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Therapist Interventions in Marital Therapy with Highly Distressed Couples

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THERAPIST INTERVENTIONS IN MARITAL THERAPY WITH HIGHLY DISTRESSED COUPLES

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CHAPTER I

INTRODUCTION

Marital distress and divorce have been linked to a variety of negative consequences, including alcohol abuse, spouse abuse, increased incidence of psychopathology, and numerous health problems (Jacob & Krahn, 1988; O'Farrell & Birchler, 1987; Margolin, John, & Glebermen, 1988; Hops, et al., 1987; Bloom, et al., 1978; Schmoldt, Pope, & Hibbard, 1989). Children of divorce are at an increased risk for depression, poor social competence, health problems, poor academic achievement, and conduct-related disorders (Emery, 1982; Howes & Markman, 1989). While outcome research has convincingly established the efficacy of marital therapies (Pinsof & Wynne, 1995), little is known about the process of these therapies. That is, we know that marital therapy works, but we don't know why.

Previous process research has been particularly limited in the area of therapist behaviors. While it is commonly assumed that therapist's interventions have an effect on the successful treatment of maritally distressed couples, only two systematic studies focus directly on therapist behaviors in marital therapy (Brown-Standridge & Piercy, 1988; Cline et al., 1984). This exploratory project examined therapist interventions in marital therapy with eight highly distressed married couples who were at risk for divorce. The purpose of the study was to identify specific therapist interventions that

related to successful and unsuccessful therapy outcomes. It was hypothesized that therapist interventions related to couple's improvement would be different from those related to no improvement. Additionally, this study examined a model of marital therapy known as integrative problem-centered therapy (IPCT; Pinsof, 1995). Consistent with this model, it was hypothesized that therapist interventions associated with improvement would be primarily behavioral in nature at the beginning of therapy. As therapy progressed, interventions that were experiential in character should have also been seen with improved couples. The results of this study provided preliminary support for the IPCT model, as well as guidance to therapists about strategies that facilitate positive change in marital therapy.

CHAPTER II

REVIEW OF RELATED LITERATURE

Effects of Marital Distress and Divorce

Today separation and divorce are common phenomena; one-half to two-thirds of all first marriages are expected to end in separation or divorce (as of 1989; Castro-Martin & Bumpass, 1989). Those who remarry after a divorce are more likely to become divorced again (Brody, Neubaum, & Forehand, 1988). While marital conflict is not always viewed as negative (Gottman, 1993), evidence suggests that marital distress and instability exact a high toll on the emotional and physical well-being of the family members involved (Bloom, et al., 1978). For example, marital distress has been linked to depression (Hops, et al., 1987), alcohol abuse (Jacob & Krahn, 1988; O'Farrell & Birchler, 1987), and spouse abuse (Margolin, et al., 1988). Separation and divorce have been linked to an increased risk of psychopathology, increased number of automobile accidents, and increased incidence of illness, suicide, violence, and homicide (Bloom, et al., 1978).

In addition, the quality of marital interaction has been found to be related to the self-reported health and well-being of the marital partners (Schmoldt, et al., 1989). In a study of male cardiac patients, marital conflict was associated with greater anxiety,

depression, and negative cognitions (Waltz, Badura, Pfaff, & Schott, 1988). Not surprisingly, spousal disagreement is related to poorer rehabilitation for male patients after their first heart attack (Bar-On & Dreman, 1987). Also, women patients with rheumatoid arthritis who had critical spouses engaged in more maladaptive coping behaviors and reported poorer psychological adjustment (Manne & Zautra, 1989). In another study, negative marital interaction surrounding the wife's arthritis was a determinant of both partner's psychological adjustment (Manne & Zautra, 1990). Also, psychosocial stress has been found to influence immunological functioning, although the basis of this relationship is not yet understood (Jemmott & Locke, 1984). Thus, Gottman (1989, p. 213) writes, "I think we will soon find that family relationships have more to do with health than diet and exercise."

Lastly, marital conflict and divorce clearly have a negative effect on children. Child behavior problems, such as oppositional behavior and aggression, have been linked to marital distress and divorce (Bloom, et al., 1978). Marital discord has also been associated with negative peer interactions and poorer physical health of children (Gottman & Katz, 1989). Depression, poor social competence, health problems, poor academic achievement, and conduct-related disorders have all been connected to divorce (Emery, 1982; Howes & Markman, 1989). In sum, marital conflict and divorce have clearly been linked to negative consequences for all of the family members involved.

The Effectiveness of Marital Therapy

Not surprisingly, the popularity of marital and family psychotherapies has rapidly

accelerated since these interventions first appeared in the 1950s. Family therapy can be defined as, "Any psychotherapy that directly involves family members in addition to an index patient and/or explicitly attends to the interaction among family members. Marital therapy, a subclass of family therapy, directly involves both spouses and/or explicitly attends to their interaction (Pinsof & Wynne, 1995, p.586)." Marital and family therapies are commonly taught to students in the mental health professions (Friedlander, Wildman, Heatherington, & Skowron, 1994). Theories of family treatment are described by clinicians and scholars in practice-oriented books and journals of psychotherapy research. Perhaps most importantly, outcome research has convincingly established the efficacy of marital and family treatments. We turn now to a review of the considerable evidence that marital therapy works. Studies have been excluded if they do not distinguish marital therapies from the broader category of family therapy. A more comprehensive review can be found in a recently published special issue of the *Journal of Marital and Family Therapy,* which examines the existing research on the efficacy and effectiveness of both marital and family therapies for a variety of specific problems and disorders (Pinsof & Wynne, 1995). This issue highlights the consensus in the field that marital therapy can be effective in reducing marital distress.

Shadish and his colleagues have conducted the most recent and comprehensive meta-analysis of the effects of marital therapy (Shadish, et al., 1995). Meta-analysis is a form of literature review which quantifies the characteristics of the literature by converting the outcomes of each study to a common unit of measurement called an

effect size. The effect size is then interpreted like any other standard score. For example, an effect size of $\underline{d} = .5$ means that the treatment group did half a standard deviation better than the control group on the outcome measure. Shadish et al. reviewed 163 randomized experiments of the effects of marital and family therapy with distressed clients. Sixty-two of these studies tested marital therapy specifically. Results indicated that those clients who received some form of marital therapy (MT) or family therapy (FT) did significantly better than those clients who did not receive therapy. The overall effect size was .51. The researchers also tested family and marital therapy separately and found that the effect sizes for both were significant: (MT, $\underline{d}$ =.60; FT, $\underline{d}$ =.47). These forms of therapy did not differ significantly from each other. The authors point out, however, that the two forms of therapy are difficult to compare because they so often address different kinds of presenting problems. For example, Shadish et al. (1995) reported that FT studies treated more behavioral presenting problems than did MT.

The authors also examined 23 studies which compared marital therapy with individual therapy. The differences in outcome were nonsignificant. The presenting problems in these studies did not adequately represent the kinds of problems traditionally presented for marital therapy, however, which may have put marital therapies at a disadvantage.

Another result of this analysis was that, despite superficial evidence, differences between theoretical orientations do not appear to be significant. The researchers looked at 105 studies that directly compared orientations to each other rather than

control groups. Computing pairwise comparisons among orientations yielded nonsignificant effect sizes for all analyses. The authors conclude that orientations are likely to be confounded with other variables, making claims of superiority of one over another untenable.

Lastly, this investigation explored the clinical significance of marital therapy as well as the statistical significance. If a couple is clinically distressed at the beginning of therapy, but is no more distressed at the end of therapy than the average nondistressed couple, this result meets the criteria for clinical significance. The authors found that MT produced clinically significant improvement in 41% of the couples studied, when the outcome measures included either the Dyadic Adjustment Scale (Spanier, 1976), the Marital Adjustment Scale (Locke & Wallace, 1959), or both.

Shadish's (1995) extensive empirical review essentially confirms the conclusions of several previous researchers (Dunn & Schwebel, 1995; Hahlweg & Markman, 1988). In sum, researchers believe there is reason to be optimistic about the effects of marital therapy. It appears that marital therapy produces moderate to high effects that are statistically and, in many cases, clinically significant and comparable to those produced by individual therapy. Lastly, outcomes do not vary significantly across theoretical orientations.

Finally, several authors have conducted narrative reviews of the literature on the effects of marital therapy (Gurman, Kniskern, & Pinsof, 1986; Jacobson & Addis, 1993) which tend to support the conclusions of the meta-analyses. Of these, the review of Gurman and his colleagues is the most comprehensive. Gurman, Kniskern, and

Pinsof (1986) included 21 articles specifically on marital therapy. Of the 21 total studies, seven studies had compared distressed couples who received behavioral marital therapy (BMT) to distressed wait-list control couples on measures of communication skill. Behavioral marital therapy is generally thought to be divisible into two major components: a content component called behavior exchange, which is rather loosely defined as emphasizing the instigation of positive behavior changes in the home environment, and a process component, which emphasizes training in communication and problem-solving skills during the therapy session (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). The BMT couples in all but one of these studies showed statistically significant decreases in negative verbal behavior compared to controls. Additionally, eight of the total 21 studies compared BMT to wait-list controls on measures of improvement of presenting problems. In seven out of these eight studies, the BMT couples improved significantly more than the wait-list couples on presenting problems and requests for behavior change. Also, in eight of eleven studies which measured marital satisfaction and adjustment, couples receiving BMT showed significantly more improvement on self-reported measures of marital satisfaction and adjustment than did couples in control groups. One weakness of this analysis is that it is a narrative review which lacks the empirical rigor of techniques such as meta-analysis.

At this time, only three outcome studies focus on the long-term effects of marital therapy for the prevention of divorce (Snyder, Wills, & Grady-Fletcher, 1991; Jacobson, Schmaling, and Holtzworth-Munroe, 1987; Crowe, 1978). Each of these

studies compares marital therapy between theoretical orientations. The results from these studies tend to support the long-term effectiveness of marital therapy. Additionally, results indicate that long-term outcomes do not vary significantly across theoretical orientations.

