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THE ANALYSIS OF AN INTEGRATED MODEL OF THERAPY
USING STRUCTURAL AND GOTTMAN METHOD
APPROACHES: A CASE STUDY

by

Taylor Herrin

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

of

MASTER OF SCIENCE

in

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

Approved:

Thorana S. Nelson, Ph.D.
Major Professor

Scot M. Allgood, Ph.D.
Committee Member

Michael K. Hinds, M.S.
Committee Member

Byron Burnham, Ed.D.
Dean of Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah

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ABSTRACT

The Analysis of an Integrated Model of Therapy Using Structural and
Gottman Method Approaches: A Case Study

by

Taylor C. Herrin, Master of Science

Utah State University, 2009

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

The purpose of this study was to investigate the usefulness of an integrated model of therapy for one therapist. Qualitative and quantitative data were gathered from three family dyads. Ten therapy sessions were coded and analyzed to evaluate fidelity to the treatment model. Several themes emerged from the data that provided a foundation for analysis and clarification of the integrated model. The results of this research are organized into four research categories: fidelity to the integrated model, clients and change, how one session or case informs another, and how therapeutic decisions were made. Results indicate that the therapist maintained fidelity to the integrated model and client changes resulted. An analysis of the treatment model is discussed, along with schemes for decision-making and the implementation of therapeutic techniques. Clinical implications and limitations are discussed.

(140 pages)

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Taylor C. Herrin

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CHAPTER I

INTRODUCTION

Research indicates that the lifetime prevalence rate of divorce among first marriages is 40-50% (Kreider & Fields, 2002). Of marriages that end in divorce, 40% occur within the first five years of marriage, and 67% occur within ten years (Gottman & Levenson, 2002). Data suggest that failure rates for second marriages are similar or potentially higher than for first marriages. Numerous studies indicate the consequences of marital dissolution on adults and children (Graham, Christian, & Keicolt-Glaser, 2006; Holt-Lunstad, Birmingham, & Jones, 2008; Kpasowa, 2003; Martin, Friedman, Clark, & Tucker, 2005). Researchers have found that the quality of marriage also affects children (Amato & Sobolewski, 2001; Gottman, DeClaire, & Goleman, 1998; McLanahan & Sandefur, 1994; Seltzer, 2000). Although research shows that children benefit from growing up with two parents in a low-conflict marriage, little rigorous research has been performed to ascertain how these kinds of marriages are to be promoted and accomplished (Gottman, 1999).

The Scientist-Practitioner Model

The scientist-practitioner model is based on the philosophy that trained mental health professionals should be knowledgeable in both research and clinical practice (Jones & Mehr, 2007). This approach incorporates science and practice where “each must continually inform the other” (Belar & Perry, 1992, p.72). The architects of the scientist-practitioner model believed that psychological education was to be viewed as fluid and experimental rather than predetermined and prescribed (Baker, 2000). A mental health

professional is practicing from the scientist-practitioner model when the role of clinician and researcher has been blended into one entity (Jones & Mehr). The scientist-practitioner is “someone who applies critical thought to practice, uses proven treatments, evaluates treatment programs and procedures, and applies techniques and practices based on supportive literature” (Jones & Mehr, p. 770). Lebow (2006) suggested that examining one’s own practice is beneficial and can lead to improved therapy.

Problem

Given the need for promoting healthy marriages, clinicians are under increased scrutiny to show effectiveness in their services and treatment (Yates, 2003). The purpose of this study is to examine the usefulness of an integrated model of therapy for one therapist in a clinical setting. The integrated model of therapy examined in this study is composed from elements of Minuchin’s structural family therapy (SFT; Minuchin, 1974; Minuchin & Fishman, 1981) and Gottman method couples therapy (GMCT; Gottman, 1999). This study attempted to integrate aspects of SFT and GMCT into a cohesive model of therapy and apply this model to clients who seek therapy.

The aim of the research was to find themes and methods of intervention that are most beneficial to the researcher in a therapeutic setting. These findings have allowed the researcher to better understand the integrated model of treatment, how this model fits with the researcher as a therapist, and how and when to use this integrated model in ways that are beneficial to clients seeking therapy.

Clinicians in the field of mental health services have a duty to become proficient in their craft to ensure that clients can feel secure in knowing that they are receiving the best care possible. For the researcher, this project was anticipated to be an initial step toward this proficiency. This research was not intended to establish generalizable evidence that this integrated model of therapy is effective, but to discover its usefulness to this researcher in a clinical training setting.

CHAPTER II

REVIEW OF LITERATURE

This chapter examines key concepts, techniques, and mechanisms for change posited by structural family therapy (Minuchin & Fishman, 1981) and Gottman method couple therapy (Gottman, 1999). Each of these models of therapy has its foundation in systems thinking (Gottman; Minuchin, 1974). An integration of these models of therapy will be presented as a basis for the research focus of this project.

Systems Concepts

Systems thinking is counterintuitive to traditional ways of thinking in Western society (Becvar & Becvar, 1998, 2006). Rather than focusing on the individual and individual problems viewed in isolation, systems thinking attends to context and to relationships and relationship issues between individuals. Understanding comes as the context of the interaction is considered: each person influences every other person in a relationship. This interactional process of mutual causality recognizes the interdependence of the observer and the observed. Understanding “requires assessing patterns of interaction, with an emphasis on *what* is happening rather than *why* it is happening” (emphasis in original; Becvar & Becvar, 2006, p. 8). From the systems thinking perspective, the focus in therapy shifts from treating individuals to recognizing patterns of interaction, recursion, and mutual influence; emphasis is placed on relational processes rather than the content of interaction.

Recursion

Systems thinking posits that people operate in *recursive relationships* (Becvar & Becvar, 1998). From this perspective, people or events are viewed in the context of mutual influence and mutual interaction. Instead of examining individuals in isolation, relationships and how each person “interacts with and influences the other” is the focus (Becvar & Becvar, 2006, p. 65). Each individual in a relationship or system influences the understanding and experience of every other member of the relationship or system. This concept can be applied to entire systems as well; every time one system comes in contact with another system, each influences and is influenced by the other.

Feedback

The aspect of recursion that involves self-correction is called *feedback* (Watzlawick, Beavin, & Jackson, 1967). Feedback specifically refers to information about past behaviors, experiences, or interactions that is fed back into the system. The system then responds to this information by either maintaining the status quo or accommodating the new behaviors or interactions through systemic changes. According to Watzlawick et al., “Feedback is known to be either positive or negative; the latter . . . characterizes homeostasis and therefore plays an important role in achieving and maintaining the stability of relationships. Positive feedback, on the other hand, leads to change” (p. 31). Systems are self-correcting because feedback provides a system with information that is used to create or maintain the best conditions for the system, whether that is change or no change. This feedback is

utilized in making necessary alterations and rejecting undesirable changes according to the system's rules, tolerance, and ability to accept change.

Rules and Boundaries

Every system operates according to certain rules. These rules are made up of “characteristic relationship patterns” within each system (Becvar & Becvar, 2006, p. 69). Rules determine what behaviors are appropriate within the system. A system's rules demarcate the *boundaries* between it and other systems—the system's rules form the boundaries that make each system unique. Boundaries are established from repeated patterns of behavior within a system. When a new behavior is introduced to the system, results are put into the system in the form of feedback. The system then uses this information to either accommodate the new behavior by altering the boundaries of the system, or to exclude the behavior by maintaining the previous boundaries in a return to the status quo. Boundaries regulate the amount and type of information that comes into a system. Boundaries may be clear, rigid, or diffuse (Becvar & Becvar). Clear boundaries are firm and yet flexible; family members offer support, but each is allowed a degree of autonomy (Minuchin & Fishman, 1981). Rigid boundaries imply “disengagement within and between systems” (Becvar & Becvar, pp. 178-179). This may include isolation and distance between family members. Diffuse boundaries occur when family members rely on each other at the expense of autonomy (Minuchin & Fishman). The key to appropriate boundaries is balance (Minuchin & Nichols, 1993).

Structural Family Therapy

Structural family therapy emerged in the 1960s and 1970s through the work of Salvador Minuchin and his work at the Jewish Board of Guardians, the Wiltwyck School for Boys, and the Philadelphia Child Guidance Clinic (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Minuchin & Nichols, 1993). According to Simon (2008), Minuchin and his colleagues grew frustrated with the traditional psychoanalytic ideas of linear causality (A causes B), which posits that each person's behavior is caused by his or her internal psychodynamics. Minuchin's group began to follow the lead of early systems theorist Don Jackson by experimenting with a systemic view of "circular causality" (A influences B, which influences A, which influences B, and so forth), which views each person's behavior as both an effect and a cause of his or her interactional partner's behavior (Minuchin & Nichols; Simon). Minuchin (1974) found that these dyadic concepts were unable to comprehensively describe interactional dynamics in a system composed of more than two people.

Minuchin and colleagues attempted to develop concepts that would bring a systemic way of thinking to whole families rather than just dyads (Minuchin, 1974; Minuchin et al., 1967; Minuchin & Nichols, 1993; Simon, 2008). Minuchin's group began to view families as systems comprised of subsystems demarcated by boundaries, which govern the behaviors of family members (Minuchin; Minuchin & Nichols). Structural family therapy as set forth by Minuchin views family functionality as the ability to negotiate well the demands of the world outside the family (Minuchin & Fishman, 1981). Successful adaptation to these demands requires

the family itself to change within the social environment or to exercise some agency in changing its environment in ways that leave the environment more supportive of the family's functioning. This requires that the family subsystems interact with each other in ways that allow the family to collectively benefit from its own resources (Simon). This interaction allows the family to perform its essential tasks of supporting individuation while providing a sense of belonging (Minuchin & Fishman).

Mechanisms of Change

Structural family therapists see the family as an “organism: a complex system that is underfunctioning” (Minuchin & Fishman, 1981, p. 67). When clients present for treatment, the goal of the therapist is to undermine the existing structure, creating a crisis that will jar the system toward the development of a better functioning organization. According to SFT, the mechanism of change is “the production of new relational experiences for clients” through a clinician’s facilitating differences in how family members experience each other (Simon, 2008, p. 327). Minuchin and Fishman stated that “the structuralist challenges the family’s accepted reality with an orientation toward growth” through a search for new patterns of relating between family members (p. 67). Changes occur as the family’s definition of the problem and the nature of their responses to the problem are challenged. Change further occurs as the family’s view of the problem is reframed in ways that elicit its members’ search for alternative “behavioral, cognitive, and affective responses” (Minuchin & Fishman, p. 68). In therapy, the therapist’s job is to facilitate new ways of interacting within the

family. In essence, family members change each other by behaving toward each other in new and different ways. The structural therapist implements interventions that facilitate new patterns of interaction (Minuchin & Fishman).

Enactment

An integral component of SFT is *enactment* (Aponte, 1992; Minuchin & Fishman, 1981; Simon, 1995). Enactment refers to family members' interacting with each other within the therapy setting (Minuchin & Fishman). These transactions between family members allow accustomed family rules of relating to take over, providing the therapist with an indication of transactional rules within the family system. The therapist constructs opportunities in the therapy session for dysfunctional transactions among family members to play out (Minuchin & Nichols, 1993). Minuchin and Fishman stated that "the family structure becomes manifest in these transactions and that the therapist will therefore catch a glimpse of the rules that govern transactional patterns in the family" (p. 80). This glimpse can provide the clinician with a soft map to follow when facilitating new relational experiences for clients (Minuchin, 1974; Minuchin & Fishman). These new relational experiences constitute mechanisms of change in SFT (Simon, 1995, 2008).

Enactments can be utilized in several ways. The SFT model uses enactments as a way to observe some of the problems that the family considers dysfunctional (Minuchin & Fishman, 1981). Each enactment provides opportunity for the therapist to assess the interactional processes of each couple or family through observation. Enactment can also be used as an intervention, giving the couple or family the

opportunity to practice new communication and interaction skills with a focus on positive interactions (Davis & Butler, 2004; Nichols & Fellenberg, 2000). Challenges to the family's preferred interactional style often occur through enactment (Minuchin & Fishman). Enactment can be evaluative when the couple or family demonstrates interactions that employ the clinical interventions practiced throughout the therapeutic process. It is the duty of the therapist to direct or coach the couple or family in positive and healthy interactional processes (Butler & Gardner, 2003; Davis & Butler). The purpose of the focus on assessment, evaluation, and intervention during enactment is to slowly phase out the therapist, leading the couple to "increasingly self-reliant interaction" (Davis & Butler, p. 324).

Joining

According to SFT, the therapist must appropriately determine family structure and boundaries, an assessment that requires the therapist to *join* the family system (Minuchin & Fishman, 1981). This process should be second nature for the therapist because "joining is more an attitude than a technique" (p. 31). The therapist joins the family system by adapting and accommodating to the family rules, style, and patterns (Minuchin, 1974). Structural family therapy views *accommodation* as the adjustments and alterations a therapist must make to become a part of the family system. This process requires that the clinician establish empathy and understanding (Minuchin & Fishman). Therapy will be most effective after successful joining through accommodation (Minuchin & Nichols, 1993).

In order to join with the family or couple, the therapist must become subject to

the structural demands of the family system (Minuchin & Fishman, 1981). Joining occurs as the therapist searches for common ground with clients by behaving in ways that are determined by the rules of the family system. At times the therapist must be comfortable with being boisterous, verbal, quiet, and asking questions to aid in understanding the client system (Minuchin & Fishman). The therapist also joins through validation of the family system by searching for and verbally rewarding positives, while also acknowledging areas of pain or stress. Responding to the family system with sensitivity is a key to effective joining (Minuchin, 1974). The clinician can know that joining has occurred when the family knows and acknowledges that the clinician understands them and is working with and for them (Minuchin & Fishman).

Minuchin (1974) looked at several things when attempting to join a family system: Who is the family spokesperson? Why is this individual the spokesperson? Does the family's verbal content match its behavioral actions? To what rules must the clinician be subjected in order to become a part of the couple or family system? These questions are important for the clinician if he or she is to properly join the family system and adhere to its current rules. It is important for the therapist to continuously join and assess the family throughout the therapy process by asking him- or herself these kinds of questions, and accommodating to the family's established rules of operation (Minuchin & Fishman, 1981). The clinician must emphasize aspects of his or her personality and experience that are syntonic with the family's (Minuchin).

Boundaries

Boundaries separate subsystems (e.g., parental subsystem, sibling subsystem)

within the family structure and are based on the family's rules of interaction (Minuchin, 1974). The boundaries and rules that govern family behavior may be manifest through gestures, ways of communicating, physical proximity, touch, and ways of resolving conflict. The therapist is continually assessing the family boundaries. He or she asks questions to obtain information and create family interaction; looks for patterns of communication; and observes boundaries and ways in which they are demonstrated, both implicitly and explicitly (Minuchin & Fishman, 1981). The therapist watches to see who interrupts whom, who completes another's sentences, who gives validation and praise, who expresses disapproval, and who gives help (Minuchin). Physical indicators may also be present, such as who sits next to whom, whether a couple holds hands, or when children speak to the therapist through the parents instead of directly (Minuchin). The patterns of interaction demonstrated by the family or couple give insight into which members of the family are close or distant. These patterns may also show dependence, autonomy, or a sense of belonging (Minuchin & Fishman). As treatment proceeds, the observed patterns serve as a map that will later be corroborated or dismissed through the clinician's efforts to join the family system (Minuchin).

Families often enter therapy because the family structure is "unworkable" (Minuchin & Fishman, 1981, p. 71). The therapist can intervene by challenging the family's sense of reality, symptoms, structure, and assumptions (Minuchin & Nichols, 1993). The clinician begins to pinpoint transactional patterns and boundaries, and to make hypotheses about which patterns are functional and which are dysfunctional

(Minuchin, 1974). Challenges to the family structure are often accomplished through the process of *boundary making* or *boundary marking*. Boundary making techniques are utilized to create boundaries between family members, subsystems, or the family and social systems; boundary marking techniques alter the rigidity and permeability of family boundaries by challenging the family's interactional processes and views of reality (Minuchin; Minuchin & Fishman). These challenges can come from emphasizing positive or negative interactions, which allow the family or couple to focus on relational and family processes (Minuchin & Fishman).

Boundary marking can challenge the family structure by setting limits, reorganizing family boundaries, and reframing the problem (Minuchin, 1974). The family then reorganizes within the context of new family boundaries; the new boundaries change the nature of the family relationships vis-à-vis each other (Minuchin & Fishman, 1981). These challenges to family structure and boundaries often happen when utilizing enactment within the therapeutic setting (Minuchin & Fishman).

Reality and the Role of the Therapist

For the therapist to adequately join the family system, it is necessary to understand the family's framing of reality (Minuchin & Fishman, 1981). This occurs as the clinician experiences what the family considers relevant through enactment. It becomes the therapist's task to *reframe* the family's views of reality. The therapist is to "convince the family members that reality as they have mapped it can be expanded or modified" (p. 76). Supports for a new reality, where the meaning of the symptom

or problem changes, can be developed through raising intensity during enactment (Minuchin & Fishman). The intensity of a therapist's message is determined by what is being challenged (Minuchin, 1974). The "therapeutic message must be 'recognized' by family members, meaning that it needs to be received in a way that encourages them to experience things in new ways" (Minuchin & Fishman, p. 117). This can be done through repetition of the message, repetition of specific processes, practicing skills, or changing the distance between certain family members.

