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The Evolution and Application of an Integrated Theoretical Approach to Couple Therapy: A Case Study

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ABSTRACT

The Evolution and Application of an Integrated Theoretical

Approach to Couple Therapy: A Case Study

by

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Utah State University, 2010

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Few therapists test their assumptions about how they do therapy against what they actually do. The purpose of this study was to test how well integration is practiced within the proposed theoretical framework of one therapist. Qualitative and quantitative data were designed to answer four research questions: fidelity to the integrated model, client change, how working with the integrated model influenced ongoing sessions or cases, and change in the integrated model through the course of the study. Three couples were used as the sample; 17 sessions were coded and analyzed to answer the research questions. Results indicate that the therapist maintained fidelity to the integrated model that resulted in positive change for each couple. Using the integrated model was found to influence ongoing sessions and cases in a number of ways that also resulted in changes of the integrated model. Other findings, limitations, and clinical implications are discussed.

(138 pages)

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Mathew C. Withers

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CHAPTER I

INTRODUCTION

Problem

When family therapy was in its beginning, integration of models was considered problematic (Nichols & Schwartz, 2004). More recently, eclecticism is the most common theoretical orientation reported by therapists (Gurman, 2008). Nichols and Schwartz defined eclecticism as taking concepts from a variety of different approaches (Nichols & Schwartz, 2004). Nichols and Schwartz also argued that "eclecticism robs therapy of the intensity made possible by focusing on certain elements of experience. There may be many ways to skin a cat, but it might not be advisable to try all of them at once" (p. 348). Integration on the other hand, is specially designed to combine two or more approaches that have complementary elements (Nichols & Schwartz, 2004).

Lebow (1997) called the recent movement toward integration the revolution in couple therapy. "The major virtue of integrative approaches to couple therapy is an enhanced understanding of human behavior that enhances treatment flexibility" (Gurman, 2008, p. 383). Lebow (1987) advised therapists using an integrative approach to make a determined effort to understand their theories and to make clear how they use them. The use of an integrative approach comprised of two models that have an evidence base in couple therapy is the foundation of this study.

The integration used in this study is a multiple base or "levels of mastery"

(Fraenkel & Pinsof, 2001, p. 73) integration using Gottman method couple therapy (GMCT; Gottman, 1999) and cognitive-behavioral couple therapy (CBCT; Baucom & Epstein, 1990). The levels of mastery integration states that the therapist combines two or more approaches into one fundamental, base theory (Fraenkel & Pinsof, 2001). The assumptions for GMCT and CBCT are similar in many ways and GMCT could be viewed as stemming from CBCT because of the significant overlap in assumptions. Chapter II will present a discussion of each therapy model and the integration used in this study.

Lebow (2006) stated that we have a subjective bias as clinicians that pull on our perceptions to see what we want to see. In other words, we think we know exactly what we are doing and how much change the client has made, but our biases make it difficult for us to know for certain. "To counterbalance that pull, we need consistent methods of information gathering and consistent measures of that information" (Lebow, 2006, p. 222). In other words, research must inform a therapist's practice (Lebow, 2006). The problem is that few therapists test their assumptions about how they work against what they actually do. Having data on client change and method of treatment is a crucial part of therapy (Lebow, 2006). "We still need to see how methods work for us, determine our strengths, and develop our best method of working" (Lebow, 2006, p. 10).

Purpose of Research

The purpose of this study was to test how well integration is practiced within the

proposed theoretical framework for one therapist. "A successful integrative approach draws on existing therapies in such a way that they can be practiced coherently within one consistent theoretical framework" (Nichols & Schwartz, 2004, p. 365). This study focused on the integration of Gottman method couple therapy (Gottman, 1999) and cognitive-behavioral couple therapy (Baucom & Epstein, 1990) as conceptualized by this one therapist. The goal of the research was to find themes and practices that are most beneficial to the researcher/therapist in a therapeutic setting. The goal for this study was a systematic investigation of one therapist's approach in a case study of application to three couples by identifying how accurately the therapist practiced the integrative approach ascribed to, how each particular session influenced the next, whether a session with one couple influenced how an intervention was used with another couple, and what changed in the therapist's model of therapy through the process of conducting the study. The therapist in this study is also the author. The study used a multiple case study design with mixed quantitative and qualitative methods of analysis.

CHAPTER II

REVIEW OF LITERATURE

This chapter reviews basic assumptions, key concepts, and interventions presented by Gottman method couple therapy (Gottman, 1999) and cognitive-behavioral couple therapy (Baucom & Epstein, 1990). Each of these models of therapy bases its concepts within systems theory (Dattilio & Padesky, 1990; Gottman, 1999; von Bertalanffy, 1950). An integration of the basic assumptions, concepts, and interventions of these models will be presented as the foundation of this study as well as the implementation and application of the integration. Systems concepts evident in each model will be discussed followed by the purpose of the study.

Gottman Method Couple Therapy

Basic Assumptions and Concepts

Gottman method couple therapy is based on John Gottman's (1999) research on why marriages succeed or fail. Gottman studied the negative and positive affect and communication patterns of couples. "The basic result of these predictions is that the ratio of negativity to positivity predicts marital outcome" (Gottman, 1999, p. 40). Gottman concluded that negative affect and conflict are part of human heritage and marital therapy should not declare war on it.

Gottman (1999) then turned to how couples could communicate better when negative affect was present. He found that he could predict divorce by watching the first three minutes of an argument. He noticed that couples who used *softened startups,*

keeping affect neutral to begin disagreements, had lower divorce rates than those who started conversations about differences with what he called *harsh startups*, escalating from neutral to negative affect. Gottman believed the way a topic of disagreement is approached is critically important in predicting marital outcomes. If the topic is approached harshly, affect escalates from neutral to negative. This, in turn, begins the cycle of the *four horsemen* (defined next) and inevitably, the conversation ends on a negative tone (Gottman & Silver, 1999).

Gottman (1999) suggested that it is important to examine negative interactions. Certain negative interactions, if allowed to run rampant, are so deadly to relationships that they themselves can cause divorce. These negative interactions are labeled the *four horsemen of the apocalypse* (Gottman & Silver, 1999). The four horsemen are *criticism*, *defensiveness*, *contempt*, and *stonewalling*. "Criticism is any statement that implies that there is something globally wrong with one's partner, something that is probably a lasting aspect of the partner's character" (Gottman, 1999, p. 41). Defensiveness occurs after a partner is criticized or shown contempt. This horseman is used to defend oneself from an attack (Gottman, 1999). Contempt is the worst of the four horseman: "Contempt is any statement or nonverbal behavior that puts oneself on a higher plane than one's partner" (Gottman, 1999, p. 45). Contempt can include sarcasm, mocking, name-calling, or belligerence. Contempt can also be nonverbal, for example, eye-rolling. The final horseman is stonewalling. Stonewalling happens when the other three horsemen have been running wild, which causes one partner to withdraw from the conversation.

The four horsemen usually start with criticism and follow in order to stonewalling

(Gottman, 1999). Contempt, as the worst of the four horsemen, is the best predictor of divorce; the four horsemen alone can predict divorce with 85% accuracy, according to Gottman.

Happy couples use criticism, defensiveness, and stonewalling but the difference is they learn ways to deescalate conflict using what is called a *repair attempt* (Gottman, 1999). A repair attempt is "any statement or action—silly or otherwise—that prevents negativity from escalating out of control" (Gottman & Silver, 1999, p. 22). In other words, a repair attempt can be anything that deescalates the conflict. "[The partners] comment on the communication itself, or they support and soothe one another, or they express appreciations to soften their complaints" (Gottman, 1999, p. 48). Teaching couples how to use and detect each other's repair attempts is important in marital therapy (Gottman, 1999).

Gottman (1999) did not only look at the negative interactions in a relationship. He compared happy marriages to unhappy marriages and concluded that

> marriages that are headed for divorce or unhappy stability are characterized by greater negativity than positivity in interactive behavior and perception and by chronic levels of diffuse physiological activation and the inability to self-soothe or be soothed by one's partner. Marriages that are working well are characterized by a specific form of gentleness and kindness toward one another that involves starting a discussion of a marital issue in a softened way and accepting influence from one another. (p. 85)

Gottman also found that in happy relationships, positive interactions outweigh negative

interactions during both conflict and peaceful times.

Through his research, Gottman (1999) constructed the Sound Marital House (SMH) theory. There are two necessary staples of healthy marriages through the SMH. These are the overall level of positive affect and the ability to decrease negative affect during conflicts. The levels of the SMH, as shown in Figure 1, are very distinct. The foundation is composed of *love maps*: creating a map of the partner's intrapsychic world; a *fondness and admiration system*: the level of fondness and admiration felt toward the partner; and *turning toward versus turning away*: being aware of the partner (Gottman, 2010).

The friendship formed in the foundation leads to the next level: *positive sentiment override* (PSO; Gottman, 1999). Positive sentiment override occurs when there is sufficient positive affect in nonconflictual interactions that the partner receives a neutral message positively. The next level consists of the regulation of conflict. There are three parts to this level: (a) establishing dialogue with perpetual problems, (b) solving solvable problems, and (c) physiological soothing. This level includes the four horsemen. The next level consists of helping the couple make dreams and aspirations come true. This level is used to assist in avoiding marital gridlock. The final level of the SMH involves creating a shared meaning system, which consists of making dreams and admirations come true and meshing rituals, goals, roles, and symbols.

Gottman's (1999) method of therapy assumes that therapy is conducted primarily with dyads rather than individuals. Therapy focuses on increasing the couple's positive affect toward each other because in Gottman's theory, couples primarily present to

therapy with low positive affect. The therapist acts as a coach and provides tools that the couple can use with one another and eventually make their own. The therapist coaches the couple to soothe each other but should never do the soothing. This leads to one major goal in therapy, which is to empower the couple to create a shared meaning. Overall, therapy should be primarily a positive affective experience for the couple (Gottman, 1999).

Creating
Shared
Meaning:
Rituals of Connection, Roles,
Goals, Symbols (Culture)

Making Dreams and Aspirations Come True
(Avoiding Marital Gridlock)

(1) Dialogue with Perpetual Problems
(2) Effective Problem-Solving of Solvable Problems
(3) Physiological Soothing

Positive Sentiment Override

Turning Toward Versus Turning Away
The Emotional Bank Account

Fondness and Admiration System

Cognitive Room
Love Maps

Figure 1. Sound marital house.

Interventions

Gottman's (1999) interventions are designed in stages, which makes it easy to use the interventions that are needed for each individual case and omit interventions that are not needed depending on which level of the SMH is the focus. Gottman's overall structure for treatment is simply to create initial, rapid, dramatic change, and then follow with structured change.

Initial, rapid change occurs during assessment in the form of having the couple interact with each other. In this initial interaction, the couple is usually in one of two negative interaction patterns: "Either the Four Horsemen are present and repair is ineffective, or there is great emotional distance and isolation with lots of tension, underlying sadness, and an absence of any positive affect" (Gottman, 1999, p. 186). If the four horsemen are present in the interaction, the therapist should educate the couple on how damaging the four horsemen are to their relationship and ask them to refrain from using them in session and at home. The therapist also instructs the couple about soft startup, repair attempts, and flooding as part of the four horsemen intervention (discussed further in later sections of this paper). The goal to achieve structured change at this stage is for the couple to effectively repair a negative interaction without the use of the therapist (Gottman, 1999). For this to happen, the couple needs to be in positive sentiment override and have the ability to *metacommunicate*, that is, communicate about how they communicated during the negative interaction.

To begin the process of structured change, Gottman's (1999) interventions are used to focus on enhancing the marital friendship. Marital friendship interventions

involve those that aim to change the negative affect surrounding dysfunctional conflict. According to Gottman, the fundamental disconnection in a relationship at the core of the marital friendship is the *failed bid.*

> Even in the most distressed marriages, partners keep making bids for one another's attention, interest, humor, affection, emotional support, solidarity, sex, and so on. The failed bid becomes the central event on which to focus the couple's attention for improving the marital friendship. (Gottman, 1999, p. 201)

Enhancing the marital friendship includes using interventions that focus on love maps, fondness and admiration system, and turning toward versus turning away from each other during conflict. This base of interventions greatly impacts the positive sentiment override that is available in the relationship, which helps determine how the couple deals with minor conflicts that happen every day (Gottman, 1999). Gottman has laid out numerous interventions. However, the following will describe the interventions that were the focus for this study: love maps, fondness and admiration system, and the four horsemen.

Love map interventions. The first set of interactions are to be done in the therapist's office (Gottman, 1999). During the session, the couple is coached to take turns as speaker and listener during three types of interaction. In the first interaction, the couple discusses the most important recent and upcoming events in each of their lives. In the second interaction, the couple is instructed to discuss what they would like their lives to be like when therapy is finished, in one year, and in five years. The final in-session interaction consists of the couple's discussing any changes they would like to make in

their personal lives (other than their marriage). Example of topics for this interaction are to lose weight or get in shape (Gottman, 1999). The therapist assists the couple during in-session activities by coaching appropriate speaking and listening, especially if the four horsemen are still present. However, the therapist should allow the couple to discuss the topic that they believe is important. For each interaction, the couple is asked to have a similar conversation at home at least once during the week that follows the therapy session.

Homework assignments for the love maps portion of the SMH could include instructing the couple to first take turns interviewing each other and filling out the *love maps houndout* (see Appendix C). Each partner is instructed to correctly and fully write responses from the other on the form. If one spouse records incorrect information, the other, who is giving the information, corrects the information. This activity allows the couple to connect through information about important events, people, stresses, and aspirations. Second, the couple is asked to find at least one way of making contact with each other every day when they are apart (Gottman, 1999). The contact is based on each partner's explaining what is going on in his or her life that day. At the end of the day, the couple are instructed to talk about their day together.

Fondness and admiration system. The fondness and admiration system interventions are used to reconnect partners with feelings of fondness and admiration (Gottman, 1999). This is done by focusing on qualities that brought them together in the past and qualities that have kept them together to this point in the marriage. These interventions aim to increase the amount of praise and appreciation between the spouses.

The first intervention used is to have each partner show appreciation to the other for positive qualities of his or her personality that were attractive when the couple first met. Each spouse must describe three to five items that he or she thinks was characteristic of the partner that attracted him or her to the other, even if it was shown slightly or infrequently. For each characteristic, the partner describes a specific incident that exemplifies the characteristic. The therapist should ask for details of the incident and ask for a story about the event because "troubled couples tend to be somewhat vague about details of these events" (Gottman, 1999, p. 206).

The next fondness and admiration intervention is for each partner to show appreciation for qualities the other shows currently (Gottman, 1999). Each spouse describes three qualities that he or she appreciates about the other and shares them, explaining the choices. "This can be a simple statement like, 'I really like the way you are sensitive to my moods'" (Gottman, 1999, p. 208). In the final intervention, the couple creates their own fondness and admiration checklist with everything they each value about the other (Gottman, 1999). Each is asked to express appreciation for something at least once every day. "They are asked to focus on what their partner is *adding* to their life that day and to make it a point to touch the partner (both verbally and physically) in a purely affectionate manner" (Gottman, 1999, p. 209).

Turning toward versus turning away. Turning toward versus turning away interventions will not be used in this study; however, it is important to note them as part of Gottman's (1999) model. These interventions are used to create an emotional bank account that helps the couple evaluate the strengths in their relationship that they wish to

build on (Gottman, 1999). Turning toward versus turning away helps the couple give each other support and share emotions (Gottman, 1999). Couples tend to try to show support by generating solutions to problems. For support to be successful, "understanding must precede advice" (Gottman, 1999, p. 214).

Dialogue with perpetual problems. When the four horsemen of the apocalypse are present in the initial assessment, the therapist needs to educate the couple on what the four horsemen are and what they can do to a marriage. The therapist also explains communication behaviors that aim to lower the use of the four horsemen. These interventions are *softened startup*, *repair attempts*, and *flooding* (Gottman, 1999; Gottman & Silver, 1999).

"The most obvious indicator that this discussion (and this marriage) is not going to go well is the way it begins" (Gottman & Silver, 1999, p. 26). When the discussion starts harshly, criticism and/or contempt are usually present and affect escalates from neutral to negative (Gottman, 1999; Gottman & Silver, 1999). The therapist educates the couple on rules of a soft startup and provides examples of both harsh and softened startups. Rules for a soft startup include complaining but not blaming; making *I* statements, not *you* statements; being clear; being polite; being appreciative; not storing up things; and being precise about behavior without judging the other person (Gottman & Silver, 1999). After educating about the elements of a soft startup, the therapist instructs the couple to practice this skill in session in the form of an enactment. The therapist assists the couple's learning by coaching them through this process. If the topic is started harshly, the therapist instructs the couple to stop, take a break, and try again, just as the

couple should handle a harsh startup at home (Gottman, 1999; Gottman & Silver, 1999).

The strength of the couple's marital friendship determines how successful a repair attempt will be (Gottman & Silver, 1999). For this reason, interventions listed above should be implemented in conjunction with repair attempts interventions. Gottman (1999) believed that repairing negativity may be the most important part of the conflict resolution process. The therapist should reframe repair attempts as a natural process that each couple does differently (Gottman, 1999). Since each couple handles repair attempts differently, the keys to repair attempts are *externalizing the repair, accepting the repair,* and *practice.*

Externalizing the repair could be the easiest of the three steps. However, if the couple is in negative override (overall tone of the couple's relationship is negative) and the marital friendship is low, this step can be difficult. For this reason, communication of a code word or action about the beginning of a repair attempt can be helpful. An example of this could be as simple as saying, "this is a repair attempt" (Gottman & Silver, 1994). This is called externalizing the repair attempt. Making the repair attempt known in the conversation helps make it easier for the spouses to identify that a repair is being attempted, which helps them accept the repair attempt. Accepting the repair attempt by the other partner is the most important of the three steps. Again, if the couple is in negative override and the marital friendship is low, acceptance of repair attempts may be difficult. The receiver should view the interruption of the discussion as an attempt to make things better and it is the therapist's job to point this out (Gottman, 1999). The final step in repair is practicing, especially at home, whenever either spouse notices that

the conversation is escalating negatively.

Flooding happens when one spouse's negative emotions are so overwhelming that the other spouse is shell-shocked (Gottman, 1999; Gottman & Silver, 1999). This negativity may be expressed in the form of criticism, contempt, or even defensiveness (Gottman & Silver, 1999). The natural reaction of a partner when feeling flooded is to stonewall.

