish this by initiating a significant change in content or shift in focus of the session or by maintaining the focus on topics which she/he wants to discuss. If no guidance was provided OR if the guidance that was provided was not explicit, this item should be rated 1.

26. Homework Assigned.

Therapist developed or helped the couple develop homework.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Homework is a specific assignment which the client is to engage in (but not necessarily complete) before the next session. Rate this item low if the therapist off-handedly suggested, in order to bring the discussion to an end, that the clients engage in some behavior between sessions. Rate low to medium if the therapist asked the couple to do something between sessions but did not attempt to make the assignment more specific. Do not rate this item higher than a 4 unless the therapist helps the couple anticipate and resolve difficulties they might have in performing a homework assignment.

27. Homework reviewed.

Therapist paid attention to homework previously assigned to the couple.

1	2	3	4	5
not at all	some	moderately	considerably	extensively

Homework refers to one or more specific assignments given by the therapist for the couple to complete between sessions. A high rating should be given only if the therapist attempted to use the couple's experiences with the homework as a basis for further discussion in the session.

Regardless of whether the clients completed the homework, the therapist can use the clients' experiences with the assignment as a basis for discussion (e.g., "*Were you able to attempt the homework? If not, what happened to prevent you from trying it?*"). In other words, this item should be rated independently of whether the couple completed or even attempted the homework; a rating of up to 5 can be given in such cases.

28. Generalization and Maintenance.

Therapist fostered the couples' ability to continue to apply skills or ideas learned in therapy to improve the relationship when problems arise in the future.

1 2 3 4 5
not at all some moderately considerably extensively

The therapist initiated discussion of how what the couple has learned in therapy can be continued outside the session or after therapy has stopped. A high rating should be given when the therapist thoroughly plans how the couple can continue to use what they have learned in therapy outside the session or after therapy has ended. For example, the therapist may introduce the idea of state of the relationship meetings in which the couple agree to meet at a specific time to function as their own therapist after therapy.

Important Distinction. Item #28 Generalization and Maintenance is different from Item #19 Preparing for Slip-ups and Lapses in that Generalization and Maintenance has to do with how the couple will maintain change, whereas Slip-ups and Lapses the focus is on accepting a lack of change.

APPENDIX F

Acceptance Promoting and Interfering Interaction Rating System

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Acceptance Promoting and Interfering Interaction Rating System

APPENDIX D

Acceptance Promoting and Interfering Interaction Rating System

Revised for Future Use

Laura D. Wiedeman & Kathleen A. Eldridge

Pepperdine University

General Instructions

The Acceptance Promotion and Interference Interaction Rating System (APIIRS) consists of five categories of acceptance promoting interactions that are used to rate dyadic couple behavior during therapy sessions. These categories are based on the types of couple interactions that may directly serve to enhance partner acceptance (e.g., validating the perspective of one's spouse) and those behaviors that are believed to harm the potential for acceptance (e.g., criticism). Through rating the presence and absence of these interaction styles, a comprehensive depiction of the complex dynamics that occur during couple therapy becomes possible.

Each category of acceptance promoting interactions is rated on a scale of one to nine after the rater has observed the entire selected segment of therapy. The nine-point scale is anchored at one end by "None" (or not at all) and at the other end by "A lot." The rating is based on two main judgments regarding the quantity and quality of interactions that were observed. The *quantity* of the interactions refers to the frequency with which the couple displays the behaviors or attributes in question, relative to other spouses in therapy. The *quality* of the interactions relates to the intensity or depth of the couple's involvement in the interaction, relative to other spouses in therapy. This combined appreciation of both quantity and quality is intended to address the variability

with which couples may engage in these acceptance promoting interactions. For example, acceptance promoting behaviors or attributes may be displayed frequently but with minimal depth, or infrequently but in substantial depth when they do occur.

In order to make accurate judgments about the quantity and quality of acceptance promoting interactions, raters will need to develop a “nomothetic” sense of what is typical for spouses in these kinds of situations. This sense will be developed during a training period when raters practice using the coding system with a series of tapes from couples in therapy. Second, the rater will need to develop “idiographic” knowledge of the particular couple’s differences and pattern of interaction surrounding conflict. This will be gained through watching an initial therapy session in which the therapist and couple collaboratively discuss the couple’s main difference(s), interaction pattern(s), and emotional experiences.