The therapist may also suggest or demonstrate alternative ways of functioning within context-specific situations. Alternate ways of functioning may be demonstrated through raising intensity, repetition of an intervention or message, or having the clients perform an enactment (Minuchin, 1974; Minuchin & Fishman, 1981). It is appropriate for the clinician to use educational techniques to teach families about functional family structure (Minuchin & Fishman).

The fundamental task of a structural family therapist is to help clients replace a dysfunctional family structure with a more adaptive structure through facilitating new patterns of relating (Simon, 2008). The therapist is an "activator of resources that are assumed to lie latent" within the family (Simon, p. 333). A therapist's effectiveness will increase with the acceptance of his or her own strengths and limitations. The clinician must tailor the process of therapy to each family's unique situation.

Evidence Base

Researchers have applied structural family therapy to many different groups

and problems (Simon, 2008). Research on SFT's effectiveness has "tended to focus more on the model's application to family treatment, in which a child, adolescent, or young adult is presented as the identified patient" (Simon, p. 343). Applications of SFT have been shown to be effective with several different populations. Structural family therapy developed from the work of Minuchin and colleagues' work with poor, urban families in Philadelphia, Pennsylvania (Minuchin et al., 1967).

Subsequent reports indicate that clients from numerous ethnic backgrounds have reported benefits from SFT (Minuchin, Lee, & Simon, 2006; Minuchin, Nichols, & Lee, 2007). Greenan and Tunnell (2003) have developed a model for therapy with homosexual couples that is based on Minuchin's structural family therapy. This model utilizes SFT concepts of enactment and joining as integral in the treatment of same-sex couples. Studies have shown structural family therapy to be effective in treating anorexia in children (Minuchin, Rosman, & Baker, 1978); school adjustment, depression, and anxiety in adolescents diagnosed with attention deficit/hyperactivity disorder (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992); conduct disorder and drug use in adolescents (Santisteban et al., 2003); heroin addiction in young adults (Stanton, Todd, & Associates, 1982); and psychosomatic asthma and anorexia nervosa in children (Minuchin et al., 1975). Each of these studies indicates that SFT can be effective with diverse populations and problems, but researchers have not been able to pinpoint what makes the model successful among these populations.

Gottman Method Couple Therapy

Gottman method couple therapy (Gottman, 1999) is based on decades of John Gottman's research into what makes relationships succeed or fail (e.g., Gottman, 1994a, 1994b, 1999; Gottman & Levenson, 1984, 1985, 1988, 1992, 2002). The results of these studies indicate that couples with successful relationships developed "three primary objectives: They sustained their romance through the fundamentals of friendship, they managed their conflicts well, and they created a shared sense of meaning that knitted their lives together" (Gottman, 2004, p. 7). Gottman (1999) also found that successful relationships balance positive and negative interactions so that positive interactions outweigh negative interactions both during conflict and during peaceful times. Gottman method couple therapy relies on theoretical components of education and behavior models. The method also includes a series of interventions designed for couples to achieve and maintain these objectives and goals.

Gottman's (1999) research led to his construction of the "Sound Relationship House" (SRH) theory. The two staples that make up the SRH are (a) the overall level of positive affect in a relationship, and (b) the ability to reduce negative affect in conflict discussion (Gottman). As shown in Figure 1, the SRH is made up of distinct levels. The foundation of the SRH is love maps and the fondness and admiration system (FAS), important components of building a strong marital friendship. These components of friendship lead to the next level: sentiment override. If the components of a couple's friendship are not strong, negative sentiment override persists. Positive sentiment override (PSO) occurs when a relationship is based on a

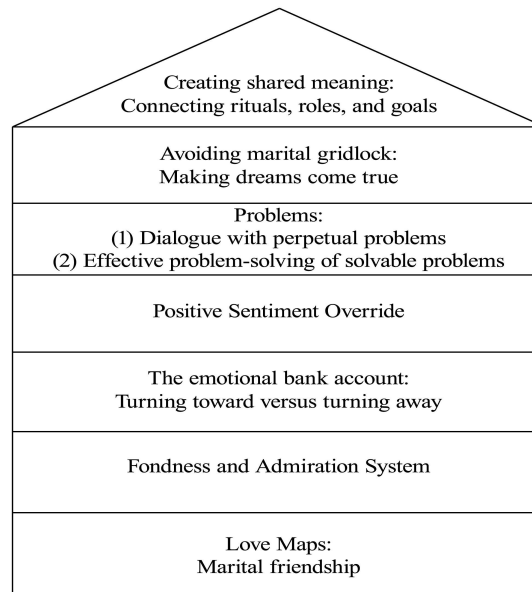


Figure 1. Sound relationship house.

strong friendship (Gottman & Gottman, 2008). The upper levels of the SRH include regulating conflict and creating shared meaning (Gottman).

Mechanisms of Change

The process of change in GMCT occurs through the initial goal of preliminary, dramatic, rapid change early in the therapeutic process followed by more structured, lasting change (Gottman, 1999; Gottman, Swanson, Tyson, & Swanson, 2002). The initial rapid change occurs through the use of an assessment enactment in the form of a conflict discussion. The therapist asks the couple to discuss an issue that has been a source of recent conflict. The clinician facilitates this interaction between the couple in order to identify the stability of the relationship rather than the content of the conflict. The therapist is looking for spontaneous expressions of fondness and

admiration, negativity, a degree of united “we-ness,” how couples describe their lives, and the amount of friendship demonstrated through interactional processes (Gottman). The goal of the therapist is to then follow the assessment enactment with instruction intended to facilitate dialogue on the issue. It is not important for the therapist to help them solve the problem, but to change the affect around which they do not solve the problem (Gottman & Levenson, 2002). The therapist facilitates a change in the marital influence patterns through GMCT intervention techniques designed to promote respect and friendship. These temporary changes give the couple hope that therapy will be beneficial to the relationship (Gottman).

Concepts and Techniques

Once the initial goal of rapid, initial change has been accomplished, the next goal in GMCT becomes teaching the couple how to “effectively repair negativity during their interaction about a conflictual issue without the help of the therapist” (Gottman, 1999, p. 188). This occurs in several steps. First, the therapist facilitates an enactment where the couple discusses a topic that is the subject of recent conflict. The therapist observes the interaction, looking for the presence of the four horsemen, repair, and sentiment override. Based on what is seen, the therapist then implements interventions that aim to increase the positivity of the family’s or couple’s communication. These interventions can occur through enactments that move the couple or family from “attack-defend” mode to an “admitting mode, where people are willing to accept some responsibility for the problem and admit mistakes” (Gottman, p. 188). The next step is to assist the couple in moving from the admitting mode to a

collaborative mode where the conversations include the expression of feelings and needs without defensiveness or criticism. As part of the enactment, the therapist assists the couple in effective repair when criticism and defensiveness occur. As part of this intervention, the clinician often points out repair attempts and the acceptance of repair attempts so that the clients can become more aware of opportunities to repair negative interactions. It is also important for the therapist to supply different ways of behaving; for example, the clinician may explain how to complain without using criticism, which is an example of a repair attempt. The last step occurs when a couple can effectively repair negativity without the assistance of the therapist during a conflict discussion. The therapist teaches the couple to process the conflict together in ways that promote understanding and shared meaning (Gottman).

The overall goal of GMCT is to change the trajectory of a relationship (Gottman, 1999). The goal of having a great marriage is left to the couple to accomplish, armed with new skills learned through the therapeutic process. When the couple can process their own interaction and effectively repair negative interaction without the assistance of the therapist, the therapist can consider the termination of treatment.

Gottman method couple therapy was developed from research that intended to discover what is functional when a marriage is working well (Carrere, Beuhlman, Coan, Gottman, & Ruckstuhl, 2000; Gottman, 1994a, 1994b; Gottman, Coan, Carrere, & Swanson, 1998; Gottman & Levenson, 1984, 1985, 1988, 1992, 2002). Gottman (1999) said, "Marriages that are working involve a variety of very positive

factors that need to be built into any marital therapy program design to help couples create a satisfying relationship” (p. 87). The interventions and techniques utilized in GMCT come from concepts that are designed to facilitate happy and stable relationships that are tailored to the particular needs of each couple. These concepts include *soft startup*, *the four horsemen of the apocalypse*, and *repair attempts*.

Startup. Gottman’s research indicated that the way a conversation starts makes a difference in the overall quality of a relationship (Gottman, Gottman, & DeClaire, 2006). This research also showed that how a problem is initially raised determines its course (Gottman 1994a, 1994b, 1999). Startup is “the way a topic of disagreement is broached” (Gottman, 1999, p. 41). A startup is considered harsh when the speaker uses criticism, sarcasm, mockery, or blame. Harsh startups often begin with “you” and blame others without stating one’s needs (Gottman, 2004). A softened startup is “the ability to start talking about a complaint or a problem gently, without criticizing or insulting your partner” (Gottman et al., p. 5). When a softened startup is used, the speaker states his or her feelings without blame, describes the situation that troubles him or her in neutral terms, and clearly expresses his or her own needs (Gottman, 2004).

Gottman’s (1999) research indicated that startup is an important indicator of marital communication patterns. A harsh startup often begins a cascade of the four horsemen (described in the next section) that leads conversations to become more and more negative. Conversations that begin with negativity typically end on a negative note (Gottman). This finding led Gottman to hypothesize that a softened startup is

more likely to facilitate discussions that build understanding and emotional connection. Thus, an important intervention in GMCT is helping clients learn how to use a softened startup when approaching a disagreement or conflict.

In Gottman method couple therapy, the therapist assists clients in learning how to use a softened startup when approaching one's partner with a difficult topic (Gottman, 1999). The clinician gives examples of a harsh startup and asks the couple to come up with ways of softening the startup. For example, the clinician will give the clients a phrase such as, "I'm sick of you going out with your friends all the time." The therapist will then help the couple or family create ways of saying the same thing in a less critical way. The therapist explains that a softened startup is done without blame while clearly stating one's needs (Gottman, 2004). Eliminating a harsh startup is an initial step toward more positive couple and family interactions.

The four horsemen of the apocalypse. Gottman's research showed that not all negatives within a relationship are equally corrosive (Gottman et al., 1998; Gottman & Levenson, 1992; Levenson & Gottman, 1985). Four behaviors were found to be most corrosive: *criticism*, *defensiveness*, *stonewalling*, and *contempt*. These behaviors have been labeled "the four horsemen of the apocalypse" (Gottman, 1999, p. 41). Research has indicated that these behaviors are present in higher frequency in relationships that are reported to have lower satisfaction (Carrere et al., 2000; Gottman et al., 1998; Gottman & Levenson, 2002). This research has shown that criticism, stonewalling, and defensiveness are also present in most "good" marriages, but in lower abundance and with successful repair (Gottman, 1994b).

A harsh startup typically involves *criticism*. Criticism is “any statement that implies that there is something globally wrong with one’s partner” (Gottman, 1999, p. 42). Criticism can be particularly corrosive of relational satisfaction because multiple criticisms create the effect of a global rejection of the other’s personality. The result of criticism is often *defensiveness*. Defensiveness is “any attempt to defend oneself from a perceived attack” (Gottman, p. 44). This often perpetuates relational conflict because defensiveness usually includes counter-attacking with criticism while denying responsibility for the problem. Gottman (1994a) found that a common pattern occurs: criticism, defensiveness, counter-complaining or counter-attacking, and *stonewalling*. This pattern seems to have a cascading effect where one partner criticizes the other, the partner who has been criticized then feels a need to defend himself or herself by counter-attacking, and this cascade continues until one of the partners eventually tunes the other out through stonewalling. Stonewalling occurs when the listener completely withdraws from interaction, usually in the form of one partner’s leaving. Body language is often a manifestation of stonewalling in the form of looking away or down, a stiff neck, minimal vocalization, and monitoring glances at one’s partner (Gottman, 1994a, 1994b, 1999). Gottman’s (1994a, 1994b) findings indicate that 85% of stonewalling is done by men.

The most corrosive of the four horsemen is *contempt* (Gottman, 1999). Contempt is “any behavior that puts oneself on a higher plane than one’s partner” (Gottman, p. 45). This includes mockery, sarcasm, insults, and facial expressions (Ekman & Friesen, 1978; Gottman). Criticism, defensiveness, and stonewalling occur

in happy, stable marriages, although the amount of contempt in these marriages is essentially zero. The implications of this finding led Gottman to focus relationship treatment on the *repair* of the four horsemen and the elimination of contempt.

Repair. The definition of repair is fluid: “It can be almost anything, but it is generally the spouse’s acting as their own therapist,” or any attempt to make the interaction between partners less negative (Gottman, 1999, p. 48). Gottman’s research findings indicate that in stable marriages the ratio of positive to negative interactions during nonconflict moments is essentially 20 to 1, while the ratio of positive to negative interactions during conflict should be 5 to 1 (Gottman). Enabling couples to repair their own interactions is a central goal of Gottman method couple therapy.

The basis for successful repair attempts is what Weiss (1980) termed *positive sentiment override*. Weiss hypothesized that reactions during marital exchanges could be determined by a global affection present within the relationship. Gottman (1999) has extended this idea of Weiss’s to suggest that PSO has its “basis in everyday, mundane, nonconflict interactions” (p. 107). The basic premise of sentiment override is this: In a relationship with PSO, a spouse can say something with a negative affect and it will be received by the partner as a neutral message. When *negative sentiment override* (NSO) is present, a neutral message is received as being negative. Gottman explained that “sufficient positive affect in nonconflict interactions makes PSO possible” (p. 107). When PSO is present, a partner will recognize the other’s anger/negativity as important information without taking it as a personal attack.

Positive sentiment override is the basis of successful repair attempts that de-

escalate negative affect during conflict discussions (Gottman, 1999). For repair attempts to be successful, the receiving partner must accept the attempt as important information rather than as an attack. When repair attempts are rejected, the negativity of the interaction and the relationship escalates (Driver & Gottman, 2004; Tabares, Driver, & Gottman, 2004). Studies have found that the escalation of negativity is prevalent in unstable marriages, particularly in husbands' refusal to accept influence from their wives (Driver, 2007; Gottman et al., 1998; Tabares et al.). This led to Gottman's hypothesis that "marriages will work to the extent that men accept influence from, and share power with, women" (p. 52). In one study of 130 newlywed couples, Gottman et al. (1998) found that the relationships where men did not accept influence from their wives later dissolved. The results of this study indicated that in relationships that worked well, both partners consistently searched for common ground. A goal of the therapist is to help couples lower the levels of negativity in their interactions through increasing the success of repair attempts and finding ways to help each partner honor the other partner's viewpoint. The goal of the therapist is to assist the couple in establishing a respectful dialogue around their problems rather than to help the couple solve their problems (Gottman).

Evidence Base

Gottman method couple therapy is a therapeutic model aimed to address the findings of John Gottman's years of couple research (Gottman, 1999). Much of Gottman's research was inspired by research conducted by Neil Jacobson, who "made the field face the truth" about therapeutic outcomes (Gottman, p. v). Jacobson found

that only 35% of couples from four marital studies were nondistressed at the end of therapy (Jacobson, 1984). Jacobson and Addis (1993) found that of the couples that made initial gains in therapy, 30-50% relapsed within 2 years. Jacobson, Schmaling, and Holtzworth-Munroe (1987) conducted a 2-year follow-up of couples who received marital therapy. The couples were divided into two groups: “relapsers,” whose gains in therapy had evaporated, and “maintainers,” who maintained therapeutic gains. The follow-up study indicated that 100% of those in the “relapsers” category reported that therapy had a positive impact on them. This finding led Gottman to conclude that “we cannot rely on ‘customer satisfaction’ data to evaluate our interventions” (Gottman, p. 6). This led to GMCT, John Gottman’s attempt to derive a model of couple therapy from his research findings.

Interventions and treatment methods in GMCT are aimed at decreasing negative affect within relationships through altering negative communication patterns and fostering positive regard for one’s partner and family (Gottman, 1999). Gottman (1980, 1994a, 1994b) found that negative affect has been the most consistent discriminator between happily and unhappily married couples, particularly *negative affect reciprocity*. Negative affect reciprocity refers to the “probability that a person’s emotions will be negative right after his or her partner has exhibited negativity” (Gottman, 1999, p. 37). Assessment methods for Gottman’s studies of positive affect were derived from Ekman and Friesen’s (1978) facial action coding system. Researchers were trained to recognize facial features involved in emotion; researchers also coded for voice, gestures, and the content of what was said (Gottman, 1980).

Emotions and behaviors such as sadness, fear, anger, disgust, contempt, interest, affection, humor, listener tracking, and neutrality were coded. Physiological data were gathered and correlated with the observational coding done by researchers.

Gottman (1980) studied couples that were assigned two tasks: a high-conflict, decision-making task and a low-conflict, non-decision-making task. Each interaction was video recorded and observed by researchers, who coded for emotions and facial actions (Gottman, 1980, 1994a, 1994b). This study indicated that negative interaction across couples was more consistent than was positive interaction (Gottman, 1980). In researching interaction over time, Gottman (1999) asked the question, “How important is the way conflict starts?” (p. 41). The results of this research showed that 96% of the 15-minute interactions ended the way they began (Gottman). Based on this finding, Gottman hypothesized that avoiding a negative beginning to interaction through the use of a softened startup could lead to avoiding a negative ending.

Gottman (1999) also asked the question, “Are all negatives equally corrosive?” (p. 41). Gottman’s (1993) research found that the four horsemen are most corrosive in stable marriages. Gottman (1994a, 1994b, 1999) found that the four horsemen are present in most relationships, but in stable marriages they occur less often and are countered by effective repair. Gottman (1999) said, “The fact that the other three horsemen were not zero in happy, stable marriages has profound implications for intervention. It means that what we must focus on is repair” (p. 47). These findings led to Gottman method couple therapy, which focuses on positive affect during interaction, effective repair, cultivating and sustaining marital

friendship, and the development of shared meaning (Gottman 1999; Gottman, 2004).