The more often you feel flooded by your spouse's criticism or contempt, the more hypervigilant you are for cues that your spouse is about to "blow" again. All you can think about is protecting yourself from the turbulence your spouse's onslaught causes. And the way to do that is to disengage emotionally from the relationship. (Gottman & Silver, 1999, p. 35)

To intervene in this process, the therapist describes the difference between males' and females' physiological reactions as found in Gottman's (1999) research. Gottman found that males generally tend to become more vigilant and remain in that state longer than females when faced with perceived danger. Males also generally take longer to recover from cardiovascular arousal than females. For this reason, when spouses notice feelings of being flooded, they should be allowed to take breaks and calm down. The therapist describes what constitutes a good break: (a) it should last at least 20 minutes, (b) both partners should find safe places where they can truly relax, and (c) they should not think about the conflict. Not thinking about the conflict is typically a very difficult task. Gottman suggested having partners go to safe rooms where they can occupy themselves with something that will help take their minds off of the conflict. The couple should have

a set time scheduled to come back and discuss the topic (Gottman, 1999). This break

"significantly reduces heart rate and makes the next interaction on the conflict topic much

more positive" (Gottman, 1999, p. 231).

Making dreams and aspirations come true. In order to help couples make their

dreams and aspirations come true, dreams within conflict interventions are used

(Gottman, 1999). These interventions help the couple understand the underlying dream,

or symbolic meaning, of their entrenched positions when the couple finds themselves in

marital gridlock (Gottman, 1999). The dreams within conflict interventions will not be

focused on in this study.

Creating shared meaning. When each couple starts a relationship, they create

their own unique culture. This culture has its own symbols, metaphors, and meaning

(Gottman, 1999). Creating shared meaning interventions help the couple create shared

meaning in their family rituals, family roles, family goals, and family symbols (Gottman,

1999). The creating shared meaning interventions will not be focused on in this study.

Gottman's (1999) interventions are delivered so that the couple believes they are

easy to do. The couple should have fun with this experience and improve their

relationship at the same time. I have found that practicing new skills in therapy sessions

is important before assigning them for practice at home. As already stated, not all of

these interventions fit with every couple. The therapist must determine where and how

couples struggle in their relationships and to use and prescribe appropriate interventions

(Gottman, 1999). The overall goal for therapy is to increase positive affect through

building a strong friendship. This goal is evaluated through the clients' reports. The

therapist works with the couple in practicing these interventions until the couple is able to determine for themselves which work best during sessions and at home. When the couple is able to effectively prescribe their own interventions, the therapist and the couple discuss finishing therapy. Thus, finishing therapy is the therapist's and the couple's joint decision.

Research Base

Gottman method couple therapy is based on research that investigated how marriages succeed or fail (Gottman, 1999). Most of Gottman's research was conducted through observations of couples in his "love lab" in Seattle, Washington through a one-way mirror, and observations of videos from cameras that recorded every word and facial expression of studied couples as well as heart beat sensors to track physiological signs of stress (Gottman & Silver, 1999). Through this research, Gottman was able to predict whether a couple would stay married or get divorced with over 90% accuracy. He also was able to predict the couple's marital satisfaction levels if they stay married (Gottman, 1994).

Gottman method couple therapy has been shown to increase positive affect and create a positive attractor for the couple (Gottman, Ryan, Swanson, & Swanson, 2005). "A positive attractor is a stable steady state that repeatedly draws a couple toward this positive place" (Gottman et al., 2005, p. 167). The SMH interventions have also been found to form an effective premarital education program for engaged couples (Barnacle & Abbott, 2009).

Gottman, Coan, Swanson, and Carrere (1998) found that 6 years into marriage,

positive affect during marital conflict was the only predictor of both marital satisfaction and marital stability. In addition, Cartenson, Gottman, and Levenson (1995) reported that humor and affection was a characteristic of happily married, stable, older, and middle-aged couples that were still in their first marriages. The question is, how can a couple get to that point? Driver and Gottman (2004) attempted to answer that question: They found that "couples build intimacy through hundreds of very ordinary, mundane moments in which they attempt to make emotional connections. Bids and turning toward may be the fundamental units for understanding how couples build their friendship" (p. 312).

It is notable that Gottman and many colleagues have also conducted research on domestic violence. Gottman et al. (1995) suggested a possible typology of batterers based on reactivity of their heart rates. *Type-1* batterers were the men whose heart rates dropped below their baseline levels during marital conflict. *Type-2* batterers were all other physically abusive men, who comprise 80% of batterers (Gottman et al., 1995). The difference between the two types is astounding: Type-1 batters showed more antisocial behavior, sadistic aggression, and emotional abuse, and were much more severe in their violent behavior (Gottman et al., 1995).

Next, Coan, Gottman, Babcock, and Jacobson (1997) studied type-1 batterers in more detail. In this study, Coan and his colleagues speculated that type-1 batterers do not accept influence from their partners because it is against their *honor culture* (preoccupied with saving face with the natural right to control their wives with intimidation and control). Any attempt by spouses to exhibit influence on type-1 batterers would be perceived as challenges to their positions of being in control. Coan and colleagues

(1997) suggested a different type of treatment for type-1 batterers that includes learning

that accepting influence from a woman does not imply a loss of power or control. These

typologies and suggestions overlap with and are supported by Johnson and colleagues'

findings on domestic violence (e.g., Johnson, 1995, 2008; Johnson & Ferraro, 2000;

Kelly & Johnson, 2008).

Cognitive-Behavioral Couple Therapy

Basic Assumptions and Concepts

In cognitive-behavioral couple therapy (Baucom & Epstein, 1990; Beck, 1976;

Dattilio, Epstein, & Baucom, 1998; Dattilio & Padesky, 1990; Epstein, Schlesinger, &

Dryden, 1988), problems in relationships are viewed as steming from behavioral,

cognitive, and affective components that influence each other equally (Baucom &

Epstein, 1990). One component may contribute more to problems than the others in

particular relationships. However, for *second order change*—change that occurs in the

rules of the system and thus in the system itself—to occur (Becvar & Becvar, 2006), all

three components should be altered in therapy (Baucom & Epstein, 1990; Dattilio &

Padesky, 1990). In contrast, *first order change* occurs within the system and is consistent

with the rules already set for that system (Becvar & Becvar, 2006). In therapy based on

systems theory, second order change typically is the goal over first order change.

Distressed couples tend to have four negative behavioral aspects to their

relationships that detract from their relationship satisfaction. Distressed couples tend to

(a) exchange higher rates of negative behavior and lower rates of positive

behavior, (b) use less effective (i.e., indirect, unclear) and more aversive (i.e.,

critical) communication to express their thoughts and feelings, (c) attempt to solve

relationship problems with less effective problem solving skills, and (d) use more

coercive methods for attempting to change their partners' behavior than do

nondistressed couples. (Baucom & Epstein, 1990, p. 11)

These negative behaviors can alter cognitions each partner has about the relationship

(Baucom & Epstein, 1990).

Within the cognitive component of CBCT, there are five types of interconnected

thought processes that appear to play important roles in marital distress (Baucom &

Epstein, 1990). The first category is called *selective attention*. The main premise of this

category is the perception of an individual that some aspects of an event occurred but not

others. The second category is *attributions*, which are the explanations of the cause of an

event that an individual provides for his or her relationship. The third category is

expectancies, or predictions of what events will occur in the future. This prediction can

be a result of the individual's specific behavior or the prediction of his or her partner's

behavior. The fourth category is based on the idea that an individual will develop

assumptions of characteristics of a relationship and how a relationship should work. The

final category builds on assumptions and is called *standards*. Standards are specific

characteristics that an individual holds for how the relationship should be or

characteristics his or her partner should have. These categories tend to come from

schemas and automatic thoughts that will be discussed later. "Cognitive-behavioral

theorists propose that these five types of cognitions have the potential to erode

satisfaction in family relationships and to elicit dysfunctional family interactions"

(Dattilio et al., 1998, p. 9).

Schema or *schemata* are central beliefs that shape an individual's personality and are an integral concept of CBCT (Baucom & Epstein, 1990; Dattilio et al., 1998; Dattilio & Padesky, 1990). Schemas are learned early in life from an individual's personal experiences with parents, family, and other members in the society. "Life events activate an individual's *schemata*, which are the longstanding and relatively stable basic assumptions that he or she holds about the way the world works and his or her place in it" (Epstein et al., 1988, p. 13; italics in original). Most of the time, individuals are not completely aware of these schemas that guide their responses to family interactions (Dattilio et al., 1998).

When two people form a relationship, they each bring their own schema from their families and other important life experiences. These schemas influence perceptions and assumptions about events in the current relationship but can be altered through experiences in the current relationship. However, preexisting schemas that are associated with strong feelings may be more difficult to modify (Dattilio et al., 1998). In addition to schemas that each person brings into a relationship, each partner develops a schema about his or her partner, the relationship, and themselves as a couple. "A basic tenet of cognitive-behavioral family therapy is that each individual family member maintains schemas about every member of the family unit (including himself or herself), in addition to schemata about family interaction in general" (Dattilio et al., 1998, p. 7). Schemas can also be altered after an important event such as an affair, birth of a child, or death in the family. After years of interaction within a family system, a family schema is developed

that holds joint beliefs from each individual in the family system (Dattilio et al., 1998).

The schema shapes the content of the individual's thinking, which encompasses the individual's *automatic thoughts*. Automatic thoughts are defined as an individual's stream-of-conscious thoughts, ideas, beliefs, expectancies, or images that are obtained from any event (Baucom & Epstein, 1990; Dattilio et al., 1998; Epstein et al., 1988). A person's automatic thoughts appear like a reflex and are oftentimes out of a person's conscious control. A person does not question these thoughts even though they may not be accurate depictions of life events. "The person perceives these thoughts as though they arise by reflex—without any prior reflection or reasoning; and they impress him [or her] as plausible and valid" (Beck, 1976, p. 237). Until an individual has been taught to monitor these thoughts, he or she may not be aware of them (Beck, 1976). "By shifting his [or her] attention to these thoughts he [or she] becomes more aware of them and can specify their content" (Beck, 1976, p. 239).

Automatic thoughts, whose content are based on the schema, can be shaped by *cognitive distortions*. "These are errors in logical thinking which distort rational conclusions from either internal or external sources of data" (Epstein et al., 1988, p. 14). This changes the person's perception of his or her reality, which, in turn, can form more distortions. There are eight common cognitive distortions that are likely to contribute to conflict in a relationship (Beck, 1976; Dattilio et al., 1998; Epstein et al., 1988):

1. *Arbitrary inference*: somebody jumps to a conclusion from an event when there is no supporting evidence or the evidence differs from the conclusion.

2. *Selective abstraction*: information is perceived out of context and thus misses

the significance of the total situation.

3.   *Overgeneralization*: a belief made after a single incident, usually unjustified.

4.   *Magnification and minimization*: a situation or circumstance is believed to have greater or lesser significance than what is valid.

5.   *Personalization*: a form of arbitrary inference; an unsupported perception that a single event is attributed to oneself.

6.   *Dichotomous thinking*: all or nothing, black or white thinking.

7.   *Labeling and mislabeling*: past behaviors are generalized as personality traits of oneself or another family member.

8.   *Mind reading*: another form of arbitrary inference; believing that one knows what another is thinking or will do in the future.

When thought distortions are present, they usually evoke negative emotions and behaviors. In turn, negative emotions and behaviors influence negative cognitions. Although these assumptions are focused on the cognitive aspect within CBCT, it is assumed that emotion and behavior are equally influenced by cognition and cognition is influenced by emotion and behavior.

The therapist must undertake multiple roles in CBCT. These roles include for the therapist to be a director, collaborator, educator, facilitator, and advocate (Baucom, Epstein, LaTaillade, & Kirby, 2008). Goals are important in the CBCT process and are utilized at the micro and macro levels, specific and overall goals. Goals are collaborative and explicit. Goals for assessment in CBCT are to (a) identify the problem and potential areas of growth; (b) explain the cognitive, behavioral, and affective factors in all aspects

of the relationship that contribute to the presenting problem; and (c) determine how appropriate couple therapy is in addressing the presenting problem (Baucom et al., 2008).

Interventions

There are a variety of interventions that have been developed for use in CBCT (Baucom et al., 2008). These interventions focus on one of the three domains used in CBCT: behavior, cognition, and affect. When change occurs in one of the three domains, change is typically generated in the other domains. Therefore, when discussing interventions specific to each domain, it is important to remember that most interventions alter all three domains of relationship functioning (Baucom et al., 2008).

Cognitive interventions. Cognitive interventions are very important in CBCT because when one partner changes his or her behavior positively but the other partner attributes the behavior as negative, the change will not be helpful. In intimate relationships, behaviors carry great meaning and not considering cognitive factors can limit the effectiveness of treatment (Baucom et al., 2008).

Cognitive interventions are used to induce restructuring of cognitions. The first thing that should be done when using the cognitive aspect of this model is for the therapist to educate the couple about the model because the therapist will be continually referring to it and making references to specific concepts (Dattilio & Padesky, 1990). The therapist educates the couple about cognitive distortions and how to identify them. One exercise that can assist the couple in labeling their individual distortions is by having each of them keep a log of negative thoughts during the week and label the distortions that come with these thoughts (Dattilio & Padesky, 1990). The therapist reviews this list

with each individual to ensure that they are labeling correctly (see form in Appendix C).

When the couple begins to understand cognitive distortions and is able to identify them, the therapist instructs the couple to keep track of their automatic thoughts and identify the distortions that are involved in these automatic thoughts (Dattilio & Padesky, 1990). When writing these automatic thoughts, each partner should also give a brief description of the event and the resulting emotional response (Dattilio & Padesky, 1990). This exercise also helps the couple label their emotions as discussed later. The therapist can also instruct the couple to derive alternative thoughts or possibilities for each automatic thought. This helps restructure cognitions about partners' behaviors.

Socratic questioning is the main intervention used in restructuring cognitions. The therapist asks "a series of questions to help an individual reevaluate the logic of his or her thinking, to understand the underlying issues and concerns that are not at first apparent, and so forth" (Baucom et al., 2008, p. 52).

Behavioral interventions. The major forms of behavioral intervention is training in more effective communication, assertiveness, problem-solving, and behavior-exchange agreements (Dattilio et al., 1998; Epstein et al., 1988). One of the major goals of behavioral interventions is for partners to behave in more positive and less negative ways toward each other.

Enactments in session may be helpful in skills training of any sort. The therapist instructs the couple to discuss an issue or a recent argument. An enactment can be used as assessment and intervention. When the therapist identifies communication for which a couple needs assistance, the therapist acts as a coach and helps the couple practice more

effective skills. When coaching these skills, the therapist can have the couple discuss relatively benign topics so as to not elicit strong negative emotions. This helps the couple practice without negative emotions, which interfere with learning effective communication (Dattilio et al., 1998).

Communication training is used to teach assertiveness and problem-solving skills (Baucom & Epstein, 1990). Partners are instructed to speak for themselves in terms of their thoughts and feelings using "I statements" (Baucom & Epstein, 1990, p. 270). The couple is also instructed to stay solution-oriented by focusing on the what future changes can be made to the problem. Part of staying solution-oriented is helping the couple to *not* establish the truth (Baucom & Epstein, 1990). Many arguments stem from the couple's attempts to find the truth of an incident. When each person has a different perception of what happened or what something means, searching for the truth can cause more problems.

Homework assignments are used to achieve specific goals and are a major part of behavioral interventions and behavior-exchange agreements. At the end of each session, the therapist should work collaboratively with the couple in designing a homework assignment. The assignment should specify what behaviors each partner will perform during the time between sessions (Dattilio et al., 1998). One strategy that can be used to increase positive behaviors is the *caring days* activity (Stuart, 1980), in which partners first list acts that they would perceive as caring from the partner. Each partner is then instructed to do at least five acts from the list each day. Whether caring days is prescribed or not, having a couple engage in more pleasurable activities together can be

appropriate (Baucom & Epstein, 1990).

Emotion interventions. Many times, the cognitive-behavioral approach to altering emotions is to use cognitive and behavioral interventions (Baucom & Epstein, 1990). The thought here is that when people change their behaviors and cognitions about behaviors, emotional changes will follow. However, there are some interventions that can be directly helpful for changing emotions. For example, some couples have difficulty recognizing the emotions they are feeling. In this case, the therapist assists the couple in recognizing and labeling these emotions (Baucom & Epstein, 1990). At times, one or both of the spouses will be aware of his or her feelings but is unable to express these feelings. When this is the case, the therapist helps the individual express his or her feelings in an appropriate manner. Finally, an individual may be experiencing emotions that are interfering with the functioning of the couple. For example, one could still be holding on to anger about a series of events that happened many years in the past. In this case, the therapist assists in changing these emotions so they are not disruptive in the relationship (Baucom & Epstein, 1990). In any case, the therapist teaches the couple better skills in handling their emotions to assist in increasing positive interactions.

Research Base

Cognitive-behavioral therapy has been shown to assist in the treatment of many presenting problems including personality disorders (MacFarlane, 2003; Rasmussen, 2005), major depressive disorder (Addis & Jacobson, 2000; Beck, 1976; Beck, Rush, Shaw, & Emery, 1979), and alcohol problems (McCrady, Epstein, & Hirsch, 1999). "The focus on cognitions and behaviors in treatment is now widely embraced by marriage and

family therapists because of the effectiveness of the approach and its flexibility and integrative potential" (Dattilio & Epstein, 2005, p. 7).

Behaviorally oriented couple therapies that have shown the strongest clinical outcome are those that balance both overt behavioral change and affective-cognitive change (Baucom et al., 2008). Fals-Stewart, Kashdan, O'Farrell, and Birchler (2002) found that, as compared to individual behavioral therapy, behavioral couple therapy significantly reduced male-to-female aggression in couples. Individual behavioral therapy did not show any significant improvement on partner violence. This finding supports systemic philosophy as well as behavioral couple therapy. Cognitive-behavioral couple therapy is an empirically supported intervention for treatment of distressed couples (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998).

Integration of the Models

The theoretical model utilized in this study uses an integrative approach that combines fundamental concepts from Gottman method couple therapy and cognitive-behavioral couple therapy. The dominant trend in family therapy, as it grows, is integration (Nichols & Schwartz, 2004). The integration for this study can be referred to as "specially designed integrative model" (Nichols & Schwartz, 2004, p. 348). Specially designed integrative models are "pragmatic models that combine elements of two complementary approaches" (Nichols & Schwartz, 2004, p. 348). Fraenkel and Pinsof (2001) called this type of integration, "levels of mastery" (p. 73) or multiple base.