As a rater’s clinical understanding of a couples’ interaction patterns may develop over time, it may be important to re-watch significant aspects of prior sessions observed for each couple to ensure accurate coding of the type of interaction and of the intensity of an interaction. For example, in a couple for whom expressing distress is a vulnerable act (which is often the case for partner(s) with a tendency to withdraw in the face of conflict), the expression of anger can be a vulnerable act; a novice rater may initially misconstrue the voicing of anger as something other than vulnerability, but when re-watching the interaction may see a lower intensity of vulnerability present in the interaction. Raters are also instructed that if, while viewing the tape, raters miss or do not understand what occurs, they should immediately stop the tape and replay that portion of the tape. Raters should take notes while viewing the tape, particularly related to the

initiating and responding partner, and the type of initiation that occurs. After viewing the entire session, raters should evaluate whether they have enough information to make ratings on all of the categories. It is recommended that raters make note of segments in which multiple acceptance promoting and/or interfering interactions were coded and review those selections once more.

The rating categories used during the coding are defined in the subsequent section. It is critical to note that they are not mutually exclusive; any behavior or reaction by a spouse might be an exemplar of more than one item. Due to the complex nature of dyadic interactions, the best way to comprehensively depict what is observed often requires the use of multiple codes. Within each rating category, specific types of dyadic interactions are described in order to help raters recognize these interactions and complete an overall rating for each category after watching the entire therapy session. While the subcategories of each code are intended to provide examples of what interactions constitute each code, the final rating is made based on the overall category and *not* the specific subcategories. It is important to note that in addition to coding the in-session interaction that spouses engage in, in-session spousal reports of acceptance promoting interactions that occur *outside* of the therapy session should also be coded (however are often coded with a lower intensity level).

Raters should focus primarily on the interaction between both spouses. Particular attention should be paid to which partner is engaging in a particular behavior and which partner is responding to the particular behavior. Raters will provide a score for each type of acceptance promoting interaction that the husband initiates and that the wife initiates; therefore, the initiating and responding partner are noted in the coding. In many

situations, determining which partner is initiating and which is responding can be a difficult task. Since each part of the interactional sequence could be considered a reaction to the previous behavior, there are likely to be many shifts in who is initiating and who is responding. However, as the coding is focused on rating the occurrence and intensity of specific interactions throughout the entire session, not the moment-by-moment sequences of interaction, raters will need to develop an overall sense of the various types of interactional sequences that occur in order to capture the complexity of what is observed. For example, consider the following interaction:

Wife [*looking at therapist*]: I do think he is a good dad and he is a good provider and the kids love him to death. [*Husband is looking down without any apparent physical or verbal reaction to Wife's statement*]

Therapist: And I think that's important that you say that and I think it's important that you hear that, [*Husband*].

Wife [*turns to Husband*]: Have you never heard me say that before?

Husband: First time [*laughs, looks at Wife and then looks down*].

Wife [*looking at Husband*]: Do you want to take an oath on that?

Therapist: But what I'm thinking is that it's important for you to hear that tonight.

Husband: Mm-hmm.

Therapist: I'm sure it's not the first time you have heard that.

Husband: No, it is important to hear that tonight, because in the midst of an argument, it is nice to hear a diffusing statement like that. [*Husband turns to look at Wife*] But I'm not giving you one! [*laughs*].

Wife: *[looks down, laughs, raises her eyebrows and fidgets with paper in her hand]*

Husband: No, *[Wife]* is a great mom, she is a great mom, our kids-

Wife: *[interrupts Husband and proceeds to talk about how Husband was instigating a fight at dinner]*

This sequence demonstrates the complexity of the interaction patterns coded with APIIRS. Four codes can be applied to represent this interactional sequence.