Integration of the Models

The theoretical model utilized in this project is an integrative approach that combines elements of structural family therapy and Gottman method couple therapy. Integrative models can provide a comprehensive approach that “bring[s] a wider range of human experience into focus” (Nichols & Schwartz, 2004, p. 357). The integrated model presented for this project can be referred to as an “assimilated integration” (Fraenkel & Pinsof, 2001, p. 61). Assimilated integration refers to an integrated model of therapy that is primarily based on one therapeutic model that adopts tools and techniques from another treatment model. These techniques and tools are adapted to fit within the parameters of the base model (Fraenkel & Pinsof). The integrated model used for this project is based on the assumptions and concepts from structural family therapy (Minuchin, 1974) with techniques and interventions from Gottman method couple therapy (Gottman, 1999) being used to accomplish therapeutic goals. Nichols and Schwartz warned that a therapist operating with an integrated model must guard against switching “haphazardly from one strategy to another” (p. 357). In efforts to follow the counsel of Nichols and Schwartz, the foundation of this integrated model is firmly based in SFT; the GMCT concepts set forth in the previous section are used to assist the therapist in accomplishing the goals of SFT.

The integration of these models begins with the structural *boundaries* of

families and couples. The family structure is made up of invisible rules and boundaries that set functional demands on family members (Minuchin, 1974). These rules and boundaries make up the “skeleton” of the family; they impose limits and organize the way families prefer to function (Minuchin & Nichols, 1993, p. 40). Family boundaries demarcate and define the contact allowable between and among members of the family, and between the family and the environment. The clinician constantly assesses the family boundaries to determine how well they facilitate appropriate communication; in order to effectively become a part of the family system, the therapist must recognize and abide by the family boundaries.

Assessment must occur continuously throughout the therapeutic process (Minuchin & Fishman, 1981). This continuous assessment is an evolving, ongoing process based on information from several areas: family structure, system flexibility, relationship between system and individual, family developmental stage, style of interaction between family members, the presence of the four horsemen, and affect during interaction (Gottman, 1999; Minuchin, 1974; Minuchin & Fishman).

Enactment is an essential assessment tool for the therapist (Minuchin & Fishman, 1981). Through this continual process of assessment, the therapist observes patterns of transactions evident in the family system. These patterns and sequences reveal the family structure, as well as potential communication style problems (Minuchin, 1974). Once this structure is discovered, the therapist must derive ways of breaking the patterns and sequences to either strengthen or loosen boundaries as appropriate. Gottman method couple therapy techniques are used to change couple or

family patterns or sequences if the clinician's assessment deems these techniques to be potentially useful in treatment. Many restructuring interventions challenge and destabilize the system, requiring realignment of the family rules and boundaries, often with the recognition and implementation of new skills, such as repair and softened startup.

Central to the effectiveness of this integration is the therapeutic alliance (Patterson, Williams, Grauf-Grounds, & Chamow, 1998). This alliance is formed as the therapist becomes a part of the family or couple system through the SFT technique of *joining* (Minuchin & Fishman, 1981). The therapist must become accepted by the family system and become a part of the system so that information received by the therapist comes through an observational and experiential lens. Minuchin (1974) described the goals of therapy not as problem-solving, but as facilitating the restructuring of the family, while Gottman (1999) viewed the goal of treatment as changing the trajectory of the marriage through structured change. Problem-solving will naturally occur within the family through the restructuring of boundaries, experiencing family members in new ways, and the acquisition and implementation of new skills (Gottman, 1994a, 1999; Minuchin; Minuchin & Fishman).

For use within this integrated model, the most important assessment and treatment technique is enactment, which is used in SFT and GMCT (Gottman, 1999; Minuchin, 1974). Through enactments, the clinician determines which interventions and techniques will be used to help clients reach their therapeutic goals. Interventions

may focus on boundary making, boundary marking, repair, or altering the role of the four horsemen within relational interaction.

The therapist collaborates with the clients to determine therapy goals and the therapist intervenes with those goals in mind. For example, if a family presents for therapy with communication problems, the clinician must join the system in order to assess and experience the family boundaries and rules that dictate the nature of communication through enactment (Minuchin & Fishman, 1981). The therapist observes and experiences the nature of communication, asking himself or herself questions such as, “How do conversations begin”?; “Who interrupts whom”?; “Does negativity escalate or can disagreements be discussed while maintaining a positive affect”?; “Are any of the four horsemen present”?; or “Are repair attempts being made and are they accepted”? Based on the answers to these questions, the clinician implements interventions that aim to allow the clients to alter the family rules based on new ways of experiencing each other through new interactions. Change occurs as the family experiences each other in new ways vis-à-vis each other within altered (and accepted) family boundaries (Minuchin, 1974; Minuchin & Fishman).

Structure of Treatment

I conduct treatment sessions based on the integrated model of therapy designed by me with input from the Utah State University MFT program’s clinical supervisors and faculty. This format is based on the integrated model of SFT and GMCT (Gottman, 1999; Minuchin, 1974; Minuchin & Fishman, 1981). This

integrated model stems from an ongoing project required by the Marriage and Family Therapy program at Utah State University, which requires each student to develop a theory of therapy and change based on established models of therapy. The format for this project did not consist of specific questions but did provide a basic philosophy and format to guide the treatment process. This format is designed to accomplish certain tasks in every session, with other tasks or interventions utilized based on information gathered throughout the treatment process. Structural family therapy tasks or techniques to be used in every session follow:

1. *Joining*. To adequately join the family or couple system, I must be “comfortable with different levels of involvement” (Minuchin & Fishman, 1981, p. 31). I may attempt to join the family system through conveying empathy, expressing concern, verbal compliments, humor, mimesis, discussing common interests, and so forth. I display or present aspects of myself that “facilitate the building of common ground” with the couple or family (Minuchin & Fishman, p. 32). Depending on the perceived rules of the family system, I may at times be direct, distant, supportive, validating, affirming, angry, vocal, or submissive. I may validate the reality of the system through commenting on positives or acknowledging stress, disappointment, or pain. In each session, I attempt to present aspects of myself that are congruent with the client system; I must join and join again many times in therapy (Minuchin & Fishman).

2. *Boundaries*. I must constantly be aware of the couple or family boundaries; this requires me to assess and observe boundaries in each session. The observation of

boundaries in therapy provides a map of possible family rules that will later be either corroborated or dismissed (Minuchin & Fishman, 1981). When assessing for couple or family boundaries, I notice who sits by whom, body posture, who the family spokesperson is (if there is one), and who interrupts whom. It is also important to look for patterns of communication: Do partners look at each other during conversation? Do they hold hands or touch each other? Is interaction between partners spontaneous or must these interactions be facilitated? How do partners and families solve conflicts? Is there closeness or distance in certain relationships within the family system? Answers to these questions and others can provide a sense of the permeability of family boundaries. As I join with the family, I feel the pressures and pulls of the family boundaries, allowing me to join through accommodation to the family rules.

3. *Enactment*. In this integrated model, enactment is utilized for assessment, intervention, and evaluation. It is important for me to notice whether the couple or family interacts with each other without the facilitation of the therapist; this insight can help me begin to develop theories about family rules and boundaries. For example, I will often ask a client couple to tell me how they met. This will be followed up by more specific questions as the discussion progresses, but I pay close attention to several things after asking this question: Who begins to answer? Do they both speak? Does one partner talk to the other or does communication go through me? When talking about how they met, does each partner look at the other? Do they have spontaneous conversations with each other? Through this process, I begin

creating a hypothesis about family rules and boundaries.

If the couple or family interacts with each other easily, I notice and take appropriate measures to join the family system. If the couple or family speaks through me with minimal enactment occurring, I then attempt to facilitate enactment. This happens as I inquire about a recent conflict discussion between the couple or family. I then ask the family to discuss this topic with each other again. I typically either move my chair away from the family in order to withdraw, or leave the room to watch the interaction from behind the mirror. The goal is for the family to fall into their usual processes of interaction. I observe to assess family or couple boundaries, the presence of the four horsemen, and repair attempts and acceptance. I also evaluate who dominates the conversation, whether positive affect is present within interaction about a negative topic, and whether everyone is allowed to speak. Enactments provide a wealth of information to the observant clinician (Minuchin, 1974).

Enactment is utilized as an intervention tool as therapy proceeds. It is important that changes are noticed in interactional processes throughout therapy. After I teach certain skills and information, I watch for these skills to be implemented during enactments. For example, if the potential benefits of approaching a conversation with a softened startup have been discussed, these skills will be looked for during enactments. If I have sufficiently joined the family system, I will be comfortable intervening and pointing out opportunities for applying newly learned skills. For example, if a client couple is having a discussion and one partner makes a repair attempt that the other partner does not accept, I must be comfortable in

pointing this out to the couple.

Within the integrated model used for this study, the structural family therapy concepts of joining, boundaries, and enactment are implemented in every therapy session. Each of these concepts can be a means of assessment, evaluation, and/or intervention.

Some concepts and techniques are used in certain sessions as a matter of ethics and in accordance with the USU MFT Clinic policies and procedures. Also, interventions from Gottman method couple therapy may be implemented when previous assessments and evaluations indicate that they may be useful to the clients. These techniques and interventions include:

1. *Preliminary questions and risk assessment.* In accordance with the Marriage and Family Therapy Clinic policies and procedures, initial paperwork is filled out by the clients prior to the first treatment session. This paperwork includes informed consent for treatment, optional informed consent to do research (see Appendix A), a Family Intake Form, the OQ-45.2, and a Health Insurance Portability and Accountability Act (HIPAA) brochure receipt. A risk assessment is conducted if clinical screening indicates that it is necessary (e.g., if a client marks anything other than a 0 for “never” on any of the OQ-45.2 high risk assessment items). A risk assessment may include questions about substance use, suicidality, intimate partner violence, and current use of medications. In accordance with clinic policy and ethical standards, if the results of this assessment indicate that it is necessary, a safety plan is created and signed by all parties and a supervisor is consulted. I may conduct a risk

assessment in subsequent sessions as a follow-up or when information is presented that leads the therapist to find it necessary.

2. *Softened startup*. Startup may be implemented in order to restructure family boundaries. If I observe that a couple or family typically begin interactions with a harsh startup, I teach the concept of a softened startup. This is usually done through having the clients develop ways of starting a conversation without criticism. I may give an example of a harsh startup (e.g., “You never take me anywhere”) and have the clients turn it into a softened startup (e.g., “I really enjoyed it when we went out last week. I wish we would do that more often”). I then ask the clients to set goals for accomplishing this task in their interactions at home and in session. It is important that the clients view using a softened startup as an attempt to win friendship and understanding rather than a formulaic technique (Gottman, 1999).

3. *The four horsemen*. If the assessment of family or couple interaction reveals the presence of the four horsemen (Gottman, 1999), interventions may be implemented to decrease the presence of the horsemen. Within this integrated model, the most important part of this intervention is the recognition of the four horsemen. It is important that the four horsemen be explained in detail. It is critical that an antidote be provided with each of the horsemen in order to illustrate the differences between horsemen-saturated interactions and more positive interactions (e.g., turn a criticism into a complaint). I then begin to bring attention to the presence of the horsemen in the conversation of the couple or family. As treatment progresses, I ask the clients to identify the presence of the four horsemen within their own conversations. This is

why enactment is critical; I can observe the progress of the clients throughout therapy as they are able to decrease the presence of the horsemen in conversation and conflict. As the clients become more aware of the four horsemen, they become more aware of opportunities for repair.

4. *Repair*. Repair is critical in regulating conflict (Gottman, 1999). It is crucial that I frame repair attempts as a natural process that deescalates negativity during interaction. Repair is unique to each couple and family; all families will have their own methods of repair that work for them. I ask family members to discuss previous conflicts and how they were able to repair them during or after the interaction. I point out possible ways of repair such as apology, humor, stating how one feels, acknowledging one's own role in the situation, and so forth. One possible course of repair is to take a break from the conflict and approach the subject with a softened startup at a later time. Once the clients have identified acceptable modes of repair, they will be asked to discuss a minor conflict. The clients then attempt to use softened startup and avoid the four horsemen; however, if the horsemen show up, the clients are asked to attempt to use repair. I may intervene to point out the presence of the four horsemen and of repair attempts. It is critical that the recursiveness of this process be explained; it is just as important to accept the repair attempt as it is to make the repair attempt. The receiver is to attempt to view the repair attempt as an effort to make things better (Gottman).

Purpose and Research Questions

The purpose of this study was to explore an integrated model of therapy and how it fits with one therapist. This project is intended to be a feedback mechanism for the researcher/therapist to evaluate performance in a therapeutic setting. This feedback of clinical treatment was gathered through analysis of video and audio recordings, case notes, SFT/GMCT Checklist, supervision notes, and therapist observations and reflections.

The reviewed literature indicates that structural family therapy and Gottman method couple therapy may be beneficial treatment modalities. This study seeks to conceptualize and analyze four research questions:

1. How well did I maintain fidelity to the integrated treatment model?
2. When this integrated model is used as set forth in Chapter II, do clients report meaningful changes?
3. How does the work in one case or session inform the work in another?
4. How did I make decisions about use and timing of interventions and techniques?

CHAPTER III

METHOD

The current study was designed to explore the integration of structural family therapy (Minuchin, 1974) and Gottman method couple therapy (Gottman, 1999), how it works for one therapist, fidelity to the model, and how the integration can/should be modified based on the results of this study. The research questions focus on the fit between the model and the therapist, whether or not the clients perceive or experience change, how one session or case informs another, and the decision-making of the therapist for how and when to use which specific interventions and techniques. The case study design was beneficial for focusing on the in-depth data collection and case-based themes within a bounded setting/context/system (Creswell, 2007). This was a collective and instrumental case study. This section will outline the procedures for sampling, data collection and management, and analysis.

Design

The design for this project is a combination of instrumental and collective case studies. An *instrumental case study* is designed to provide insight into a particular issue or to refine a theory (Stake, 2008). The goal of an instrumental case study is to facilitate understanding about something other than the case. For this project, cases have been used to advance the understanding and practice of an integrated model of therapy with couples and families. This project also qualifies as a *collective case study* because more than one case is being studied, and the research

focus is on better understanding the integrated model of treatment (Creswell, 2007). Case study reports allow us to learn propositional and experiential knowledge (Stake).

Case study provides an opportunity for the researcher to seek out what is common between cases and what is particular. Case study can be a small step toward grand generalization, but it is imperative that the researcher (or therapist in this case) not focus on generalization because the intricate details that reveal information may be missed (Stake, 2008). Each case studied is “expected to be something that functions, that operates; the study is the observations of the operations” (Stake, p. 128). Instrumental and collective case studies allow each case to be observational but also reflective. Researcher or therapist reflections for each case provide the foundation for theory development. Case study reflections should include therapist impressions, recollections, and meanings (Stake).

Triangulation is an approach to data collection and analysis that synthesizes data from multiple sources to establish face validity for qualitative evaluations (Dooley, 2000). Triangulation compares different views and perceptions of the same subject, behavior, or event (Dooley). In efforts to create face validity for this project, data were gathered using several methods: video recordings, case notes, reflection notes, and the SFT/GMCT checklist. This allowed the researcher to look, listen, and feel perceptions from different points of view.

Sample

This study was designed to learn more about the process of therapy when

using a SFT- and GMCT-integrated model in a clinical setting. Because SFT and GMCT are both primarily relational treatments, one criterion for the sample for this study was that more than one person attend therapy sessions. No specifications were placed on the family structure or the presenting problems that would be treated during the course of therapy, only that the sample would be composed of clients seen in a relational context. Participants for the sample were selected from those who voluntarily presented to the Utah State University Marriage and Family Therapy Clinic for therapy and were assigned to the researcher as clients. This sample was selected from the client pool at the MFT Clinic for convenience and because each couple or family voluntarily presented for therapy with concerns about their family relationships. In order to protect confidentiality a pseudonym will be used for each client who participated in this project.

The sample consisted of three family dyads: one parent-child family and two heterosexual married couples. One client family consisted of a mother in her late 40s and her teenaged daughter. This family sought therapy to assist the daughter with symptoms of depression and boundary issues with her friends. Tonya and Cindy each identified themselves as atheist. Neither the Tonya nor Cindy reported any previous mental health treatment. The family lived near Logan, Utah, in Cache Valley. Each of the married couples presented for therapy with communication difficulties. Each client was in their early to mid-twenties, and all four clients were residents of Logan, Utah. Each client was Caucasian, and all four identified themselves as either atheist or non-religious. In accord with policies and procedures for the MFT Clinic, all

clients read and signed the Clinic Informed Consent for Treatment. Study clients also voluntarily signed an Informed Consent for Research for participation in MFT Clinic research (see Appendix A for Informed Consent for Treatment, Informed Consent for Research, and the IRB approval letter).

The cases examined for the purpose of this study were conducted simultaneously. The intake interviews of each case were conducted within three months of the others. This overlapping of cases allowed the therapist to apply information gathered from one case to another.

Instruments

Therapist

The therapist is a fundamental instrument in clinical case study research. The therapist in this study was the master's candidate of this thesis. Researcher bias is inherent in qualitative research (Creswell, 2007). The therapist's gender, past life experiences, family, and ethnic background influence the interpretation of the therapy process. I am a married, Caucasian male in my late 20s. I am a longtime resident of the state of Utah and a member of The Church of Jesus Christ of Latter-day Saints (LDS). In order to be aware of how these factors influenced my interpretation of the participants, their experiences, and narratives, I discussed with colleagues how these cultural factors may affect the therapeutic process and my views of the clients. An emphasis on culture and self-recognition influenced how I viewed similarities to and differences from the clients.