Integration Basic Assumptions and Concepts

Even though GMCT and CBCT have different assumptions, concepts, and interventions, the ideas behind the two approaches overlap significantly. For example, both GMCT and CBCT work on communication skills and assume that communication skills are a key to marital happiness. Gottman method couple therapy could be viewed as stemming from CBCT because of its focus on communication. Both models also suggest that it is important for the couple to think about their relationship in a different way. Gottman (1999) does this through the SMH, specifically, the foundation levels, where cognitive room (love maps) is the first. Cognitive-behavioral couple therapy works on changing how the couple thinks through cognitive interventions. Cognitive-behavioral couple therapy also believes that cognitions, behavior, and emotions influence each other equally (Baucom & Epstein, 1990). In GMCT, working on cognitive room helps the couple connect with each other, thus increasing their feelings towards each other (Gottman, 1999).

Relative to the idea of the couple's thinking about their relationship differently, GMCT and CBCT both suggest that perception is important in relationships. Gottman (1999) said that behavior, perception, and physiology are the three domains of human experience; perception and physiology are synonymous with cognitions and emotions. "These three domains are not independent; rather, they are intricately linked in a relationship I call the 'core triad of balance'" (Gottman, 1999, p. 33). In CBCT, "Problems arise from family members' distorted perceptions of each other and from dysfunctional behaviors among members" (Epstein et al., 1988, p. 11).

Finally, cognitive-behavioral and Gottman's assumptions both suggest that emotions are important and the first step in therapy is being able to label emotions (Baucom & Epstein, 1990; Gottman & Declaire, 1997). Both models suggest that change toward positive emotions will come with increased positive interactions and changed cognitions.

Integration Interventions

Both GMCT and CBCT work to change interactions to be more positive, which changes each spouse's outlook on the relationship and in turn increases positive affect. Other integration ideas will be discussed in the next section on implementation and application of GMCT and CBCT.

Implementation and Application of GMCT and CBCT

I like to view my integration of these models using an analogy similar to the one used by Minuchin (1974). A therapist using this framework can be compared to a technician with a zoom lens. "He [or she] can zoom in for a closeup whenever he [or she] wishes to study the intrapyschic field, but he [or she] can also observe with a broader focus" (p. 3). When I zoom in with my lens, I am using the cognitive-behavioral aspects of my model to focus on each individuals' cognitions, behaviors, and feelings. As I zoom out, I see how these cognitions, behaviors, and feelings interact systemically with cognitions, behaviors, and feelings of others. The more I zoom out with my lens, the more aspects of the system are revealed to me. This is where I utilize more aspects of Gottman method couple therapy.

The process that I follow in the first session of therapy is fairly similar on a case-by-case basis. The first session consists of assessing affect, presence of the four horsemen, cognitive distortions, and communication skills (Baucom & Epstein, 1990; Gottman, 1999). At the beginning of the first session, I always ask the couple for the reason they came to therapy. The answer to this question helps me understand what each individual perceives as the problem in the relationship. It also gives me clues to the couple's cognitive and communication styles. *How* each individual answers the question may be more important than *what* they answer. How they each answer helps me assess for the presence of the four horsemen and any cognitive distortions. After I get a good idea of what each spouse perceives to be the problem, I use an assessment measure called the Dynamic Relationship History (DRH; Gottman, 1999). I ask the couple how they met, what attracted them to each other, what type of things they did for fun when they were dating, who brought up the idea of marriage (if married), what the wedding was like, and so forth. If the couple is able to reminisce about positive feelings when they started dating, there is a greater possibility that the couple will stay together (Gottman, 1999). In essence, the DRH is used as assessment for positive affect and intervention to help the couple see some positive reasons they started dating in the first place. The DRH also assesses for communication skills and communication process.

The final part of the first session consists of a discussion of goals, which is consistent with CBCT (Baucom & Epstein, 1990; Dattilio & Padesky, 1990). Another way for me to develop goals is through an enactment that is consistent with GMCT and CBCT. I start by educating the couple about positive rephrasing, which is consistent with

CBCT (Dattilio & Padesky, 1990). I then have the couple take turns telling each other what they would like to see in their relationship or each other. I ask the couple to phrase their goals in a positive manner that is not blaming. If one spouse starts to blame, I stop him or her and ask for a rephrase of the statement. The homework assignment that I like to use after the first session is consistent with Gottman's fondness and admiration system interventions: I instruct the couple to find at least one way of making contact with each other every day when they are apart. The contact is based on each partner's explaining what is going on in his or her life that day. The couple also are instructed to talk together about their day at the end of the day. There may be some instances that giving this homework may not be beneficial such as times when the couple has experienced affairs, in cases of domestic violence, or if one of the partner's job forbids them to talk on the phone or otherwise communicate during the day.

The structure of second and following sessions depends on the assessment from the first session. However, assessment is a continuous process which means the structure could change. In my opinion, couples present to therapy because negative affect is present more often than positive affect in their relationship. In order to increase positive affect early in the therapeutic process, I use both the love maps and fondness and admiration systems interventions. These interventions can also be used to assess communication skills, presence of the four horsemen, and cognitive distortions. If I notice the presence of the four horsemen, for example, I address it but continue the current intervention.

If the four horsemen are present, interventions for them are used in the second or

third session. These interventions can begin in one session and continue for several

sessions as needed. When I discuss interventions related to the four horsemen

(educating, soft startup, repair), I also use communication skills training from CBCT.

Depending on the communication skills deficit present in the relationship,

communication skills training may take up to three or four sessions before the couple

feels sufficiently comfortable with the skills to implement them at home. Depending on

the couple and their ability to express emotions, I could also use an emotional

intervention to help the couple recognize and label their emotions (Baucom & Epstein,

1990; Dattilio & Padesky, 1990). The process of cognitive restructuring may be used

early in the therapeutic process if the presence of cognitive distortions is minimal. If

addressing cognitive distortions only is not sufficient to alleviate the cognitive

distortions, I work with the couple in identifying their automatic thoughts and changing

cognitive distortions. This intervention is usually used later in the therapeutic process.

Socratic questioning is used throughout the therapeutic process when I believe the

questioning may be helpful (Dattilio & Padesky, 1990).

Systems Concepts

Systemic ideas are evident in GMCT and CBCT. Gottman method couple

therapy and cognitive-behavioral couple therapy both examine the relationship between

individuals and how each individual interacts with and influences the other. This reflects

the systems concept of *recursion.* "We see people and events in the context of mutual

interaction and influence" (Becvar & Becvar, 2006, p. 65). Gottman method couple

therapy focuses on each spouse's accepting influence from the other, which increases marital happiness. In CBCT, the perception of each interaction within the relationship influence marital happiness is important and discussed.

Another systemic idea that is present in both theories is *feedback*. Feedback is an aspect of recursion that involves self-correction (Becvar & Becvar, 2006). This concept plays a major role in CBCT, specifically when discussing an individual's schema of his or her expectations for relationships. Feedback refers to the process by which an individual's past experiences shape his or her schema and are fed back into the system, which contributes to the already existing schema as strengthening it or making it weaker. This assumption is also involved in GMCT through positive or negative sentiment override (Gottman, 1999). When a couple has negative sentiment override or low positive affect in their relationship, a neutral act will be perceived as negative, strengthening the schema. The therapist attempts to induce positive feedback that helps the couple system accept changes in therapy and change their schema.

Each system operates under implicit rules about what behaviors, emotions, and thought processes are appropriate. These rules are said to form the *boundaries* of the system (Becvar & Becvar, 2006). In CBCT, these boundaries are addressed through examining expectations of roles in the relationship. This is another way to assess the couple's schema about their relationship. The boundary of the system also involves the entrance and exit of information from the system (Becvar & Becvar, 2006). In therapy, the couple needs to have an open boundary when it comes to this aspect. The couple will need to accept influence from the therapist as well as each other. Having this open

boundary to accept influence from each other is a major part in GMCT (Gottman, 1999).

Purpose and Research Questions

The purpose of this study was to test how well my therapy integration was practiced within the proposed theoretical framework. This study was used to guide me in implementating my integration of GMCT and CBCT. The review of literature indicates that GMCT and CBCT can be beneficial treatment modalities. However, the goal of this study was not to generalize this integration to other therapists. The study used case notes, reflection journal notes, an intervention checklist, and therapist observations and reflections as data points. The following research questions were used to guide this study:

1. How well did I maintain fidelity to my integrated treatment model?

2. When this integrated model was used, did clients report meaningful changes?

3. How did working with an integrative model influence ongoing sessions or cases?

4. What did I change in my model through the course of this study?

CHAPTER III

METHOD

The current study was designed to explore one therapist's integration of Gottman method couple therapy (Gottman, 1999) and cognitive-behavioral couple therapy (Baucom & Epstein, 1990). The study investigated the therapist's commitment to the integrated model, whether the approach resulted in change for the couples in the study, how each session and case affected the therapist's work in other sessions and cases, and how the integration was modified based on the results of this study. In order to be systemic, therapists must integrate theory, research, and clinical practice (Olson, 1976). This study attempted to do so. This section outlines the procedures for sampling, data collection and management, and analysis.

Design

This study used mixed methods of collecting and analyzing quantitative and qualitative data with a multiple-case study design. Creswell (2007) described a case study as a qualitative approach where the researcher explores one or more cases "over time through detailed, in-depth data collection involving multiple sources of information" (p. 73). In a multiple-case study, the researcher uses multiple case studies to illustrate the topic (Creswell, 2007). Yin (2003) suggested that the multiple-case study design uses replication of procedures to generalize the findings.

This study also utilized the concept of *triangulation*. Triangulation is a multi-method approach to data collection and analysis that utilizes multiple perceptions

(e.g., observation, case notes, reflection journal notes, and client reports) to establish face validity for qualitative evaluations. Triangulation also explains the meaning and verifies the ability to repeat the interpretation that was found (Stake, 2008). Using this concept as a guide, the data were gathered through a CBCT/GMCT intervention checklist, the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995), Outcome Questionnaire-45.2 (OQ-45.2; Burlingame & Lambert, 1996), reflection notes, case notes, and teammate and supervision consultation notes.

Sample

This study was used to gain knowledge of the therapy process when integrating CBCT and GMCT for one therapist. Because the literature focused on the couple aspect of these models, the sample used in this study consisted of three couples who voluntarily presented for therapy at the Utah State University marriage and family therapy (MFT) clinic. When the participants contacted the clinic, they were informed that the therapist was a master's level student who was under supervision, and they were assigned to a therapist by convenience per clinic policies of rotating new clients among therapists. The researcher served as the therapist for these three cases. In order for couples to become participants, they agreed to and signed an informed consent for research form (see Appendix A). All typical clinic procedures were followed. In order to protect confidentiality, pseudonyms are used when discussing participants in this study. Five of the six participants were Caucasian. One participant was Hispanic. Two of the three couples were married

with all three couples having children; one couple had children from previous relationships. Four of the six participants had completed or were attending Utah State University at the time the study was conducted. All of the participants were between the ages of 27 and 32.

Couple One

Jason, a 32-year-old Hispanic male, and Stacey, a 27-year-old Caucasian female, had been married for 6 years when they presented for therapy. They had two daughters, age 3 years and 10 months, who were never present in therapy. Jason completed a master's of science degree in social sciences. Stacey indicated that she had almost completed her master's degree in education. At the time of intake, both identified that their religious affiliation was Latter-day Saint (LDS).

The couple presented with communication issues that centered around their values and religion. Jason was contemplating leaving the LDS church while Stacey was very involved in the church. They disagreed on what values they should teach their children. Their communication difficulties did not stem solely from religion; they reported having trouble communicating over any important issue that they disagreed on.

Stacey attended 11 sessions and Jason attended 10 sessions. Stacey attended an individual session because she felt that she was not getting her point across when Jason was also present in therapy. The individual session was the 10th of 11 sessions.

Couple Two

Gwen (29) and Zane (29) were a Caucasian couple who were not married when they presented to therapy. Gwen and Zane previously dated for about a year and a half, a year of which they were cohabiting. Gwen had a 5-year-old son from a previous relationship. Zane had a 7-year-old daughter, a 5-year-old daughter, and a 3-year-old son from a previous marriage. Gwen and Zane had primary custody of their respective children during this time. They broke up for about 6 months before starting to date again 5 months before presenting to therapy. When they began therapy, they were each living in separate residences. A stressor for Zane was a custody battle with his ex-wife over his children. Zane was planning on receiving full custody within the next month. Neither of them indicated that religion was a major part of their lives.

The couple reported having communication issues, specifically, communicating about their feelings. This had led to each of them being guarded and not fully committing to the relationship. They both reported that they wanted to "make sure they [were] doing the right thing this time." The couple attended two sessions.

Couple Three

Alan (31) and Lucy (27) were a Caucasian married couple with two children ages 3 and 1. The couple had been married for 7 years when they presented to therapy. They both indicated that they were LDS and strongly believed that religion was a major part of their lives. Lucy completed her bachelor's degree and Alan completed his junior year in college. They both grew up in California and came to Utah for college, which is where they met.

The couple report frequent fighting that included yelling without calling names or physical violence. The fighting increased in severity over the 2 to 3 months before presenting to therapy. Lucy reported finances could be a factor in this increase. Lucy also reported "feeling grossed out" by Alan at times. This started after the birth of their 1-year-old child. Lucy reported not wanting to be around Alan at times. The couple attended four sessions and continued therapy after the study.

Instruments

Fidelity Checklist

An interventions checklist (see Appendix B) was created with concepts and interventions from my integrated model, which was used to gather data to answer the first, third, and fourth research questions. This checklist was used when observing the video recordings of the sessions by myself and another coder. The checklist was created to identify fidelity of my integrated model and to identify ways in which I deviated from the model. Not all possibilities for interventions within GMCT and CBCT were included in the checklist because of the large number of interventions possible for each theory. The interventions that were chosen were believed to be the most likely to be used across multiple cases.

The checklist was a dynamic document because it changed based on its use and my reflections of each session and case data recorded in it. That is, after each therapy session, I revisited the checklist and made modifications to my approach as I identified through my experiences of the therapy. The checklist provided each coder with specific

concepts for each component model that might be used during the therapy session. Each coder indicated whether the concept was used or not and filled in the details section, which provided descriptions of specific techniques used in each session and how clients responded to the intervention. This allowed me the opportunity to determine whether I implemented the concept, by what means, the client's response, and other interventions not listed on the checklist. For the observer to mark *Yes* on the checklist, the therapist must accomplish any of the concepts described in the fidelity checklist training manual (see Appendix B).

A second coder observed four sessions to fill out the interventions checklist for each session to establish reliability of the instrument. The second coder was given a training manual on how the checklist should be used (see Appendix B). The manual also was updated as the checklist was changed. The second coder and I watched the video recordings separately. The second coder was another master's level student in the Utah State University marriage and family therapy program who was familiar with the models of therapy and the integration model that I used. The second coder used aspects of each model but conceptualized her integration differently in her own therapy. She also has biases that may have affected the way she coded the checklist. The second coder and I are friends and colleagues, which may have influenced her coding for this project because of her desire for my success of this research project.

The codes of each session were compared. The first session was compared with one discrepancy being found that contributed to an updating of the checklist. The next two sessions were compared that showed one more discrepancy. We discussed this

discrepancy and reached consensus. The fourth and final session was reviewed with

100% agreement. With confidence in the reliability of the instrument, I coded the

remaining 13 sessions.

Revised Dyadic Adjustment Scale

The Revised Dyadic Adjustment Scale (Busby et al., 1995; see Appendix B) was

used in this study to answer research question number two related to client change. The

couples filled out the RDAS before each therapy session. The RDAS questionnaire has

14 items and was used in this study to assess relationship satisfaction as perceived by

each couple partner. The subscales within the RDAS are dyadic consensus, dyadic

satisfaction, and dyadic cohesion. Scores from each of the subscales are added together

to provide a total relationship satisfaction score. Although the RDAS is a

multidimensional instrument, its use in this study focused on the overall or total

relationship satisfaction score. Lower scores indicate lower relationship satisfaction with

the clinical cutoff score being 48. Therapists benefit from using distress/nondistress

cutoff points within the assessment measures because this allows them another form of

assessment for high levels of marital distress and assists in applying treatments

accordingly (Crane, Middleton, & Bean, 2000).

The RDAS was chosen for several reasons: it is considered a more parsimonious

measure of marital satisfaction than the Dyadic Adjustment Scale (DAS; Busby et al.,

1995; Spanier, 1976) and the Marital Adjustment Test (MAT; Locke & Wallace, 1959),

with which it was correlated with an *r* value of 0.68. It also has a high level of construct

validity with the DAS and the MAT (Busby et al., 1995). The RDAS has been shown to

have a satisfactory level of criterion validity and internal consistency and split-half

reliability (r = 0.90 and 0.94, respectively; Busby et al., 1995). Revised Dyadic

Adjustment Scale scores were not used for statistical comparisons because of the low

number of participants in this study; rather, the scores were compared in terms of gross

numbers and in context with data from other sources to answer the research questions.

Outcome Questionnaire-45.2

The Outcome Questionnaire-45.2 (OQ-45.2; Burlingame & Lambert, 1996) was

used as a triangulation tool with the RDAS in this study to measure client change over the

course of therapy. The OQ-45.2 was designed to measure client progress in therapy by

being administered throughout treatment and at termination (Burlingame & Lambert,

1996). Client progress is measured along three subscales as suggested by Lambert,

Christensen, and DeJulio (1983): subjective distress, interpersonal relationships, and

social role performance. The MFT clinic procedures request that the OQ-45.2 be

administered before the first and 10th sessions, as well as at termination. The OQ-45.2 is

proprietary so it is not provided in the Appendix.

The OQ-45.2 consists of 45 statements that clients rate on a five-point Likert scale

on their experiences in the previous week (0 = *never*; 5 = *almost always*). The total score

is calculated by summing the scores of the three subscales. Cutoff scores for the

subscales and the overall totals were created after extensive research using a community

sample and several clinical samples (Burlingame & Lambert, 1996). The cutoff for the

OQ-45.2 total score is 63 with lower scores indicating less distress. The cutoff scores for

the subscales are 36 for symptom distress, 15 for interpersonal relations, and 12 for social

roles (Burlingame & Lambert, 1996). The OQ-45.2 has been shown to have a satisfactory level of internal consistency and test-retest reliability ($r = 0.93$ and $r = 0.84$, respectively; Lambert et al., 1996).

The OQ-45.2 was administered at the initial session and the third, fifth, seventh, and ninth sessions when clients attended more than two sessions. The interpersonal relations subscale was put into more focus than the other subscales because the client in this study is the couple's relationship. Similar to the RDAS, the OQ-45.2 was not used for statistical comparisons because of the low number of participants in this study; rather, the scores were compared in terms of gross numbers and in context with data from other sources to answer the research questions.