- (1) Wife Validation + Husband No Response *[Occurs when Wife compliments Husband's parenting, and Husband does not make any apparent verbal or behavioral shift in reaction]*
- (2) Wife Validation + Husband Compassion / Appreciation / Reassurance / Apology *[Occurs after Wife compliments Husband's parenting, when Husband (after therapist's prompting) says that it is nice to hear a diffusing statement like that]*
- (3) Husband Aversive Partner Behavior (being sarcastic) + Wife Withdrawal and/or Decrease in Positive Nonverbal Gestures *[Occurs when Husband jokes that he is not giving Wife a compliment in return, and Wife looks down and raises her eyebrows in response]*
- (4) Husband Validation + Wife Criticism / Attack *[Occurs when Husband starts to compliment Wife's parenting and Wife interrupts to bring up something negative Husband did recently]*

This example highlights the complexity of interactional coding. Given that this type of interactional sequence may occur multiple times throughout the session, detailed notes

and observations are necessary. Through keen observation and notes, it is possible to complete the global ratings to best represent the various initiating and responding interactions occurring throughout the observed material.

While the focus of this coding system is not on the therapist's statements or behaviors, it should be noted when a spouse engages in a significant initiating behavior (as described in the categories listed in the next section) and the therapist, not the other partner, is the one who responds. When the partner does not have an opportunity to respond because the therapist begins speaking, perhaps focusing on a different part of the spouse's statement or behavior than what is considered to be acceptance promoting, it may hinder the partner's opportunity to provide a response. Details about how to code this type of therapist involvement will be explained in the following sections.

Although the focus of the coding is on the entire session instead of a microanalytic analysis of interactions, it is essential that raters distinguish between various types of initiating and responding behaviors. Raters will need to be able to determine whether responses are positive, negative, absent, or prevented by the therapist's response. Some responses result in a difficult distinction, particularly a neutral response (within the positive response category), withdrawal and/or decrease in physical non-verbal behaviors (within the negative response category), and no response. It is imperative to remember that it is the *behavior* that is being rated, not the rater's interpretation of the individual's underlying emotional state or intent. While behavioral distinctions between neutral, no and withdrawal responses may be minimal, raters can rely on the following definitions: a *neutral* response is where the spouse seems to acknowledge and/or actively listen to what his or her partner is saying without a

significant change in physical or verbal behavior; *no* response occurs when there is no change in physical or verbal behavior during or after an initiating behavior by one's spouse, otherwise understood as a lack of behavioral acknowledgment of the initiating component of an interaction; lastly, the *withdrawal* response occurs when a decrease in positive nonverbal gestures occurs, such as the removal of eye contact. As these three responses represent three different categories of responding (positive responding, no responding, and negative responding), raters should take particular care in appropriately identifying the most representative response for the observed behaviors. In order to make these challenging distinctions, raters should be guided by consultation with research supervisors, clinical judgment, this coding manual, and the specific knowledge of the couple being studied.

To manage the multitude of data present in an entire therapy session raters are encouraged to utilize a notational system to make note of interactional sequences while coding sessions. Upon completion of viewing a session, raters should review their notes in order to select the most appropriate ranking on the global rating Likert scale of one to nine. This notation framework instructs raters to document the initiating and responding partners, the details of the interaction, any other notes or observations, the intensity level of the interaction, and any questions that result. It should be noted in particular that the assignment of an intensity level (low, low/moderate, moderate, moderate/high, and high) is determined based on the entirety of the interaction, including both the intensity of the initiating behavior as well as the responding behavior. For example, an interaction that involved a fairly intense vulnerable statement followed by reciprocal vulnerability would

generally be rated as higher in intensity than if the initiating statement were followed by a neutral response (to be defined in subsequent sections of this manual).

When determining the global Likert scale ratings, raters can rely on the intensity level ratings such that an interaction with a low intensity is considered to be about 1/3 of a point, an interaction with low/moderate intensity is considered to be about 1/2 of a point, an interaction of moderate intensity is considered to be about 1-2 points, an interaction of moderate/high intensity is considered to be about 2½ points, and an interaction of high intensity is considered to be 3 points. A total rating for a particular interaction pattern can be created through the sum of these ratings, rounding down if necessary. However, please note that these quantitative designations are not to be used rigidly; raters should review the global Likert scale ratings to ensure that they provide an adequate representation of what was observed in-session.