The similarities shared by the participants and me may have facilitated a more comfortable environment for relating personal information (Minuchin & Nichols, 1993). However, these similarities may also have led me to make erroneous assumptions about the clients. I was similar in marital status, residence in Utah, race, and age. I also shared a common gender with two of the participants. Similarities with one couple extended to having children. Alternatively, differences between the participants and me may have impacted the treatment process. Differences may have set up a boundary between the clients and me, or they may have led me to be curious in asking questions to gain a better understanding of each family. A significant difference between the participants and me was religion. The participants were not told that I am LDS and the topic was not broached by the participants; however, my religious lens may have influenced the interpretation of information gathered from therapy sessions. The gender difference between four of the participants and me, and an age difference with two clients may have influenced the therapist-client relationship. It cannot be determined how the similarities and differences between the participants and me affected the therapeutic process, but it is important that they be acknowledged.

Prior to this study, I was trained in interview techniques by the State of Utah's Division of Child and Family Services (DCFS) and Utah State University's (USU) Marriage and Family Therapy (MFT) program. The training I received through the USU MFT program exposed me to specific training in structural family therapy and Gottman method couple therapy (Gottman, 1999; Minuchin & Fishman, 1981). Prior

to the fieldwork for this study, I had participated in over 300 therapy sessions and conducted more than 1,000 non therapy interviews. These experiences provided me with skills to conduct and manage therapy sessions while implementing interventions designed to facilitate client's goals.

Outcome Questionnaire-45.2

The Outcome Questionnaire-45.2 (OQ-45.2; Burlingame & Lambert, 2007) was used in this study to measure client change over the course of therapy. The OQ-45.2 is based on the suggestion of Lambert, Christensen, and DeJulio (1983) that a client's life be monitored in three specific aspects: subjective functioning, interpersonal relationships, and social role performance. The OQ-45.2 was constructed as an assessment tool with application for multiple treatment modalities and decisions. The instrument can be administered repeatedly throughout the course of treatment to measure change. In accord with MFT Clinic procedures, the OQ-45.2 is routinely administered before the first session, before the tenth session, and at termination.

The OQ-45.2 is a questionnaire that utilizes five-point Likert scales. The instrument consists of 45 statements that clients rate based on their experiences in the previous week. Each statement is accompanied by these possible responses: never, rarely, sometimes, frequently, and almost always. The scale is typically completed in three to 10 minutes. A total score is calculated by summing the ratings across all three subcategories: symptom distress (SD), interpersonal relations (IR), and social roles (SR). Cutoff scores for each subscale and the instrument as a whole have been

determined from research on community and clinical samples. This cutoff is “the most logical place to compare individuals for treatment outcome” (Burlingame & Lambert, 1996, p. 4).

The OQ-45.2 is administered before the initial therapy session in accordance with the standard procedures of the MFT Clinic. For the purposes of this study, the instrument was also administered after the third and fifth sessions (where applicable). This instrument allowed me to compile quantitative data that indicated the changes taking place as reported by clients throughout the course of therapy. These data were used as one way to measure change as treatment progressed. Because one focus of the integrated model used for this study is assisting clients in establishing more functional ways of interaction within the family system, focus was on results of the interpersonal relations subscale of the OQ-45.2 to assess the clients’ perceived changes in relational interaction.

Fidelity Checklist

Video recordings were observed and coded in order to monitor fidelity to the integrated model of treatment using the SFT/GMCT checklist (see Appendix B). I created this checklist with input and approval from the project supervisory committee. This checklist was created to align with the format for treatment that was previously explained. The checklist was created with the understanding that, based on its use by another coder and me, certain aspects of the SFT/GMCT checklist might change. When I coded the first session, it became clear that more detail on the checklist would be helpful for analyzing which constructs and techniques were being used. This

insight led to the addition of a details section of the SFT/GMCT checklist. The details section allowed the coders to write down which specific tasks within each construct or technique were used in each session. This provided me with the opportunity not only to find out whether the concept was implemented, but by what means and methods. This checklist provided each coder with details about specific SFT and GMCT concepts that may have been used during a therapy session. The checklist allowed the coders to indicate that a certain technique had been used.

The researcher developed a training manual that established definitions for each concept and category on the checklist (see Appendix B). Some details in the training manual changed as the checklist was used. The enactment section was expanded to specify the differences between an assessment enactment and an intervention enactment so that this information could be reported in the details section of the checklist. Each session checklist has nine coding areas, three within each domain (e.g., the structural family therapy domain consists of joining, boundaries, and enactment).

One graduate student colleague and I independently watched video recordings of three sessions with the SFT/GMCT checklist. The graduate student who assisted in the coding process was from the same cohort in the USU MFT program. The colleague was selected to assist with this project because of relevant coding experience for a similar project. The student was also familiar with the concepts and techniques of structural family therapy and Gottman method couple therapy through the MFT program and personal therapy experience.

Potential biases may have influenced the coding of this project. The colleagues who coded sessions were friends; it is possible that the desire for this research project to be a success may have influenced the second coder.

The codes for each session were compared. Two of the three sessions showed 100% inter-rater reliability. The coders discussed and reconciled the differences in the third session. Each coder then independently coded a fourth session with 100% inter-rater reliability. These results were then discussed with the major advisor of this project. With an acceptable level of inter-rater reliability having been established, the researcher coded each of the remaining six sessions.

Case Notes

Case notes were used as an instrument for data collection. In compliance with MFT Clinic procedures, case notes included 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 contained details about what techniques and interventions were used in each session, including the sequence of technique implementation. Case notes also contained client reports, such as current problems and stressors, changes that had been noticed, and perceived effectiveness of homework assignments from the previous session. The format of each case note was structured to describe information from the session; these notes became a part of the client's official clinical record.

Case Reflections

Case reflections are more detailed notes that I wrote after each session. I wrote about what I considered to be of particular import. Reflections often included my role in each session, reasons behind my use of particular interventions, overall themes from the session or case, client-therapist patterns of interaction, patterns of intervention use, and what I could or would have done differently. These notes allowed me to describe how I felt during each session or at certain points in each session, including reasons for implementing specific techniques and interventions. Reflection notes contained supervisor feedback and teammate notes from sessions when such feedback was provided. These reflections were used for me to explain how I made decisions. For example, a reflection note may have explained that during an enactment, I noticed the presence of the four horsemen, which led to my decision to implement GMCT interventions that focused on decreasing the presence of the four horsemen during interaction.

I reviewed each case reflection when watching each session video. This also allowed me to analyze techniques and interventions and how they may have been used in certain situations. This process became a feedback mechanism for me in further developing the integrated model by focusing on which in-session techniques were useful and which may have needed to be adjusted. I was able to integrate information from within the system (in session as a part of the client system through joining) and from observation of the system (gathered through watching each session on video). I specifically focused on whether or not I would do the same thing if it

could be done again. For instance, when watching a session video, I asked myself whether I saw the same things that were noted in the case reflections. Watching the videos allowed me to see the session from a different perspective and allowed me to note things that occurred in sessions that I may not have been aware of at the time. Notes taken while watching each video were added to the reflection journals.

Procedures

Initial Contact and Setting

Clients contacted the MFT Clinic and scheduled appointments for initial therapy sessions. Clients were assigned to me through the clinic's regular rotation. I phoned the participants and confirmed the appointments for each initial session. All interviews took place at the Family Life Center between October 2008 and March 2009. Each session was audio- and video-recorded with the approval of the participants. The setting was unfamiliar to the participants; each participant reported having never been to the FLC before treatment.

Introduction and Informed Consent

Each family was asked to arrive early for the initial session to fill out paperwork. The paperwork included informed consent for treatment, HIPAA information, optional client consent for data to be used in research, the OQ-45.2, and a family information questionnaire administered to all clients of the clinic. This paperwork is administered to the clients by someone other than the therapist to minimize potential for coercion. After the clients completed the paperwork, I escorted

them to the therapy room. I spent the first 5 to 10 minutes of the first session providing an explanation of the paperwork, answered client questions, and described the purposes of the clinic. I ensured that all forms were filled out properly and signed by the participants. Therapy began when it was determined that all paperwork was completed and signed.

The informed consent for treatment form outlined in detail the purpose of the FLC clinic, the client's rights and responsibilities, and measures taken to protect clients' confidentiality. Each client was assigned a pseudonym in order to further protect confidentiality. This consent also described the limits to confidentiality, including the therapist's responsibility to report suspected child abuse, vulnerable adult abuse, or harm to self or others. The participants were identified with unique identification numbers that were assigned by the clinic to protect their identities in data processing and analysis. All contact and case information were kept in locked cabinets at the clinic. The information gathered was used for clinical, research, and training purposes. Clients for this project also voluntarily signed an informed consent for research form, acknowledging that therapy sessions and clinical data could be used for these purposes. Clients who did not want their clinical data used for research continued in therapy as usual.

Data Management

The recordings of each session were kept on DVDs that were stored in a locked cabinet in the FLC to preserve confidentiality until the conclusion of this study. Case notes for each session are kept for a period of ten years in a locked office

in the Family Life Center in accordance with Utah law. The coding checklists and my notes and reflections were kept with the DVDs until the completion of this study. These materials were destroyed upon the completion of this project.

Data Analysis

The benefits of my analyzing the data myself were that I had specific goals in mind when analyzing each source of data and each research question. My familiarity with SFT and GMCT allowed me to pinpoint certain transactions that occurred during therapy that were of particular import to me as a therapist. I believe that my closeness to this project allowed me to notice details that may not have been noted otherwise. This familiarity may also have been a weakness; personal biases likely contributed to my subjective analyses and prevented my observing other elements of the therapy.

Research Question 1: How Well Did I Maintain Fidelity to the Integrated Treatment Model?

The SFT/GMCT checklist was used to code each therapy session. The therapist and one graduate student coded four sessions independently. When acceptable inter-rater reliability was established, the remaining 6 sessions were coded by the researcher. The codes were then analyzed to determine how well the therapist adhered to the integrated model used for this study. The therapist then consulted with the committee chair to identify similarities and resolve discrepancies. The codes gathered from the SFT/GMCT Checklist allowed the therapist to verify whether or not he was following the model through charting specific interventions and

techniques used in each session.

The clinician applied the data gathered to determine whether interventions and techniques utilized in sessions were consistent with the integrated model as outlined in Chapter II. If the data suggested that certain interventions were not consistent with the integrated model, the clinician reevaluated the model, how certain interventions fit within the integrated model, how the interventions may be adjusted or utilized differently to be consistent with the model, or whether the interventions should be discarded from the model.

Research Question 2: When This Integrated Model Is Used as Set Forth in Chapter II, Do Clients Report Meaningful Changes?

This research question was approached in two ways: (a) do clients report changes between sessions, and (b) is change taking place over the course of treatment? In order to assess client changes that may have taken place, I triangulated the data by using the OQ-45.2, client report, case notes, and case reflections. The OQ-45.2 was administered before the initial session. One married couple also completed the OQ-45.2 after the third and fifth sessions. The other married couple did not complete a follow up administration because therapy ended after two sessions. The mother and daughter attended three therapy sessions with the mother completing the OQ-45.2 before the initial session and after the third session. The daughter did not complete the OQ-45.2 because it is not standardized for children. The results of each administration were compared in order to measure changes that were taking place as

reported by the clients.

Changes that took place between sessions were analyzed through in-session client report. These reports may have occurred at any point throughout the session. At the beginning of each session, I typically followed up on homework by asking how and when the homework was implemented, and what was different during the previous week, positive or negative. Reported changes were discussed and documented in the case notes.

In addition to the documentation of reported changes by the clients, case notes and case reflections were used as I noted observable changes in the clients. These included patterns of interaction between clients, changes in affect or demeanor, and changes in how the clients interacted with me. For example, I may have noted that a couple held hands during the session, a behavior that had previously been absent.

*Research Question 3: How Does
the Work in One Case or Session
Inform the Work in Another?*

During this process, the therapist used criss-crossed reflection and analysis, meaning that the results and observations gathered from one case informed the therapeutic process in other cases (Spiro, Vispoel, Schmitz, Samarapungavan, & Boerger, 1987). This occurred as outcomes in one case influenced decision making in another. If an implemented technique or intervention appeared useful in one case, I used this information in planning for another session or case. This did not mean that I utilized the technique the same way in other sessions, but may have influenced which techniques were used, including how and when the technique was implemented.

When interventions were applied and did not appear useful, I examined why the intervention may not have led to the desired results and either modified it or removed it from the therapeutic approach.

Criss-crossed reflection was performed for this study through the use of case notes, case reflections, and videos. Case notes were utilized to note what, when, and how interventions were used in each session. I ascertained the effectiveness of these interventions based on observation and client report. This information was useful in deciding how to approach subsequent sessions and other cases.

Case reflections and videos provided me with the opportunity to explain why and how specific interventions and techniques were utilized at specific times. I watched the videos with the case notes and case reflections in order to analyze which interventions were used in what context and the results of these interventions. For example, if the clients reported in session that they were able to implement a softened startup during conversations at home, but that their traditional patterns of interaction did not change, I documented this in the case notes. When looking at these situations on video, I paid specific attention to context. While watching each video, case reflections also provided a means to answer questions: Did I not explain the intervention well enough? Did the clients implement the intervention correctly? What did I see that led to the use of a startup intervention? Would an intervention focusing on the four horsemen have allowed the startup intervention to be more effective? Attention to context allowed me to further scrutinize the effectiveness of interventions and when to use them. This process provided useful information for me

in future sessions and with other clients.

*Research Question 4: How Did
I Make Decisions About Use
and Timing of Interventions
and Techniques?*

Data for this question were taken from case reflection notes and coding the session videos. While watching the videos, I noted pertinent interventions and client responses. When analyzing these data, I looked at the delivery and implementation of techniques and interventions, as well as what was happening just before the intervention. Concurrently, the reflection notes provided additional useful information to the videos in the form of what I noticed, felt, and saw that influenced the decision to utilize each intervention. By combining the codes and the case reflection notations, I developed a tentative decision scheme. Over multiple data points, themes for common processes of decision making emerged from the data. I then hypothesized that the same or a similar decision-making process would be used in subsequent sessions. This analysis influenced the plan for future sessions and cases. Similarities and differences among these decision points were noted in the case reflections.

CHAPTER IV

RESULTS

The purpose of this study was to discover themes and methods of intervention that are beneficial to me in a therapeutic setting. The study was designed to explore my fidelity to an integration of structural family therapy (Minuchin, 1974) and Gottman method couple therapy (Gottman, 1999), changes reported by clients, how one session or case informed another, and how decisions were made about use and timing of interventions. The 10 therapy sessions examined produced a vast amount of information regarding me, the integrated model of therapy, and how therapeutic decisions were made.

The findings are arranged sequentially through each of the research questions with themes that emerged from specific therapy sessions and the overall course of therapy for each case as well as across cases. To maintain confidentiality, each of the participants has been assigned a pseudonym by which they will be referred throughout this chapter. Jimmy and Julie are a married couple who had no children. Allison and Shawn are a married couple who had one child. The mother-daughter companionship is Tonya and Cindy, respectively. The names are in no way connected with the actual participants. The original plan for each set of clients was to have at least three sessions with each family. One set of clients, Allison and Shawn, attended only two sessions. Five therapy sessions with Jimmy and Julie were used for this study, along with two sessions with Tonya and Cindy and one session with Cindy alone. The results presented in this chapter come from information gathered from these 10 therapy sessions.

Research Question One: How Well Did I Maintain

Fidelity to the Integrated Treatment Model?

To determine whether I maintained fidelity to the integrated model of treatment, the SFT/GMCT checklist was used to code each therapy session. Every session was coded by me and four sessions were coded by a colleague. The codes were compared to establish acceptable inter-rater reliability. The codes gathered from the SFT/GMCT checklist allowed me to verify how well I was following the treatment model through charting specific interventions, concepts, and techniques used in each session (see Table 1).

Structural Family Therapy

The SFT/GMCT checklist was designed to code for three concepts from structural family therapy: joining, boundaries, and enactment (Minuchin, 1974; Minuchin & Fishman, 1981). These concepts were selected because they are integral to structural family therapy and because each of these concepts is important to reaching the treatment goals of the integrated model used for this study.

Joining. The therapist joins the family system by adapting and accommodating to the family rules, style, and patterns (Minuchin, 1974). Within the integrated model, joining should occur in each session. Analysis of the coding sheets showed that I used joining techniques in each of the three initial sessions and in 8 of the 10 coded sessions. The coding sheets revealed that finding common ground/interests, humor, compliments, and validation were the most frequently implemented methods of joining. Validation

Table 1

SFT/GMCT Checklist Results

Constructs/ techniques	Initial session	Session 2	Session 3	Session 4	Session 5
<i>Jimmy and Julie</i>					
Structural					
Joining	X	X	X		X
Boundaries		X	X		
Enactment	X	X		X	X
Gottman					
Startup	X	X	X	X	X
Four					
horsemen	X	X	X	X	X
Repair	X	X	X	X	X
<i>Shawn and Allison</i>					
Structural					
Joining	X	X			
Boundaries	X				
Enactment	X	X			
Gottman					
Startup	X	X			
Four					
horsemen	X	X			
Repair		X			
<i>Tonya and Cindy</i>					
Structural					
Joining	X	X			
Boundaries	X				
Enactment	X				
Gottman					
Startup					
Four					
horsemen		X			
Repair					

Note. Each X indicates that the construct or technique was implemented in accord with the SFT/GMCT checklist. Under Tonya and Cindy, only Cindy attended session 2.

and compliments were each implemented in 9 of the 10 sessions. Finding common ground/interests was implemented in each of the three initial sessions but was used only once in the other seven sessions. Mimesis was used in two sessions, and self-disclosure was utilized in 3 of the 10 sessions.