Therapist

In qualitative research, the therapist is a primary instrument (Creswell, 2007). The therapist's past life experiences, family, training, cultural experiences, and gender contribute to how the therapist interprets the therapeutic process, data collection, and data analysis. The therapist in this study is a master's level student who is also the researcher. At the time the study was conducted, I had 1 year of clinical experience using the integration of CBCT and GMCT. I am an unmarried, Caucasian male in my mid 20s. I grew up in the state of Utah but I lived in the state of Missouri for 5 years.

My position as a couple therapist includes considerable bias in this study. One bias is my view on marriage. I believe that a marriage is built on the foundation of a strong friendship. This friendship allows the couple to depend on each other through difficult times. I believe that good communication does not include criticism or

contempt. I also believe that when couples are married, they should try to work out disputes and stay together. However, there are appropriate times for divorce such as abuse of any kind and infidelity. When working with a married couple who is considering divorce, I try to suspend judgment about my thoughts on divorce. The described above biases affected therapy, the coding sheet and its use in coding of sessions, my case notes, my reflection journal, discussions with the second coder, and data analysis as well as the report and conclusions of this research.

There may have been some bias on the part of the clients because of the presence of the camera and their knowledge that they were being recorded. They could also have a bias because of the one-way mirror and the possibility of other therapists or a supervisor observing the session. The presence of these objects and the idea that these sessions were for my thesis may have contributed to a bias for myself.

Case Notes

In accordance with the MFT clinic procedures, case notes were recorded by the therapist after each therapy session. These notes were used to record events in each session and to lay out the course of the next session and provided data for all research questions. Case notes include the following sections: data (session information: what happened, what was noticed, what client said, what therapist did), analysis/assessment (progress, impairments, effectiveness of interventions, patterns), and plan (homework, objectives for next session, changes in treatment plan). Case notes include which interventions are used in the course of the session. They also include any changes observed in the clients since the previous session as well as client reports of changes that

occurred since the previous session. This information also helps with constructing plans for upcoming sessions. Case notes are part of the clients' official clinical record. Case notes were used to answer research questions two and four.

Reflection Journal

The reflection journal was filled out after each session, after coding each videorecording, after discussing the session with the second coder, and after supervision, and was used to answer all research questions. The reflection journal is a more detailed reflection of what I consider to be important from the session, video observation, consultation with the second coder or teammates, or consultation with my supervisor. The journal included my role as the therapist in each session, reasons for particular interventions, overall themes from the session or case, observations of clients' responses to interventions, how the plan for next session changed and why, and what I could or would have done differently. These notes allowed me an opportunity to think through interventions that were used, what could have been done differently to improve implementation of the intervention, and plans for interventions in the next session, as well as general thoughts about the implementation of my integrated model.

Procedures

The participants of this study were gathered through convenience sampling. Each session was held at the marriage and family therapy clinic at Utah State University. The participants contacted the MFT clinic on their own volition, seeking couple therapy. The couples were assigned to me through the clinic's normal rotation. When clients arrived

for therapy, they were asked to sign forms for informed consent for treatment, client's

rights and responsibilities, and informed consent for research (see Appendix A). Couples

that did not wish to sign the informed consent for research received therapy as usual with

no penalty. A memo from the program director was received, approving the use of

existing clinic data in this study (see Appendix A), which was the basis for approval for

the research from Utah State University's Internal Review Board (see Appendix A).

Couples were asked to complete the RDAS questionnaire before each session and

the OQ-45.2 before every other session. The second observer observed sessions either

live or on videorecordings. Vidoerecordings of four sessions were observed by the

therapist and the second observer. The fidelity checklist was filled out during these

observations. The case notes were filled out after each session per the MFT clinic rules

and regulations. Notes were recorded in the reflection journal after each session, after

and during observing the videorecording, and after teammate and supervision

consultation.

Data Analysis

I analyzed the data myself. The benefits of analyzing the data myself are that I

have specific goals when analyzing each source of data. My closeness to this study

allowed for strengths and weaknesses. My familiarity with GMCT and CBCT integration

allowed me to notice details in therapy that are of importance. However, my closeness

may have resulted in personal biases of my subjective analysis of the integration.

Consultation with the second coder for the first four sessions helped increase my

confidence in the reliability of the checklist. The coding of the checklist also assisted in

my altering some of the interventions. Case notes and the reflection journal also assisted

in my analysis of the data.

Research Question One: How Well Did I
Maintain Fidelity to My Integrated
Treatment Model?

After establishing reliability of the instrument, checklist codings were examined

to verify how well I remained consistent with the integrated model for this study. If the

examination suggested that I did not remain consistent with the interventions of the

integrated model presented in chapter II, I reevaluated my therapy and the model to

determine how certain interventions could be adjusted or utilized differently, which

intervention may need to be adjusted or removed from the model, and how the checklist

may be adapted by altering intervention descriptions or adding interventions.

Interventions that were used but not included in the GMCT/CBCT checklist were noted

in the reflection journal.

Research Question Two: When This Integrated
Model Was Used, Did Clients Report
Meaningful Changes?

Data for this research question were approached in two ways: (a) did client's

report changes between sessions, and (b) was change taking place over the course of

treatment? In evaluating client changes for between sessions and over the course of

treatment, I triangulated the data by using the RDAS, OQ-45.2, client report, case notes,

and case reflections. The RDAS was administered before each session and the OQ-45

was administered before the first, third, fifth, seventh, and ninth sessions, respectively.
Fifty-minute sessions were held on a weekly basis. Because the focus of this study was
relationship satisfaction, client change refers to the relationship rather than individual
change only. Change between sessions was reviewed as well as overall change from first
to final session. Scores gave a perception of marital satisfaction for each spouse over
time. This information was also used to provide clinical information for therapy.

In-session reports of change were discussed at the beginning of each session. I
began the session by asking about what was different in the previous week, good or bad.
I also asked the couple about the homework assignment and how it was implemented.
Client reports were described in case notes. I reported observable changes in the couple
within sessions in the case notes as well as in the reflection notes. These reports included
descriptions of patterns of interaction between clients, changes in affect or demeanor, and
changes in how the clients interacted with me. Data were aggregated to provide pictures
of change both between sessions and over the course of the case. Data are reported in
both graphical and narrative forms.

**Research Question Three: How Did Working
With an Integrative Model Influence
Ongoing Sessions or Cases?**

The GMCT/CBCT checklist was used to analyze clients' responses to
interventions. If the therapist or the second coder reported that the client did not receive
the intervention as well as expected, the therapist found ways to alter the presentation of
the intervention for the next time it was used. If the intervention was received positively
from the couple through report or coding, the therapist used the reflection notes to

describe how the intervention was presented and any changes that could be made to make it better.

This process worked well to inform the use of one intervention to different cases; it also informed me of the direction of treatment for each case. For example, if the couple responded well to communication training in one session, I continued using this intervention. However, if the couple did not respond well to communication training, I chose a different route of treatment. Change from an intervention depends on many factors that include my presentation of the intervention and the client's readiness to change (DiClemente, Schlundt, & Gemmell, 2004). However, Talmon (1990) observed that most clients who quit after a single session do so because they have accomplished their goals for therapy. When working with a couple dyad, one person may be coerced to come to therapy, which can bring short-term compliance but long-term resistance (Prochaska, 2000). Many times, it is believed that the traditional male is less likely to recognize relational problems (Moynehan & Adams, 2007), thus being coerced to attend therapy. Whatever the case, early engagement for both spouses with validation to the male and female in the first session may enhance motivation and retention rate in the early stages of therapy (Moynehan & Adams, 2007). I included information of the use of an intervention in case notes and reflection notes. Patterns noted in the coding charts and reflection notes are reported in the Results section of this document.

Research Question Four: What Did I Change in My Model Through the Course of This Study?

Data for this question were taken from all instruments. The case notes and

reflection notes were used to discuss the presentation of the interventions and how they were implemented. What was going on in the sessions before, during, and after the intervention was also noted. The GMCT/CBCT checklist was used in a similar fashion but was used to record which interventions the therapist used the most and how they were received by the clients. The RDAS and the OQ-45.2 were used to report change by the couple in graphical form. Changes in my approach, either in terms of interventions or overall, were noted through examination of these data and are reported in the Results chapter of this document.

CHAPTER IV

RESULTS

This study was designed to explore my fidelity to my particular integration of Gottman method couple therapy (Gottman, 1999) and cognitive-behavioral couple therapy (Baucom & Epstein, 1990), whether the approach resulted in change for the couples in the study, how each session and case affected my work in other sessions and cases, and how the integration was modified as a result of this study. The findings are reported sequentially through the research questions. Themes that presented themselves from specific sessions and overall course of therapy for each case and across cases are reported. The results in this chapter come from information gathered from 17 sessions with the three couples discussed in Chapter III.

Research Question One: How Well Did I Maintain
Fidelity to My Integrated Treatment Model?

The GMCT/CBCT checklist was created to determine how well I used the integrated model of treatment that I prefer and was used to code each session. Four sessions were coded by a colleague and I coded every session. The other coder and I coded these sessions separately and then compared our results to establish acceptable reliability of the instrument. The information gathered through the checklist allowed me to determine how well I was following the integrated treatment model through charting specific interventions, concepts, and techniques used in each session. Data are depicted in Table 1.

Table 1

Interventions Across Sessions For All Couples

Session	1	2	3	4	5	6	7	8	9	10	11
GMCT											
Love maps											
Couple 1	X	X	X					X			
Couple 2	X	X									
Couple 3	X	X									
Fondness and admiration system											
Couple 1	X										
Couple 2	X										
Couple 3	X		X								
Four horsemen											
Couple 1			X	X	X	X					X
Couple 2											
Couple 3				X							
CBCT											
Socratic questioning											
Couple 1				X			X	X	X	X	X
Couple 2	X										
Couple 3	X	X	X								
Skills training											
Couple 1	X	X	X	X	X	X	X				
Couple 2	X	X									
Couple 3	X	X		X							
Cognitive restructuring											
Couple 1			X	X					X		
Couple 2											
Couple 3											

Note. Line indicates final session for the couple.

Gottman Method Couple Therapy

The GMCT/CBCT checklist was designed to code for three concepts from Gottman method couple therapy: love maps, fondness and admiration system, and the four horsemen (Gottman, 1999). These concepts were selected because they are integral to reaching the treatment goals in Gottman method couple therapy and the integrated model for this study.

Love maps. Love maps interventions are used in creating a map of a partner's intrapsychic world (Gottman, 1999). Love maps interventions are used early in therapy to begin to enhance the couple's friendship. For all three couples, love maps interventions were used in the first two sessions.

Fondness and admiration system. The fondness and admiration system interventions are used to reconnect partners with feelings of fondness and admiration (Gottman, 1999). These interventions aim to increase the amount of praise and appreciation between spouses. For all three couples, fondness and admiration system interventions were used in the first session. Couple 3 received these interventions again in session 3.

Four horsemen. The four horsemen interventions are used to decrease the use of negative interactions that can be detrimental to a relationship (Gottman, 1999). These interventions include educating and/or coaching about the four horsemen, soft startup, repair attempts, and flooding. In this study, the four horsemen interventions were usually used in concurrence with CBCT's communication training interventions. The four horsemen interventions were used mostly with couple 1.

Cognitive-Behavioral Couple Therapy

The GMCT/CBCT checklist was designed to code for three concepts from cognitive-behavioral couple therapy: Socratic questioning, skills training, and cognitive restructuring. These concepts were selected because they are integral to reaching the treatment goals in cognitive-behavioral couple therapy and the integrated model for this study.

Socratic questioning. Socratic questioning is a series of questions to help an individual reevaluate the logic of his or her thinking, understand how the individual has reacted in similar situations, and for the individual to gain a deeper understanding of assumptions, expectations, and perceptions (Baucom & Epstein, 1990). This questioning can be used at any time throughout therapy. Socratic questioning was used with all three couples, couple 1 receiving the most during sessions 4 through 11. Socratic questioning was used more frequently toward the end of the study, implemented in 9 of the final 10 sessions.

Skills training. Skills training interventions are behavioral and emotional interventions in which the main goal is for partners to behave in more positive and less negative ways toward each other (Dattilio et al., 1998; Epstein et al., 1988). The main behavioral skills training intervention used in this study was communication skills training. Skills training was used with all three couples in the first two sessions and was used mostly with couple 1.

Cognitive restructuring. Cognitive interventions are used to help the couple attribute behavior positively. In intimate relationships, behaviors carry great meaning

and not considering cognitive factors can limit the effectiveness of treatment (Baucom et al., 2008). Cognitive restructuring can be used in terms of automatic thoughts, cognitive distortions, or by being discussed as negative thoughts that can hinder the relationship. For couple 1, cognitive restructuring was used in three sessions. Cognitive restructuring interventions were not used with couples 2 or 3.

Research Question Two: When This Integrated Model Was Used, Did Clients Report Meaningful Changes?

Data from clients' reports as reflected in case notes, RDAS and OQ-45.2 scores, and reflection journal notes were utilized to determine changes reported by the clients. The RDAS was administered before each session. The OQ-45.2 was administered before the initial session and before each third, fifth, seventh, and ninth sessions when clients attended more than two sessions. These assessments were used to quantitatively measure change. Client report was documented in case notes for each session as well as in the reflection journals. Case notes and reflection journal notes also reported observable in-session changes in the clients. The RDAS was administered to each client before each session. The score on the initial administration of the RDAS was used as a baseline to measure change as treatment progressed.

Part One: Did Clients Report Changes Between Sessions?

At the beginning of each session, each couple was asked how their previous week had been and if they had noticed any changes. These questions were asked with an

emphasis on what was discussed in the previous sessions. Responses varied from seeing significant positive results to noticing negative changes. The negative changes that were reported stemmed from the presenting problem and somebody who was not satisfied with the level of change they had observed. The RDAS was administered before each session and was a helpful tool in determining change between sessions. The OQ-45.2 was not administered every session; therefore, data from that instrument were not used to answer this research question.

Homework was similar for each couple after the first session. This homework addressed Gottman's (1999) love maps. Partners in each couple were instructed to connect with each other every day. This homework was discussed at the beginning of the second session.

Couple 1. Jason and Stacey reported positive changes from the homework. They reported opening up about their day more and they both felt more appreciative of each other's sharing more. Jason and Stacey continued to report positive changes each session until the seventh session. The sixth session consisted of Gottman's (1999) intervention that addresses dreams within conflict. The dreams within conflict interventions were not included on the GMCT/CBCT checklist; however, I felt that this intervention was appropriate for this couple and noted in my reflection journal. The couple struggled to remember communication skills previously learned in therapy. Jason was more interested in convincing Stacey why he had changed rather than having a balance of the deeper meaning of his position and learning to accept influence from Stacey. The couple reported that it took a couple of days to recover from the previous session. The dreams

within conflict intervention was used again. This time, Stacey did much better at using active listening skills and validating Jason's dream. Stacey's dream was much more evolved than the previous session. Jason became defensive during Stacey's turn, which caused him to attack Stacey's dream, which caused Stacey to cry.

Per Gottman's instructions when finding resistance, I asked each person what it was that they were afraid of to accept influence from the other. This proved to be helpful because the couple reported positive change at the beginning of the eighth session. This positive change was initiated by Jason who proposed finding common values to teach their children. The couple appeared to let their guard down and make the first step toward accepting influence from each other.

At the ninth session, the couple reported that they had had a big argument the night before the session. Jason decided to get drunk at home and Stacey did not want their children to see Jason drunk. This argument reverted the couple back to thinking that there was no hope for the relationship. As a result, the ninth session consisted of conflict management, Socratic questioning, and cognitive restructuring.

Stacey requested an individual session that took place 2 days after the ninth session. During this session, Stacey asked for ideas about how she could respond to Jason when Jason attacks her and calls her names. I reminded Stacey about the concept of flooding and to utilize taking a break.

The couple reported more positive changes at their final session. The couple stopped coming to therapy because, as Stacey reported in a phone call, Jason did not want to come to therapy any more. However, Stacey reported positive changes since their final

session during a phone call 2 weeks after their final session.

Both Jason and Stacey's total scores for the RDAS in their initial session was below the clinical cutoff of 41 (lower scores indicate more distress; see Figure 2). Stacey's initial score of 35 was lower than Jason's initial score of 38. Scores for both increased to above the clinical cutoff score by the third session. Jason's score continued to increase until the sixth session. Stacey's scores increased until the fifth session. They both experienced a dramatic decrease in scores in the ninth session. By their final session, scores for both were above the clinical cutoff score. Stacey's scores suggested the biggest change with a difference of 16 points and being above the clinical cutoff by 10 points at 51. Jason's final score was 42. His highest score was 48 at session 5.

Couple 2. Zane and Gwen reported that they already connected with each other every day on the phone so the homework did not do much to increase their positive communication. It was more difficult for Zane and Gwen to connect on a deeper level
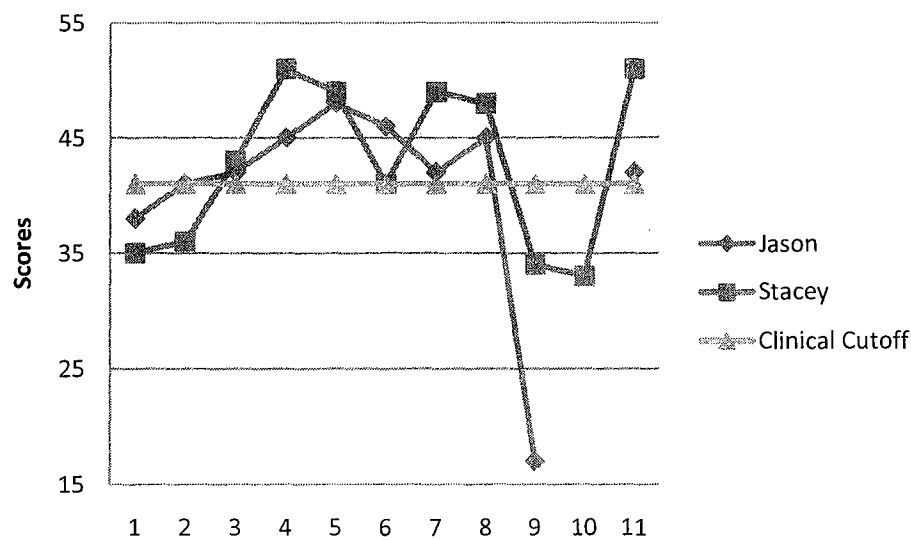

Figure 2. Couple 1 change in RDAS total scores.

because they were not living together and saw each other only a couple of times a week. Zane reported positive change in terms of his drinking. The biggest improvements with regard to this issue were that he was not drinking on the weekends after he got home from work, and was not drinking and driving.