While, admittedly, studies on the long-term effectiveness of marital therapy are scarce, findings such as these reflect the promise of such therapies for increasing marital stability in the long-term. With regard to the evidence of short-term effectiveness, the literature tentatively supports the following conclusions: a) marital therapy is significantly more efficacious than no psychotherapy for a variety of problems, including marital distress and conflict; b) marital therapy is as effective as individual treatment for relieving marital distress; and c) there are few data to support the superiority of one particular orientation of marital therapy over another (Pinsof & Wynne, 1995).

The Process of Marital Therapy

While there is consensus among researchers that marital therapy can be effective in alleviating marital distress, much less is known about precisely how therapeutic change occurs. Therapeutic change is presumably influenced by a variety of factors, including characteristics of both clients and therapists. It is commonly assumed that one factor influencing therapeutic change is the therapist's in-session behavior, or interventions. Identifying therapist interventions that have been shown to work is one of the most direct ways that marital therapy process research can improve clinical practice. A review of the existing literature on therapist behaviors which are thought to

promote change in marital therapy follows.

Some research suggests that therapists facilitate critical events in therapy which are associated with change. A study by Wark (1994) examined therapist and client perceptions of what these critical events might be; that is, therapists and clients identified what was helpful and not helpful in therapy. Immediately following therapy sessions, five couples and their five therapists described those significant aspects of therapy which they viewed as particularly helpful and those they felt were hindering. Husbands, wives, and therapists were interviewed individually; none were aware of the others' responses. Each participant was then asked to describe how each aspect of therapy that they had reported was related (or unrelated) to change. The data were analyzed inductively; all data were sorted to form categories, based on the judgments of four sorters. These sorters were trained marriage and family therapy graduate students.

Helpful incidents, as perceived by couples, were grouped into six categories: positive outcomes during therapy, the routine and structure that therapy provided, alternative perspectives offered by the therapist, the non-directive style of the therapist, the directiveness of the therapist, and the therapist's sense of optimism and encouragement. Couples reported hindering events which fell into three categories: no follow-through on assignments, therapist imposition, and no resolution of problems. The therapists identified helpful incidents that fell into four categories: client's signs of readiness for change, client interaction in session, and change outcome. Lastly, the therapists reported two categories of hindering incidents: therapist took on too much

responsibility for change, and the therapist did not do enough data gathering. The author concludes that shared conceptions of therapy are lacking except in the area of positive therapy outcome. Couples expressed positive therapy outcome with statements such as, "We started talking again. It wasn't always positive, but we were communicating." Similarly, therapists expressed positive outcome with statements such as, "A goal of therapy was reached." Wark posits that the incongruence between client and therapist's perceptions may affect the success of therapy. In particular, she argues that the therapists may overlook the aspects of therapy that are most important to clients. She does not specify these aspects, however.

This study has a number of weaknesses which constrain any conclusions one might draw. First, the data were not analyzed quantitatively. Also, therapists were not asked to report what they felt clients perceived as important. Therefore, any conclusion about therapists overlooking what clients feel is important is unfounded. In fact, given that therapists and clients presumably have very different roles in therapy, one would not expect their perceptions to match exactly. Finally, as Wark herself notes, there is no empirical evidence that common perceptions are related to the therapeutic relationship, therapeutic effectiveness, client satisfaction, outcome, or any other relevant dimensions of therapy.

Perhaps more important than the conclusion that shared conceptions of therapy are lacking is the emphasis that both clients and therapists placed on specific therapist behaviors. For example, alternative perspectives offered by the therapist, the therapist's sense of optimism and encouragement, and the therapist's use of techniques

for change are all perceived as helpful. Additionally, it appears to be important that therapists know when to be more or less directive. Lastly, it seems that therapists should follow-up on tasks assigned to couples, should not take on too much responsibility for change, and should do enough data gathering.

Another study that focused on critical events that therapists facilitate in marital therapy was conducted by Greenberg, James, & Conry (1988). Researchers examined change incidents in Emotionally Focused Marital Therapy (EFT) as reported by twenty-one couples. Partners were interviewed independently, four months after the completion of eight sessions of EFT. The couples were asked to describe specific incidents in therapy that stood out as helpful or hindering. The results revealed that five major change processes were reported by couples: expression of underlying feelings by one partner leading to change in interpersonal perception, expressing feelings and needs, acquiring understanding, taking responsibility for experience, and receiving validation. The authors conclude that the importance of expressing underlying feelings in couples therapy may lie in changing the partner's perceptions of each other, rather than changing an individual's self-view. Additionally, the results support the psychodynamic view that understanding that is not merely intellectual, but also emotional in nature, leads to change. Lastly, this study reveals processes that therapists can facilitate which seem to be linked to change. Namely, therapists can encourage the expression of feelings and needs, and can help clients acquire understanding, take responsibility, and give and receive validation.

Other therapist behaviors that correlate with positive outcomes were revealed in a

study of social learning-based behavioral marital therapy by Holtzworth-Munroe, et al. (1989). Thirty-two White couples were treated by thirteen therapists. Therapy sessions were held weekly, and each session was 60-90 minutes long. The mean number of sessions for couples was 23, spanning a mean of 6 months; the range was 17-53 sessions.

Immediately following each therapy session, therapists, wives, and husbands made independent process ratings of in-session therapist and client behaviors. Therapists rated sixty-one items measuring their own behaviors (e.g., set an agenda, explained new concepts clearly, reinforced instances of collaboration) on a three point scale from (1) ineffective to (3) effective. Therapists also rated three items of client behavior (collaboration during the session, active participation in the session, and compliance with homework assignment). These ratings were made for both the husband and the wife on a nine point scale. At the end of each session, each client rated self and spouse on collaboration, participation, and homework compliance as well. Clients also rated eleven therapist behaviors which fell into two categories: therapist competence (e.g., therapist was clear) and emotional nurturance (e.g., therapist was warm). Lastly, a Dyadic Adjustment Scale (DAS; Spanier, 1976) was also completed by the husband and wife pre- and post-treatment to assess therapy outcome. Wife and husband pre-therapy DAS scores were averaged to give a measure of pre-therapy marital satisfaction; post-therapy marital satisfaction was similarly computed from post-therapy DAS scores.

Items from the therapist ratings were combined to form seven composite scales

(e.g., structuring skills, inducing a collaborative set, fostering homework compliance, teaching skills, etc.) One composite scale was formed by combining the six items measuring client behavior. Six composite scales were similarly formed from the client ratings. Using multiple regression analyses, the researchers examined the partial correlation between each (composite scale) predictor variable and post-therapy marital satisfaction level, controlling for pre-therapy satisfaction level. Analyses revealed that from the therapist's perspective, couples who respond positively to therapy behave in a facilitative manner both in and out of therapy ($r = .43$, $p < .05$), meaning that they are active participants in therapy, and comply with homework assignments outside of therapy. Clients responded similarly. From both the husband's and wives' perspectives, better outcome was significantly related to greater participation in treatment and better compliance on homework assignments (Wife $r = .51$, $p < .005$; Husband $r = .63$, $p < .001$). Positive outcomes were also significantly related to therapist's perceptions of effectively creating a collaborative atmosphere ($r = .39$, $p < .05$).

A sample of 29 couples receiving 8-10 sessions of Emotionally Focused Therapy (EFT) provided data for a series of more rigorous investigations. These studies are notable for several reasons: they are methodologically sound, they each test a clinical theory, and they each provide evidence for the importance of certain therapist behaviors in promoting therapeutic change.

Therapy according to the EFT model integrates an experiential approach to psychotherapy, which emphasizes affect and intrapsychic experience, with a systemic

approach, which emphasizes modifying communication and interaction patterns that maintain problem states. Change in therapy is thought to occur when the therapist helps clients access emotional responses that underlie rigid interactional positions. The individual experiences new aspects of themselves which evoke new responses from the partner.

Therapists in this group of studies averaged four years of clinical experience that included marital therapy. All therapist's had at least a master's degree in clinical or counseling psychology or in social work. All therapists were trained in an orientation congruent with EFT. Each therapist was given an additional twelve hours of training in the implementation of an EFT therapy manual. Therapists were also given brief telephone consultations and 2 hours of group supervision during the study (Johnson & Greenberg, 1985). To ensure adherence to the treatment manual, therapist interventions in two ten minute segments were rated by two trained graduate student raters using a checklist. This checklist was comprised of six categories of interventions including: general interventions (i.e. information gathering), problem definition, dealing with attacking behavior, directing the process of therapy, facilitating listening, and facilitating problem resolution. The authors report that only 2.5% of the interventions checked were coded in categories that were inappropriate to EFT treatment.

In the first investigation in the series, Johnson & Greenberg (1988) studied six couples who were selected from the larger sample of couples receiving Emotionally Focused Therapy (EFT) described above (Johnson & Greenberg, 1985). Couples had

received eight sessions of EFT. Therapy was conducted by two male and four female master's level marital therapists who were trained in the EFT model. These six couples were identified on the basis of their extreme change scores. The three couples for whom EFT had created the least amount of change in marital satisfaction as measured by the Dyadic Adjustment Scale (DAS; Spanier, 1976) were chosen, as were the three couples who had shown the most positive change after EFT, as measured by scores on the DAS. This method of identifying couples in extreme outcome groups increases the probability of detecting differences in therapy process when they are present. Additionally, the DAS has been shown to be a reliable discriminator between distressed and nondistressed couples and has well-established psychometric properties. It is, therefore, an excellent measure on which to base extreme groups. The post-therapy DAS scores of the three high change couples rose an average of 47 points from pretreatment scores ($\underline{M} = 88.6$, $\underline{SD} = 17.0$). The score of the low-change couples rose an average of 2 points from pretreatment scores ($\underline{M} = 93.8$, $\underline{SD} = 13.91$). High scores on the DAS represent better dyadic adjustment. Scores below 100 are considered to be in the distressed range. Therefore, most couples in this sample would be considered moderately distressed pre-treatment. The high change couples no longer appeared distressed post-treatment; the low change couples seem to have remained distressed.