Description of Items

Vulnerability

The code "Vulnerability" involves the expression of vulnerable emotions, thoughts or behaviors by the initiating partner and a positive, neutral or negative reaction from the responding partner. Expressions of hurt, insecurity, sadness, tenderness, loneliness, shame, guilt, fear, needs, love or desire are soft expressions when they are shared in a vulnerable way. Behaviors such as self-disclosure, confiding, nervous humor, putting one's self down, expressing hurt, pain, disappointment or grief may also be soft expressions. Expressions of vulnerability might include anger, self-deprecating humor, and other more indirect, tentative displays of underlying insecurity. Examples might include one partner saying, "I don't know, I just have had a general feeling of

dissatisfaction the past couple weeks” or “I know this sounds pathetic...” Both of these statements include a vulnerable component related to expressing a concern out loud to one’s partner.

This code requires that the rater make a judgment about the genuineness of both the initiator and responder. When one spouse expresses his hurt in an angry, hostile, or accusatory way, he is generally much less vulnerable than a spouse who expresses his hurt in a soft and heartfelt way. When vulnerable expressions are couched in an angry tone, less vulnerability is apparent because anger serves to hide the vulnerable expression and often relates to a defensive stance in which the partner is already “armed” in case of attack. In fact, some people may feel more vulnerable when expressing anger if their normal stance is to withdraw and not express themselves, as this reveals feelings or beliefs not normally expressed. For example, a spouse may use a loud tone to say, “You made time to accompany this other woman to a stupid baseball game, but you can’t seem to make any time for me!” This statement is more likely to make the responding partner defensive or feel attacked, however may still be a vulnerable expression in that the spouse is revealing underlying feelings of rejection. If she were to express the same underlying sentiment in a softer way, such as by saying, “I just don’t feel important to you,” the responding partner might be more apt to provide a positive response instead. Thus, vulnerable statements can be both soft and hard expressions. The rater’s idiographic knowledge of each partner and their relationship will help the rater determine what behaviors and expressions put each individual in a vulnerable state within the relationship. In general, initiating behaviors that include eye contact and are directed to

the spouse are considered to be more vulnerable than those vulnerable statements that are made without eye contact and/or to the therapist.

After the initial display of vulnerability, the responding partner's reaction is critical to understand. Positive responses may include reciprocal vulnerability, conveying an emotional or intellectual understanding of the vulnerable partner's experience, validation, non-blaming clarification questions that demonstrate interest and/or compassion. These responses support the initiating partner's vulnerability, whereas negative responses are thought to create conflict and/or obstruct further vulnerable expressions. Negative partner responses include criticism, defensiveness and blame, among others.

In the situation where a partner engages in a vulnerable behavior and the therapist responds (whether or not the response is directly related to the vulnerable behavior), thus hindering the opportunity for the spouse to respond, this should be coded as vulnerability + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the partner's vulnerability removes an immediate opportunity for the spouse to directly respond. If the initiating partner's vulnerable behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in non-verbal behavior), then the vulnerability + no response code should be used. If the spouse appears to display a nonverbal behavioral response *during* the initiating component of the interaction (e.g., nods his or her head), a code should be used in conjunction with the therapist response code to best represent

what was observed (e.g., vulnerability + therapist response and vulnerability + neutral response).

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of vulnerability followed by positive or negative partner responses, or the therapist responses, that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Vulnerability + positive response:

- Vulnerability + reciprocal vulnerability (both partners sharing emotions or personal history/issues in a vulnerable way)
- Vulnerability + emotional understanding/empathy (having an emotional understanding of the perspective and experience of one's partner)
- Vulnerability + intellectual understanding (having a logical, conceptual understanding of the perspective and experience of one's partner)
- Vulnerability + validation
- Vulnerability + compassion/appreciation/reassurance/apology
- Vulnerability + use of non-belittling humor
- Vulnerability + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Vulnerability + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Vulnerability + negative response:

- Vulnerability + criticism/attack
- Vulnerability + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Vulnerability + contempt
- Vulnerability + blame/defensiveness
- Vulnerability + pressure to change
- Vulnerability + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Vulnerability + sarcastic/belittling/inappropriate humor