Zane and Gwen attended only two sessions. They both presented above the clinical cutoff score of 41 on the RDAS at intake (see Figure 3). Zane's score at intake was 42 and increased by 2 to 44 at session 2. Gwen's intake score was 43 and decreased at session 2 to 42.

Couple 3. During session number 2 for Alan and Lucy, the couple reported not arguing as much in the previous week. They attributed this progress to connecting with each other more often. Because they did not argue as much and connected more, they reported feeling closer to each other than at the initial session. Session 3 was 2 weeks later at which time the couple reported doing better but they were not sure why. Socratic
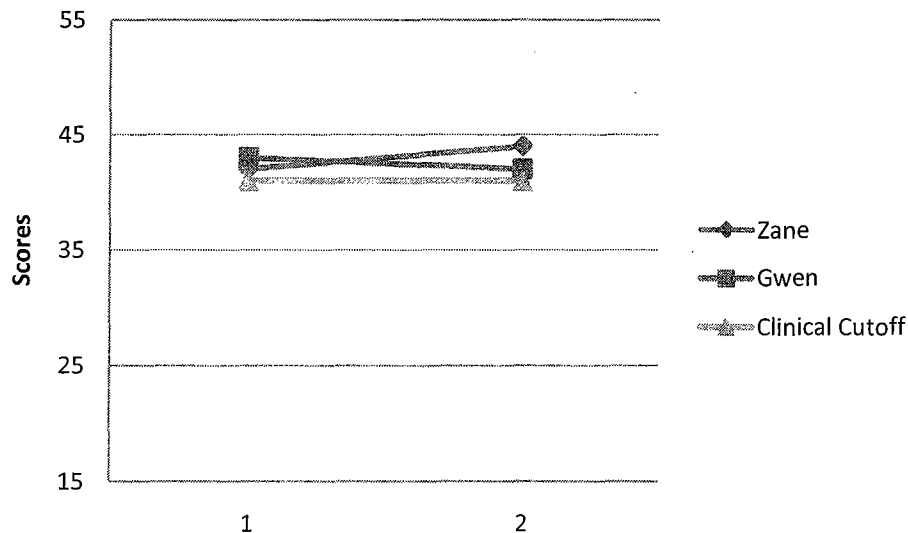

Figure 3. Couple 2 change in RDAS total scores.

questioning was used. Lucy then attributed the positive change to connecting with each

other. Alan agreed and added that connecting with each other had helped him become

more aware of Lucy's needs, which helped them make it through the 2 weeks between

sessions without an argument. The fourth session for Alan and Lucy was 3 weeks later at

which time the couple reported having a discussion rather than an argument. The couple

agreed on more positive change from connecting. Lucy attributed the change to showing

each other more appreciation and "everything else we have done in here."

Alan and Lucy attended four sessions. At intake, Alan's total score was above

the clinical cutoff at 47 points (see Figure 4). His score did not change at session number

2 but did at the third session and in the final session to 55. Lucy's intake score was

below the clinical cutoff at 40 points. Her score dramatically increased by 14 points to

54 at session 2. For session 3, her score decreased to 45 but had another dramatic
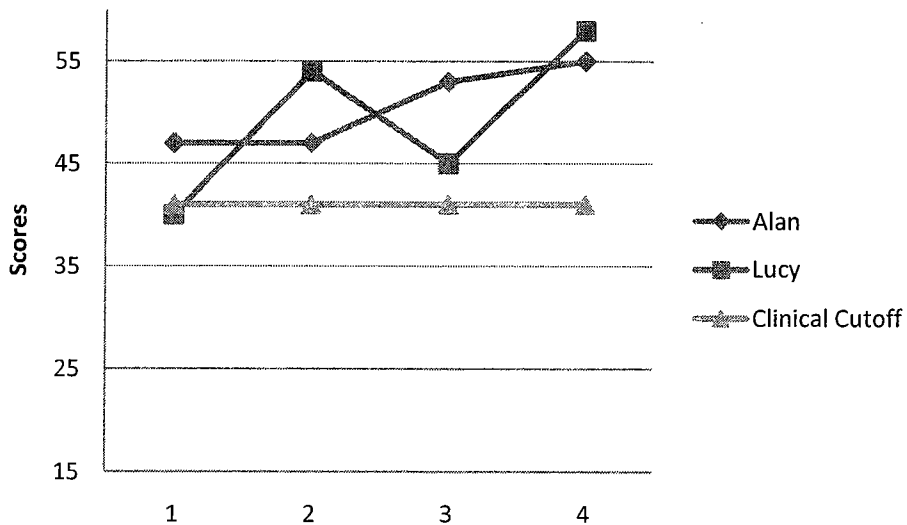
increase by 13 points to 58 at session 4.

Figure 4. Couple 3 change in RDAS total scores.

All 3 couples reported positive changes between sessions as reported by the couples and by analyzing RDAS scores. Couple 1 reported positive changes in 7 of the 10 sessions they attended as a couple. Couple 2 reported positive changes between the first and second sessions. However, the RDAS scores did not reflect these reported improvements. Couple 3 reported positive changes at every session they attended. The final session couple 3 attended showed the highest scores each of them reported, which reflected the couple's report in session. Overall, all three couples made improvements between sessions.

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

The RDAS was administered to each client before each session. The score on the initial administration of the RDAS was used as a baseline score to measure change as treatment progressed. The OQ-45.2 was administered to each client before the first session. The score on the initial administration of the OQ-45.2 was used as a baseline score to measure change as treatment progressed. The clinical cutoff for the overall score for the OQ-45.2 is 63 points with lower scores suggesting less distress. The scores on the interpersonal relations subscale of the OQ-45.2 were helpful to me in following stress levels regarding the relationship. The clinical cutoff for the interpersonal relations subscale is 15 points with lower scores indicating less distress. Using cutoff points on these scales, therapists can easily examine the clinical significance of reported and observed changed (Crane et al., 2000). When clients attended more than two sessions, the OQ-45.2 was administered to each client before the third, fifth, seventh, and ninth

sessions. Observable changes were reported in case notes and journal reflections.

Couple 1. Both Jason's and Stacey's total scores for the RDAS in their initial session were below the clinical cutoff of 41 points. Stacey's initial score of 35 was lower than Jason's initial score of 38. By their final session, both scores were above the clinical cutoff. Stacey's scores suggested the biggest change with a difference of 16 points and going above the clinical cutoff by 10 points to 51. Jason's final score was 42. His highest score was 48 at session 5. The RDAS score changes match the changes from observations, client report, and teammate consultation as reported in case notes and reflection journals.

Jason and Stacey completed the OQ-45.2 before the first, third, fifth, seventh, and ninth sessions. Stacey completed the OQ-45.2 before her individual session 2 days after the ninth session (see Figure 5). Jason's overall initial score was 97 points, which was above the clinical cutoff (see Figure 6). This score decreased to 87 at session 3, increased to 100 at session 5, decreased to 95 at session 7, and decreased again to 88 at session 9. Jason's scores were all above the clinical cutoff level. Stacey, on the other hand, never reported overall scores above the clinical cutoff level. Her intake score was 52, which decreased to 41 at session 3, decreased again to 35 at session 5, increased to 41 at session 7, increased to 48 at session 9, and decreased to 47 at her individual session.

For the interpersonal relations subscale of the OQ-45.2, Jason reported scores above the clinical cutoff every administration of the instrument and his score increased each administration. The intake score for Jason was 21, which increased to 22 at session 3, increased to 23 at session 5, increased to 25 at session 7, and increased again to 26 at

session 9. Stacey's score at intake was above the clinical cutoff at 16 and decreased to

below the clinical cutoff at 11 at session 3, and decreased to 10 at sessions 5 and 7. At

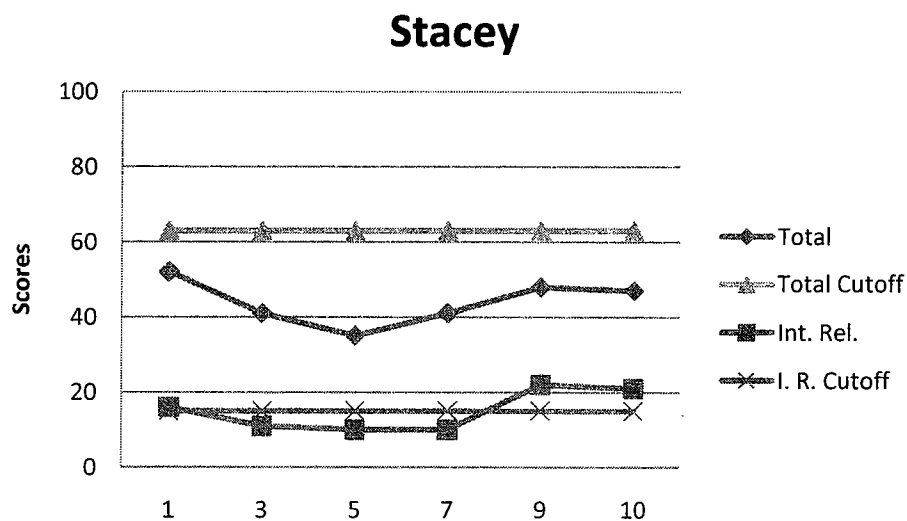session 9, Stacey's score increased to 22, which was above the clinical cutoff and 6

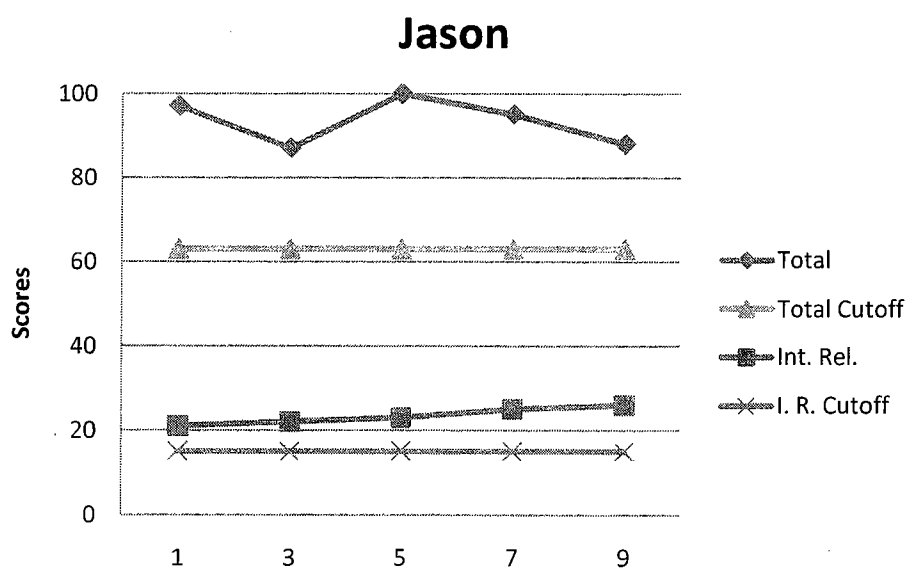*Figure 5.* Stacey's OQ-45.2 scores.

Figure 6. Jason's OQ-45.2 scores.

points higher than at intake. Before Stacey's individual session, her score decreased to 21.

When the intervention of the four horsemen for Jason and Stacey was used in the third session, it appeared that the couple tried not to use the four horsemen during the enactment. In the fourth session, the first enactment was started harshly with criticism by Jason. I let the enactment continue to help the couple see the effects of a harsh startup. The enactment ended harshly as I expected, which was a good introduction to the soft startup intervention. The second enactment was started softly and the couple did not use as many horsemen. By the fifth session, the couple's communication skills were steadily improving, which was demonstrated by the enactment used in session. For the sixth session, I decided to use Gottman's (1999) dreams within conflict intervention because the couple appeared to be making steady progress. The couple reverted to their previous communication strategies during the dreams within conflict intervention. The following was taken from my reflection journal after the session:

Jason was caught in the cycle of telling Stacey his point of view, even during Stacey's turn to discuss her dream within the conflict. Jason was instructed to listen as a friend would listen. Instead, he cut her off and tried to contradict her side with his side. This happened a couple of times throughout the session. Since the therapist stopped Jason, he gave his point of view when it was his turn. Again, the therapist had to stop him and redirect him to the topic. Jason criticized the church, which caused Stacey to cry. This could be perceived as an attack toward Stacey. I sense more resistance from Jason as we go. Stacey asked good

questions to try to understand Jason's position. Jason did not do anything to soothe Stacey when he attacked her and made her cry. Even when Stacey was crying, she validated Jason.

The dreams within conflict intervention was continued during the seventh session with the couple's showing improvement in the formulation of their dreams. However, a similar pattern presented itself: Stacey used active listening and validated Jason while Jason defended his position and used criticism, making Stacey cry. At this point, I was more directive and asked the couple what they were afraid of in accepting influence from each other. This question was aimed more at Jason than Stacey. It appeared to help because the couple reported coming to a compromise between sessions.

Couple 2. Zane and Gwen attended only 2 sessions; both presented with scores above the clinical cutoff score of 41 points on the RDAS. Zane's score at intake was 42, which increased by 2 to 44 at session 2. Gwen's intake score was 43. At session 2, Gwen's score decreased by 1 to 42.

Gwen and Zane did not take the OQ-45.2 a second time because they did not attend a third therapy session. As a result, the data obtained from their OQ-45.2 scores cannot be compared to follow-up scores.

Gwen and Zane were present for only two sessions but there were some beginning stages of change observed in the second session, particularly with Zane's expressing his emotions. Zane started to cry when he was discussing his relationship with his family and how it was not a good model for his children. Gwen did a good job in soothing Zane while he was sharing his feelings. The couple also showed positive changes in

communication when discussing their goals for their relationship in 1 and 10 years. They both used active listening skills and validated each other.

Couple 3. Alan's intake score on the RDAS was above the clinical cutoff at 47 points before the initial session. His final score was the highest he reported at 55, an increase of 8 points from the initial session. Alan's score never decreased during the four sessions. Lucy's initial score was below the clinical cutoff at 40. Her final score increased dramatically by 18 points to 58. The RDAS score changes match the changes from observations, client report, and teammate consultation as reported in case notes and reflection journals.

Alan and Lucy were administered the OQ-45.2 before the initial session and session 3. Alan's total initial score was 58 points, which is below the clinical cutoff (see Figure 7). Before the third session, Alan's score decreased 4 points to 54. Alan's interpersonal relations subscale was 16 for the initial and third sessions. Lucy's initial overall score was 46; her score decreased by 16 points to 30 at the third session (see Figure 8). Her interpersonal relations subscale score at intake was 18, which is above the clinical cutoff. Before the third session, Lucy's interpersonal subscale decreased to 13 points. Alan and Lucy were present at four sessions. During this limited time period, the couple made many improvements. They presented to therapy with communication difficulties and low affect manifested by Lucy's feeling "grossed out" by Alan. By the fourth session, the couple reported feeling much closer to each other and having "discussions" rather than arguments. After the fourth session, I questioned how much more communication training would be beneficial for Alan and Lucy, as reported in the

reflection notes.

All three couples reported positive changes. These improvements were reflected

in each person's RDAS scores but not in the OQ-45.2 interpersonal relations subscale
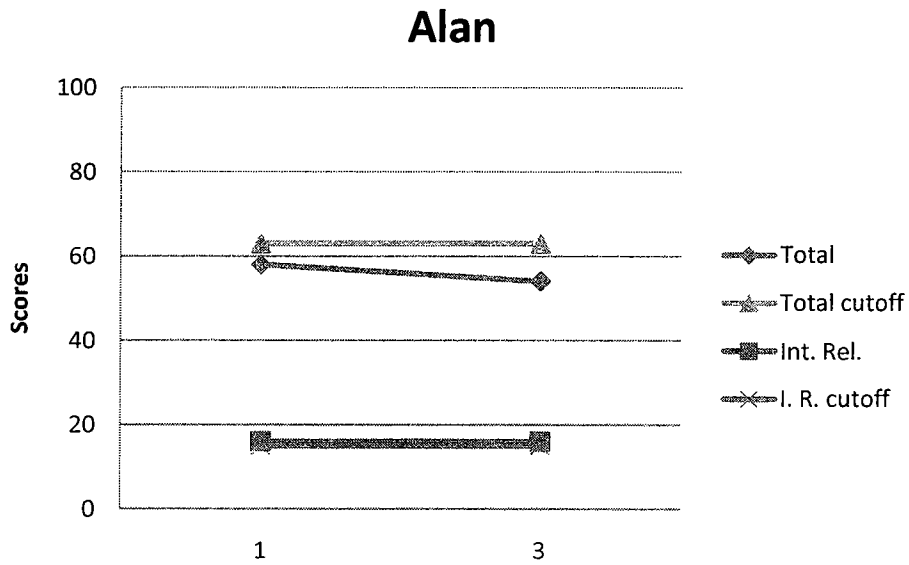
Alan

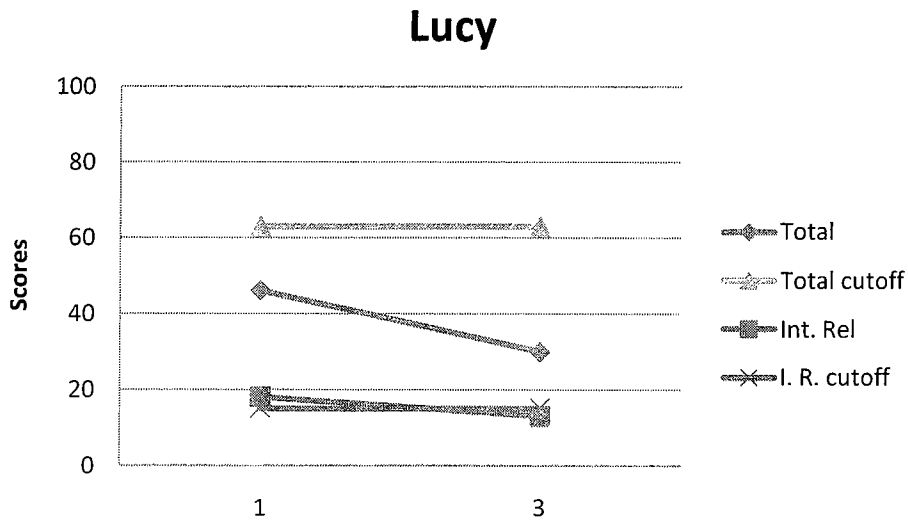*Figure 7.* Alan's OQ-45.2 scores.