Once the couples had been identified, the researchers selected the "best" therapy session for each couple, based on post-session questionnaires filled out by the therapist and each partner. The questionnaires indicated which sessions were viewed by the

couple and therapist as most relevant, useful, and productive. Transcripts of the last half of the sessions were made and analyzed. Every client statement was rated on the Experiencing Scale (Klein, et al., 1969) and on the Structural Analysis of Social Behavior (SASB; Benjamin, 1974). Using the SASB involves coding client statements as to whether they involve self or other, and then coding the responses on an affiliation dimension, and on an autonomy dimension. These two dimensions form four quadrants: autonomous affiliation (sharing, understanding), hostile autonomy (rejecting, ignoring), hostile influence (accusing, blaming, appeasing, managing), and affiliative influence (clinging, trusting, protecting).

According to EFT, change occurs when a "blaming" partner is helped by the therapist to reprocess intense affective experience. Therefore, a blaming spouse was identified in each couple based on the SASB. The blamer's scores on the Experiencing Scale were then analyzed using a chi-square statistic. The researchers found that couples who benefited from marital therapy were characterized by more affiliative and autonomous responses (more acceptance, less hostility and coercion) and higher emotional experiencing (greater emotional involvement and self-descriptions). Specifically, for successful couples, a spouse who took the blaming (hostile influence) position also scored high in emotional experiencing and used more affiliative, autonomous behaviors. In unsuccessful couples, blaming was less often accompanied by high experiencing and affiliative, autonomous behaviors. The difference between the groups was statistically significant, $\underline{x}^2$ (I) = 36.2, $\underline{p}<.001$. The authors believe that this result provides support for the theoretical process of "softening", when a blaming

dominant spouse accesses vulnerability and asks for closeness and comfort. "Softening" was found to occur in the best sessions in successful EFT and to be absent in the process of unsuccessful couples. In EFT, the facilitation of this process may be a crucial goal for the therapist.

In a subsequent study drawing on the same sample of couples receiving 8-10 sessions of EFT, Greenberg, et al. (1993) focused on conflict events which occurred in session. It was hypothesized that during conflict events, couples would show a greater proportion of hostile behaviors (rejecting, ignoring, accusing, blaming) at the beginning of therapy than at the end of therapy, and a greater proportion of affiliative behaviors (sharing, understanding, trusting, protecting) at the end of therapy than at the beginning. An important role for the therapist may be to facilitate this shift in couples' behavior.

Audiotapes were made of 22 couples' second and seventh sessions. In-session events were selected by the following method. The first twenty minutes of the session were bypassed. The beginning of an episode was identified by a marker, as determined by Structural Analysis of Social Behavior (SASB; Benjamin, 1974) codes. This marker consisted of a negative interactional pattern between the spouses. The first marker that was followed by the therapist focusing on feelings or needs was chosen. The next twenty minutes of the session was the "episode" used for coding. Three raters independently listened to the audiotapes of the episodes, then rated transcripts using the SASB. Each talk turn was given a single rating. Cohen's kappa for the combined rating of the three coders yielded a reliability of .52. Change scores on the Dyadic

Adjustment Scale (DAS, Spanier, 1976), were used as a measure of therapy outcome; unfortunately, none of these DAS scores were reported. T-tests showed that successful couples, as determined by change scores on the DAS, were significantly more affiliative ($t = 2.03$, $p < .05$) and less hostile ($t = 1.88$, $p < .05$) during in-session conflicts in session 7 than in session 2. A third study (Greenberg, et al., 1993) in this series hypothesized that conflict events in "peak" sessions (those that couples rated as highly productive) would differ in depth of experiencing and degree of affiliation from events in unproductive sessions. Sixteen couples from the larger sample were studied. The procedure was essentially the same as that reported in Johnson & Greenberg (1988) and outlined above, except that there was no attempt to relate depth of experiencing or degree of affiliation to therapy outcome in this study. Additionally, this study focused specifically on conflict events occurring within the entire therapy session, as opposed to the last half of sessions. The conflict "episodes" were chosen in the same manner as the first study in this series (Greenberg, et al., 1993, Study 1). As expected, a chi-square analysis revealed that there was a significantly different distribution of statements in the four "quadrants" of the SASB (Benjamin, 1974) in "peak" versus unproductive sessions: autonomous affiliation, hostile autonomy, hostile influence, and affiliative influence, x^2 (3, N = 932) = 44.13, $p<.05$. Based upon the combined affiliative and hostile quadrants, additional chi-square analyses revealed significant differences between peak and poor sessions in affiliative and hostile responses. As expected, affiliative statements were more characteristic of peak sessions than poor sessions, and hostile statements occurred in larger proportion

during poor sessions in comparison with peak sessions. Finally, a chi-square analysis of the depth of experiencing scores showed that peak sessions contained a significantly greater proportion of deeper levels of experiencing as compared to poor session segments, $\underline{x}^2$ (15, N = 216) = 47.25, $\underline{p} < .05$. These results suggest the importance of therapist interventions which promote affiliative behavior and deeper levels of experiencing, as well as those interventions that inhibit hostility during within-session conflict.

Lastly, the final study of the series sought to assess one of EFT's basic theories: that self-disclosure of feelings and needs with a high level of affect leads to changes in couple's interactions and the creation of intimacy. The authors hypothesized that emotionally intimate self-disclosures from a spouse in session would lead the partner to respond affiliatively. One session for each of 14 couples from the larger sample was selected. This selection was based on therapist and couples' post-session ratings which indicated that it was a good session in terms of progress and resolution. The second twenty minutes of the videotape of each of these sessions was examined by one of the authors in order to isolate an intimate self-disclosure. Whenever one partner spoke and the other partner responded, the initial partner's turn was coded on a 5-point scale which measures level of intimacy (Self-Disclosure Coding System; Chelune, 1976). Those disclosures that rated a four or five on this scale were given to a second coder, whose selections were used for the analysis. An episode to be analyzed consisted of the partner's response to the initial self-disclosure and that same partner's next four talk turns. A control segment was also selected by rewinding the tape to twenty

minutes before the self-disclosure, and selecting the first time one partner spoke and the other responded. The response and the responder's following four talk turns made up the control segment. The control segment and self-disclosure segments were then rated by one coder for degree of affiliative behavior, using the SASB (Benjamin, 1974).

A 2 x 5 MANOVA was conducted on the disaffiliative and affiliative SASB codes in the two segments with five talk turns in each segment. A significant main effect for condition was found, $F(1, 13) = 13.72$, $p = .003$. After self-disclosures, the proportion of affiliative codes was 90% as compared to 54% in the control segments. The main finding of this study, therefore, was that spouses in EFT are more likely to respond affiliatively after intimate self-disclosure by their partners than in control segments. This result suggests that therapists would be wise to choose interventions that promote intimate self-disclosures in therapy.

This group of studies (Greenberg, James, & Conry, 1988; Johnson & Greenberg, 1988; Greenberg et al., 1993) suggests processes that may be related to within-session change in Emotionally Focused Therapy. It appears that change in EFT may be associated with the expression of feelings and needs, leading to changes in interactional patterns, such that couples become more accessible and responsive to each other.

While the work of Greenberg and his colleagues provides data supporting the use of particular therapist operations, it focuses primarily on those client responses that are associated with change in EFT. Two studies have focused more directly on

therapist interventions. Brown-Standridge and Piercy (1988) studied husbands' and wives' responses to therapists' reflections and reframings. Thirteen couples were randomly assigned and treated by six therapists. Male therapists saw eight of the cases; female therapists treated five. Each couples' first session and one later session (either the third, fourth, or fifth session) were videotaped. Each of the 26 videotapes were then cued by the senior author to a portion which contained an "effective" reflection or reframing. A reviewer corroborated the researcher's choices on nine of these tapes. Unfortunately, little information is provided about how the authors identified "effective" reframing and reflecting. Next, coders rated the ten seconds of videotape prior to and following the target intervention using the Brown-Standridge Marital Therapy Interaction Scale (Brown-Standridge & Piercy, 1988). Husbands and wives were coded separately on ten pre- and post-intervention variables, including but not restricted to judgments about the presence or absence of overt conflict, whether couples are defensive or supportive, whether they are attentive or nonattentive, and their reaction to the intervention. Coders also rated the intervention as either a reflection or reframing. The scale provides nominal level data. Unfortunately, little psychometric data are available on this scale.

The quantitative data collected for each variable were tallied in frequency tables and converted to 100-point scales to compute the conditional probability of consequent events, given antecedent events. Analyses of variance (alpha = .05) and t-tests (alpha = .001) tested for significant differences. Results showed that based upon the 26 intervention segments, therapists in this sample used reframing 54.1% of the

time and reflections 45.9% of the time when husbands appeared open to their partners. This result was statistically significant. Additionally, husbands tended to respond significantly more positively to reframing, as opposed to reflecting. When husbands responded with agreement, 58.5% of the time it was a response to a reframing and 41.5% of the time it was a response to a reflection. Wives, however, responded somewhat, but not significantly, more positively to reflecting than reframing. When wives exhibited agreement, 51.8% of the time it was a response to a reflection; 48.2% of the time it was a response to a reframing. The authors suggest wives may prefer a therapist who tries to understand them. Husbands, on the other hand, may favor the "expert" who can add new ideas to the discussion.

Lastly, after the quantitative data had been collected, therapists were asked ten open-ended questions about their thoughts when employing reflections and reframings. When asked, five out of six therapist (incorrectly) denied having behaved differently with husband and wives. Given that the study focuses on gender as a variable, therapist gender may play an important role. Analysis of this variable was hampered in this study, however, by the use of two female coders, a limited number of therapists tested (6), and the fact that male and female therapists did not treat an equal number of cases.