Boundaries. Boundaries separate subsystems within the family structure and are based on the family's rules of interaction (Minuchin, 1974). The integrated model set forth in Chapter II posits that the assessment of boundaries must continually occur throughout the therapeutic process; interventions are implemented when boundaries appear too diffuse or rigid.

Analysis of the coding sheet indicated that boundaries were addressed in 4 of the 10 sessions. Each of the 10 sessions contained at least one of the indicating concepts for a focus on boundaries, but only 4 of the sessions met the criteria of having three of the concepts present in the session (see coding manual in Appendix B). I frequently addressed interruptions, the family spokesperson, touch, and repetition. I called attention to interruptions in five sessions and addressed the family spokesperson and touch in four sessions. Repetition was utilized in five sessions, frequently during intervention enactments. Proximity was utilized in two sessions, once by moving my chair closer to where one of the clients was sitting, and once through asking the clients to turn their chairs so that they could more easily talk with each other during an assessment enactment.

Enactment. Enactments are utilized in both SFT and GMCT, but are listed under structural family therapy because the utilization of enactments in the integrated model

aligns more closely with how enactments are implemented in SFT. Using the coding sheets, analysis revealed that assessment enactments were used in seven out of nine relational sessions and intervention enactments in five of those sessions. In four of the seven sessions that contained an assessment enactment, I facilitated the enactment. On three occasions, I used an opportunity to coach soft startup and moved what started as an assessment enactment into an intervention enactment. Three sessions contained spontaneous enactments that were utilized as assessment enactments. Assessment enactments became interventions on two other occasions as I called attention to the presence of the horsemen and opportunities for repair. Startup and the four horsemen were addressed in each of the five intervention enactments; repair was coached in three of the interventions.

Gottman Method Couple Therapy

Within the integrated model utilized for this study, Gottman method couple therapy techniques and interventions were often utilized to reach therapy goals. Startup, the four horsemen of the apocalypse, and repair were included in the SFT/GMCT checklist to be coded for fidelity to the integrated model.

Startup. Startup is “the way a topic of disagreement is broached” (Gottman, 1999, p. 41). In Gottman method couple therapy, the therapist assists clients in learning how to use a softened startup when approaching one’s partner with a difficult topic (Gottman).

The coding sheets revealed that startup was addressed in seven sessions. Startup was described in two of the three initial sessions and was addressed during intervention enactments in the five subsequent sessions for each of the married couples. Startup was

not addressed in either of the sessions with Tonya and Cindy or in the individual session with Cindy.

The four horsemen. Gottman's research showed that not all negatives within a relationship are equally corrosive (Gottman & Levenson, 1992; Gottman et al., 1998). Four behaviors were found to be most corrosive: criticism, defensiveness, stonewalling, and contempt. These behaviors have been labeled, "the four horsemen of the apocalypse" (Gottman, 1999, p. 41).

The four horsemen were discussed in 8 of the 10 sessions that were coded. The only sessions that did not include a discussion or intervention about the four horsemen were in both relational sessions with Tonya and Cindy. After the assessment enactment in the initial sessions for each of the married couples, I explained the four horsemen and asked the clients to identify the horsemen in their own interactions. The horsemen were addressed in each of the five sessions that included intervention enactments. Client report was utilized to identify the presence of the four horsemen in five sessions during follow-up from previous sessions.

Repair. Repair is an attempt to make the interaction between partners less negative (Gottman, 1999). A goal of mine is to help couples lower the levels of negativity in their interactions through increasing the success of repair attempts. Enabling couples to repair their own interaction is a central goal of Gottman method couple therapy.

Using the coding sheets, analysis indicated that repair was addressed in 6 of 10 sessions. Repair was typically addressed in the context of an explanation about the four horsemen, during intervention enactments, or through the description of taking a break

during conflict discussion.

Research Question Two: When This Integrated Model Is Used as
Set Forth in Chapter II, Do Clients Report Meaningful Changes?

Client report, case notes, case reflections, and the OQ-45.2 were utilized to ascertain changes as reported by clients. I also watched the videos and noted times when the clients reported changes that may not have been documented in the clinical notes. The OQ-45.2 was administered before each initial session and after each third and fifth session when applicable. These data were used as one way to measure change over the course of therapy. I do not typically use formal assessments in therapy, but the OQ-45.2 was included in this study in order to quantitatively measure change. Client report was utilized as I inquired whether clients had noticed changes taking place between sessions and over the course of treatment. Client responses were documented in the case notes from each session. Case notes were also implemented as observable in-session changes in the clients were noted and documented.

*Part One: Do Clients Report
Changes Between Sessions?*

Clients mentioned several changes taking place between sessions. At the beginning of each session, clients were asked what changes they had noticed since the previous session with an emphasis on what had been discussed in previous therapy sessions. I asked this question to each family in order to obtain their ideas and views about any differences they may have noted between therapy sessions. Responses varied

from seeing no changes to having significant positive results based on implementing the interventions discussed in therapy. No negative changes were reported, but some patterns that the clients considered negative persisted from before therapy began.

Startup was discussed in the first therapy session with Julie and Jimmy and also with Allison and Shawn. At the beginning of session two, Jimmy and Julie explained that they had fought less during the previous week than was typical. They attributed this, in part, to their ability to implement a softened startup to begin a conflict discussion. The assessment enactment from the initial session indicated the presence of a harsh startup. Jimmy and Julie explained that they noticed specific changes in how they responded to each other during conflict between sessions one and two. When Jimmy used a softened approach to begin a conflict discussion, Julie disclosed that she viewed his use of a softer approach as an attempt to make the relationship better. According to Julie, this perspective allowed her to be less defensive about the discussion because “at least he was trying.”

Allison and Shawn reported that they saw no obvious changes between sessions one and two. They reported having two arguments during the week. When asked what changes were noticed during the conflicts, Shawn reported that the pattern of fighting remained the same. He explained that a softened startup was not used to approach either discussion, nor was it used to begin other discussions during that week. Allison disclosed that after Shawn used a harsh startup, she immediately became defensive and used criticism. Shawn and Allison reported no positive changes, but I noted that they were able to recognize the presence of criticism and defensiveness in their interactions.

Julie and Jimmy reported changes at the beginning of each session. Each week, they explained that their fights were becoming less frequent and less severe. They attributed these improvements to two specific concepts: startup and repair in the form of a break. Jimmy and Julie reported that as they became comfortable with the concept of taking a break during arguments, they were happier and more comfortable approaching each other about difficult topics.

Cindy disclosed changes in her overall feelings of happiness. At the beginning of session two, she reported feeling “better just by coming” to therapy and that she did not let things bother her as much. Cindy disclosed that she had just found out that a friend had been spreading negative rumors about her. This was difficult for Cindy to cope with, but she explained that being able to talk about her feelings openly in therapy allowed her to not be “consumed by it.” In session three, Tonya explained that she had seen changes in Cindy’s overall level of happiness. When asked what she had seen, Tonya described Cindy as more cheerful, more open about school and homework, and more willing to help around the house. Tonya noted that although Cindy’s school performance had not improved, they were more able to communicate about school.

A recurring theme concerning between-session changes was noted. The clients noticed changes when the concepts and interventions discussed in session were implemented outside of therapy.

*Part Two: Is Change Taking Place
Over the Course of Treatment?*

OQ-45.2. The OQ-45.2 was administered to each client before the initial

treatment session. The score on this initial administration of the OQ-45.2 was then used as a baseline against which to measure change as treatment progressed. When applicable, the instrument was administered to each client after the third and fifth sessions.

Allison and Shawn did not take the OQ-45.2 a second time because they did not attend a third therapy session, so the data obtained from their OQ-45.2 scores cannot be compared to follow-up scores. Tonya completed the assessment before the initial session and after the third session. Fifty days had passed between administrations. Tonya's scores indicated minimal change, and her score was four points lower on the second administration. Tonya scored in the nonclinical range at each administration.

For Julie and Jimmy, the differences between first, second, and third OQ-45.2 scores were considerable. Jimmy's second overall OQ-45.2 score was eight points lower than his initial score, dropping from 78 to 70. The third administration took place after the fifth session, 28 days after the initial session. Jimmy's third overall score was 53. Julie's overall scores showed a more significant drop. Her initial overall score was 97, the second score was 79, and the third score dropped to 45. The clinical cutoff for overall OQ-45.2 scores is 63. Jimmy and Julie each moved from the clinical range to the nonclinical range over the course of treatment. The scores on the interpersonal relations subscale were helpful to the therapist in following stress levels regarding the marital relationship. Jimmy's IR score declined with each administration. His first IR score was 26, the second was 22, and the third was 13. Julie's scores also indicated a reduction in stress levels. Her IR score at first administration was 26, the second was 22, and the third was 8. These scores indicate that changes did take place over the course of therapy,

including changes within the marital relationship. The clinical cutoff for the IR domain is 15. The scores for both Jimmy and Julie moved from the clinical to the nonclinical range over the course of five therapy sessions.

Observed changes. I observed and documented changes I observed in each client. Allison and Shawn reported no changes between sessions one and two, but I noticed changes in their interactional patterns during the second session. In the case reflections, I noted that during session one, Allison avoided making eye contact with Shawn. I facilitated enactment during the first session, but Allison did not make eye contact with Shawn during the interaction. In session two, Allison looked directly at Shawn when speaking to him. In response to my questions, both of them spontaneously turned toward each other during the second session instead of directing answers to me. In the second session, Shawn and Allison held hands at times. This behavior was absent in session one.

Cindy maintained similar mannerisms throughout the course of treatment, but some changes were noticed. During the initial session, Cindy spoke frequently about her friends and their behaviors. In sessions two and three, Cindy progressively spoke more about what she called “emotional subjects,” such as her feelings of hurt and rejection. In sessions one and two, Cindy made infrequent eye contact with me, often looking at the floor. In session three, she made eye contact with Tonya and me during conversation. Comments in the case notes and case reflections indicated that the most obvious change between sessions one and three was that Tonya interrupted Cindy less. In session one, Tonya interrupted Cindy on several occasions. In the third session, Tonya interrupted Cindy only once.

Numerous changes were observed between Julie and Jimmy. As treatment progressed, Julie became more comfortable turning toward Jimmy and addressed difficult topics in session. In the initial session, Jimmy and Julie were asked to discuss Julie's eating habits, a recent source of conflict between them. Julie explained that she felt awkward talking about this in front of someone else, but she was able to do so. In the fourth session, Julie turned toward Jimmy and approached the topic without hesitation. A spontaneous enactment ensued during which I coached a softened startup and repair. After the enactment, Julie explained that she felt less apprehensive about personal discussions in therapy.

Julie's affect and demeanor changed dramatically over the course of therapy. In early sessions, she rarely smiled and frequently fidgeted in her chair. As therapy progressed, Julie laughed and smiled more frequently, and physical contact between Jimmy and her increased. Even during enactments about a topic of recent conflict, Julie laughed and smiled during interactions. Julie disclosed that she felt good in therapy because she understood that Jimmy was making efforts to improve their relationship. She explained that she knew that he wanted the relationship to improve because he attempted to implement what was discussed in therapy such as a softened startup and a break. Jimmy laughed and joked with Julie and me during later sessions, actions that were absent in previous sessions. Jimmy also began to bring up specific topics sooner. Instead of waiting until the latter stages of the session to bring something up, Jimmy addressed certain subjects or incidents toward the beginning of sessions. For example, about 35 minutes into the second session, Jimmy mentioned that they had had a big argument that

he wanted to talk about. In the fifth session, Jimmy brought up a fight from the previous week within the first 10 minutes of the session.

Research Question Three: How Does the Work in One Case or Session Inform the Work in Another?

Criss-crossed reflection and analysis were used for this study through the use of case reflections, case notes, and videos (Spiro et al., 1987). Case reflections contained explanations from the therapist about why specific interventions and techniques were used at certain times. Case notes were utilized to note what, when, and how interventions were used in each session. I watched each session video with the case notes and case reflections in order to analyze which interventions were used in what context and the results of these interventions.

The work in sessions with each married couple influenced the therapeutic process with the other. Julie and Jimmy presented with communication issues and conflict over Julie's eating habits. Allison and Shawn described communication, conflict regulation, and parenting struggles as the presenting problems for treatment. Due in part to the similar nature of the presenting communication problems, the therapeutic process in each case was influenced by the other.

Interventions utilized with Shawn and Allison were influenced by the results of similar interventions with Jimmy and Julie. The initial session with Julie and Jimmy occurred one week before the initial session with Allison and Shawn. When an intervention appeared to work well with Julie and Jimmy, it was more likely that I

implemented the same technique with Allison and Shawn. For example, toward the end of the first session with Julie and Jimmy, I facilitated an enactment for assessment. The enactment showed a harsh startup and the presence of three of the four horsemen: criticism, defensiveness, and contempt. This observation led me to implement a startup intervention and assign homework to implement a softened startup before the next session.

At the beginning of the second session, Julie and Jimmy reported that they were able to effectively implement a softened startup on two occasions during the previous week and that they felt it made a difference in their communication. In the first session with Shawn and Allison, an assessment enactment revealed similar findings: a harsh startup and the presence of criticism, defensiveness, and contempt. Based in part on how well the startup intervention appeared to work with Julie and Jimmy, I implemented the same intervention technique with Allison and Shawn.

In the second session with Allison and Shawn, I implemented interventions for startup and the four horsemen, as well as a discussion about repair. When watching the videos with the case notes and case reflections, the interventions and discussion appeared to be rushed and crammed. To me, the interventions appeared hurried. After watching the video, I made a decision to be more thorough when implementing interventions and to not implement interventions for more than two constructs in a session. This information from sessions with Shawn and Allison influenced future sessions with Jimmy and Julie: When I implemented interventions with Jimmy and Julie about startup, the four horsemen, or repair, I took special care to be meticulous when explaining the concepts.

The techniques and interventions I used with the married couples were different from what was implemented with Tonya and Cindy. My attempts to join and implement boundary concepts with Tonya and Cindy were influenced by previous experiences with the married couples. The joining process for each client family was influenced by every other case. If a certain technique worked well in one session, I was more likely to use it in another session. For instance, Julie appeared to be somewhat nervous during the initial session, so I asked questions intended to make her more comfortable (e.g., “tell me about how you and Jimmy first met”). When Julie answered, I allowed her to go on a bit longer than I normally would have in hopes that Julie would feel more comfortable in the session. This same joining strategy came into play with Cindy and Tonya. It was explained at the beginning of the initial session that Cindy was nervous about therapy and would only keep coming if she felt like she could trust me. In efforts to create trust, I asked questions that would allow Cindy to speak frequently and openly. I did not intervene or interrupt when I normally would have, because I wanted to create a solid therapeutic alliance with Cindy. This technique appeared to work well with both clients: Julie grew more comfortable as treatment progressed and Cindy continued to attend therapy.

My assessment of each family led to the implementation of specific techniques with each family dyad, and the context around specific techniques that were used with one family influenced how those techniques were implemented with other clients. For example, an assessment enactment with Julie and Jimmy became an intervention when I intervened to point out opportunities for repair. This intervention appeared useful with

Julie and Jimmy, so the same technique was implemented in a similar fashion with Shawn and Allison. I facilitated an assessment enactment in the second session to assess for the use of startup and to gauge the presence of the four horsemen. Shawn began the conversation with a harsh startup. Allison responded with defensiveness and criticism. This led to a back and forth exchange of criticism and defensiveness. This pattern was similar to what happened with the assessment-turned-intervention enactment with Julie and Jimmy. Because it was useful with Julie and Jimmy, I intervened with Shawn and Allison by calling attention to an opportunity for repair.

Research Question Four: How Did I Make Decisions About Use and Timing of Interventions and Techniques?

Data for this question were gathered through case reflection notes and coding the session videos. While watching the videos, pertinent interventions and client responses were noted. When analyzing these data, the focus was on the delivery and implementation of techniques and interventions, as well as what was happening just before the intervention and how the clients responded to implemented techniques. Concurrently, the reflection notes provided additional context to the videos in the form of what I noticed, felt, and saw that influenced the decision to utilize each intervention. Combining the codes, client responses, and the case reflection notations allowed me to develop a tentative decision scheme. I then hypothesized that the same or a similar decision-making process would be used in subsequent sessions.

Based on data from observing the videos, coding interventions from the videos,

and reading case reflection entries over time, I noted several common themes and decision-making processes. These themes clustered around times that boundaries appeared too rigid or diffuse, when one spouse used a particular horseman, when one spouse used a harsh startup, and when repair attempts were not accepted. The timing of interventions and techniques was often influenced by the usefulness of interventions in other cases and sessions. The videos and reflection notes revealed that specific interventions were used at similar stages of therapy with different clients.