Lucy

Figure 8. Lucy's OQ-45.2 scores.

scores, which indicates that these instruments may not be measuring the same thing. The only person that improved on the interpersonal relations subscale was Lucy; Jason, Stacey, and Alan reported either no change or negative change.

Research Question Three: How Did Working With an Integrative Model Influence Ongoing Sessions or Cases?

The GMCT/CBCT checklist was used to analyze clients' responses to interventions. If the second coder or I observed that the client did not receive the intervention as well as expected, I changed the presentation of the intervention for the next use or stopped using the intervention. Case notes and journal reflections were used to describe the presentation of the intervention and any changes that could be made to make it better.

Communication training was received positively by Jason and Stacey throughout treatment, so it was continued with all three couples. The love maps intervention in which the couple is instructed to discuss recent and upcoming events in each other's lives was used with Jason and Stacey in session 2. The couple stated that the activity was easy because they had already discussed these issues. In session 2 with Zane and Gwen, I had planned to use the same intervention but the couple reported that they knew what was going on in each other's lives. Therefore, I used the goals intervention in love maps. Because of couple 1's and couple 2's reports, I did not use this intervention with couple 3. However, from the positive response to the goals intervention with Zane and Gwen, I used the same intervention with couple 3 with a positive response.

In the third session with Jason and Stacey, I addressed cognitive restructuring by discussing how negative thoughts can be detrimental to a relationship and discussed the cognitive distortion of overgeneralization. The couple understood this concept. I liked the informal use of this intervention, so I used the same format during the fourth session when Stacey brought it up. During the ninth session, the use of this concept backfired because Jason stated that Stacey was overgeneralizing and needed to stop, which I perceived as an inappropriate use of the concept. I did not use this intervention with couple 2 or 3 because I was afraid of another backfire.

In the fourth session with Alan and Lucy, I changed how I presented the four horsemen interventions. With Jason and Stacey, I spaced the interventions across multiple sessions, starting with educating about the four horsemen in one session, using a soft startup in the next session, and repair attempts and flooding in the final session. With Alan and Lucy, I combined all interventions into one session. One reason I chose to do this was that Alan and Lucy appeared to have better communication than when they presented to therapy. Another reason I changed how I presented these interventions is that they all work together. Alan's and Lucy's responses to these interventions were positive and they agreed to work on them as homework.

Research Question Four: What Did I Change in My
Model Through the Course of This Study?

Case notes, reflection notes, and the GMCT/CBCT checklist were utilized to determine the effectiveness of interventions and how they were received by the clients.

The RDAS and OQ-45.2 questionnaires were utilized to assess client change between sessions and throughout therapy. All data were utilized to make possible alterations to the integrated model throughout the course of the study and after the collection of data was completed.

I did not use cognitive restructuring interventions from CBCT as much as I thought I would. When I used these interventions, the clients' responses were not always positive. After the third and final use of cognitive restructuring interventions, I decided not to use them for the remainder of the study. The main intervention used from CBCT throughout the study was communication training. Socratic questioning was also used often but more toward the end of the study.

I used more of Gottman's sound marital house ideas than I thought I would. With Jason and Stacey, I went higher in the sound marital house than I planned for this study. Even with the mixed response from Jason and Stacey about the dreams within conflict intervention, I think it contributed to positive change.

After reviewing the use of interventions for each model, one may think that my integration has changed to selective borrowing of CBCT interventions. However, I believe my integration of assumptions of GMCT and CBCT has not changed. I still perceive problems as couples' being in negative sentiment override, which contributes to their negative thinking patterns and poor communication skills. I presented these assumptions in Chapter II. However, the interventions I use to elicit change are primarily from GMCT and Gottman's SMH.

CHAPTER V

DISCUSSION

The purpose of this study was to test how well an integrated model of therapy is practiced within the proposed theoretical framework for one therapist. Three couples who presented for therapeutic services participated in the study. Seventeen therapy sessions were conducted. Each session was videorecorded and coded with the GMCT/CBCT checklist. Case notes and a reflection journal were used to describe the course of each session and the therapist's decision-making process for each session. The RDAS was administered before each session and the OQ-45.2 was administered before the initial session and before the third, fifth, seventh, and ninth sessions, when clients attended more than two sessions. The results of this study suggest that I applied interventions consistent with my integrated model of therapy. The application of the integrated model of therapy was shown to be beneficial to every couple in certain ways.

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

Research Question One: How Well Did I Maintain
Fidelity to My Integrated Treatment Model?

Gottman Method Couple Therapy

Love maps. The GMCT/CBCT checklist coding sheets showed that love maps interventions were used in 8 of the 17 sessions. The majority of the use of love maps

interventions were in sessions 1 and 2. The most commonly implemented interventions were having the couple discuss how they handled previous and current events and the homework of connecting every day.

Love maps interventions are critical in the early stages of my integrated model. I had hoped to use love maps more frequently when this study began. However, after reviewing the videorecordings and the checklists, I believe that I used the love maps interventions twice when they should not have been used. I am referring to the events intervention during the second session with couples 1 and 2. This intervention asks for the couple to share significant events that have recently happened or are about to happen in their individual lives. The goal is to have couples begin to communicate and to connect more with each other about all aspects of their lives. Couple 1 did not respond well, stating that they already knew these things about each other and they had conversations similar to this all the time. Couple 2 had a similar reaction to the same intervention. I did not use this intervention with couple 3 because of couple 1's and 2's responses. This intervention can still be useful, but perhaps with couples that are much more disconnected than the couples that participated in this study.

The events assessment of love maps was also addressed in the initial session for all three couples in terms of the dynamic relationship history. During the dynamic relationship history, I asked the couples about the course of their relationships and how they handled significant events in the past. This type of questioning is important in helping me understand how couples cope with significant events and transitions in their relationships. It is also important in reminding the couple about previous successes and

how they were triumphant in the past. After couple 2 did not respond well to the events intervention in the second session, I decided that I needed to pay better attention to this assessment in terms of the couple's communication about current events. This helped with couple 3 and my decision not to use that intervention with them.

Love maps homework was used in all eight sessions that love maps interventions were used. In the first session, this homework was phrased in terms of connecting with each other on a deeper level. The first-session homework was simple in asking the couple to have a conversation about their day both during the day and at home when the day was over. All couples reported positive change from this homework, which enabled it to evolve into finding more ways for the couple to connect.

Fondness and admiration system. An examination of the coding sheets revealed that I used fondness and admiration system interventions in 4 of the 17 sessions. The most commonly implemented intervention within the fondness and admiration system was assessment.

Assessment within the fondness and admiration system was done during the dynamic relationship history. This assessment was used to assess the level of fondness and admiration the couple had toward each other. This is assessed through the level of positive affect the couple exhibits when reminiscing about the past, for example, if they are able to joke and laugh about their first date, if their descriptions of qualities about what attracted them to their partner are positive, if they physically touch, or if they communicate together while giving detailed descriptions.

This assessment is crucial in my integrated model, specifically in GMCT. This

assessment determines where to begin in Gottman's SMH (1999). Jason and Stacey showed positive affect during the assessment and they reported knowing everything about each other during the love maps intervention. The couple showed that they were able to move up in the SMH past love maps. However, I disregarded my assessment of their fondness and admiration toward each other and immediately moved up the house to work on the four horsemen. The results showed that the couple were not in positive sentiment override which caused the communication training of the four horsemen and the dreams within conflict interventions to fail. I discussed this during a meeting with my supervisor. Her advice to me was to slow down, which was helpful.

With couple 3, I spent more time in the fondness and admiration system, using the third session to help the couple create an appreciation checklist. The result was that when the couple was introduced to the four horsemen, they had not had an argument in so long that they could not create an enactment to work on the four horsemen. In essence, I slowed down and worked on the couple's fondness and admiration system which sped up the couple's progress so that communication was not a major factor they needed to work on.

Four horsemen. An examination of the coding sheets revealed that I used the four horsemen interventions in 6 of the 17 sessions. The four horsemen interventions were usually used in concurrence with CBCT's communication training interventions. The most commonly implemented intervention was education and/or coaching of the four horsemen.

It was interesting that both couple 1 and couple 3 reported using defensiveness in

the first session when describing their communication styles. I did not address the four

horsemen at this time because I felt that it important for the couple to be in positive

sentiment override before discussing the four horsemen. However, I might have used the

four horsemen with couple 1 before the couple was in positive sentiment override and the

response of the four horsemen intervention did not exhibit as much change as was

expected. I learned from couple 1's response and waited until couple 3 was in positive

sentiment override with a more positive response before introducing the concept.

Another interesting response from the education of the four horsemen with couple

1 was that Jason became defensive with me. It is possible that he was defensive so much

with Stacey that this was his natural response; both Jason and Stacey described being

defensive on multiple occasions. Because of Jason's response, I paid close attention to

my presentation of the four horsemen while watching the video. I observed that it is

important for me to state early in therapy what I have seen with the couple without

pointing blame. Also, early pointing out of the cycle that the four horsemen usually

follow is helpful: criticism –> defensiveness –> contempt –> stonewalling. I used this

technique with couple 3, which resulted in a much more positive response.

Another technique I changed in the presentation of the four horsemen from couple

1 to couple 3 was the duration of all interventions within the four horsemen. With couple

1, I spaced out each intervention to take up a full session by itself. For example, I used

the third session to educate and coach the couple about the four horsemen; I used session

4 to help them learn about using softened startups. Session 5 consisted of educating and

practicing repair attempts and flooding. By the fifth session, I noticed that Jason looked

bored when repair attempts were being discussed. With couple 3, I presented all aspects of the four horsemen in the same session as one intervention. Again, this was met with a positive response from couple 3.

Watching videorecordings with a reflection journal was beneficial in identifying observable changes. However, after reviewing the videorecordings, I was disappointed to note some things that I did not notice during session. When using the dreams within conflict interventions with Jason and Stacey in session 8, I became frustrated because they were not grasping the concept. When reviewing the videorecording, I noticed more nonverbal interactions that were manifestations of contempt from Jason to Stacey. Jason also criticized her by criticizing the church and easily became defensive. It is likely that I would have intervened had I detected this at the time. Watching the videos brought to light the fact that I need to pay attention to verbal and nonverbal cues, particularly in terms of the four horsemen.

Cognitive-Behavioral Couple Therapy

Socratic questioning. An examination of the coding sheets revealed that I used Socratic questioning in 10 of the 17 sessions. The most commonly used techniques were probing and guided discovery. Socratic questioning was implemented in 9 of the final 10 sessions used in this study.

Socratic questioning is a major aspect in my integrated model and needs to be used more to reach its potential, which is shown by the increased usage toward the end of the study. Socratic questioning is important in couple therapy in identifying each partner's perceptions of change throughout the week. This is especially important if the

couple has had an argument in the previous week. Jason and Stacey presented with a couple of different arguments that happened during the week, so I probed their perceptions. Perceptions of each individual's perspective were identified as well as each partner's perception of their overall progress after the argument. The increase of its use toward the end of the study is a positive sign that I am feeling more comfortable with the integrated model.

Skills training. The coding sheets revealed that I used skills training in 12 of the 17 sessions, the most-used intervention in the study. The most commonly used technique in skills training was communication training.

Each couple presented with skills deficits in communication, which could have contributed to the high number of usage. Another possibility is that communication training is easily integrated into Gottman's (1999) SMH interventions. Many of Gottman's interventions have a communication-training component. In my approach to therapy, I make communication training more explicit to the couple by having them work on active listening, validating, using "I" statements, and speaking about how they think and feel. Because of the easy integration, communication training was used in the first two sessions with all three couples.

Communication training was used with couple 1 as the primary intervention. The couple was asked to create an enactment to work on their communication skills. The couple provided the topic, which consisted of their original argument about religion. However, the couple was not in positive sentiment override, which contributed to their easily reverting to an argument with the four horsemen present. I should have worked

more slowly in helping the couple create positive sentiment override before I implemented communication training.

Communication skills training is important in my integrated model but its role is not as large as when the study began, especially in terms of communication training as its own intervention. I learned that positive sentiment override is the first and most important thing to develop with a couple. Communication training can be used along with some aspects of the love maps interventions to achieve the beginning goal of creating initial, rapid change toward positive sentiment override. When positive sentiment override is established, communication training is easier to do and may not be needed in some cases.

Cognitive restructuring. Coding sheets revealed that I used cognitive restructuring in 3 of the 17 sessions, the least used intervention of the study. The only used technique of cognitive restructuring was discussing the use of negative thoughts and how they can hinder a relationship.

This intervention was only used with couple 1, during which I described the cognitive distortion of overgeneralization. However, later in therapy, Jason used this concept to attack Stacey, stating that she was overgeneralizing and needed to stop it. I perceived this as an inappropriate use of the concept. I was afraid to use cognitive restructuring with couples 2 or 3, fearing another inappropriate use.

Research Question Two: When This Integrated Model Was

Used, Did Clients Report Meaningful Changes?

Part One: Did Clients Report
Changes Between Sessions?

The RDAS was administered to each client before each session. The score on the initial administration of the RDAS was used as a baseline score to measure change as treatment progressed. Observable changes were reported in case notes and journal reflections. Couples mentioned several changes taking place between sessions. At the beginning of each session, each couple was asked how their previous week had been, the progress of any homework that was given, and whether they had noticed any changes. These questions were asked with an emphasis on what was discussed in the previous sessions. Responses varied from seeing significant positive results to noticing negative changes. The negative changes that were reported stemmed from the presenting problem and that somebody was not satisfied with the level of change they had experienced.

Couple 1 reported the majority of the negative changes in this study. These negative changes happened between sessions 6 and 9. Gottman's (1999) dreams within conflict interventions were used during these sessions to help the couple come to an understanding of each partner's symbolic meaning underlying religion. However, the couple was still caught in the cycle of the four horsemen, so this intervention was not as effective as it could have been.

It may also be that the use of this integrated model did not address the therapeutic goals for this couple. If interventions are being implemented to target certain goals and

these goals are not being reached by the level of change needed, some changes to the integrated model may be necessary. After reviewing the use of the integrated model for couple 1, I made substantive changes in my conceptualization of the integrated model: the focus early in therapy is to create positive sentiment override and when this is achieved, and only when this is achieved, can the couple move on to communication training with the four horsemen or dreams within conflict interventions.

Couple 1 also reported a lot of positive change throughout this study. From the intake session to session 6, Jason and Stacey reported positive changes that included decreased arguments, increased acknowledgment of the presence of the four horsemen, and closer connection. Jason reported a better awareness of when Stacey became defensive during conversations and he did not think he was using criticism. This helped because he used a repair attempt in apologizing and the couple tried the conversation again. These positive changes led me to believe the couple was ready to move on to the dreams within conflict interventions. The couple's worst session was session number 9. However, the couple reported positive change in their final session that appeared to give the couple hope about their relationship. Two weeks after the final session, Stacey reported in a phone call that the couple had made more positive changes including Jason's not criticizing or using contempt and Stacey's being more assertive. The RDAS scores coincided with the couples' report of positive and negative changes between session.

Couple 2 reported minor changes between the first and second session. They reported that the homework did not do much to increase their positive communication

because they already connected with each other on the phone every day. Zane reported

positive changes in terms of his not drinking as much. This positive change could have

stemmed from the use of scaling questions from the solution-focused therapy model (De

Jong & Berg, 2008).

The most positive change between sessions was reported by couple 3. During

session number 2, Alan and Lucy reported feeling more connected to each other, which

helped them not argue as much the previous week. This positive change stemmed from

the homework, which was for the couple to connect on a daily basis. The couple reported

more positive change in the third session, attributing this change to learning new ways to

connect with each other on a deeper level. They also reported not having an argument in

the 2 weeks between the second and third sessions. Alan attributed this to the couple's

deeper connection, which helped them be more aware of each other's feelings. During

the third session, the couple worked on the appreciation checklist, which appeared to be

very powerful for both partners. They shared things that they each appreciated in the

other and were instructed to complete the checklist at home, show each other appreciation

every day, and touch each other in an affectionate manner (physically and emotionally).

In the fourth session, 3 weeks later, couple 3 reported more positive changes

stemming from showing each other more appreciation. They reported that showing each

other appreciation had helped them be more aware of the little things that they each do

that enhance their lives every day. In the fourth session, the four horsemen interventions

were used and the couple was asked to create an enactment to help them be more aware

of the presence of the horsemen. The couple stated that they could not think of anything

that they could talk about that would be negative that would bring up the four horsemen. This positive change may have stemmed from the couple's being in positive sentiment override when they were introduced concepts of communication skills training. These changes align with the positive changes reported in the RDAS.

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

The RDAS was administered to each client before each session. The score on the initial administration of the RDAS was used as a baseline score to measure change as treatment progressed. The RDAS was not designed to be sensitive to change between sessions, which makes the overall change in scores more important. The OQ-45.2 was administered to each client before the first session. The score on the initial administration of the OQ-45.2 was used as a baseline score to measure change as treatment progressed. When clients attended more than two sessions, the OQ-45.2 was administered to each client before the third, fifth, seventh, and ninth session. Observable changes were reported in case notes and journal reflections.

Jason and Stacey attended 10 sessions together and Stacey attended one individual session. The couple reported to therapy with scores below the clinical cutoff or the RDAS total score, suggesting low marital satisfaction. By the last session, scores for both improved to above the clinical cutoff, suggesting overall positive change and marital satisfaction. Zane and Gwen attended only two sessions. They both presented with scores above the clinical cutoff at intake and neither's scores declined below the clinical cutoff at the second session. Alan and Lucy attended four sessions. Alan's

intake score was above the clinical cutoff and improved by the final session, suggesting an increase in marital satisfaction. Lucy's intake score was below the clinical cutoff at intake and showed a dramatic improvement to climb above the clinical cutoff by the final session suggesting an increase in marital satisfaction.

The interpersonal relations subscale of the OQ-45.2 was put into more focus than the overall score for the OQ-45.2 in this study. Jason scored above the clinical cutoff at every administration and his score declined at every administration, suggesting a decrease in distress in his interpersonal relationships. Stacey's score at intake was above the clinical cutoff at intake and declined by the final administration. Gwen and Zane attended only two sessions so their intake score could not be compared with follow-up scores. Alan's interpersonal relations subscale score did not change and was above the clinical cutoff for both sessions. Lucy's intake score was above the clinical cutoff at intake and improved to below the clinical cutoff at the third session, suggesting a decrease in distress in her interpersonal relationships.