Vulnerability + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Vulnerability + therapist response

Non-blaming, intellectual problem discussion

The code *Non-Blaming, Intellectual Problem Discussion* involves talking about a relationship issue, such as a general pattern or theme, in a non-blaming and intellectualized manner. A partner's description of his or her own component of the interaction, his or her spouse's contribution to the interaction, and/or the combined interaction dynamics would constitute a non-blaming intellectual problem discussion. This type of discussion frequently involves relating a specific incident to the overall conceptualization of the couple's main differences, interaction patterns, and/or emotions. The key is that the discussion of the conflict, or the couple's interaction around the conflict, occurs without simultaneously experiencing the emotional reactions that are

typically involved. It is essential that the discussion be non-blaming and somewhat intellectualized in that spouses may be discussing negative emotional reactions, but they are not acting upon them. For example, if the initiating spouse says, "If he would just leave me alone when I'm upset, this would all be fine!" it indicates a blaming or accusatory tone. A non-blaming and somewhat intellectualized version of this statement might be, "If I admitted when I was upset instead of denying it, he probably would respond better and I wouldn't get so annoyed with him constantly asking me "What's wrong?" "

Another example of a non-blaming discussion could include pointing out similarities in each spouse's experience during an interaction by saying, "We were both misinterpreting each other - you were processing the information silently while I wanted to discuss it aloud." In describing the difference or pattern of interaction, partners may refer to a label (e.g. pursue-withdraw) or a humorous name. This can also take a form similar to "We were doing our thing again."

It follows that non-blaming, intellectual discussions often involve discussing relationship dynamics using words such as "we," "our" and/or "us" (e.g., "Our pattern" or "When we do this..."), suggesting a sense of togetherness and mutual responsibility for their interactional pattern. While the use of these words does not always occur during a non-blaming problem discussion, nor do they signify that a non-blaming problem discussion is definitively occurring when they are used, they are often a good indication that a non-blaming discussion might be occurring.

When the responding partner resorts to reactions such as criticism, blame, defensiveness, or withdrawal, the couple often becomes emotionally engaged in the

problem. Partners are no longer gaining an intellectual understanding of their interaction patterns, but instead may experience a rise in emotional reactivity or become fixated on a particular incident rather than discussing patterns in a more general way.

In the situation where a partner attempts to start or continue in a non-blaming, intellectual discussion and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as non-blaming, intellectual problem discussion + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the partner's non-blaming discussion removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in nonverbal behavior), then the non-blaming, intellectual problem discussion + no response code should be used. If the spouse appears to display a nonverbal behavioral response *during* the initiating component of the interaction (e.g., nods his or her head), a code should be used in conjunction with the therapist response code to best represent what was observed (e.g., non-blaming, intellectual problem discussion + therapist response and non-blaming, intellectual problem discussion + neutral response).

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of non-blaming, intellectual problem discussions followed by positive or negative responses that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Non-blaming, intellectual problem discussion + positive response:

- Non-blaming, intellectual problem discussion + non-blaming, intellectual response
- Non-blaming, intellectual problem discussion + sharing of personal information (personal history and/or issues)
- Non-blaming, intellectual problem discussion + increase in soft emotions/vulnerability
- Non-blaming, intellectual problem discussion + validation
- Non-blaming, intellectual problem discussion + use of non-belittling humor
- Non-blaming, intellectual problem discussion + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Non-blaming, intellectual problem discussion + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Non-blaming, intellectual problem discussion + negative response:

- Non-blaming, intellectual problem discussion + criticism/attack

- Non-blaming, intellectual problem discussion + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Non-blaming, intellectual problem discussion + contempt
- Non-blaming, intellectual problem discussion + blame/defensiveness
- Non-blaming, intellectual problem discussion + pressure to change
- Non-blaming, intellectual problem discussion + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Non-blaming, intellectual problem discussion + sarcastic/belittling/inappropriate humor

Non-blaming, intellectual problem discussion + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Non-blaming, intellectual problem discussion + therapist response

Validation

A spouse demonstrates validation through stating something positive about his or her partner's behavior or emotional experience, whether through a direct positive statement, compassion, empathy, encouragement, appreciation, and/or support (e.g., "It's okay to feel that way"). Validation occurs when one spouse displays understanding for his or her partner's feelings, such as expressing understanding and empathy through commenting, "I never realized how hurt you feel when I forget to call and come home late." Validation may also involve a spouse offering an apology, sympathy, empathy, to help, or normalization (e.g., "I do that too sometimes"). Other behaviors included as

validation are: offers of reassurance, admitting fault, showing caring and understanding, showing trust or acceptance of the partner, and mentioning something positive about partner's behavior (e.g., "You're a good mom").