Another study directly examined therapist behaviors. Cline et al. (1984) studied 77 distressed middle and lower class couples in marital therapy. Nineteen male therapists were assigned four couples each, two couples from a low socioeconomic status (SES) group, and the other two from a middle SES group. Total number of therapy sessions

was not reported and may have varied across couples. Each couple was administered a battery of marital assessment measures before therapy, after therapy, at three months post-therapy and at six months post-therapy. These outcome assessment instruments included the Locke-Wallace Marital Adjustment Scale (Locke & Wallace, 1959). At termination, the therapist also completed a therapy progress report which included assessments of couple's improvement or deterioration on twelve areas of marital functioning (e.g., direct expression of feelings, shared decision making, shared activity time, expressions of affection, sexual satisfaction, ability to negotiate change, ability to tolerate different goals or values of the partner, etc.). Therapy process was assessed by coding random ten minute excerpts from audiotapes of the first and last two sessions with each couple. The total number of random segments coded was not reported. Couple behavior was coded with a modified version of the Marital Interaction Coding System (MICS; Hops, et al., 1972). Spouses were individually rated on their positive social behavior, negative social behavior, and expression of personal feelings. Therapist behaviors were evaluated using a rating system based on dimensions derived by Alexander et al. (1976). Therapist behavioral categories included: directiveness, reflectiveness, problem-orientation, relationship-orientation, affect-behavior integration, structuring skills, and relationship skills.

Results showed that in middle SES couples, therapist directiveness was negatively correlated with increases in couples' positive social exchange. When therapists were less directive, and instead used more reflections and probes for affect, these couples increased their expression of feelings. This trend was more pronounced for husbands.

The findings for lower SES couples are less clear. For these couples, therapist's reflections were related to decreases in positive social behavior, an opposite result from that obtained with the middle SES couples. Additionally, lower SES husbands responded well to therapist directiveness; these men increased their positive social behavior in response to directives from the therapist. The authors conclude that no one marital therapy technique will be appropriate for those couples with different SES backgrounds. This result seems to be based upon husbands' experiences in therapy.

Summary of marital process findings

Research on the process of marital therapy, and in particular, that which focuses on therapist behaviors, is rare. The studies that are available provide preliminary evidence for the importance of certain therapist behaviors. Specifically, there is evidence that the therapist should create an atmosphere of mutual collaboration (Holtzworth-Munroe, 1989), should not take on too much responsibility for change (Wark, 1994), and should provide a sense of optimism and encouragement to the couple (Wark, 1994). There is also evidence that wives respond well when they feel understood by the therapist (Brown-Standridge & Piercy, 1988). Therapeutic techniques that have been shown to be helpful include: following-up on assigned tasks, gathering sufficient data, and providing alternate perspectives (Wark, 1994), the last of which appears to be particularly important to husbands (Brown-Standridge & Piercy, 1988). Additionally, therapists should help clients disclose their feelings and needs (Greenberg, James, & Conry, 1988; Johnson & Greenberg, 1988; Greenberg et al., 1993), validate their partners (Greenberg, James, & Conry, 1988), increase their

affiliative behaviors (Greenberg, et al., 1993), and decrease their hostile behaviors (Greenberg et al., 1993). Lastly, it appears that marital therapy techniques affect members of different classes (Cline et al., 1984) and gender (Brown-Standridge & Piercy, 1988) differently.

Studies such as those of Greenberg and his colleagues (Greenberg, James, & Conry, 1988; Johnson & Greenberg, 1988; Greenberg et al., 1993) exemplify what can be gained from marital therapy process research. A theoretical approach is clearly identified. Additionally, the results support theories of change and suggest techniques to facilitate that change. While these studies provide data endorsing the use of particular therapist operations, they focus primarily on those client responses to EFT that are associated with change. The natural complement to these studies is to examine more directly therapist interventions that are associated with change and/or in other forms of marital therapy. That is, what are therapists doing that facilitates processes associated with change? How do therapists promote change in other forms of marital therapy?

Integrative Problem-Centered Therapy

One model of marital therapy that has been carefully delineated is integrative problem-centered therapy (IPCT; Pinsof, 1995). IPCT is a problem-focused therapy model that provides a framework for integrating different therapeutic techniques, in order to maximize their benefits and minimize their deficits. This therapy approach combines three treatment modalities (family-community, couple, and individual) and six theoretical orientations (behavioral, bio-behavioral, experiential, family of origin,

psychodynamic, and self psychology.) The model outlines which modality and orientation the therapist should use at any given point in treatment. For example, in the earliest sessions, the therapist functions as a behaviorally oriented family therapist by focusing on the reinforcement contingencies or structural characteristics of the family or couple. As therapy progresses, the therapist shifts to work from a more experiential orientation. The therapist eventually moves into the role of a psychodynamically oriented family therapist, and may include members of the client's family of origin in treatment. Lastly, the therapist increasingly employs individually oriented psychodynamic interventions. In this model, the therapist becomes increasingly less active as therapy proceeds. It should be noted that not all couples receive all modalities and orientations. If a couple's presenting problem is resolved early in treatment with behavioral interventions, there may be no need to shift to a more experiential treatment focus. Likewise, if experiential interventions succeed in resolving treatment issues, the therapist need not shift to more historic and psychodynamic approaches.

The advantages of integrative approaches such as IPCT are delineated in several articles (Lebow, 1984, 1987; Pinsof, 1983, 1992, 1994). For example, these approaches involve a broad theoretical base which may account for a larger range of human behavior. Also, integrative approaches draw upon the strengths of a range of techniques of psychotherapy, thereby allowing greater flexibility in the treatment. Treatment can be readily adapted for diverse patient populations, and therapist personal styles. Lastly, the integrative approaches are easily modified in the face of new research findings.

Integrative approaches also have some limitations. Some "eclectic" approaches lack a theoretical basis. When this is the case, it is doubtful that effective treatment follows. Additionally, some integrative treatments may try to solve all (i.e. too many) aspects of a problem, for example by having too many foci, or overly ambitious goals. Within the IPCT model, however, the goal is to intervene in the simplest, most efficient manner to attain the desired endpoint. Lastly, the integrative approaches could be criticized because they demand so much of the therapist. That is, therapists must become expert in a number of theoretical orientations, and must be competent to decide when each approach is merited. Models like IPCT can help in this regard by specifying the logical progression from one set of techniques to another, and by outlining indicators that signal a shift should be made.

The Present Study

One of the most direct ways that marital therapy process research can improve clinical practice is by identifying therapist interventions that have been shown to work, especially with highly distressed client populations. Given this potential contribution, the dearth of studies examining therapist interventions is surprising. For example, one of the empirical studies focused exclusively on two types of therapist interventions, reflections and reframings (Brown-Standridge & Piercy, 1988). Clearly, researchers are far from recommending empirically supported interventions to marital therapists.

In contrast, the marital therapy process studies of Greenberg and his colleagues focusing on client behaviors and critical change events (particularly in Emotionally Focused Therapy) can potentially impact the field (e.g., Greenberg et al., 1993). These

studies identified and tested a theoretical orientation, and provided support for theories of change and recommendations for facilitating that change.

This study applies the methodology of Johnson & Greenberg (1988), but focuses directly on therapist interventions. The project examines therapist interventions in marital therapy with a unique sample of eight highly distressed married couples who are at risk for divorce. The purpose of the study is to identify specific therapist interventions that relate to successful and unsuccessful therapy outcomes.

Following the procedure used by Johnson and Greenberg (1988), change scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976) were calculated for fifteen couples from a larger sample of highly conflictual married couples. The four couples whose change scores indicated the most improvement in marital satisfaction were considered the "improving" therapy group. Likewise, those four couples whose marital satisfaction remained unimproved made up the "not improving" therapy group. Transcripts of these eight couples' first and ninth therapy sessions were made from audiotapes. Three five-minute segments of therapy were selected from the first-, second-, and third-third of each session transcript. Every therapist utterance within the five minute segments of these tapes was coded with the Family Therapy Coding System (FTCS, Pinsof, 1980), a coding system assessing nine scales of therapist behavior. These codes were analyzed to determine which therapist behaviors related to improved outcomes and which were linked to no improvement. Several a priori hypotheses, which were based on the principles of IPCT, were tested.

First, this study examined Pinsof's (1995) assertions that successful therapist interventions are primarily behavioral in nature at the beginning of therapy. This supposition has been supported in the research that suggests that behavioral marital therapy is effective for alleviating marital distress (Hahlweg & Markman, 1988), reducing negative verbal behavior, ameliorating presenting problems (Gurman, Kniskern, & Pinsof, 1986), and promoting significant changes in behavior (Dunn & Schwebel, 1995). Other researchers have shown that directive therapist interventions are linked to significantly more improvement in general adjustment than purely interpretive or supportive therapies (Crowe, 1978).

Additionally, Pinsof posits that as therapy progresses, interventions that are experiential in character should also be seen with successful couples. Research supports the effectiveness of experientially focused interventions. Snyder, Wills, & Grady-Fletcher (1991) found evidence in support of therapy focusing on uncovering unconscious feelings for the prevention of divorce at four years post-therapy. Greenberg, James, & Conry's (1988) results revealed that couples viewed the following five processes within therapy to be helpful in promoting change: expression of underlying feelings by one partner leading to change in interpersonal perception, expressing feelings and needs, acquiring understanding, taking responsibility for experience, and receiving validation. Higher emotional experiencing has been related to significantly more productive sessions (Greenberg, et. al., 1993) and significantly more successful courses of marital therapy (Johnson & Greenberg, 1988). Finally, emotionally intimate self-disclosures by one spouse have been linked to significantly

more affiliative responses by the other spouse (Greenberg, et. al., 1993).