The RDAS scores showed more improvement in scores than the interpersonal relations subscale for the OQ-45.2. Five of the six participants' RDAS scores improved from the intake to final sessions. Gwen's score was the only decline. However, she scored above the clinical cutoff and declined by only one point. Comparatively, the interpersonal relations subscale of the OQ-45.2 reported negative changes across the course of therapy. Three out of the four participants with scores compared did not report positive changes. The only positive change reported was from Lucy. She reported scores above the clinical cutoff at intake and declined to below the clinical cutoff by the next

administration. This discrepancy from the positive changes reported in the RDAS, client report, and observations with the interpersonal relations subscale in the OQ-45.2 may result from the possibility that the RDAS and the interpersonal relations subscale are measuring different things. After noticing this discrepancy, I reviewed some literature and the individual questions in each questionnaire. It appears that the interpersonal relations subscale is looking at problems individuals have with any relationship as shown by the question, "I have trouble getting along with friends and close acquaintances." The RDAS, on the other hand, appears to be measuring relationship satisfaction with a partner as shown by the question, "Do you and your mate engage in outside interests together?" Pedhazur and Schelkin (1991) agreed and suggested that the two measures are assessing different constructs.

Using cutoff points on these scales, therapists can easily examine the clinical significance of reported and observed changed (Crane et al., 2000). The most important change in these instruments is change from clinical to nonclinical levels. Three of the six participants reported scores in the clinical level on the RDAS at intake. Jason, Stacey, and Lucy all reported changes from clinical to nonclinical levels by the last session. However, this change was not reflected in the interpersonal subscale of the OQ-45.2. Three of the four participants who had their scores compared remained in the clinical level at the final administration.

The discrepancy in the changes of the scores between the RDAS and the interpersonal relations subscale of the OQ-45.2 is interesting to me. It may be that the interpersonal relations subscale by itself is not sensitive to the kinds of changes targeted

by my approach.

Scores from the RDAS and OQ-45.2 were triangulated with client report in session and observable changes that I noticed. The majority of the observable changes coincided with the RDAS scores. Couple 1 made positive observable and reported changes from intake to the end of therapy. These changes included a decrease in the use of the four horsemen, an improvement in positive affect, and a better understanding of each partner's symbolic meaning behind religion. The dreams within conflict interventions were not received positively by the couple and they did not report positive changes between sessions when this intervention was used. However, I believe the couple gained a better understanding of each other's position, which helped them make beginning improvements to an agreement of *how* they would negotiate parenting their children with different religious beliefs. Stacey reported an improvement of assertiveness during a phone call to me after the couple's final session. This may help Stacey stop the cycle of the four horsemen in the future if she feels that Jason is using criticism or contempt toward her.

Couple 3 showed the most improvement of the three couples who participated in this study. The biggest improvement was observed in Lucy. Lucy reported to therapy feeling "grossed out" by Alan and did not want to be around him at times. By the final session, Lucy showed positive feelings toward Alan in many ways. She laughed with him while telling stories, touched him on the arm while she laughed, and showed emotion when discussing things that she noticed had changed. The improvement in RDAS scores aligned with these changes.

Research Question Three: How Did Working With an Integrative

Model Influence Ongoing Sessions or Cases?

The work done in each case was an integral source of feedback for this study. When an intervention appeared to work well with a couple, it was more likely that I used the same technique for presenting the intervention with other couples. Some similar techniques were used with each couple. The use of interventions with couple 1 strongly influenced the work with couples 2 and 3. Interventions that did not seem to be helpful were altered or no longer implemented. This information was vital in planning for subsequent sessions.

The initial session format for the first session that was proposed in Chapter II was used with all three couples and received positive responses from all three couples. Because of the positive responses, the techniques used to implement the interventions were not changed. One technique that was not changed across the course of this study was Socratic questioning. Socratic questioning was not used as much in early sessions with couple 1. However, it was used in 9 of the final 10 sessions in this study. Most of the other interventions were either changed or not used again.

Communication training was used similarly in early stages of therapy with all three couples. This stems from communication training's ability to be easily integrated with GMCT interventions. Communication training was the primary intervention used with couple 1 past the third session. The couple reported positive changes from this intervention; however, when it came to the couple's using these skills to discuss their presenting problem, they were unable to do so. I now attribute this only short-term

change to the couple's not being in positive sentiment override. Because the couple was in negative sentiment override, neutral comments were perceived as attacks, which lead to the cycle of the four horsemen, and repair attempts were unsuccessful. I changed the use of communication training after completing therapy with couple 1, and focused on helping couple 3 create positive sentiment override before communication training was implemented. The response from couple 3 was much more positive than from couple 1. In fact, couple 3 was unable to create an enactment in which they could use the four horsemen. I do not know whether couple 1 would have had a similar response as couple 3 because of the nature of their presenting problem regarding religion, but I believe it would have given them tools to communicate about religion without using the four horsemen. In order to help couple 3 create positive sentiment override, I used the appreciation checklist which was not used previously in the study. However, the positive response to this intervention helped solidify my hypothesis about couples' needing to be in positive sentiment override before beginning communication training.

Supervision feedback was exceptionally helpful throughout this study. During the process of working with implementing the dreams within conflict intervention with couple 1, my supervisor assured me that I was following my integration well but was missing a key aspect with the couple and within my integration. He stated that Stacey was making bids for connection to Jason, who was not accepting the bids. This feedback was used in the following session with Jason and Stacey and started the process of creating the hypothesis of creating positive sentiment override before communication training.

Supervisor feedback was also helpful in solidifying my belief that therapy cannot be completely manualized. There were times during the process of therapy with couple 1 that therapy almost seemed robotic: assess for how the previous week went, brief introduction to a communication skill, facilitate an enactment for the couple to work on the skill, notice how the discussion process occurs, and give feedback with additional communication skills for the couple to work on. This process may be a useful template for some sessions, but it influenced me to have tunnel vision at times. After I watched a videorecording, I noticed bids for connection presented by Stacey and watched for such bids in sessions with other couples. The positive result was apparent with couple 3. The template was not used with couple 3; instead, I focused on the couple's connection and creating positive sentiment override rather than helping them communicate better.

Some interventions were no longer used after a negative response from one couple. Cognitive restructuring is the best example of this. When Jason used overgeneralization against Stacey as a way to criticize her, I was afraid to implement the CBCT intervention again, fearing a similar response. My level of training as a new therapist at the time of this study may have influenced this because of my lack of understanding about how to use the concept without negative results.

Research Question Four: What Did I Change in My Model Through the Course of This Study?

Case notes, reflection notes, and the GMCT/CBCT checklist were utilized to determine the effectiveness of interventions and how they were received by the clients.

All were utilized to make possible alterations to the integrated model throughout the course of the study and after the collection of data was completed.

After reviewing the use of interventions from my integrated model, I noticed that GMCT interventions elicited more positive change than CBCT interventions. I found myself more comfortable working within the framework of GMCT and integrating interventions from CBCT. Communication training is easily integrated into many steps within the GMCT SMH.

It may appear that I have changed my integration to selectively borrowing from aspects of CBCT with GMCT as my base theory. However, the way I view my integration is exactly how I proposed in Chapter II. I believe this integration fits equally because of the significant overlap in the theory's assumptions. Some may think that GMCT is an extension or stems from CBCT because of this significant overlap. I use more terminology from GMCT because of its ease of use for couples. What has changed is the interventions I use to elicit change, which are primarily through GMCT.

I have adapted Gottman's (1999) SMH to fit my own conceptualization. I have done this by creating an assumptions SMH (see Figure 9) and an interventions SMH (see Figure 10). These different houses are based in Gottman's SMH but separated for better understanding for myself.

The base for the assumptions house is labeled as *positive sentiment override*. This level consists of three sublevels: cognitive room, fondness and admiration system, and turning toward versus turning away. These three sublevels have been condensed into one level called positive sentiment override because I think positive sentiment override is the

overall goal when looking at the couples' cognitive room, fondness and admiration, and

ability to turn toward versus away. The first sublevel is called cognitive room because in

order for positive sentiment override to be present, partners need to create room in their

intrapsychic worlds for each other before they can create a map of each other's
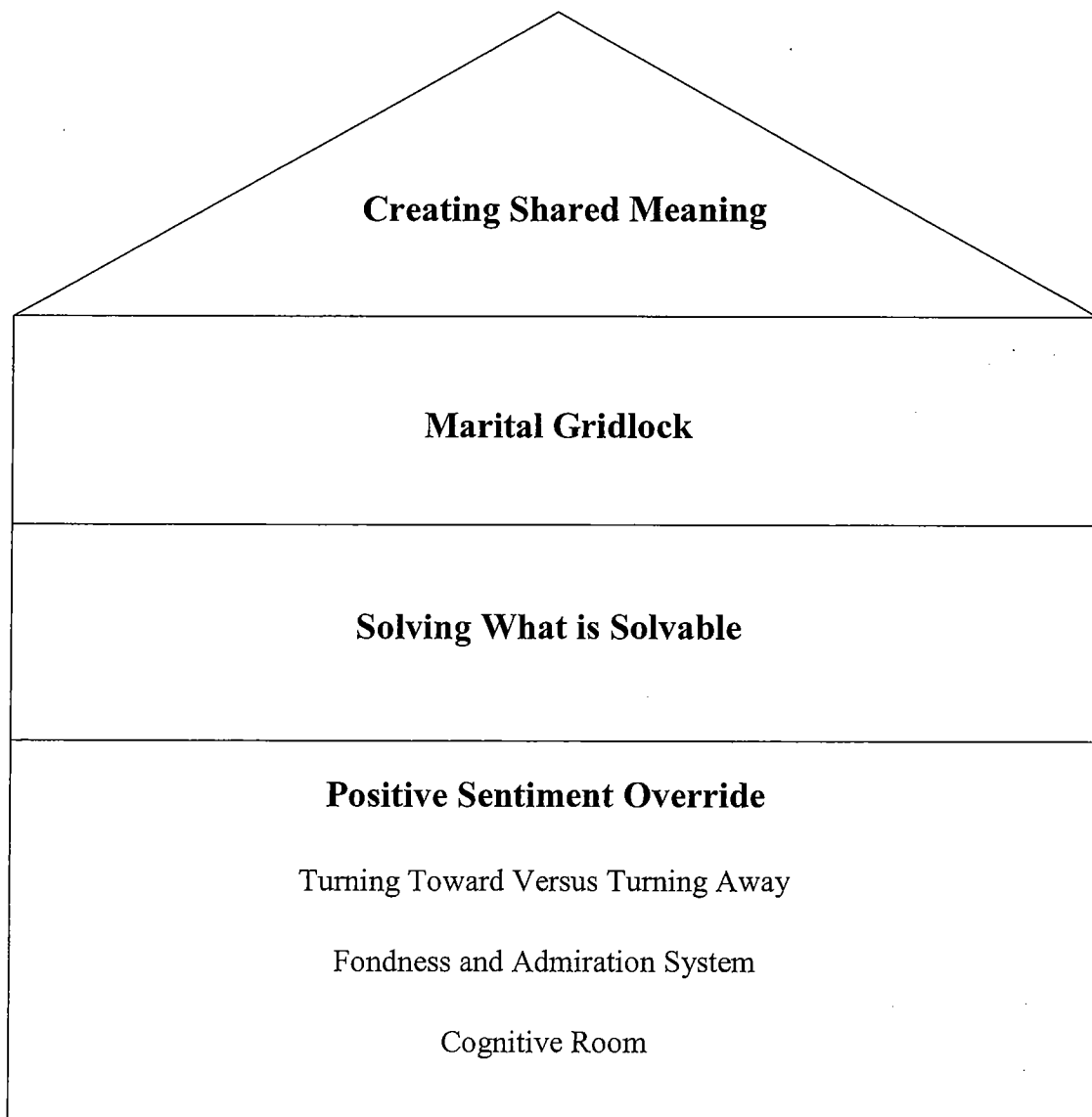
Creating Shared Meaning

Marital Gridlock

Solving What is Solvable

Positive Sentiment Override

Turning Toward Versus Turning Away

Fondness and Admiration System

Cognitive Room

Figure 9. Assumptions house.

intrapsychic world. The next level is called *solving what is solvable*. In this level, the couple learns communication skills that are integral to solving problems that are solvable. However, in order for the couple to reach this level of the house, they must have positive sentiment override. If the couple argues over perpetual problems, problems that will continue to be problems in their relationship, the couple is in *marital gridlock*. Examples of perpetual problems that can cause marital gridlock are religious differences and money spending. The goal of this level is to help the couple move from gridlock to dialogue (Gottman & Silver, 1999). This level can be used similarly as Jacobson, Christensen, Prince, Cordova, and Eldridge's (2000) model of therapy, integrative behavioral couple therapy. Integrative behavioral couple therapy is an acceptance-based couple therapy that "includes strategies to help spouses accept aspects of their partners that were previously considered unacceptable" (Jacobson et al., 2000, p. 352). If the couple does not have issues that are causing marital gridlock, they can skip this level of the house. The final level is unchanged: *creating shared meaning*.

The layout of this house is helpful in my conceptualization of problems within a relationship. An assumption of mine that helped in my conceptualization is that friendship is the foundation of a relationship. The bottom level of the assumptions house labeled as positive sentiment override, which represents the foundation of the house. If the foundation of a house is not positive and strong, the house will crumble. This is similar to relationships because if the couple is in positive sentiment override, solving problems becomes easier, perpetual problems are more likely to be accepted with less resentment, and it is easier to have a shared meaning system.

The interventions house is similar to the assumptions house in many ways but differs in some important aspects. Positive sentiment override is still the base level, which consists of three sublevels: *love maps, fondness and admiration system,* and the *emotional bank account.* The first sublevel is now changed to love maps because creating love maps is an intervention to create a map of partners' intrapsychic worlds. The third sublevel is changed to the emotional bank account. An emotional bank
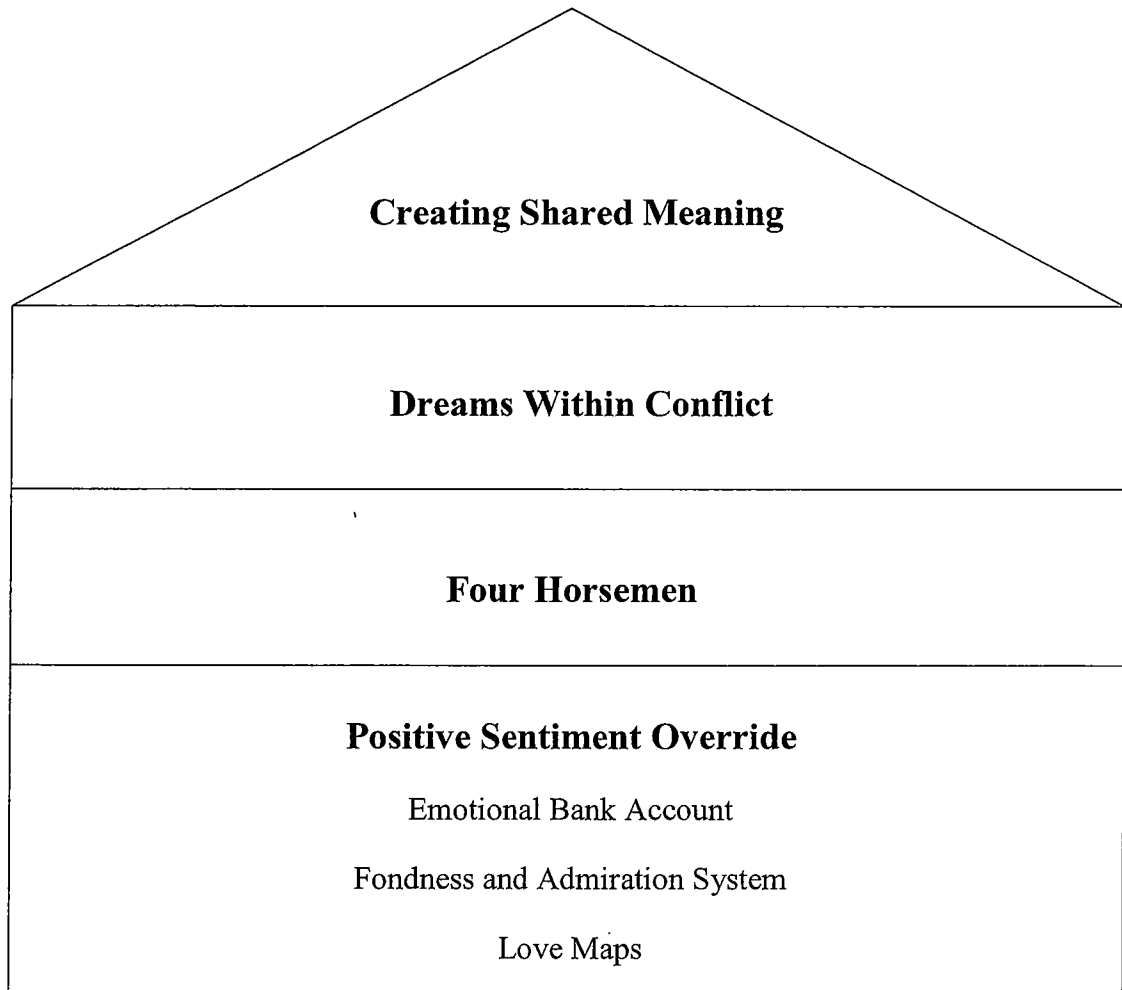
Creating Shared Meaning

Dreams Within Conflict

Four Horsemen

Positive Sentiment Override

Emotional Bank Account

Fondness and Admiration System

Love Maps

Figure 10. Interventions house.

account is where positive interactions are deposited and negative interactions are withdrawn (Gottman, 1999). This is the aspect of Gottman's theory that states that for a couple to be in positive sentiment override, they must have *at least* a ratio of five positive interactions to one negative interaction during conflict (Gottman, 1999). These interventions help couples create emotional bank accounts that will help them be more aware of their partners.

I have labeled the next level as the *four horsemen.* I used this label because in order for the couple to solve problems that are solvable, the four horsemen interventions must be used. However, positive sentiment override must be present if repair attempts will be successful in de-escalating negative affect during an argument (Gottman, 1999).

This helps in my conceptualization of the interventions house in terms of where to start if I notice that the four horsemen are present; that is, I may need to start lower in the house. The next level in the interventions house is creating *dreams within conflict.* Dreams within conflict interventions are used when marital gridlock is present and the couple is arguing over a perpetual issue. The final level again is unchanged and is labeled *creating shared meaning*, which consists of making dreams and admirations come true and meshing rituals, goals, roles, and symbols. These changes are based on Gottman's (1999) original SMH. However, splitting the SMH into an assumptions house and an interventions house makes it more simple in my conceptualization of Gottman's (1999) assumptions and interventions.