Another way that validation might occur is through a spouse agreeing with the therapist's positive or non-blaming conceptualization of the partner's feelings, thoughts, and/or behaviors. For example, the therapist could explain, "Even though being 30 minutes late doesn't seem important to you, she experiences it as a threat of being left alone and gets scared." If the husband responds by saying, "I didn't realize she was scared, I didn't see it that way before," it indicates that he is validating the wife's perspective. Interactions that demonstrate a willingness to appreciate one's partner's feelings, thoughts, or behaviors as differences, rather than as negative qualities, are considered to be validation.

While the first aspect of validation involves a positive comment about some aspect of a partner's behavior or emotional experience, the second component of validation entails how the partner responds. Positive responses include appreciation, vulnerability or reciprocally validating comments about the initiating partner's behavior or emotions. Negative partner responses include becoming defensive, showing indifference, decreasing physical contact (e.g., moving to sit further away from partner), or blaming. For example, if the initiating partner says, "I didn't know how unappreciated you felt, I'm sorry," and the responding partner reacts by saying, "*Now* you act like you understand, but it's just because you're trying to look good in front of the therapist!" it demonstrates a defensive response.

APPENDIX G

Therapist and Consultant Post Treatment Questionnaire

APPENDIX G

Therapist and Consultant Post Treatment Questionnaire

ID _____

Date _____

Therapist and Consultant Post Treatment Questionnaire

Therapist / Consultant (circle one) # Total Sessions: _____

of Sessions observed: _____
(Consultant Only)

Major Themes in Therapy

1. Briefly describe the major issue or theme that created problems for this couple.

Please rate the extent to which each of the common themes below was a problem for this couple:

2. **Closeness/independence** (issues about the amount of closeness, contact, connection, and intimacy on the one hand and amount of autonomy, freedom, and independence on the other)

Not an Issue Major Issue
1 2 3 4 5 6 7 8 9 10

Husband / Wife wanted more closeness.

3. **Trust, Jealousy, Boundaries** (issues about what kind of contact is okay with other men and women, flirtatiousness)

Not an Issue Major Issue
1 2 3 4 5 6 7 8 9 10

Husband / Wife was jealous or did not trust the other partner

4. **Infidelity, Affairs** (either past or current affair/s, sexual or emotional)

Not an Issue Major Issue
1 2 3 4 5 6 7 8 9 10

Husband / Wife had past or current affair. (Note: may circle both. If both, Husband's / Wife's affairs are more problematic for the relationship.)

5. **Responsibility and control** (issues about who should be in charge of what areas in the relationship, who should have control, who should take responsibility, etc.)

Not an Issue										Major Issue
1	2	3	4	5	6	7	8	9	10	

Select One: Husband / Wife wanted other spouse to be more responsible

Husband / Wife wanted more control in the relationship

6. **Emotionality** (issues about whether one is under- or overreacting emotionally)

Not an Issue										Major Issue
1	2	3	4	5	6	7	8	9	10	

Husband / Wife wanted other partner to be more / less emotional

7. **Sex** (issues about desired frequency, desired activities)

Not an Issue										Major Issue
1	2	3	4	5	6	7	8	9	10	

Husband / Wife wanted more frequent or involved sexual activity

Major Patterns of Interaction

1. Briefly describe the major pattern of interaction around the major theme identified above. If the pattern has shifted over the course of therapy, describe the pattern as it existed early on in treatment.