The following hypotheses were proposed:

Hypothesis 1

Consistent with the principles of IPCT (Pinsof, 1995), it was expected that therapist interventions at the beginning of therapy would be more behavioral in nature with the "improving" couples than with the "not improving" couples. Specifically, on the Topic Scale of the FTCS, which assessed the content of the sessions, it was expected that, at session one, "improving" couples would receive a higher frequency of the codes involving **Positive Behavior, Negative Behavior, Verbal Behavior,** and **Nonspecific Behavior.**

Additionally, therapists using behavioral interventions were expected to be very active in therapy. In the first session, therapists were predicted to be more confrontive, directive, and problem-focused with "improving" couples than with "not improving" couples. This would be reflected by higher frequency scores of the codes **Disagree-Disapprove, Direction, Refocus,** and (identifying) **Problem** with "improving" couples on the Intervention Scale, which assessed the intention or function of the therapist's intervention.

Lastly, behavioral interventions were expected to be more focused on the present than the past or future. It was therefore hypothesized that at session one, interventions with "improving" couples would include a higher frequency of the codes **Now** and **Current** than "not improving" couples on the Temporal Orientation Scale, which focused on the time period targeted by the therapist intervention.

Hypothesis 2

The principles of IPCT specify that as therapy progresses, interventions should become increasingly more experiential in character. Several codes on the Topic Scale reflect an experiential orientation. Experiential interventions focus on emotions. It was hypothesized that "improving" couples would receive a higher frequency of emotion codes on the Topic Scale at session nine than they received at session one. The emotion codes on the Topic Scale included: **Positive Emotion, Negative Emotion,** and **Nonspecific Emotion**.

Additionally, it was hypothesized that, at session nine, "improving" couples would receive a higher frequency of emotion codes on the Topic Scale than unsuccessful couples at session nine. Again, these codes included: **Positive Emotion, Negative Emotion,** and **Nonspecific Emotion** on the Topic Scale.

Therapists using experiential interventions were also expected to focus on experiential processes, or sequences of events. It was predicted that "improving" couples would receive a higher frequency of the code **Process** on the Intervention Scale at session nine, than they did in session one.

Additionally, in keeping with the proposition that successful treatment would be more experiential in nature as therapy progressed, it was predicted that, at session nine, "improving" couples would receive a higher frequency of the code **Process** on the Intervention Scale than "not improving" couples at session nine.

Also, experiential therapy should focus on the "here and now". It was predicted that

"improving" couples at session nine would receive a higher frequency of **Now** codes on the Temporal Orientation Scale than "not improving" couples at session nine.

CHAPTER III

METHODS

Setting

The current investigation was part of a larger study of marital therapy conducted at The Family Institute. The Family Institute is a not-for-profit independent affiliate of Northwestern University, which offers marital, family, and individual psychotherapy and training. Treatment providers included highly experienced staff clinicians and graduate and postgraduate level therapists in training.

Participants

Couples

Eight married, heterosexual couples were included in the study. Primarily, these couples were recruited for the study from referrals to the Family Institute. Several couples were also recruited through an advertisement in Chicago Parent magazine. During intake interviews, the following criteria were met in order for a couple to be accepted into the study: a) the couple had been married for at least three years; b) this was the first marriage for both partners; c) marital dissatisfaction and the possibility of divorce were identified by at least one of the married partners during intake; d) both partners were available and consented to participate in the study and treatment; e) each

partner wished to improve the relationship and avoid separation and divorce if possible; f) neither partner met criteria for a DSM-IV (APA, 1994) diagnosis of Major Affective Disorder or Psychotic Disorders. (See Appendix A for a breakdown of couple characteristics by group.) Once the couple met the inclusion criteria, they were invited to join the study. They were then sequentially assigned to therapists based on fees and therapist availability. Couples received a $15 reduction in their session fees for participating.

Therapists

Therapists included three staff therapists and three advanced therapists in training. All of the advanced trainees were receiving didactic instruction and clinical supervision from experienced staff therapists as part of a two-year training program in marital and family therapy at the Family Institute. Three therapists treated the four couples in the "improving" group. (One therapist treated two couples in this group.) Two of them were staff therapists and the other was a therapist in training. Two of these therapists were female and one was male. The four couples in the "not improving" group were treated by three staff therapists and one therapist in training. Two of these therapists were female; two were male (See Appendix B for a breakdown of therapist characteristics by group). All therapist participants had received extensive training in integrative problem-centered therapy (IPCT; Pinsof, 1995), and followed this model in their practice.

Coders

Three female coders were trained in weekly 2-hour meetings over the course of six months. Two of these coders were graduate students in clinical psychology; a third coder was a bachelor's level psychology major. The meetings consisted of review, discussion, and practice of each of the codes of the system. Meetings were supplemented with approximately two hours of weekly "homework", in which trainees practiced coding. The FTCS Coding Manual (Pinsof, 1980) provided guidelines for this training. Ambiguous coding distinctions not addressed by the manual were discussed among the coders until a consensus was reached.

Design

The study utilized a 2 x 2 (level of improvement x phase of treatment) post-hoc extreme groups design. In this quasi-experiment, two levels of outcome ("improving" and "not improving") represented the first independent variable. Phase of treatment (sessions one and nine) was the second independent variable. The decision that session nine was chosen to represent the outcome of therapy was based on the frequently cited work of Howard, Kopta, Krause, & Orlinsky (1986). These researchers found that between sessions one and eight, the proportion of clients displaying measurable improvement increased from approximately 15% to 50%. By the 26th session, that proportion increased to 75%. By the end of the first year, it expanded to 85%. The authors concluded that most gains occur early in therapy, with progressively diminishing returns over time. While this study focused on individual therapy, it was

reasonable to presume that these findings would generalize to marital therapy.

Therapist intervention codes (as measured by the Family Therapist Coding System [FTCS; Pinsof, 1980]) were the dependent variable. Interventions were compared across the two groups at two points in time: "improving" couples at session one, "improving" couples at session nine, "not improving" couples at session one, and "not improving" couples at session nine. Three specific comparisons were made. In particular, the study examined differences in therapist interventions between the "improving" and "not improving" couples at session one, differences in therapist interventions between the "improving" couples' first and ninth sessions, and differences in therapist interventions between the "not improving" and "improving" couples at session nine. Also, pre-therapy dyadic adjustment, age, and ethnicity were compared between the two groups of couples to provide assurance that the groups were initially equivalent. Lastly, pretherapy dyadic adjustment, age, and ethnicity were compared between those couples who remained in treatment through session nine and those couples from the larger sample who dropped out prior to the ninth session.

Measures

Dyadic Adjustment Scale

The Dyadic Adjustment Scale (DAS; Spanier, 1976; see Appendix B) is among the most extensively used instruments for measuring adjustment in relationships (Holtzworth-Munroe, et al., 1989; Johnson & Greenberg, 1988; Greenberg et al., 1993), has been shown to be a reliable discriminator between distressed and

nondistressed couples, and has well-established psychometric properties. The scale has a theoretical range of 0-151. High scores on the DAS represent better dyadic adjustment. Scores below 100 are considered to be in the distressed range. In a study of the DAS (Spanier, 1976), married couples had a mean of 114.8 (SD= 17.8); divorced couples had a mean of 70.7 (SD = 23.8); the total mean was 101.5 (SD=28.3). This self-report questionnaire measures four dimensions of marital functioning: consensus on matters of importance to marital functioning, dyadic satisfaction, dyadic cohesion, and affectional expression. The sum of the scores in these four areas (total DAS score) was used as a measure of global marital adjustment in this study.

Family Therapist Coding System

The Family Therapist Coding System (FTCS; Pinsof, 1986) is the most complex and refined system designed to describe and differentiate verbal behaviors of marital and family therapists from various theoretical orientations. It consists of nine nominal scales. They are: Topic, Intervention, Temporal Orientation, To Whom, Interpersonal Structure, System Membership, Route, Grammatical Form, and Event Relationship. The scales can be used collectively, individually, or in various combinations to test a variety of hypotheses. In this study, three scales were used: Topic, Intervention, and Temporal Orientation. The FTCS has been shown to be reliable; the mean interjudge k score for all scales was .70 (Pinsof, 1986), and ranged from .49 to .92 ($p<.001$). Tests of the system's discriminant validity showed that the system was able to distinguish advanced from novice therapists, and to distinguish therapists of different orientations.

Procedure

Couples completed the DAS at the time of their first and ninth sessions. All measures were completed individually; husbands and wives did not view each other's measures, nor were therapists permitted access to these forms.

Creation of extreme groups

Following the procedure used by Johnson and Greenberg (1988), couples were selected to form two groups: "improving" and "not improving". First, couples who had completed at least nine sessions of therapy were selected from the larger study sample (N=35). DAS scores at the time of sessions one and nine for each partner were used as a measure of marital satisfaction. A change score was calculated for each partner to represent outcome of marital therapy; these change scores were then averaged across husbands and wives within each couple. The four couples whose marital adjustment improved the most were selected to form the initial "improving" therapy group; likewise, the four couples with the least amount of improvement formed the initial "not improving" therapy group. Lastly, one couple was excluded from the "not improving" group because the husband and wife did not agree about the direction in which their marital satisfaction moved. The next least improved couple replaced the excluded couple.

Sampling the therapy sessions

Audiotapes of the entire first and ninth therapy sessions of each couple in the extreme groups were transcribed verbatim. If the first or ninth session was an individual session, or was unavailable for transcription due to mechanical failure, the

second, and eighth or tenth sessions were used respectively as replacements. Sessions at the Family Institute typically lasted sixty minutes. Every therapist talk turn (or floor shift) was numbered on the transcript. The number of therapist talk turns that represented a five-minute segment was then calculated, by dividing the total number of therapist talk turns by sixty and multiplying by five. (It was assumed that each session was 60 minutes long.) The transcript was then split into thirds by dividing the total number of therapist turns by three. Three five-minute segments were selected from the middle of the first, second, and third third of the transcript. These five-minute segments were then coded with the Family Therapist Coding System (FTCS; Pinsof, 1980) to assess the process of marital therapy.