Other Findings

Other Interventions and Models

Interventions that were not listed as a part of my integrated model were implemented in some sessions. Aspects of solution-focused therapy (De Jong & Berg, 2008) were implemented in sessions with couples 2 and 3. Specifically, scaling was used with each couple. Scaling is a technique used to measure the clients' perceptions of progress toward goals as well as to motivate and encourage further improvement (de Shazer, 1994).

Scaling was used with Gwen and Zane in terms of assessing and making goals for Zane's level of drinking. I asked Zane and Gwen to each rank on the scale where they saw drinking for Zane to be a problem. They each reported a problem on the scale. Zane was then asked what the details of that number looked like and whether he wanted to change this number or not. He stated that he did, so he was asked what a small improvement would look like by the next session. In the second session, Zane reached and even passed his goal set forth in the previous session. This appeared to give Zane a sense of pride and Gwen a sense of hope.

Scaling was used in the first session with Alan and Lucy in terms of the couple's level of connection. They reported a very low level of connecting and were at a 2 on the scale. This scale was used again in the fourth session in which the couple reported being at 7 or 8 in terms of connection. This also appeared to give Alan and Lucy a sense of hope and pride that they had made such positive changes.

My observations of the use of scaling from the solution-focused model (De Jong

& Berg, 2008) led me to believe that it may be a useful addition to my integrated model of therapy. Scaling was helpful in terms of assessment early in therapy and helped couples make and observe small changes. When they reported positive change on the scale, it gave them hope, which, in turn, created more positive change by creating more connection. As I implement solution-focused therapy into my integrated model, the ability to provide hope to couples in beginning stages of therapy will be important.

An intervention that was used but not listed in the GMCT/CBCT checklist that is part of my integrated model is the dreams within conflict intervention from GMCT. I used this intervention with couple 1 in the sixth and seventh sessions. I used this intervention to try to help the couple describe to their partner the symbolic meaning underlying their position with religion. The couple had a difficult time identifying the symbolic meaning in the sixth session. The intervention was used again in the seventh session with a better response by Stacey.

Level of Training

The interventions used during the course of this study were implemented in ways that were specific to my level of training as a relatively new therapist. As a beginning therapist, it may be more common to abandon an intervention if one client does not respond well or the intervention backfires. An example of this is the use of cognitive restructuring with couple 1. I taught the couple about overgeneralizaiong and how it can be detrimental to the relationship. A couple of sessions later, Jason told Stacey to stop overgeneralizing when the couple were in an argument. I did not use that intervention again in this study. As my training has progressed, I have learned that the client's context

should affect when I implement interventions. I might not use cognitive restructuring with couples anymore, but I use it with individuals who present with depression or anxiety. This project has helped me to pay attention to details in therapy and in my integrated model. I am more confident in my abilities as a therapist, as well as my knowledge of GMCT and CBCT. Using what I have learned in this study continues to influence how and when I implement techniques and interventions.

Limitations

This study provided an in-depth look at the integrated model for one therapist. While many appealing patterns emerged from the results, it is necessary to note the limitations to this study. I created the GMCT/CBCT checklist used in this study to track my use of interventions, decide which interventions would be used throughout the course of therapy, analyze the use of interventions, write the case notes and the reflection journal, and provide the therapy. My subjective report in these items likely resulted in a biased interpretation of many aspects of change with the clients. The second coder also has biases that may have affected the way she coded the checklist. The second coder and I are friends, which may have influenced the coding of this project because of her desire for my success in this research project.

The sample used in this study was small and relatively homogeneous. All participants were within five years of age of each other and lived in Cache Valley; cultural factors may not have been explored in this study. Couples were selected through convenience sampling as they presented for therapy at the Utah State University MFT

clinic. They were assigned to me based on the regular rotation per clinic policy. The size of the sample prevents the possibility of this study being generalized, even by myself to my own therapy.

Reliability of the checklist was determined by the use of the two coders. The checklist has not been used in other studies to further determine its validity or reliability. Future research using the GMCT/CBCT checklist could assist in alteration of the checklist or the training manual to further establish reliability. Triangulation of the qualitative research was relied on by self-report questionnaires, which likely contain bias. However, the triangulation of these questionnaires, client report, and journal notes was an effort to increase validity of the results of this study.

The OQ-45.2 was administered before the initial session and if the couple attended more than two sessions, before the third, fifth, seventh, and ninth sessions. There were some limitations in terms of the OQ-45.2 score's triangulating with client report, observations, and RDAS scores. This may be because the RDAS and the OQ-45.2 were measuring different things. Pedhazur and Schelkin (1991) agree and suggested that the two measures are assessing different constructs. The RDAS measures relationship satisfaction with a partner while the OQ-45.2 interpersonal relations subscale measures distress in any family or friend relationship.

Clinical Implications

The results of this study directed several implications for me and for my integrated model of therapy. Although the interventions used in this study were not the

entire integrated model of therapy, this study did spotlight concepts, techniques, and interventions that I deemed central to my integrated model. In order to track changes in this study, some additions were made to my therapy practice for this study that I do not generally implement in therapy. Other than at the MFT clinic, I do not typically use the RDAS or the OQ-45.2. I do not typically ask the clients about what specific changes they have noticed since the previous session. Changes are usually noted through client reports as sessions progress and observations of their interaction patterns. Changes are also reported during a discussion of the homework because I usually give some type of homework for the couples to work on during the week. When a couple describes the homework or how their week went, I assess for changes in affect as shown by their body language, touching of each other, turning toward and talking with each other, or using humor. These interactions serve as natural enactments that assist in my continuous assessment of couples' levels of positive sentiment override. However, assessing for change in the manner that was used for this study was beneficial for my understanding of what helps couples change between sessions and over the course of therapy.

Changes to the Integrated Model

The purpose of this study was to evaluate my fidelity to the integrated model of therapy presented in Chapter II. The results of the study indicate that the model is useful for me in most regards. However, some alterations to the model will be made as a result of this project.

Watching videos, reviewing reflection journals, and evaluating the self-report questionnaires changed my conceptualization of the process of change with couples. At

the beginning of this project, communication skills training was used in early sessions because I believed couples needed to learn how to better communicate if they were going to have a happy relationship. When this approach was used, I noticed couples' using the communication skills they were taught, which made their communication among trivial topics much better. However, when the marital gridlock topic was broached, they reverted to their previous communication strategies. This caused a lot of frustration on my part as the therapist because I did not understand why they continued to use the four horsemen after I coached them about their presence. My supervisor reminded me of a major aspect that I was missing with the couple's interaction and in my integrated model: their level of sentiment override. After this reminder, I reviewed the case notes, reflection journals, and self-report questionnaires, which all supported this idea. This insight refined my conceptualization of my integrated model.

The process of conducting this research has allowed me to find a new way of assessing and creating hope. My integrated model of therapy is behaviorally based and is helpful for couples who are motivated to change. However, if a couple presents with one or both partners' not having hope for the relationship, they may not be motivated to complete interventions.

I recognize how important the element of hope needs to be in my integrated model. There are different models of therapy that focus on hope that can be added to my integrated model. Solution-focused therapy (De Jong & Berg, 2008) helps create hope with clients early in therapy in ways other than scaling. The main reason solution-focused therapy helps create hope is it helps the client see what positive changes they

want to make and the little steps that it takes to reach goals. I could also include a

narrative concept of reasonable hope (Weingarten, 2010). Reasonable hope "suggests

something both sensible and moderate, directing our attention to what is within reach

more than what may be desired but unattainable" (p. 7). Whichever aspect of hope I

choose to include in my integrated model, hope for the couple will be an important

addition.

Implementation of the Integrated Model

This study permitted me to spotlight the implementation of specific techniques

and interventions. Videorecordings and reflection journal notes indicated that several

changes to how I implement interventions may be beneficial to the therapeutic process.

The videos and client responses indicated that the use of some love maps interventions

may only be helpful for a couple that is disconnected in a way that they do not

communicate about current and upcoming events. Watching the video of the assessment

of events indicated that this level of communication can be observed and assessed during

the dynamic relationship history.

Comparing case notes and reflection journals to the videos helped me condense

the four horsemen interventions into one session. It appeared that clients' responses to

implementing these interventions in different sessions was negative. Client response to

all four horsemen interventions in one session was much more positive.

This project was beneficial to my understanding of my integrated model and

myself as a therapist. Watching the videorecordings helped me identify my strengths and

weaknesses of my therapy and my integrated model. This project provided me a unique

opportunity to critique and improve my skills as a therapist. This study helped me identify the benefit of using videorecordings to find things I may have missed during session. I will use videorecordings in the future with my own work outside of training.

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APPENDICES

Appendix A

Informed Consent for Treatment

Informed Consent for Research

Memo From the MFT Director

IRB Approved Letter

UtahStateUniversity

Case #:
Therapist:

Marriage & Family Therapy Clinic

INFORMED CONSENT FOR TREATMENT

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

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

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

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

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

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

Signed: _____   Date: _____

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature of PI

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

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

UtahState
UNIVERSITY.
Department of Family, Consumer, and Human Development
USU MFT Program
2700 Old Main Hill
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INFORMED CONSENT FOR RESEARCH
Utah State University Marriage and Family Therapy Program

_____

Participant's signature

_____

Date

_____

_____

_____

Witness

_____

Date

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

_____

Name

_____

Date

_____

_____

_____

_____

.

Permission granted? ___ Yes   ___ No

ID # _____

UtahState
UNIVERSITY

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

October 8, 2009

IRB Board

The Marriage and Family Therapy Program at Utah State hereby grants Matt Withers permission to use our clinical data for his thesis research.

Thank you

Scot M. Allgood, Ph.D.

Marriage and Family Therapy Program Director

Utah State University

UMC 2700

Logan, UT 84322

435-797-7433

UtahState University

Institutional Review Board
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SPO #:
AES #: UTA00

10/27/2009

MEMORANDUM

TO: Thorana Nelson
        Mathew C. Withers

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

SUBJECT: The Application and Evolution of an Integrated Theoretical Approach to
          Couple Therapy: A Case Study

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

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

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

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

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

Appendix B

GMCT/CBCT Checklist and Training Manual

Revised Dyadic Adjustment Scale

GMCT/CBCT Checklist

Client ID: Session #:
Date of Session: Date of Review:
Reviewer:

CBCT Concepts, Techniques, and Interventions

Concepts and Techniques	Yes	Details—client response
Socratic Questioning		
Guided Discovery		
Exceptions		
Probing		
Skills Training		
Skills Deficit		
Communication Skills		
Emotional-Expressiveness		
Cognitive Restructuring		
Addressed		
Automatic Thoughts		
Cognitive Distortions		

GMCT Concepts, Techniques, and Interventions

Techniques/Interventions	Yes	Details—Client response
Love Maps		
Events		
Goals		
Homework		
Fondness and Admiration System		
Assessment		
Appreciation		
Checklist		
Four Horsemen		
Education and/or coaching		
Startup interventions		
Repair		
Flooding		

FIDELITY CHECKLIST TRAINING MANUAL

Each of the concepts, techniques, and interventions on the GMCT/CBCT Checklist are described below. The observer will check the box next to the concept, technique, or intervention on the checklist based on the descriptions provided below. The observer will describe the client's response to the intervention in the details box next to the specific intervention. After the session is over, the observer will return to the category and describe subjective impressions of the overall effectiveness of interventions. A description will follow each heading to detail what may be done by the therapist in order to achieve each of these therapeutic goals.

Cognitive-Behavioral Couple Therapy

Socratic Questioning

For the observer to mark *Yes* on the Checklist, the therapist must accomplish any one of the concepts described in this section.

Guided discovery: The therapist uses logical questioning to help the clients identify alternative ways of viewing something. In therapy, the end goal is for client insight. This insight can be what the therapist is going for or something else that is more positive than the current perception.

Exceptions: The therapist asks questions about how the client reacts in similar situations but different contexts. For example, when working with a client with anger management issues with his wife, the therapist may ask, "What have you done when you get angry with someone at work or school?" This type of questioning helps the client understand that he or she has reacted differently in different situations.

Probing: Probing can begin with simply asking more in-depth questions about assumptions, expectations, perceptions, etc. Later in therapy, this can also be used to alter assumptions, expectations, perceptions, etc.

Skills Training

For the observer to mark *Yes* on the Checklist, the therapist must accomplish any one of the concepts described in this section.

Skills Deficit: The therapist assesses for skills deficits through an enactment. When the therapist notices a skills deficit within the couple's interaction, it will be pointed out. With any type of skills training, content of the training is specified first. For example: communication skills or emotional-expressiveness training.

Communication skills training: The therapist works on this skill in session in the form of an enactment. Each partner learns to express his or her current desires and

preferences, acknowledge her or his partner, and assist in staying appropriately solution-oriented.

Emotional-expressiveness training: The therapist works on this skill in session in the form of an enactment. This includes teaching expresser skills to the person expressing emotions and empathic listener skills to the receiver. The expresser is to express valid emotions and the thoughts that are associated with the emotions. The receiver accepts the expresser's right to have these thoughts and feelings through validation. This can be done with positive or negative emotions. Expressing positive emotions may be easier to express at first, so the first step may be to practice expressing these emotions and empathically listening.

Cognitive Restructuring

For the observer to mark *Yes* on the Checklist, the therapist must address negative thoughts and accomplish at least one of the concepts described in this section.

Addressed: The therapist notices negative thoughts and addresses this. The therapist will explain why negative thoughts are detrimental.

Automatic thoughts: The beginning step of cognitive restructuring. The therapist discusses the interaction of thoughts, feelings, and behaviors. This leads to the discussion of automatic thoughts and the homework of identifying automatic thoughts.

Cognitive Distortions: The therapist educates the clients about this concept and asks for them to identify which distortions they use the most. The therapist instructs the client to add to the automatic thoughts homework by identifying the cognitive distortions of each automatic thought.

Gottman Method Couple Therapy Techniques

Love Maps

For the observer to mark *Yes* on the Checklist, the therapist must accomplish at least one of the concepts described in this section.

Events: In the dynamic relationship history (discussed in fondness and admiration systems), the couple is asked about significant events that have influenced their relationship to this point. The therapist asks how the couple made it through these events. This intervention looks for positive affect and exceptions. The next intervention in this section consists of the couple's taking turns discussing the most important recent and upcoming events in their lives. This assists in helping each spouse be part of the other's life.

Goals: The goals section of this intervention consists of more than one intervention. In the first intervention, the couple is instructed to discuss what they would like their relationship to be like in the future. In the second intervention, the couple is instructed to discuss any changes they would like to make in their personal lives (not the marriage). For each of these interventions, the therapist coaches the couple to stick to the positive things and to state their goals in a positive manner.

Homework: For each intervention in this section, the couple is instructed to have similar conversations at home. After the couple completes the in-session love maps interventions, the therapist gives the couple a homework assignment. This homework is one of two things. In the first homework assignment, the couple is instructed to find one way of making contact with each other every day. The second homework assignment is a handout that each spouse uses to interview the other to answer the questions.

Fondness and Admiration System

For the observer to mark *Yes* on the Checklist, the therapist must accomplish at least one of the concepts described in this session.

Assessment: Assessment for the love maps intervention is primarily done in the first session. The therapist conducts a dynamic relationship history. This assessment is used for many reasons. The first is to assess for level of positive affect in the relationship. The second is for the couple to think about the reasons that they got together; this helps to initially increase positive affect.

Appreciation: The therapist instructs the couple to each make a list of three to five positive qualities that attracted him or her to their spouse when they first met and a specific incident that exemplifies the characteristic. The next intervention has the couple look at positive qualities the partner shows currently and shares them in session.

Checklist: The final intervention consists of the couple creating a checklist with everything they value about each other. The therapist instructs the couple to focus on what their partner is adding to their life each day. They are also instructed to touch their partner (both verbally and physically) in a purely affectionate manner every day.

Four Horsemen

For the observer to mark *Yes* on the Checklist, the therapist must accomplish any one of the concepts described in this section.

Educating and/or coaching: The therapist notices the presence of the four horsemen and describes them. The therapist explains how harmful they are to a relationship, especially contempt. The therapist asks for an enactment and coaches the couple in not using the four horsemen. Homework is given to work together on decreasing the use of the four

horsemen.

Startup: The therapist addresses the startup and gives examples of a harsh startup. The therapist asks for an enactment with a soft startup. The couple is given homework to use a soft startup to begin conflict discussions.

Repair: The therapist explains the importance of repair attempts and how they are done. The therapist asks the couple for examples of repair attempts that they use or could use in the future. Usually after the enactment that is prescribed for the four horsemen, the therapist points out repair attempts. In following sessions, the therapist asks what repair attempts have been implemented in their interactions.

Flooding: The therapist describes flooding as an overload of negative emotions. The therapist discusses gender differences in physiological reactions, which assists in males' stonewalling more often than females'. The therapist instructs the couple to take a break when they feel this increase in heart rate. The break should be at least 20 minutes. When the couple feels more calm, they should come back together and discuss the conflict with a soft startup and without using the four horsemen.

ID# _____
Date _____
Session # _____

Revised Dyadic Adjustment Scale
(RDAS)

Instructions: Most persons 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 Agrees	Almost Always Agrees	Occasionally disagree	Frequently disagree	Almost Always disagree	Always disagree
1. Religious matters	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. Demonstrations of affection	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3. Making major decisions	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. Sex relations	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5. Conventionality (correct or proper behavior)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
6. Career decisions	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
7. How often do you discuss or have considered divorce, separation, or terminating your relationship?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. How often do you and your partner quarrel?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Do you every regret that you married (or lived together)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. How often do you and your mate "get on each other's nerves?"	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Every Day	Almost every day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

How often would you say the following occur between you and your mate:

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. Work together on a project	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. Calmly discuss something	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Appendix C

Handouts

Love Maps Handout

Ask your partner the following questions to fill in the information requested below.

The cast of characters in your partner's life

Who are your partner's friends?

Who are your partner's potential friends?

Who are the rivals, competitors, "enemies" in your partner's world?

What are recent important events? (what has occurred recently that is important to your partner?)

What are some important upcoming events? (what is your partner looking forward to?)

What are some current stresses in your partner's life?

What are some of your partner's current worries?

What are some of your partner's hopes and aspirations for self and others?

Labeling Cognitive Distortions

Event	Automatic Thought	Emotional Response	Cognitive Distortion	Behavioral Response	Alternative Response