Boundaries

A general pattern emerged through watching the videos and coding for interventions: In each initial session, I assessed the family boundaries by asking questions that led to a spontaneous enactment or by facilitating an assessment enactment. These enactments allowed me to generate tentative hypotheses about the nature of family boundaries. These hypotheses were then tested through intervention enactments in subsequent sessions. For example, the boundaries between Julie and Jimmy appeared to be too diffuse during one session as Jimmy continually interrupted Julie. This often happened after Julie began a statement with, "I want. . . ." Jimmy interrupted by saying, "You don't want that, you want. . . ." Case reflections specified that after this pattern had been repeated three times during the enactment, I decided to intervene because I "did not want them to establish negative patterns of communication during enactment." I then intervened through proximity and repetition: I moved my chair closer to Julie and intervened each time Jimmy interrupted Julie. This process was repeated several times. As the enactment continued, Jimmy's interruptions of Julie decreased until they were

seldom occurring.

In the second session with Shawn and Allison, proximity and repetition were utilized as intervention tools in response to boundaries that appeared too diffuse. According to the case reflection notes, I decided to intervene this way in part because of its apparent effectiveness with Jimmy and Julie. I decided when to intervene based on what was observed: When Shawn began to dominate the conversation by not allowing Allison to respond to his statements (i.e., demonstrating a rigid boundary that Allison could not penetrate), I moved my chair closer to Allison and intervened by asking Shawn to allow Allison to speak. Case reflections revealed that I intervened at that point in the enactment because Allison and Shawn were following their described pattern of interaction: Allison begins the discussion, Shawn gets upset and demonstrative, and Allison shuts down. Reflection notes indicated that my decision to intervene at this point was an attempt to break the couple's typical pattern of interaction.

The Four Horsemen of the Apocalypse

Case notes and reflection notes revealed that criticism, defensiveness, and contempt were observed during assessment enactments with each of the married couples. Stonewalling was described as being present outside of therapy by Jimmy and Julie. Case reflections indicated that decisions about when and how to intervene with the four horsemen were heavily influenced by previous sessions and cases.

Jimmy and Julie frequently used criticism and defensiveness during the assessment enactment in the initial session. The decision to implement an assessment enactment was made because Jimmy and Julie presented with communication troubles.

After the enactment, I described each of the four horsemen and their antidotes and asked the couple to identify how they each used the horsemen during the assessment enactment. The couple was asked to identify the presence of the horsemen directly after the enactment in order to assess their understanding of the four horsemen. During the second session, I facilitated an assessment enactment that became an intervention enactment when I called attention to Jimmy's and Julie's use of criticism. Reflection notes reveal that the decision to intervene came because criticism was used several times. Case reflections specified that my assessment of the couple's interaction led to an intervention in order to keep the discussion from "spiraling into a cycle of criticism-defensiveness-criticism." At the beginning of the third session, Jimmy explained that he and Julie had been more able to recognize when they each used the four horsemen and that it had been helpful to have the four horsemen called to their attention in the previous session.

The assessment enactment with Shawn and Allison during the initial therapy session included frequent use of criticism and defensiveness. An assessment enactment was implemented because Shawn and Allison presented for therapy with communication difficulties. According to case reflections, the apparent success of interventions with Jimmy and Julie led me to attempt to duplicate the four horsemen interventions with Shawn and Allison. The same pattern was followed: description and explanation of the four horsemen and their antidotes, asking the couple to identify the presence of the horsemen in their own interactions, and facilitating an enactment that became an intervention. The decision to intervene by calling attention to the presence of the four horsemen was made when Shawn and Allison continued to use criticism throughout the

discussion. The case reflections stated that calling attention to the presence of criticism at that point was done to “help them recognize the criticism and reduce the negativity of the discussion.”

Startup

According to case notes, case reflections, and the SFT/GMCT checklist coding sheets, startup was addressed in each of the seven sessions with the married couples. A theme that appeared throughout the case reflections was that I struggled with decisions about when to intervene regarding startup. Case notes indicated that startup interventions were implemented through description and explanation, during enactments, and when discussing past conflict discussions. In the reflection notes, I described feeling comfortable intervening in each of those ways, yet believed that the effectiveness of the interventions varied with timing.

In a reflection note from a session with Jimmy and Julie, I stated, “in the previous session, we discussed the importance of a softened approach. When the enactment began, Jimmy used what I considered to be a harsh startup. I thought to intervene but decided against it in hopes of their repairing their own interactions. The discussion went on, and criticism and defensiveness became more prevalent as the conversation continued.” In a reflection note from a subsequent session, I wrote:

Julie explained that she and Jimmy had several conflict discussions in the past week but that none of them escalated ‘out of control.’ As they described one of these conversations, I asked them to discuss it in the session. The decision to facilitate an enactment at this point in the session was influenced by the fact that we had previously discussed startup and the four horsemen. When it was mentioned that a recent argument did not escalate, I decided to have them discuss it again so that I could observe what they were doing differently from previous

sessions that might contribute to the discussion not spiraling ‘out of control.’ Jimmy began with a harsh startup and I stopped him and asked how he could soften his approach to the discussion. . . . The enactment showed diminished use of the horsemen—I attribute this (in part) to the fact that repair occurred through changing a harsh startup to a softer one.

I decided to intervene immediately following a harsh startup in hopes of emphasizing the importance of using a softened approach. Reflection notes revealed that I believed that my intervening at this point would “reinforce the message that startup is crucial.”

Repair

Repair was most often implemented through startup, a break, and humor. According to case reflections, the methods of repair were typically decided by the clients. For example, *Dumb and Dumber* and *Austin Powers: International Man of Mystery* are two of Shawn and Allison’s favorite movies. During the second session, Shawn and Allison identified that they often utilized lines from these movies to lighten the mood during an argument. This use of repair was demonstrated during an assessment enactment that took place during that session: An intervention enactment was beginning to escalate when Shawn implemented a repair attempt in the form of a line from *Dumb and Dumber*. Allison laughed in response and accepted Shawn’s humorous repair attempt. Case reflections indicated that I was impressed with the couple’s use of repair and wanted to immediately compliment them for its use. However, I decided to wait until after the enactment to praise Allison and Shawn in successfully utilizing repair. I noted that “even though I wanted to tell them they did well, it seemed that it would have been detrimental to the flow of the enactment to interrupt—even if it was to compliment them.”

With each of the married couples, repair was implemented in the form of a break. Decisions were made about when to discuss a break with clients based on assessment enactments. If an assessment enactment revealed that a conflict discussion contained the presence of the four horsemen or escalated quickly, I suggested a break as a means of repair. I assisted each couple to decide how they would recognize when to take a break, how to call for a break, how long the break should be, and how to approach one's partner after the break. Enactment was utilized to allow each couple to discuss how they might use a break as a form of repair. Clients were coached to implement a softened startup when reconvening after a break to continue the original conflict discussion.

Reflection notes specified situations where the decision was made to not intervene during an enactment in hopes that the clients would implement repair or repair attempts without the facilitation of the therapist. This decision was made because repair had been addressed during the session and in the previous session. Case notes and case reflections revealed that I was more likely to utilize interventions for repair when the topic was initially discussed; interventions for repair decreased as the clients showed increased understanding about repair and repair attempts, as well as spontaneous implementation of these attempts.

Other Interventions

Interventions from the Halt, Express emotion, Apply compassion, Love, Solve the problem (HEALS; Stosny, 2007) model were implemented during sessions with Jimmy and Julie. These interventions were used to assist Jimmy and Julie to recognize each other's underlying emotions and feelings. HEALS was used to facilitate empathic

expression after the couple had successfully utilized repair during an enactment. Julie expressed that she had felt devalued and powerless during a recent medical procedure. Jimmy asked questions to understand how Julie felt. Jimmy then empathized with having also felt devalued and powerless, although for different reasons. Julie disclosed that because Jimmy empathized with her, it helped her feel cared for and validated. This intervention was implemented after Jimmy and Julie had been able to successfully utilize repair during an intervention enactment.

CHAPTER V

DISCUSSION

The purpose of this study was to discover whether an integrated model of therapy was beneficial to the researcher in reaching therapeutic goals. Three family dyads who presented for therapy services were studied. Ten therapy sessions were conducted. Each session was video recorded and coded with the SFT/GMCT Checklist. Clinical notes and case reflections were used to identify what happened in each session and what the therapist may have been thinking about each session. The OQ-45.2 was administered to each client before the initial session and again after the third and fifth sessions, when applicable. The results of this study suggest that the integrated model of therapy was beneficial to clients.

The organization of this chapter parallels the results section. The following sections will discuss the findings of this study as well as clinical implications and limitations. The context of this sample must be considered when drawing conclusions from the data. It is important to note that all six participants were similar in race, spiritual beliefs, and city of residence. Five of the participants were married, and four were between the ages of 22 and 24.

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

Structural Family Therapy

Joining. The SFT/GMCT Checklist coding sheets showed that joining techniques

were used in 8 of the 10 coded sessions. The most commonly implemented techniques were finding common ground/interests, humor, compliments, and validation. Mimesis and self-disclosure were implemented less frequently.

My integrated model puts a strong emphasis on joining as a building block for therapy. I noted that according to the SFT/GMCT checklist, I joined in eight of the sessions, but I had hoped for joining to be accomplished in every session. I was particularly interested in which types of joining techniques were implemented most frequently. Coding revealed that validation was implemented in 9 of the 10 sessions. It is important that my clients understand my concern for them. While joining, I often attempt to express empathy through validation. Expressing empathy to the difficulties and stresses of being a student allowed me to build a strong therapeutic alliance with Jimmy and Julie. I hope that through validation, my clients will come to understand my care and concern for them.

In analyzing the coding sheets, I recognized areas where I may need to improve. Mimesis in the form of matching the client's tempo and style of communication was implemented in just two sessions, much less than I had hoped. This may indicate that I can be more conscious of accommodating to my clients' styles of communication. At times I find myself focusing so much on the family's interactional patterns that I neglect to accommodate to these patterns. This result may be due to mimesis being difficult to code; it may be that I was attempting to match the family's usual style but it was not noticed. Another potential explanation would be that I attempted mimesis but did not do it well. When watching the videos with the coding checklist, I noticed times where I

could have implemented mimesis as a joining technique, but did not.

Boundaries. An examination of the coding sheets revealed that I addressed boundaries in 4 of the 10 sessions. Each session contained at least one of the indicating criteria for addressing boundaries, but six of those sessions did not meet the criteria set forth on the SFT/GMCT checklist to constitute marking “yes” for the boundaries category. The most commonly used techniques were addressing interruptions, family spokesperson, touch, and repetition. Proximity was implemented in two sessions.

Boundaries must be addressed more proficiently for my integrated model to meet its potential. The coding sheets revealed that boundaries were addressed in every session, but boundaries were addressed in at least three different ways in only four of the sessions. A difficult aspect of translating boundaries to the SFT/GMCT checklist is that I often assess the family boundaries in my head; I generally do not state my observations to the clients. For instance, I typically pay close attention to body language. I notice when partners turn and face each other. I notice when they hold hands, touch each other’s legs, or lean toward or away from one another. Translating these boundary assessments to the SFT/GMCT checklist in a way that an observer could be sure that boundaries were being addressed was difficult because there was no way for me to indicate to the observer that I noticed certain interactions.

Interruptions were addressed in five sessions, typically through asking the interrupter to allow the other person to finish or by using a hand gesture to indicate that I wanted to allow the speaker to finish. When using the hand gesture, I broke eye contact with the speaker and looked to the interrupter while holding up my hand to suggest,

“wait.” These attempts to hinder interruptions were discussed in supervision, where my supervisor (who was also the advisor for this project) suggested that I might use a hand gesture toward the interrupter without breaking eye contact with the speaker. Watching each session video and discussing certain techniques with supervisors provided me with opportunities to pay attention to details that I may not have otherwise noticed.

Supervisor feedback was particularly useful to how I implemented proximity. After a session that contained an assessment enactment, my supervisor suggested that I pull my chair away from the couple as a way of withdrawing from the discussion. It was also recommended that I have the clients turn their chairs toward each other so that they were facing each other rather than facing me. While watching the videos, I noted several enactments that may have benefitted from my utilizing proximity to withdraw from the couple while they spoke to each other, which would have strengthened the boundary between them and me, and diffused it between the partners, strengthening their couple-ness.

Enactment. Analysis of the coding sheets revealed that assessment enactments were used in seven of the nine coded relational sessions. In five of those sessions, assessment enactments became intervention enactments. In three sessions, assessment enactments became intervention enactments and subsequent intervention enactments were implemented. Four assessment enactments were set up and facilitated by me. Intervention enactments focused on startup and the four horsemen; repair was implemented in three intervention enactments.

Enactments are important to my integrated model of therapy because it is

important to work with the clients as they interact. If education only is used, I believe it is more difficult for clients to implement new concepts and techniques at home without in-session practice. For example, if the four horsemen are discussed in session without intervention, it is less likely that the couple will recognize the presence of the horsemen in the middle of a heated argument. Enactment provides an opportunity to observe a couple's natural patterns of interaction while intervening in ways that impede typical patterns of interaction that have become detrimental. It is my hope that by calling attention to certain behaviors or interactional patterns, the clients recognize these behaviors and patterns more easily.

Assessment enactments were included in the initial session with each client. My integrated model posits that an assessment enactment is essential to productive relational therapy. In each of these sessions, I facilitated the assessment enactment. I asked the clients to describe their typical interactions with each other. After I described these interactional patterns, I asked them to talk with each other about a recent topic of discussion. The clients would then talk with each other about a topic, allowing me to observe their patterns of interaction while comparing what I saw with what the clients had described. It was interesting to note how the married couples each performed spontaneous enactments more readily after the initial session. During the first two sessions with Julie and Jimmy, there were several times where we were discussing a particular topic and I would ask them to converse about the topic in session. In the fourth and fifth sessions, Jimmy and Julie seemed to recognize that they would be asked to discuss certain things and they spontaneously turned toward each other and discussed the

topics without facilitation from me.

Gottman Method Couple Therapy

Startup. The coding sheets indicated that startup was addressed in seven sessions. In two of the three initial sessions, startup was addressed through description and providing examples. Startup was implemented through interventions, follow-up, and homework in the five subsequent sessions for each of the married couples. Startup was not addressed in either of the sessions with Tonya and Cindy or in the individual session with Cindy.

Assessment enactments and client report are important to the decision about whether to address startup with clients. When clients present for therapy with communication troubles or conflict management difficulties, startup is something for which I immediately assess. The assessment enactment with Cindy and Tonya did not reveal the presence of a harsh startup, and they did not describe a harsh startup as part of their typical interactions. Both married couples described and manifested a harsh startup during assessment enactments. After harsh startups were observed, the importance of how a conversation is approached was described. A definition and explanation of startup was followed by a startup intervention in each of the initial sessions with the married couples. Startup interventions consisted of each couple's transforming examples of a harsh startup into a softer startup.

Three assessment enactments became intervention enactments when I coached a softened startup. Startup was coached when one person began a discussion with a harsh startup. I intervened by asking them to attempt to say the same thing with a softer

approach. In accord with my integrated model, startup interventions were implemented only after startup had been observed, defined, and explained.

Watching the videos allowed me to recognize that my descriptions and explanations of why startup is important may benefit by being condensed. In the first session with Jimmy and Julie, I described Gottman's findings about startup. I did not realize this while in the session, but my description provided some unnecessary detail that may have changed the way the message was received. It is my belief that a more direct, concise explanation will be more useful for my clients in the future.

Four horsemen of the apocalypse. The four horsemen were discussed in 8 of the 10 sessions that were coded. The only sessions that did not include a discussion or intervention about the four horsemen were in both relational sessions with Tonya and Cindy. The four horsemen were described and explained in the initial sessions with each married couple. In subsequent sessions, the horsemen were discussed through client report, client identification, interventions, and more detailed explanation.

It was interesting to see how the four horsemen were addressed with each client system. I was surprised to note that the horsemen were not addressed in either of the relational sessions with Tonya and Cindy. I paid close attention to this while watching the videos. The horsemen were present to a small extent but were not addressed. Case reflections indicated that the assessment enactment revealed that family boundaries appeared rigid, and I decided to focus on boundaries rather than the horsemen. The horsemen were addressed in the individual session with Cindy; criticism and defensiveness were discussed in the context of relationships with friends. No horsemen-

related interventions other than describing and discussing them were implemented.

The coding sheets indicate that the four horsemen were addressed in accordance with my integrated model. First, the presence of the horsemen was assessed through enactment. Then, the horsemen were described and antidotes were provided. Clients were asked to identify the presence of the horsemen in their interactions outside of therapy, and intervention enactments addressed the presence of the horsemen and the implementation of repair.

In contrast to my explanations about startup, it seemed that my descriptions of the horsemen were succinct and direct. The clients appeared to readily understand each of the horsemen and why they were being addressed. The coding sheets indicated that each session that included a description of the horsemen also included a description of their antidotes.

Repair. Analysis of the coding sheets indicated that repair was addressed in six sessions. The most frequent use of repair came from explanation and calling attention to repair opportunities during intervention enactments. Repair was also discussed during descriptions and explanations of the four horsemen. Repair was addressed through follow-up about taking a break when conflict discussions escalated.

Watching how repair was implemented in sessions with each married couple showed different ways that repair can be addressed. Shawn and Allison were quickly able to identify methods of repair that they had used in past conversations. These methods were then implemented in session during enactment, both spontaneously and through coaching. Julie and Jimmy struggled to identify repair in their interactions. This turned

out to be helpful because we discussed past interactions in specific detail. We were able to pinpoint repair attempts that had failed and that had been successful. Jimmy had attempted to use a break as a method of repair, but Julie had always viewed this as Jimmy's running away or withdrawing. The couple was able to discuss how a break might benefit their conflict discussions. Watching the videos of each of these couples showed that repair was implemented in a variety of ways.