CHAPTER IV

RESULTS

FTCS Reliability

Coefficient kappa was used to estimate interjudge reliability (Cohen, 1968). Twenty-five percent of the total 48 five-minute FTCS segments were randomly selected to assess reliability. One coder coded all twelve randomly selected segments. The other two coders each coded six of these segments. Agreement between pairs of coders for each scale was calculated and averaged, yielding an overall level of agreement for each scale. These data are summarized in Table 1. The mean level of agreement averaged .70 across scales and ranged from .64-.75, indicating that an acceptable level of interjudge agreement in coding the therapy sessions was achieved. These reliabilities were comparable to those reported by the developer of the system (mean = .61; range = .49-.70) (Pinsof, 1986).

DAS Analysis

Analysis of the DAS scores are summarized in Table 2. Results showed that this sample presented for therapy in the distressed range. The overall mean DAS score pretreatment was 79.88 (SD = 11.80). The overall mean DAS score at session nine was

Table 1

Cohen's kappa for the Family Therapist Coding System

Scale	**Mean**
Topic	.75
Intervention	.64
Temporal Orientation	.72

84.06 (SD = 13.72). Of these couples, those in the "improving" therapy group reported a mean DAS score of 77.50 (SD = 15.68) at session one and 90.63 (SD = 15.59) at session nine. Couples in the "not improving" therapy group reported a mean DAS score of 82.25 (SD = 7.98) at session one and 77.50 (SD = 9.01) at session nine. While a one-way ANOVA test revealed that the session nine DAS scores for the improving and not improving groups did not differ significantly ($F = 2.13$, $p < .195$). However, it is noteworthy that the improving group's scores improved very close to half of a standard deviation from session one to session nine, based on the DAS norms (mean = 101.5, SD = 28.3; Spanier, 1976). In contrast, the "not improving" group showed a slight decrease in marital satisfaction over time, based on the DAS norms.

Table 2

Means and Standard Deviations of DAS Scores over Time

Group	Session One	Session Nine
Improving	77.50 (15.68)	90.63 (15.59)
Not Improving	82.25 (7.98)	77.50 (9.01)
All Couples	79.88 (11.80)	84.06 (13.72)

Note. Standard deviations are in parentheses.

In order to provide some assurance that couples in both the "improving" and "not improving" groups entered therapy equally distressed, pre-therapy DAS scores for the "improving" couples were compared to the pre-therapy DAS scores of the "not improving" couples. A one-way ANOVA found no significant differences ($F = .292$, $p < 0.61$). The two groups were also compared by age and ethnicity to ensure that they were initially equivalent. A one-way ANOVA revealed no significant age differences between groups. Additionally, all but one of the sixteen partners in the sample were Caucasian.

FTCS Analysis

The behaviors of the therapists in the coded sessions were summed across the three segments of each session to give a total frequency for each behavior per session on the three FTCS scales (Topic, Intervention, and Temporal Orientation). These frequencies

were then summed across the four couples in each group for each time (sessions 1 and 9). All analyses were conducted on these summed frequencies.

Hypothesis 1

Topic Scale. Chi-square analyses were conducted on the session one FTCS codes to determine if "improving" couples received significantly more behavioral interventions at session one than the "not improving" couples. A significant difference was found between "improving" and "not improving" groups for therapist behaviors on the FTCS Topic Scale at session one ($\chi^2 = 21.31$, $p < 0.01$). Topic Scale code frequencies for each group at session one are shown in Table 3. Inspection of the data revealed a higher frequency of **Verbal Behavior** codes for the "improving" couples than the "not improving" couples (59 and 45, respectively), and surprisingly, a lower frequency of **Nonspecific Behavior** codes for the "improving couples" than the "not improving couples" (33 and 70, respectively).

Intervention Scale. A significant difference was also found between groups for therapist behaviors on the FTCS Intervention Scale at session one ($\chi^2 = 9.14$, $p < 0.01$). The frequencies of Intervention Scale codes for each group at session one are shown in Table 4. This result appeared to occur because therapists used more **Problem** interventions with the "improving" group than with the "not improving" group. At the same time, therapists used more **Direction** interventions with the "not improving" group than with the "improving" group. The latter finding was in the opposite direction than was expected according to the hypothesis.

Table 3
Frequency of Therapist Behaviors by Group on Five Categories of the Topic Scale at Session 1

	Improving Couples	Not Improving Couples
Positive Behaviors	31	31
Negative Behaviors	11	10
Verbal Behaviors	59	45
Nonspecific Behaviors	33	70
Other	226	171

Note. Chi-square of 21.31 is significant at the $p<.01$ level.

Table 4
Frequency of Therapist Behaviors by Group on Intervention Scale at Session 1

	Improving Couples	Not Improving Couples
Disagree-Disapprove	0	0
Direction	10	20
Refocus	1	0
Problem	26	12
Other	107	123

Note. Chi-square of 9.14 is significant at the $p<.01$ level.

Temporal Orientation Scale. Lastly, no significant differences were found between improving and not improving couples on the FTCS Temporal Orientation Scale at session one ($x^2 = 4.32$, $p < 0.12$). The frequencies of Temporal Orientation Scale codes for each group at session one are presented in Table 5.

In summary, although two of the three analyses related to Hypothesis 1 were significant, inspection of the data indicated that therapist behavior did not consistently occur as predicted.

Table 5
Frequency of Therapist Behaviors by Group on Temporal Orientation Scale at Session 1

	Improving Couples	Not Improving Couples
Now	58	81
Current	45	42
Other	40	32

Note. Chi-square of 4.32 is not significant.

Hypothesis 2

Topic Scale. The second hypothesis of this study predicted that "improved" couples would receive interventions that were increasingly more experiential in character over time. It was expected that "improving" couples would receive significantly more emotion codes on the Topic Scale at session nine than they received at session one. Chi-square analysis showed no significant differences between session one and session

nine interventions for "improved" couples on the emotion codes of the FTCS Topic Scale ($x^2 = 3.63$, $p < 0.31$). Topic Scale code frequencies for "improving" couples at sessions one and nine are shown in Table 6. In fact, therapists emitted very few emotion-oriented responses at either session. Only 5% of therapist behavior at session one was focused on emotions and only 7% at session nine was similarly focused.

Table 6
Frequency of Therapist Behaviors over Time on Topic Scale for Improving Couples

	Session One	Session Nine
Positive Emotion	7	7
Negative Emotion	5	14
Nonspecific Emotion	6	7
Other	342	366

Note. Chi-square of 3.63 is not significant.

It was also predicted that, at session nine, "improving" couples would receive a higher frequency of emotion codes on the Topic Scale than "not improving" couples at that session. Chi-square analysis did reveal significant differences in frequency between "improving" and "not improving" couples on the emotion codes of the Topic Scale at session nine ($x^2 = 17.81$, $p < 0.00$). Contrary to the hypothesis, however, these results appeared to be accounted for by a higher frequency of **Negative** Emotion codes for the "not improving" couples than for "improving" couples at session nine (30 and

14, respectively), and by a higher frequency of **Nonspecific Emotion** codes for the "not improving" couples than for "improving" couples at session nine (20 and 7, respectively). Topic Scale code frequencies for each group at session nine are shown in Table 7.

Table 7
Frequency of Therapist Behaviors by Group on Topic Scale at Session 9

	Improving Couples	Not Improving Couples
Positive Emotion	7	8
Negative Emotion	14	30
Nonspecific Emotion	7	20
Other	366	293

Note. Chi-square of 17.81 is significant at the $p<.01$ level.

Intervention Scale. It was also predicted that "improving" couples would receive a higher frequency of the code **Process** on the Intervention Scale at session nine, than they did in session one. No significant differences were found by the chi-square analysis on this prediction ($x^2 = .275$, $p < 0.60$). Intervention Scale code frequencies for the "improving" couples at sessions one and nine are shown in Table 8.

"Improving" couples were also expected to receive a higher frequency of the code **Process** on the Intervention Scale than the "not improving" couples at session nine. A significant difference was obtained in the analysis of this prediction ($x^2 =$

10.35, $p < 0.00$). Unfortunately, closer examination shows that these differences were not in the predicted direction. That is, "not improving" couples received a higher frequency of **Process** codes at session nine than did "improving" couples (19 and 4, respectively). Table 9 shows the frequencies of Intervention Scale codes for each group at session 9.

Table 8
Frequency of Therapist Behaviors by Time on Intervention Scale for Improving Couples

	Session One	Session Nine
Process	2	4
Other	141	179

Note. Chi-square of .275 is not significant.

Table 9
Frequency of Therapist Behaviors by Group on Intervention Scale at Session 9

	Improving Couples	Not Improving Couples
Process	4	19
Other	179	165

Note. Chi-square of 10.35 is significant at the $p<.01$ level.

The final prediction posited that "improving" couples at session nine would receive a higher frequency of **Now** codes on the Temporal Orientation Scale than "not improving" couples at session nine. Chi-square analysis revealed significant differences between the groups in the expected direction on this prediction ($\underline{x}^2 = 22.62$, $\underline{p} < 0.00$). "Improving" couples received more **Now** codes from therapists than "not improving" couples. The frequencies of Temporal Orientation codes for each group at session 9 are presented in Table 10.

Table 10
Frequency of Therapist Behaviors by Group on Temporal Orientation Scale at Session 9

	Improving Couples	Not Improving Couples
Now	118	73
Other	65	111

Note. Chi-square of 22.62 is significant at the $\underline{p}<.01$ level.

Descriptive Analyses

Since very little support was found for either hypothesis, a descriptive analysis was conducted to explore the question of how marital therapists conducted therapy. Codes on the Topic Scale for all couples were grouped into categories, according to whether the therapists talked about behaviors, cognitions, emotions, or topics other than these.