Please rate the extent to which the following patterns below characterized the interaction around the major theme you identified above:

1. **Man demand / woman withdraw interaction**

Not a pattern										Central Pattern
1	2	3	4	5	6	7	8	9	10	

2. Woman demand / man withdraw interaction

Not a pattern
1 2 3 4 5 6 7 8 9 10
Central Pattern

3. Both partners are blaming, critical, and accusatory

Not a pattern
1 2 3 4 5 6 7 8 9 10
Central Pattern

4. Both partners are avoidant, withdrawn, and rarely discuss their issues directly

Not a pattern
1 2 3 4 5 6 7 8 9 10
Central Pattern

Major Events in Therapy

During the time the couple was in therapy, did any of the following happen?

No Yes

- 1. There was physical violence. Please describe (how often, level of violence, circumstances, perpetrator):

- 2. Husband revealed he was currently having (or just ended) an affair. (indicate type) sexual or emotional
- 3. Wife revealed she was currently having (or just ended) an affair. (indicate type) sexual or emotional
- 4. Husband revealed a past affair/s. (indicate type) single or multiple ; sexual or emotional. How long ago was most recent affair _____ .
- 5. Wife revealed a past affair/s. (indicate type) single or multiple ; sexual or emotional. How long ago was most recent affair _____ .
- 6. Husband brought up the possibility of separation or divorce.
- 7. Wife brought up the possibility of separation or divorce.
- 8. Husband left home for one or more nights because of the relationship.

- ___ ___ 9. Wife left home for one or more nights because of the relationship.
- ___ ___ 10. Couple began having sexual contact (or regular sexual contact) after a period of little or no sex before therapy and early in therapy.
- ___ ___ 11. Wife became significantly more powerful relative to husband.
- ___ ___ 12. Husband became significantly more powerful relative to wife.
- ___ ___ 13. Husband had individual sessions after feedback session (how many?). ___
- ___ ___ 14. Wife had individual sessions after feedback session (how many?). ___
- ___ ___ 15. Therapist made reference to consultation group as an intervention.
- ___ ___ 16. There was a significant "crisis" in the case (something which required extra intervention, such as telephone intervention, an emergency meeting). Please describe.
- ___ ___ 17. There was a significant breakthrough in the case (an event or intervention which turned the case around). Please describe (what happened, how did it affect them, etc.):

Additional Interventions

- ___ 1. Number of sessions devoted to sex therapy.
- ___ 2. Number of sessions devoted to parent training (not sessions dealing with conflict about the children but sessions devoted explicitly to teaching parenting skills).

Miscellaneous

- 1. Indicate which spouse is now more powerful in influencing events in the relationship.

Wife more powerful	Equal Level of Power	Husband more powerful
1 2 3 4	5 6 7	8 9 10

- 2. How likely is this couple to be together by 2 year follow-up?

Unlikely to be together	Likely to be together
1 2 3 4 5 6 7 8	9 10

3. How likely is this couple to be in the normal range of happiness by 2 year follow-up?

Unlikely to be happy
 1 2 3 4 5 6 7 8 9 10
 Lively to be happy

4. To what extent were stressful circumstances affecting the couple? These stressful circumstances were:

Not at all affecting them
 1 2 3 4 5 6 7 8 9 10
 Affecting them to a great extent

5. How connected was the wife to the therapist?

Not at all connected
 1 2 3 4 5 6 7 8 9 10
 Very connected

6. How connected was the husband to the therapist?

Not at all connected
 1 2 3 4 5 6 7 8 9 10
 Very connected

APPENDIX H

Ratings After Feedback Session

APPENDIX H

Ratings After Feedback Session

Couple ID _____
 Husband / Wife (circle one)

Date of session: _____

Ratings After the Feedback Session

You have just completed a session in which your therapist provided feedback about your relationship and outlined a treatment plan. We would like to get your impressions of this session. Please complete this form independently (without discussing it with your spouse) immediately following the session and mail this form directly to the project in the envelope provided. Your therapist will **NOT** see this form.