Analyzing my use of repair while watching the videos led me to conclude that repair is something I want to integrate into my model more broadly. Repair is important to relational connection through forgiveness, taking responsibility, and attempting to decrease negativity. Repair attempts make one vulnerable, which provides a unique opportunity for connection. As I watched the videos and coded each session, I noted that repair was implemented almost exclusively in the context of the four horsemen. While this is important in helping clients recognize and counteract the effects of the horsemen, repair can be implemented in other ways that can be beneficial. During session two with Shawn and Allison, repair was implemented by the clients outside the context of the four horsemen. Shawn explained that he wanted to work hard in school but had a difficult time motivating himself. He turned toward Allison and apologized for not putting more effort into succeeding at school. Allison took Shawn's hand and told him that she appreciated the efforts that he did make. This exchange provided a tremendous moment of connection for Shawn and Allison. Shawn allowed himself to be vulnerable by apologizing, and Allison accepted this by validating Shawn and accepting him. Observing how this exchange took place outside of a discussion about the four horsemen helped me

recognize that there is something powerful in repair that need not be utilized in only one context or in a formulaic manner.

Research Question Two: When This Integrated Model Is Used as Set
Forth in Chapter II, Do Clients Report Meaningful Changes?

*Part One: Do Clients Report
Changes Between Sessions?*

Clients mentioned several changes taking place between sessions. At the beginning of each session, clients were asked what changes they had noticed since the previous session with an emphasis on what had been discussed in previous therapy sessions. Responses varied from seeing no changes to having significant positive results based on implementing the interventions discussed in therapy. No negative changes were reported, but some patterns that the clients considered negative persisted from before therapy began. A recurring theme concerning between-session changes was noted. The clients noticed changes when the concepts and interventions discussed in session were implemented outside of therapy.

The fact that some clients reported that negative patterns continued to persist between sessions may provide some important implications for the integrated model. It may be that the integrated model does not address the therapeutic goals for these clients. If interventions are being implemented to target certain changes, and these changes are not taking place between sessions, some changes to the integrated model may be necessary. It can also be speculated that certain negative patterns take longer than one to two weeks to ameliorate. A structural family therapist recognizes that a family's

homeostatic tendencies may combat rapid changes; established family patterns often override implemented changes until new patterns have been established (Minuchin, 1974). Gottman (1994b) suggested that change takes place when new patterns are practiced often, “so often, in fact, that they become almost automatic” (p. 199). New skills and patterns must be repeated several times in order to establish new norms for family interaction. When attempting to change communication patterns, it may not be realistic to expect noticeable changes to occur between sessions. In addition, subtle changes in interaction may be difficult to notice.

*Part Two: Is Change Taking Place
Over the Course of Treatment?*

OQ-45.2. Each adult client took the OQ-45.2 before the initial session. Allison and Shawn did not take the OQ-45.2 a second time because they did not attend a third therapy session, so the data obtained from their OQ-45.2 scores was not compared to follow-up scores. Tonya completed the assessment before the initial session and after the third session. Julie and Jimmy completed the assessment after the third and fifth sessions. The results of each administration showed lower overall scores, indicating lowered levels of stress. Julie and Jimmy both reported lower scores in the IR domain with each administration.

The results of the OQ-45.2 scores indicated that changes were taking place over the course of treatment. Jimmy and Julie each showed a significant decrease in stress levels, with their overall and IR scores moving from the clinical to the nonclinical range. This correlates with their report that conflict had decreased and that when conflict

occurred, it was less volatile. At each administration, Tonya was in the nonclinical range on all domains of the OQ-45.2. It was disappointing that Shawn and Allison did not return for a third session so that a comparison could be drawn between the first and third sessions of therapy.

Observed changes. The therapist noted differences in each client system throughout the course of treatment. These changes were reported in case notes and case reflections. Observed changes included increased eye contact between partners, fewer interruptions, more frequent touch between partners, and more ease in discussing difficult subjects during sessions. This increased comfort in discussing difficult subjects also seemed to lead to an increased number of arguments during some sessions.

Watching videos with case reflections was beneficial in many ways. According to the reflections, many of the observed changes were nonverbal. I noted several occasions where couples held hands, made eye contact, or touched each other. I was disappointed to note that nonverbal interactions occurred that I had not noticed during the session. In a session with Jimmy and Julie, Jimmy was describing that he had been hurt by a particular comment that Julie made during the previous week. Julie rolled her eyes and looked away from Jimmy, a manifestation of contempt (Gottman, 1999). 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 during enactment.

The observed change aspect of Research Question 3 was essential in helping me learn to better focus on the process of interaction rather than the content. At times it was difficult to not get caught up in what the clients were discussing. When I was able to spot

patterns of interaction that appeared detrimental, I was more confident in my ability to help clients change. Watching the videos with the case notes in front of me provided a unique opportunity to observe client interactions multiple times. I noted that in many cases, I was able to track processes and implement interventions that were intended to break the clients usual patterns of interaction.

Research Question Three: How Does the Work in One Case or Session Inform the Work in Another?

The work done in each case was an important source of feedback. When an intervention appeared to work well with a client system, it was more likely that the same technique was implemented with other clients. Similar techniques were used with each client family, with some similarities within the treatment of the married couples. Specific interventions that appeared to be useful for Julie and Jimmy were then implemented in similar situations with Shawn and Allison. This worked both ways: interventions that did not seem to be helpful were altered or not implemented. This information was important in planning for subsequent sessions.

How the work in one case informs the work in another case was particularly important to me with this research experience. My goal in selecting this as a research question was to learn from each session in ways that allowed me an opportunity to improve and progress as a therapist. It was interesting to see how similar interventions worked differently in different sessions and with different clients. In some cases, I implemented interventions precisely the way they had been implemented in other

sessions only to find varied results. For example, an intervention enactment was used with Jimmy and Julie to focus on the four horsemen and repair. The enactment appeared useful to the clients; they reported in the next session that they noticed different results of conflict discussions and that they attributed this to better recognition of the four horsemen and a more conscious effort to repair. In my excitement at the apparent results of this intervention with Jimmy and Julie, I decided to implement the same intervention with Shawn and Allison. The intervention was carried out almost exactly as it was with Jimmy and Julie, but the results were much different. Shawn and Allison had difficulty recognizing the four horsemen, and when they did recognize the presence of the horsemen, they struggled to attempt repair. Because the intervention seemed to work well with Jimmy and Julie, I expected a similar result with Shawn and Allison.

The varied results of a similar intervention led me to conclude that the decision to use a particular intervention is key, but how it is implemented may be more important. Interventions should be tailored to each client system. This applies to each concept within this study. For instance, each family system has different boundaries that place unique restrictions on how a therapist will be allowed to join the system. As the therapist attempts to employ certain techniques in therapy, the system's boundaries and restrictions that were discovered during the joining process should inform how the intervention is carried out. As a systemic thinker, I must be able to recognize differences in context that may alter the effectiveness of interventions, including resources and constraints of the system. Context may be influenced by culture, gender, sex, family boundaries, presenting problem, typical interaction styles, and so forth.

These cases solidified my belief that therapy cannot be completely manualized. There were times during this process that therapy almost seemed robotic: facilitate an assessment enactment, notice how the discussion begins, look for the presence of the four horsemen, and implement a startup or horsemen intervention based on what was seen in the enactment. Although this process is a useful template, it seemed that I had tunnel vision at times. When watching the videos, it became apparent that I had a focus that led to my neglecting important information. In the fourth session with Julie and Jimmy, the couple discussed their frustrations with work and school. Because I was attempting to focus on the four horsemen, I failed to notice that Jimmy did an exceptional job of soothing Julie through gestures and touch. I was so fixated on verbal repair that I did not observe an important connection between the couple. Because I watched the video after the session, I was able to implement this information in future sessions. It opened my eyes to the fact that I cannot become centered on thinking that specific interventions must be done a certain way to be effective. This project assisted me to recognize that although I may be able to construct an integrated model of therapy that is useful, I must continually look to evolve and expand my abilities as a therapist. It is important to adhere to a theory and model of therapy, but contextual factors must be noted when implementing techniques and interventions.

There were times that I found supervisor feedback to be exceptionally helpful. In the first session with Jimmy and Julie, I facilitated an assessment enactment. After the session was completed, I discussed the session with my supervisor. He suggested that proximity was not being used as well as it could have been. A possible use of proximity

during the enactment would have been to move my chair farther away in order to physically indicate my withdrawal from the discussion. This feedback was implemented in the initial sessions with Shawn and Allison and Tonya and Cindy.

Supervisor input aided me in how I implemented specific interventions. I have a tendency to be verbose. My supervisor encouraged me to develop a more concise way of explaining certain concepts and interventions, particularly with how I described the four horsemen. This feedback led me to watch the second session with Jimmy and Julie a third time. I noted situations where I explained concepts in ways that appeared to make sense to the clients and times where I could have been clearer. In the third session with Jimmy and Julie and the second session with Shawn and Allison, the discussions about the four horsemen were more concise and direct. The clients appeared to benefit from these changes, as evidenced by the way they discussed the four horsemen during enactment.

Research Question Four: How Did I Make Decisions About Use and Timing of Interventions and Techniques?

Data for this question were gathered through case reflection notes and coding the session videos. A tentative decision scheme emerged from watching videos and analyzing case reflections and client responses. This decision-making process was implemented in therapy and treatment planning. The timing of interventions and techniques were often influenced by the usefulness of interventions in other cases and sessions. The videos and reflection notes revealed that specific interventions were used at similar stages of therapy with different clients.

The decision scheme that emerged from this study was based on what I noticed, felt, and saw. Assessing the client system through joining meant that I had to note both verbal and nonverbal interactions. These observations determined what interventions and techniques were implemented and when they were implemented. Context is important to the decision-making process. For example, if a couple is discussing a recent conflict and I notice that the four horsemen are present, context determines what techniques will be used and when. If the four horsemen have been discussed in previous sessions, it is likely that I will turn the assessment enactment into an intervention enactment by calling attention to the horsemen and opportunities for repair. If the horsemen have not been discussed prior to the enactment, and the horsemen are pervasive, I am likely to describe and explain the four horsemen after the enactment.

When context has been considered and a technique has been chosen, the timing of the intervention must be contemplated. Many of the interventions I use in therapy are implemented in the context of enactment. Again, context plays a role. If clients are discussing a recent conflict and one partner uses criticism, when to intervene is based on context. If the four horsemen have been addressed in this or a previous session, I may intervene and ask the client to rephrase the statement without using criticism. This is not always my course of action, however. If repair has also been discussed with the clients, I may allow the conversation to continue in order to assess how the criticism leads to the presence of other horsemen or to repair. The timing of interventions is based on context, previous assessment, and priority. For example, in the first session with Tonya and Cindy, the four horsemen were present in conversation. The presence of the horsemen

was minimal and boundary issues were apparent, typically through interruptions and Tonya acting as the family spokesperson. My observations indicated that although the four horsemen were present, family boundaries needed more immediate attention.

Themes emerged around the use and timing of interventions. My decision-making is predicated upon my ability to assess verbal and nonverbal interactions. I rely on what I notice, see, and feel during the therapy session. Assessment becomes the basis for which techniques will be used. If I notice the presence of a harsh startup, I am likely to implement interventions to assist the family to use a softer startup. My assessment becomes particularly important when a family demonstrates several areas where intervention may occur. In this case, I rely on my observations and client report to determine which areas take priority. When techniques are implemented depends on context and experience. The timing of interventions changes when certain concepts have been discussed. If repair has been discussed, I am slower to interrupt an enactment because I want the family to initially attempt repair without my aid. Life experience and personal values may also influence my decisions about when to use interventions. If a family displays consistent interactional patterns, interventions will be utilized to inhibit these patterns. Assessment is integral to making decisions about use and timing of 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 the HEALS model (Stosny, 2007) were implemented in sessions with Tonya and Cindy, Cindy alone, and Jimmy and Julie. HEALS is a five-step model of anger management that focuses on helping individuals build a response to anger that increases self-value instead of perpetuating resentment (Stosny). Two of the steps in the HEALS model were implemented in specific situations with two goals in mind: first, to assist clients to recognize the emotions that are beneath feelings of frustration and hurt (e.g., feeling devalued or unimportant); second, to facilitate deeper levels of connection through empathy.

The second step in the HEALS model, or the E step, is to express emotions. This begins with the person's recognizing the core emotion that is underlying their feelings of hurt and anger. For example, Julie described the anger she felt toward being in tremendous pain after a car accident that was not her fault. Julie identified that she felt powerless during this situation. The third step in HEALS, the A step, is to apply compassion. In an effort to make the HEALS model fit into relational therapy, I implemented this step to apply compassion to others. In response to Julie's description of feeling powerless, I asked Jimmy to describe a time when he felt powerless and what it was like. He did so, and was able to make a connection between his and Julie's feelings of being powerless. Jimmy explained to Julie that he did not know what it was like to feel powerless to change his medical condition, but that he understood what it is like to feel powerless for other reasons. At the outset of the following session, Julie reported that she and Jimmy had discussed the situation at home and that she felt validated by his responses and attempts to empathize.

My observations of how the HEALS model was implemented led me to believe that it may be a useful addition to my integrated model of therapy. Strengthening the emotional connection between family members may lead to changes in family structure and friendship as families begin to experience each other in new ways. Clients reported successes when implementing steps two and three outside of therapy. I believe that deeper connections in relationships can be forged out of vulnerability. The HEALS model was implemented as an attempt to facilitate deeper emotional connections through recognizing one's own emotions, understanding one another's emotions, and empathic expression. As I implement an emotional element to my integrated model of therapy, I will look at Emotionally Focused Therapy (EFT; Johnson, 2004) and Gottman's recent work that implements an emotional aspect into GMCT (Gottman & Gottman, 2008).

Family Relationships

My therapy experience with Tonya and Cindy led to some conclusions about who should be included in therapy sessions. Tonya and Cindy presented for therapy with boundary struggles. In the second session, only Cindy attended therapy. It was difficult to implement boundary marking and boundary making techniques with only one member of the family present. In the third session, both Tonya and Cindy attended therapy. Interventions were implemented during enactments that were not possible with only one person attending therapy. It is important that all family members attend therapy, particularly when the presenting problem directly involves each of them.

The progression of therapy was different with Tonya and Cindy than with the married couples. This may be the result of several different things, including different

presenting problems, Cindy's age, a parent-child relationship, and that Cindy's father did not attend any of the therapy sessions. I believe that therapy is most likely to be successful when the entire family is present or, in the case of marital therapy, when both partners attend therapy. It seemed difficult to implement boundary-related interventions with only Tonya and Cindy attending therapy. Tonya explained that she and her husband were on the same page, but his not attending therapy may have indicated otherwise to Cindy. Not having the father present changed how I assessed enactments: I found myself wondering how the interactional patterns would change if the father were in the session.

Therapy with Tonya and Cindy occurred three months after the sessions with the married couples and focused mostly on SFT concepts and interventions. During the interim, I conducted approximately 120 hours of clinical practice. This clinical experience likely contributed to my comfort level in sessions with Cindy and Tonya. Because my model is an assimilative integration (Fraenkel & Pinsof, 2001), I felt comfortable with my capabilities to implement aspects of other models within the framework of SFT when I thought they would yield positive results for the clients. Implementing steps from the HEALS (Stosny, 2007) model fit within the integration because my primary treatment focus was still on the SFT concepts of boundaries and family structure.

In efforts to help Cindy feel comfortable, I allowed her to talk about random topics more than I would have with other clients. I believe that was the correct decision, but it may have been beneficial to the overall goals of therapy if I had taken more control of the conversation. By not helping Cindy focus by drawing a boundary sooner, I may

have modeled the wrong message. I was better able to help Cindy focus on therapy as treatment progressed.

Level of Training

Many of the interventions used during this study were implemented in ways that were indicative of my level of training as a relative beginning therapist. For example, when one intervention worked well with Jimmy and Julie, I attempted to implement the same intervention with Shawn and Allison. As a beginning therapist, it may be more common to utilize this strategy. As my training has progressed, I have learned that context should affect how and when I implement interventions. Months have passed since conducting the therapy sessions included in this study and this project continues to affect the way I do therapy. As my level of training has increased, I have found that the ways in which I implement interventions and techniques continues to diversify. I credit this project for bringing to my attention details about how I conduct therapy that I may not have noticed otherwise. I am more confident in my abilities as a clinician, as well as my knowledge of SFT and GMCT. My experience with this project continues to influence how and when I implement techniques and interventions.

Limitations

This study provided an intimate look at the relationships between three family dyads and how an integrated model of therapy may assist in improving their relationships. While several interesting themes emerged from this research, it is necessary to note the limitations of this study. The sample was small, and most of the research was

qualitative, preventing any possibility of generalization, even to my own therapy. Not only was the sample small, but also relatively homogenous, with all participants being Caucasian, non-religious/atheist, and living in the Cache Valley. There may be cultural factors that could not be explored in this study. Clients were selected because they presented for therapy at the Utah State University MFT Clinic and were assigned to me based on regular rotation. Although appropriate for this project, the case study design could be replicated in other communities and with a more diverse population.

Inter-rater reliability was implemented with the SFT/GMCT checklist, but the checklist had not been used in other studies to further determine its validity. With further use, the checklist could likely be refined to operationalize the concepts of the integrated model. Further research may assist in clarifying the SFT/GMCT checklist and the checklist training manual. Some of the data relied on self-report measures, which likely contains elements of bias. Client report and therapist case reflections may hinder internal validity. However, efforts were made to increase validity through the triangulation of multiple sources.