The distribution of codes in these categories for all couples at session one is presented in Table 11. Therapists talked about behaviors 42.2% of the time, more than they talked about any other topic in session one. This was consistent with Pinsof's (1995) model, which specifies that therapist interventions are primarily behavioral in nature at the beginning of therapy.

Table 11
Frequency of Therapist Behavior on Topic Scale at Session 1

Codes	Frequency	Percent
Behavior	290	42.2
Cognition	232	33.8
Emotion	37	5.4
Other	128	18.6
Total	687	100

Codes on the Intervention Scale for all couples were also examined. The distribution of therapist behavior falling into different categories of the Intervention Scale were presented in Table 4. Inspection of these data indicated that 57.8% of the therapist's interventions were from a theoretical orientation *other* than behavioral. That is, 57.8% of therapist statements fell into categories such as **Boundary-Rules**, **Communication**, **Expectation**, **Support**, **Status**, **Self-Disclosure**, **Transposition**, **Etiology-Motivation**, and **Process.** A further analysis was conducted to explore the

kinds of interventions that made up the "other" category. Table 12 presents the distribution of Intervention Scale codes for all couples in the study at session one. The frequency of each Intervention code is listed. Codes were also grouped into categories, according to whether the therapist's interventions were: (a) specifically behavioral in nature; (b) not considered strictly behavioral, but consistent with behavioral interventions, or (c) inconsistent with behavioral interventions. Codes which were considered behavioral in nature included: **Disagree/Disapprove, Direction, Refocus,** and **Problem-focus.** Codes considered to be consistent with a behavioral orientation included: **Boundary/Rules, Communication, Expectation, Support,** and **Status.** Lastly, codes which were considered inconsistent with a behavioral approach included: **Self-disclosure, Transposition, Etiology-motivation,** and **Process.** Note that a total of 46.3% of the time, therapist interventions were coded with either the **Support** code or the **Status** code. The **Support** code included "any statement in which the therapist explicitly validated, reinforced, praised, complimented, encouraged, or empathized with a person or group's behavior or experience (Pinsof, 1980; p.36)." The **Support** code may reflect therapist reinforcement of what clients say. It may also reflect therapist attention to the therapeutic alliance; the primacy of the alliance is a major tenet of Pinsof's model. Additionally, the **Status** code included statements that did not fit into any other Topic Scale codes. The therapist statement "Uh-huh" made up the vast majority of statements coded with **Status**. **Status** codes may reflect therapist encouragement to clients to continue talking. Therefore, one might interpret **Status** and **Support** codes as consistent with behavioral interventions. In this case, it appears

that therapists used behavioral interventions 23.2% of the time, and used interventions that were consistent with a behavioral approach 61.1% of the time. Thus, 84.3% of all therapist interventions at session one could be interpreted as reflecting or compatible with a behavioral focus. This is also consistent with Pinsof's (1995) assertion that successful therapist interventions are primarily behavioral in nature at the beginning of therapy.

Table 12
Frequency of Therapist Behavior on Intervention Scale at Session 1

	Frequency	Percent
Behavioral Codes		
Disagree-Disapprove	0	0
Direction	30	10.1
Refocus	1	.3
Problem	38	12.8
Codes Consistent with Behavioral Interventions		
Boundary-Rules	19	6.4
Communication	10	3.4
Expectation	15	5.0
Support	57	19.1
Status	81	27.2

Codes Inconsistent with Behavioral Interventions		
Self-Disclosure	16	5.4
Transposition	0	0
Etiology-Motivation	18	6.0
Process	13	4.4
Total	298	100

The Temporal Orientation Scale focused on the time period targeted by the therapist intervention. Codes on the Temporal Orientation Scale for both "improving" and "not improving" couples were grouped into categories, according to whether the therapists focused on the present or another temporal orientation. The distribution of codes in these categories for all couples at session one is presented in Table 13. Therapists focused on the present 75.8% of the time, three times more often than they focused on both the past or the future combined. This is also consistent with Pinsof's (1995) assertion that successful therapist interventions will be primarily behavioral in nature at the beginning of therapy, since behavioral interventions should focus on issues that are currently occurring in the couple's lives.

Table 13
Frequency of Therapist Behavior on Temporal Orientation Scale at Session 1

	Frequency	Percent
Focus on Present	226	75.8
Other Temporal Orientation	72	24.2
Total	665	100

Descriptive tables were also assembled to explore therapist interventions at session nine. Since the second hypothesis received almost no empirical support, several questions remained. If therapists did not use more experiential interventions as therapy progressed, what kinds of interventions were they using at session nine? Were they still using behavioral interventions? Table 14 presents the distribution of Intervention Scale codes for all couples in the study at session nine. The frequency of each Intervention code is listed. Codes were also grouped into categories, according to whether the therapist's interventions were: (a) specifically behavioral in nature; (b) not considered strictly behavioral, but consistent with behavioral interventions, or (c) inconsistent with behavioral interventions. These three categories were comprised of the same codes that determined these categories previously (see above). It is noteworthy that a total of 43.3% of the time in session nine, therapist interventions were coded with either the **Support** code or the **Status** code. If one interprets **Status** and **Support** codes as consistent with behavioral interventions, it appears that therapists used behavioral interventions 23.7% of the time at session nine, and used interventions that were consistent with a behavioral approach 60.7% of the time at session nine. Thus, 84.4% of all therapist interventions at session nine could be interpreted as reflecting or compatible with a behavioral focus.

Table 14
Frequency of Therapist Behavior on Intervention Scale at Session 9

	Frequency	Percent
Behavioral Codes		
Disagree-Disapprove	3	.8
Direction	26	7.1
Refocus	5	1.4
Problem	53	14.4
Codes Consistent with Behavioral Interventions		
Boundary-Rules	45	12.2
Communication	9	2.5
Expectation	10	2.7
Support	91	24.8
Status	68	18.5
Codes Inconsistent with Behavioral Interventions		
Self-Disclosure	5	1.4
Transposition	0	0
Etiology-Motivation	29	7.9
Process	23	6.3
Total	367	100

CHAPTER V

DISCUSSION

FTCS Findings

Hypothesis 1

One goal of the study was to identify therapist behaviors that help lead to improvement for couples in marital therapy. Analyses of the first hypothesis indicate inconsistent support for the assertion that therapists' use of behavioral interventions early in therapy is associated with improvement for maritally distressed couples. On the positive side, a significant difference was found between "improving" and "not improving" couples on the therapists' choice of topics. In particular, therapists commented more frequently on "improving" couples' verbal behaviors. An emphasis on verbal behavior is certainly consistent with a behavioral approach since communication training is a hallmark of behavioral marital therapies (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). That this type of therapist behavior was associated with improvement corroborates other studies in support of behavioral marital therapies (for a review see Gurman, Kniskern, and Pinsof, 1986). This finding was also consistent with Pinsof's model (1995). It appears that marital therapists should use interventions focused on verbal communication.

On the negative side was the finding that therapists focused more on the nonspecific behavior of "not improving" couples. Nonspecific behavior was defined as, "Any statement in which the therapist deals with non-specific or non-evaluative behavior or acts that do not clearly fall within any of the more specific or evaluative behavior code categories (Pinsof, 1980; p.27)." Thus, this code was considered to be somewhat of a "last resort" in coding; interventions received this code when they fit with no other behavior codes. While Pinsof's model does not explicitly make this distinction (1995), it makes sense that therapist interventions that lack specificity are associated with less improved outcomes. A goal of behavioral marital therapy, for example, is to encourage partners to state problems and solutions in specific, behavioral terms (Christensen, Jacobson, & Babcock, 1995). It seems unlikely that partners will learn to be specific if their therapists are nebulous in their interventions. In sum, this finding suggests that therapists should make focused interventions and should avoid vague, conversational topics. Additionally, it may indicate an area where Pinsof's model could be elaborated.

A significant difference was also found between the couple groups in terms of the function or intention of the therapist's interventions. In particular, therapist interventions that identified problems or solutions were associated with better outcomes. This finding is highly consistent with Pinsof's model, which is founded on the assumption that "psychotherapy is human problem-solving (Pinsof, 1995, p.1)."

Surprisingly, therapists gave more direction to couples who improved less in therapy. This finding is not consistent with Pinsof's model, which states that

behavioral interventions, which tend to be highly directive, will be most effective early in therapy (1995). Perhaps session one is too early for therapists to be highly directive, especially with highly distressed couples such as these.

Finally, the temporal orientation of therapist comments does not appear to distinguish between "improving" and "not improving" couples. However, this finding appears to be accounted for by the fact that 76% of all the therapist comments in session one, regardless of group, were focused on the present.

In sum, analyses of the first hypothesis were inconsistently supportive of the assertion that therapists' use of behavioral interventions early in therapy would be associated with improvement for maritally distressed couples. In accordance with Pinsof's model, an early focus on verbal behavior and the early identification of problems was associated with improvement in couple's dyadic adjustment. Inconsistent with the model was the finding that directions given by the therapist early in therapy were associated with less dyadic improvement. Therapist's focus on nonspecific behaviors was also associated with less improved outcomes, a finding not supportive of Pinsof's model as it is currently formulated.

Hypothesis 2

The second hypothesis of this study consisted of two parts: an examination of changes in therapist behavior over time for "improving couples", and an examination of therapist behavior between the groups at session nine. The first part predicted that "improved" couples would receive interventions that were increasingly more experiential in nature over time. Experiential interventions were characterized as those

in which the therapist talked about emotions, or identified a behavioral or experiential process (sequence or co-occurrence of events). This prediction was not supported.