1. Our therapist's feedback about our relationship and the problems that brought us to counseling was

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Completely Incorrect,
Off the Mark

Half and Half

Extremely Correct,
On the Mark

2. Our therapist's description of our treatment plan struck me as

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Irrelevant to
Our Problems

Half and Half

Just what we need

3. In our therapist's feedback to us, he/she

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Sided with wife

Was even handed

Sided with husband

My therapist:	not at all	some	pretty much	very much
4. is friendly and warm.	○	○	○	○
5. seems involved.	○	○	○	○
6. seems confident.	○	○	○	○
7. seems interested.	○	○	○	○
8. seems optimistic.	○	○	○	○
9. seems alert.	○	○	○	○
10. is one whom I would recommend to another person.	○	○	○	○

APPENDIX I

Therapist Expectancy Measure

APPENDIX I

Therapist Expectancy Measure

Couple ID _____

Date of feedback session: _____

THERAPIST EXPECTANCY MEASURE

(to be completed by therapist IMMEDIATELY AFTER the feedback session)

Directions: Fill in the bubble that best represents your expectation or prediction of what will take place in therapy.

1. To what extent will the husband change his behavior to accommodate his wife's desires?

Very unlikely to change As likely to change as not Very likely to change

2. To what extent will the wife change her behavior to accommodate her husband's desires?

Very unlikely to change As likely to change as not Very likely to change

3. To what extent will the husband come to accept his wife's problematic behaviors?

Very unlikely to accept As likely to accept as not Very likely to accept

4. To what extent will the wife come to accept her husband's problematic behaviors?

Very unlikely to accept As likely to accept as not Very likely to accept

5. To what extent will this couple benefit from their therapy (i.e., greater relationship satisfaction as a result of therapy)?

Very unlikely to benefit As likely to benefit as not Very likely to benefit

APPENDIX J

Client Evaluation of Services

APPENDIX J

Client Evaluation of Services

Couple ID _____ Date _____

Husband / Wife

CLIENT EVALUATION OF SERVICES

Please help us improve our program by answering some questions about the service you have received. We are interested in your honest opinion, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Due to the sensitive nature of the feedback you are providing, your responses will remain *confidential* from your therapist. Thank you very much, we really appreciate your help.

1. How would you rate the quality of service you have received?

Poor Fair Good Excellent

2. Did you get the kind of service you wanted?

No, definitely not No, not really Yes, generally Yes, definitely

3. To what extent has our program met your needs?

None of my needs Only a few of my Most of my needs Almost all of my
have been met needs have been met have been met needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?

No, definitely not No, I don't think so Yes, I think so Yes, definitely

5. How satisfied are you with the amount of help you have received?

-
- Quite dissatisfied Indifferent or mildly dissatisfied Mostly satisfied Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

-
- No, they seemed to make things worse No, they really didn't help Yes, they helped somewhat Yes, they helped a great deal

7. In an overall, general sense, how satisfied are you with the services you have received?

-
- Quite dissatisfied Indifferent or mildly dissatisfied Mostly satisfied Very satisfied

8. If you were to seek help again, would you come back to our program?

-
- No, definitely not No, I don't think so Yes, I think so Yes, definitely

9. How helpful were the materials the therapist gave you to read about communication and conflict (e.g. book chapters, problem-solving manuals, etc.)?

They were not at all helpful

They were a little helpful

They were quite helpful

They were very helpful

10. What were the **most helpful** and **least helpful** things about the therapy?

APPENDIX K

IRB Exemption Notice

APPENDIX K

IRB Exemption Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

February 12, 2014

Jessica Stephan

Protocol #: P0114D02 **Project Title:** Processes and Mechanisms of Change in Integrative Behavioral Couple Therapy: A Case Study of One Couple with Distress over Child Rearing

Dear Ms. Stephan:

Thank you for submitting your application, *Processes and Mechanisms of Change in Integrative Behavioral Couple Therapy: A Case Study of One Couple with Distress over Child Rearing*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Eldridge have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.nihtraining.com/ohsrsite/guidelines/45cfr46.html>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

Category (2) of 45 CFR 46.101, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to “policy material” at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the



6100 Center Drive, Los Angeles, California 90045 ■ 310-568-5600

Institutional Review Board (IRB) at gpsirb@pepperdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Thema Bryant-Davis, Ph.D. Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives Mr. Brett Leach, Compliance Attorney Dr. Kathleen Eldridge, Faculty Advisor