Researcher bias must be taken into account with this study. I compiled the integrated model and created the SFT/GMCT checklist and training manual. I was also the therapist in each of the 10 sessions, and wrote each case note and case reflection. It is possible that my subjective analysis led to a biased interpretation of what occurred in the therapy sessions. Researcher bias also likely impacted the coding of each session because of the friendship between coders. Interventions and techniques may have been interpreted in ways that would support the integrated model.

Clinical Implications

The findings of this study lead to several implications for me and for the integrated model of therapy. Although this study did not implement the entire integrated model of therapy, it did focus on the concepts, techniques, and interventions that I deemed most central to my integrated model. In order to do this, some additions were made to the model that I do not generally implement in therapy. I do not typically use the OQ-45.2 in treatment outside of the MFT clinic, nor do I specifically ask the clients at the beginning of each session what changes they have noticed since the previous session. To be most consistent with my integrated model, changes in clients are usually noted through client report and observation (e.g., new patterns of interaction during enactment). Several implications will be discussed, including changes to the model as presented in this study, additions to the model, and alterations to how certain techniques are implemented.

Changes to the Integrated Model

One purpose of this study was to evaluate the usefulness of the integrated model of therapy presented by the researcher. The results of the study indicate that the model can be useful when implemented as set forth in Chapter II. While this study indicates that the model is useful in most regards, some alterations to the model will be made as a result of this project.

Watching videos and reviewing case reflections sharpened my focus about how repair is implemented and utilized in the integrated model. At the beginning of this study, repair was used as a means of counteracting the corrosive nature of the four horsemen.

Repair was broached with clients when the four horsemen were rampant or hostility escalated to the point that it seemed that a break in conversation would be beneficial. The videos revealed that the clients implemented repair in more versatile ways than I had originally conceptualized. Clients implemented methods of repair in creative ways, even when the horsemen were not present. These methods included apology, humor, flirtatious gestures, and making faces. These actions could be defined as repair if they were performed in the presence of the four horsemen. These interactions appeared to be useful to the clients. Adding an emotional aspect to the integrated model may be a way to facilitate repair between family members. This insight has broadened my definition of repair and my ideas about how to implement methods of repair in therapy.

Additions to the Integrated Model

The process of conducting this research has opened my eyes to areas of weakness within my integrated model of therapy. First, the model does not contain a directly emotion-centered element. As I have learned more about therapy and my theories about relational connection, I recognize that attention to an emotional element may be therapeutically beneficial to clients. It is my belief that deep relational connections can be facilitated through vulnerability. New relational experiences can occur when the emotions that underlie hurt and pain are presented, and subsequently accepted. I must be mindful of whether intensifying emotional connections may benefit my clients, and how to best facilitate these new emotional experiences.

Because the integrated model is an assimilative model (Fraenkel & Pinsof, 2001) with SFT as the base, emotion-centered interventions may be added to my model. These

interventions will only be added and utilized with SFT goals in mind. For example, a structural family therapist posits that change occurs when family members experience each other differently (Minuchin, 1974). If emotion-centered interventions such as the “apply compassion” step from the HEALS model facilitate these new ways of experiencing other family members, they will be implemented in therapy to achieve these goals.

Implementation of the Integrated Model

This study allowed me to focus on the process of implementing specific techniques and interventions. A careful examination of the session videos and case reflections indicated that several alterations to how techniques are implemented may be beneficial to the therapeutic process. The videos and supervisor feedback indicated that I have a tendency to be verbose when describing certain concepts (e.g., startup). Watching the videos while spotlighting the explanations of startup, the four horsemen, and repair allowed me to find ways of condensing my descriptions of these concepts in session.

Comparing reflection notes and case notes to the videos helped me realize that I need to be more observant of nonverbal gestures. It seemed that I had tunnel vision at times by looking only for specific nonverbal behaviors or concentrating only on verbal exchanges. I noted nonverbal behaviors when viewing the videos that I did not notice during sessions. Observational information is essential to an accurate assessment of family structure and boundaries. It is imperative that I broaden my observational focus in-session.

This project was beneficial to my understanding of therapy, the integrated model,

and me as a therapist. I was able to pinpoint areas of weakness and strength, both in the integrated model and in my therapy skills. Utilizing different techniques to analyze each therapy session provided a unique opportunity to assess and hone my skills as a therapist.

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APPENDICES

Appendix A

Informed Consent for Treatment

Informed Consent for Research

IRB Approval Letter

Memo from MFT Director



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: _____

Utah State UNIVERSITY

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

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

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

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

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

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

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

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

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

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

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

Utah State UNIVERSITY

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

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

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

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

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

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

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

Signature of PI



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

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

Utah State UNIVERSITY

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

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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 # _____

Appendix B

SFT/GMCT Checklist and Training Manual

SFT/GMCT Checklist

MFT Clinic Procedures

<i>Procedure</i>	Yes	No	Details
Risk assessment/self-harm			
Risk assessment/domestic violence			
Explanation of Paperwork			

SFT Concepts, Techniques, and Interventions

<i>Concepts and Techniques</i>	Yes	No	Details
Joining			
Boundaries			
Enactment			

GMCT Concepts, Techniques, and Interventions

<i>Techniques/Interventions</i>	Yes	No	Details
Startup			
Four Horsemen			
Repair			

SFT/GMCT Fidelity Checklist Training Manual

Each of the concepts, techniques, and interventions on the SFT/GMCT Checklist are described below. The observer will check the box next to the concept, technique or intervention on the score sheet based on the descriptions provided in this manual. The observer will write the concept used in the details box. For example, if joining were used in a session, the observer might write in the details box: mimesis, humor, and validation. A description will follow each heading to detail what may be done by the therapist in order to achieve each of these therapeutic goals.

Required MFT Clinic Procedures

The paperwork must be administered and explained in each initial session with a new client in order for the coder to mark *Yes* on the SFT/GMCT checklist. The risk assessments will be done as needed.

Risk Assessment—Self-Harm: The therapist must follow Clinic protocol as listed in the 2008-2009 USU MFT Policies and Procedures Manual. A risk assessment includes the therapist assessing for mood, suicidal ideation, and intensity of ideation. The therapist will ask about specific plans, means to carry out any plans, and history of suicide attempts. The therapist may construct a safety plan (a no-harm agreement) with clients. The safety plan should include social supports (spouse, children, friends, religious leaders, etc.), removal of any means of self-harm from the home, and other conditions that fit the specific circumstances.

Risk Assessment—Domestic Violence: The therapist must follow Clinic protocol as listed in the 2008-2009 USU MFT Policies and Procedures Manual. The therapist may assess a client couple/family for sequences of violence. Safety of all parties is the therapist's first priority. The therapist will assess for level of severity and number of instances. The therapist will construct a safety plan including the offender accepting responsibility for behavior, victim accepting responsibility for safety, alternatives to violent behavior, and plans for what to do if violence occurs again (e.g., CAPSA).

Paperwork: The therapist should explain and answer any questions about the paperwork given to the clients before the initial session. The therapist will describe the clinic and its purposes. It is the therapist's responsibility to ensure that the clients understand the Informed Consent for Treatment and the Informed Consent for Research.

Structural Family Therapy Techniques

Joining

For the observer to mark *Yes* on the SFT/GMCT Checklist, the therapist must implement at least three of the six concepts described in this section.

Finding common ground/interests: The therapist may attempt to join the client system through common interests. Ideally this process would be spontaneous without the therapist asking questions such as: What do you enjoy doing? or Where are you from? The therapist and clients may share stories or talk about what they enjoy doing in order to build camaraderie between them. The therapist should emphasize common experiences to blend with the family (Minuchin, 1974).

Mimesis: The therapist uses mimesis to accommodate to a family's style and affective range (Minuchin, 1974). The therapist will adapt to what is presented by the family. The therapist will be excited when the family is excited. The therapist will adopt restricted communication if that is what is demonstrated by the family. The therapist will also adopt the family's tempo of communication.

Humor: If it is appropriate within the rules of the client's system, the therapist may attempt to use humor to join the family system. Humor will be used if the family displays an affect that fits with this joining strategy.

Validation: The therapist uses validation to join the family system. Validation is used as an attempt to understand; this may be demonstrated through empathy or sympathy. The therapist may use phrases such as, "I know what it means to be poor," or "I am a father of young children." The therapist attempts to validate the reality of the couple/family system.

Compliments: The therapist will often compliment the family/couple on family strengths, such as past or current successes.

Self-disclosure: The therapist uses self-disclosure to emphasize personal aspects which are congruent with those of the client's. This may include stories or experiences similar to those described by the client couple/family.

Boundaries

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

Proximity: The therapist notices where clients sit and in what arrangement. The therapist may ask the clients to move or change the seating arrangement in order to see if this changes the structural dynamics of the family in-session.

Touch: The therapist pays attention to whether or not a couple or family uses touch. For example, the therapist observes to see if a couple holds hands or touches one another's leg. This may be important information to the therapist's initial interpretation of family boundaries. This can be coded for if the therapist mentions it in session or if it is written about in case notes.

Interruptions: The therapist will notice if one family member interrupts others, particularly if the same person is continually interrupted. The will be coded for when the therapist brings this up in session.

Spokesperson: Is there a family spokesperson? The therapist will ask questions to each member of the couple or family. The therapist will note when a question is asked to one member of the family but answered by another. This may also happen when one client is asked a question, but before answering takes cues from another member of the family. This information is important to joining and decisions about what interventions to use in boundary making or boundary marking.

Eye contact: Do the clients make eye contact with each other? Do they make eye contact with the therapist? This is important to the therapist when attempting to join the family system, but may also provide insight as to hierarchical dynamics within the family system. The therapist will pay particular attention to eye contact in regards to a family spokesperson. The therapist must take cultural norms into account when assessing for what eye contact indicates about family boundaries. The therapist must also take sex into account, noting any apparent power differences in a couple's system.

Emphasis: The therapist will notice the level of positive and negative interactions between family members. Does the couple or family accentuate the positive or the negative? The therapist notices how positives and negatives are expressed (e.g., a negative may be expressed through a husband rolling his eyes at his wife). The therapist may give praise or disapproval to certain members of a couple or family to test the family boundaries in order to see how the family reacts to this (Minuchin, 1974).

Repetition. The therapist may emphasize family boundaries through repetition of a message or question. For example, if he believes the husband to be the family spokesperson, the therapist may ask specific questions to the wife in order to draw her out

and gauge the reaction of the couple to having the wife speak more frequently. Questions may be repeated throughout the session (or statements about who gets to speak) in order to make the point clear. The therapist may also ask multiple questions to one person in order to “repeat” the message that the therapist would like more interaction from a specific person. Repetition may also occur through repeating the importance of a softened startup, avoiding criticism, etc.

Enactment

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

Assessment enactment: All enactments are used for assessment. An assessment enactment occurs when family members discuss a topic with each other without the involvement of the therapist (the therapist may be involved to set up the discussion). Any interaction between clients can be considered an assessment enactment because the therapist is assessing for family structure, boundaries, the presence of the four horsemen, and so forth.

Intervention enactment: An intervention enactment occurs when family members interact with each other in-session and the therapist intervenes to coach specific techniques or situations. For example, if a client begins a conversation with a harsh startup, the therapist will intervene and coach a softened startup. Intervention enactments can occur in diverse ways, focusing on family structure, boundaries, startup, the four horsemen, repair, and so forth.

Spontaneous: The therapist looks for the couple to interact with each other without specific instruction from the therapist. When the therapist asks a question, does the couple or family begin to talk with each other directly? If the couple/family does not spontaneously interact with each other, the therapist will facilitate an enactment.

Facilitated: The therapist will often facilitate enactment. The therapist inquires about a recent discussion between family members. The therapist explains that it is important for him to see the family interact with each other and asks them to discuss the topic again.

Startup: The therapist notices how each conversation begins and makes a note of this. Is a harsh or softened startup used? The therapist addresses the idea of startup after the enactment ends, either complimenting the softened startup or explaining that the harsh startup must be changed.

Four horsemen: The therapist pays particular attention to the presence of the four horsemen. During an assessment enactment the therapist notices the presence of the horsemen and will address that later. During an enactment for intervention the therapist will step and point out the presence of the horsemen.

Repair: The therapist notes repair attempts and the acceptance of repair during all enactments. During enactments for intervention the therapist may point out repair attempts, particularly repair attempts that have been rejected. Successful repair must be mentioned and praised by the therapist.

Eye contact: The therapist notices how the couple or family looks at each other. Can they look each other in the eye during conversation? Does this change throughout the therapy process? The therapist will again consider cultural norms when using this as an assessment tool.

Assessing the process: The therapist assesses each enactment for interactional processes and changes in those processes over the course of treatment. The therapist notices who speaks most, who withdraws, and who is dominant (verbally and through body language). The therapist may intervene by aligning with a member of the family or couple who is not as vocal. The therapist will praise successes during enactments, including decreases in the presence of the horsemen, use of softened startup, and allowing each member to be heard.

Who is spoken to: The therapist must deflect attempts by the couple or family to speak to each other through the therapist. The clients may attempt to speak through the therapist instead of to each other directly; the therapist must remain firm in insisting that the clients speak to each other.

Utilization of new skills: The therapist notes when the clients have utilized new skills in enactment. For example, if the therapist explained softened startup during the previous session and the wife uses a softened startup during enactment, the therapist compliments this and praises the family for using new skills.

Gottman Method Couple Therapy Techniques

Startup

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

Addressed: The therapist notices what kind of startup is used and addresses this. The therapist will explain why startup is important.

Provide examples: The therapist gives examples of a harsh startup and examples of a softened startup.

Interventions: The therapist gives examples of a harsh startup (or has the clients come up with their own) and has the clients turn a harsh startup into a softened startup in the session.

Follow-up: If startup has been addressed in previous sessions, the therapist asks about the nature of the startups that have occurred at home during the past week. The therapist also looks at startup during enactments and compliments the use of softened startup and points out the use of a harsh startup.

Homework: The therapist assigns homework of using a softened startup to begin conflict discussions. The clients are asked to write down when they used a softened or a harsh startup and what happened. The therapist emphasizes the importance of using a softened startup when beginning a discussion after taking a break (repair).

The Four Horsemen of the Apocalypse

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

Presence of the horsemen: When the therapist notices any of the four horsemen during the interaction between clients it will be pointed out.

Description and explanation: The therapist describes what the four horsemen are and gives examples of each. The therapist explains why each of these behaviors is harmful to relationships and communication, including how each of the horsemen can be corrosive and that they typically build on or respond to each other.

Contempt: The therapist explains contempt and that it is unacceptable in therapy. The therapist tells clients that contempt will be brought to their attention and that therapy is expected to be a safe place where contempt will not be tolerated.

Antidotes: Each time the therapist explains any of the four horsemen the antidote for that particular horsemen should also be explained. For example, when the therapist describes criticism he will also explain how to turn criticism into something softer, such as a complaint. The therapist will give an example of a criticism and follow it with and example of the same thing as a complaint (without criticism).

Client report: After the therapist has described the four horsemen and why they are important, the therapist will ask the clients where they see the horsemen in their own interactions.

Client identification: After the four horsemen have been described and discussed, the therapist may have clients perform an enactment. The therapist watches for the presence of the horsemen throughout the enactment but before describing what he saw, the

therapist will ask the clients to process their own interaction. The therapist asks the clients which of the horsemen were present during the discussion, when they appeared, and when they recognized the horsemen (whether during the discussion or only in hindsight).

Intervention: The therapist facilitates enactments for the purpose of intervention. When the intervention focuses on the four horsemen, the therapist will intervene when the horsemen are present. For example, if a husband says to his wife, “You never touch me anymore,” the therapist will intervene by stating that the husband just used criticism. The husband will then have the opportunity to restate the criticism in the form of a complaint or need statement (e.g., “I loved the way you touched me in the kitchen yesterday. I need more of that.”). In some situations the therapist will not intervene immediately in order to allow the clients to attempt repair.

Repair

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

Explanation: Once the four horsemen have been described (or during the process), the therapist explains important concepts of repair: what it is, why it is important, and how it is done. This is typically done as the therapist explains that criticism, defensiveness, and stonewalling are present in stable marriages; repair is what keeps the horsemen from corroding a relationship. The therapist emphasizes that repair happens only as both members of the discussion allow: it is just as important to accept the repair attempt as it is to make it.

Presence during enactments: The therapist looks for repair attempts and the acceptance of repair during enactments. During an assessment enactment the therapist will mentally note repair attempts and point them out after the enactment has ended. During an intervention enactment the therapist is more likely to call attention to repair attempts as they occur or shortly after the attempt has been made (to allow opportunity for the other person to accept the attempt).

Description of repair: Repair can be anything that lessens the negativity during interaction. The therapist assists clients in recognizing what types of repair attempts are made during their interaction and what types can be implemented. The therapist explains that repair can come in the form of apology, humor, acknowledging one’s own role in the situation, and stating one’s own feelings or needs. The therapist gives examples as needed.

Follow-up: After repair has been explained and enactments have been performed, the clients will be asked to report how they have been able to repair any negative interactions that occurred since the previous session. The therapist has each couple or family member

describe how they were able to make and accept repair attempts, with particular focus on what worked and what did not work (per their report).

Break: An important means of repairing negative interactions is to take a break when conversations are escalating out of control. The therapist explains why a break is useful (physiologically and for repair) and asks the couple or family if they have attempted to take breaks during past conflicts. The therapist helps the clients develop a plan for taking a break; this plan must include how long the break will be, specific plans to reunite, and the use of a softened startup upon reunion.