The second part of Hypothesis 2 specified that at session nine, "improving" couples would receive more experiential interventions that those couples who did not improve. The two groups of couples differed significantly in the degree to which their therapists talked about emotions and identified processes at session nine. With regard to emotions, therapists talked about nonspecific and negative emotions more frequently with couples who did not improve than with those that did show improvement. While this result was contrary to the hypothesis, it supported the earlier speculation that less specific therapist interventions may be associated with less improvement for couples. Additionally, Gottman (1993) found that satisfied couples were those who maintained a 5:1 ratio of positive to negative behaviors and emotions while problem-solving. At session nine, therapists of the "not improving" couples discussed negative emotions more than twice as often as therapists of couples who improved (30 and 14, respectively). Furthermore, therapists of the "improving" couples maintained a 1:2 ratio of positive to negative emotion discussion at session nine, while those of the "not improving" couples maintained a corresponding ratio of almost 1:4 (see Table 7). Note that both of these ratios are in the opposite direction of Gottman's recommended ratio. Therapists may do their clients a disservice when they focus discussions extensively on negative emotions and do not focus on positive emotions. Finally, while this study examines how therapists' behavior influences couples' behavior, the reverse could also be true. That is, couples in the "not improving" group are likely to bring up more

negative feelings than couples in the "improving" group. Therapists may feel obliged to respond to these feelings.

The two couple groups also differed significantly in the degree to which they received interventions that focused on experiential or behavioral processes at session nine. Therapist process interventions were more frequent with couples who did not improve with treatment. This finding was not consistent with Pinsof's model, which states that experiential interventions (which focus on processes) will be related to a positive therapeutic outcome.

Finally, as expected, "improving" couples received significantly more interventions at session nine that were focused on the present than did couples who did not improve. At first glance, this finding appeared to support the second hypothesis, that experiential interventions would be received by "improving" couples as therapy progressed. Given the lack of other support for this hypothesis, however, any conclusions would be premature.

In sum, virtually no support was found for the second hypothesis. Of the three significant analyses, only one was in the predicted direction. The most noteworthy result appeared to indicate that therapists should be specific in their interventions and should avoid undue emphasis on negative emotions.

Descriptive Findings

Another goal of this study was to identify intervention strategies used in marital therapy. That is, what do marital therapists do? Consistent with Pinsof's (1995) model, therapists in this study appeared initially to use interventions that were primarily

behavioral in nature. Descriptive analyses showed that, in the first session, therapists talked about behavior 42.4% of the time, more frequently than they talked about either emotions or cognitions. Furthermore, one could argue that, at session one, therapists used interventions that reflected or were consistent with behavioral approaches 84.3% of the time. Particularly frequent were therapist inetrventions coded **Status** and **Support.** Therapists may use these interventions as a way of keeping the conversation going, reinforcing what clients are saying, or building the therapeutic alliance, all of which are consistent with Pinsof's model. Finally, at session one, therapists in this study focused on the present 75.8% of the time.

Pinsof (1995) also specifies that therapists should use interventions that are more experiential in nature as therapy progresses. Descriptive analyses of FTCS codes at session nine did not reflect this shift to experiential interventions. At session nine, 84.4% of therapist interventions reflected or were consistent with behavioral therapy. Again, this figure includes the very high frequency categories of **Status** and **Support**. It appears that marital therapists in this study used primarily behavioral interventions throughout the first nine sessions.

Several possible explanations can be invoked for therapist's failure to shift to more experiential approaches as specified by Pinsof's (1995) model. First, this sample consisted of couples who were initially highly distressed; the possibility of divorce was identified by at least one of each of the married partners during intake. Highly distressed couples may take longer to engage in therapy, thereby impelling therapists to maintain their behavioral focus longer than they might have with less distressed

couples. The fact that **Support** was the most used Intervention code for all couples at session nine is consistent with this explanation. Additionally, session nine may not be the best time to assess the shift to experiential therapy. Pinsof (1995) does not specify how long therapists should use behavioral approaches before moving to experiential interventions. In fact, he posits that the timing of the shift will vary somewhat across couples, depending on their "blocks" to effective problem-solving. Measurements at session nine may not sufficiently capture a shift if it is occurring.

Limitations

There are seven main limitations in this study. The first is the difficulty inherent in interpreting correlational relationships. For example, did some couples show no improvement because their therapists emphasized negative emotions at session nine, or did therapists focus on negative emotions at session nine as a response to couple's lack of manifest improvement? In other words, maybe therapist comments in this study were a response to what was occurring in the marital relationship rather than an influence on that relationship (i.e. a mediator of therapeutic change.)

Second, operationalizing Pinsof's therapeutic model proved difficult. While the model may provide an effective framework to guide therapist's in-session behavior, it does not lend itself well to testable hypotheses. This is primarily because the time frames in which therapists are supposed to shift from one therapeutic approach to another are not specified. While Pinsof argues that the optimal timing of these shifts varies across couples, some rough estimations of when the shifts might occur would aid researchers. In this study, as already noted, assessments at session nine may not

have adequately captured the experiential shift in therapist behavior that was sought. Third, sampling only from sessions one and nine may not have adequately represented the early phase of therapy. For example, data from session one may not typify early marital therapy because large portions of first sessions may be devoted to "fact-finding" or the logistics of therapy sessions (e.g. scheduling, fee arrangements). Session two may have been a better choice than session one in this regard. Additionally, two sessions out of nine simply may not be a large enough percentage of total therapists interventions to capture early therapy. Analyzing three, four, or more sessions may have yielded more definitive findings.

Fourth, the session nine outcome assessment may not have adequately represented the ultimate outcome of therapy. Thus, it is possible that some couples who reported decreased dyadic adjustment at session nine continued in therapy and eventually achieved improved levels of adjustment. To remedy this, outcome measures at the time of termination, drop-out, or at some later follow-up point could have also been used.

Fifth, this study also did not examine several potentially relevant factors, such as the context in which therapists intervened, for example, the "timing" of interventions. Client behaviors were not assessed, nor were the strength and quality of therapist's interventions. It is possible, for example, that therapists varied in their ability to deliver effectively their behavioral interventions. In this study, no attempt was made to distinguish a well-timed, effective behavioral intervention from a weak, poorly-timed intervention.

Sixth, it is unclear what effect studying highly distressed couples may have had on therapists' use of the model and the model's overall effectiveness. As mentioned before, therapists may have been slower to progress to experiential treatment because these highly distressed clients may have been more difficult to engage in therapy.

Finally, only eight couples were studied. A larger sample may have yielded more meaningful findings.

CHAPTER VI

CONCLUSION

This study sought to test Pinsof's integrative problem-centered therapy model for marital therapy (1995). Unfortunately, very few of the findings supported this model. The results did indicate, however, that, early in therapy, therapists who talked about couple's verbal behavior, avoided discussions of nonspecific, or vague, behaviors, and facilitated the identification of problems and solutions promoted the most improvement in dyadic adjustment for their clients.

The study was also designed to describe the in-session behavior of marital therapists. Results indicated that this group of marital therapists initially used interventions that were primarily behavioral in nature. Therapists talked about behavior more than they talked about emotions or cognitions. Additionally, therapists primarily used interventions that reflected or were consistent with behavioral orientations early in therapy. Lastly, therapists in this study focused primarily on the present. This type of approach appeared to continue at least through the first two months of therapy.

Far more research on the process of marital therapy will be needed before we can begin to answer the specificity question. Namely, "what are the specific effects of

specific interventions by specified therapists upon specific symptoms or patient types (Bergin, 1971, p.246)?" This study represents an initial effort toward that goal.

APPENDIX A

COUPLE CHARACTERISTICS

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COUPLE CHARACTERISTICS

"Improving" Treatment Group

Case	Wife Age	Husband Age	Wife Ethnicity	Husband Ethnicity	No. of Years Married	Hollingshead SES score
1	41	45	Caucasian	Caucasian	21	40
2	26	27	Asian	Caucasian	.25	53
3	30	31	Caucasian	Caucasian	04	32
4	22	27	Caucasian	Caucasian	04	66

"Not Improving" Treatment Group

Case	Wife Age	Husband Age	Wife Ethnicity	Husband Ethnicity	No. of Years Married	Hollingshead SES score
5	38	37	Caucasian	Caucasian	5	66
6	35	38	Caucasian	Caucasian	5	53
7	28	29	Caucasian	Caucasian	5	56
8	44	44	Caucasian	Caucasian	25	58

APPENDIX B

THERAPIST CHARACTERISTICS

APPENDIX B

THERAPIST CHARACTERISTICS

"Improving" Treatment Group

Case	Position	Degree	Experience	Sex	Ethnicity
1*	staff	MS	3 years	F	Asian
2*	staff	MS	3 years	F	Asian
3	student	certificate in MFT	2 years	F	Caucasian
4**	staff	PhD	15 years	M	Caucasian

"Not Improving" Treatment Group

Case	Position	Degree	Experience	Sex	Ethnicity
5**	staff	PhD	15 years	M	Caucasian
6	staff	PhD candidate	5 years	M	African-American
7	student	MA	2 years	F	Caucasian
8	staff	PhD	8 years	F	Hispanic

*Cases 1 and 2 were treated by the same therapist.
**Cases 4 and 5 were treated by the same therapist.

APPENDIX C

DYADIC ADJUSTMENT SCALE

APPENDIX C

DYADIC ADJUSTMENT SCALE

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

	Always Agree	Almost Always Agree	Occa-sionally Disagree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behavior)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents of in-laws	5	4	3	2	1	0
10. Aims, goals, and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0

14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
16. How often do you discuss or have you considered divorce?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married? (or lived together?)	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5

	Every-day	Almost everyday	Occa-sionally	Rarely	Never
23. How often do you kiss your mate?	4	3	2	1	0

24. Do you and your mate engage in outside interests together?	4	3	2	1	0	

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

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	0	1	2	3	4	5
26. Laugh together	0	1	2	3	4	5
27. Calmly discuss something	0	1	2	3	4	5
28. Work together on a project	0	1	2	3	4	5
29. Being too tired for sex	5	4	3	2	1	0
30. Not showing love	5	4	3	2	1	0

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

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

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

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VITA

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APPROVAL SHEET

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

November 26, 1996
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