Engaging in coparenting changes in couple therapy: Two contrasting cases.

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Abstract

Following the task analysis method, this study aimed to confirm the relevance of the model of resolving coparenting dissatisfaction to differentiate between two contrasting couples undergoing couple therapy. The model under study described the steps through which couples resolve coparenting issues in couple therapy for parents. Two contrasting couples were selected from a sample of parents undergoing systemic couple therapy. We analyzed videotaped discussions about the couple's coparenting relationship to select one couple whose interaction quality improved after therapy and one couple who worsened. Records of therapy sessions were rated by two independent coders to verify whether the model of coparenting change was present. Results showed that the couple that improved after therapy presented almost all the steps of the model whereas the couple that worsened after therapy presented only two steps. This study supported the relevance of the model and its various components to discriminate between two contrasting cases.

Keywords: Coparenting, Couple, Parents, Therapy, In-session Process

Engaging in Coparenting Changes in Couple Therapy: Two Contrasting Cases.

Over the years, several researchers have called for more external validity in couple psychotherapy research, raising concerns about the research–practice gap in the field (e.g., Safran et al., 2011). Process research has the potential to reduce this gap as it explores why and how change occurs in couple therapy (Hardy & Llewelyn, 2015) and provides findings more proximal to what happens in clinical practice (Kazdin, 2009). This kind of research has thus received growing attention in couple psychotherapy research (Heatherington et al., 2015), focusing on processes of change related to common factors, such as therapeutic alliance (e.g., Bartle-Haring et al., 2012) and communication (e.g., Doss et al., 2015), or to specific factors related to working on marital issues, such as establishing relational safety (e.g., Welch et al., 2019).

Process studies have explored various couple processes using a broad range of methods that includes both quantitative and qualitative methods (Gelo & Manzo, 2015; Mörtl & Gelo, 2015), such as lagged analysis (Doss et al., 2015) or multilevel modeling (Bartle-Haring et al., 2012), to explore the trajectories of changes over therapy sessions and their impact on therapy outcomes. The task analysis method applied to psychotherapy research by Greenberg (1984) was also frequently used (e.g., Welch et al., 2019). The task analysis method has the advantage of proposing a mixed method, articulating both qualitative and quantitative approaches. In this process study, we used the task analysis method to explore the process through which coparenting change unfolds in couple therapy for parents.

Task Analysis

In psychotherapy research, the task analysis method aims to identify steps through which clients, therapists, or groups of people (for example couples) successfully completed a specific emotional–cognitive therapeutic task (Greenberg, 1984; Pascual-Leone et al., 2014), such as emotionally processing distress (Pascual-Leone & Greenberg, 2007), repairing

alliance rupture (Aspland et al., 2008), and forgiving an unfaithful partner (Woldarsky Meneses & Greenberg, 2011).This method provides a detailed and sequential understanding of the subject's performance within therapy sessions. For example, within couple therapy, task analysis studies have demonstrated the importance of sharing and processing deeper emotions to enhance reconciliation after an attachment injury (Zuccarini et al., 2013). The task analysis method proposes a mixed method program composed of two phases of research: the *discovery* and *validation* phases (Pascual-Leone et al., 2014).

The discovery phase aims to build a model of change, using a bottom-up approach. The model of change is based on qualitative observation of the process as experienced within therapy sessions and analysis of its plausible theoretical meaning (Pascual-Leone et al., 2014). A sample of cases presenting good and poor performances of the task is compared to discover the essential components of change (i.e., the steps of the process). Components that are included in the model correspond to process steps that are observed in the sessions of the cases with good performances and that are not observed in the cases with poor performances. The model of change blends both observation and theory. Within this first phase, researchers also operationalize their model of change into measurement criteria to allow further validation of the model in the second phase. The creation of steps within the model is contingent upon defining observational cues that describe these steps (Pascual-Leone et al., 2014).

During the second phase, the validation phase, researchers measure and test the model of change previously discovered using a separate sample. This phase aims to verify the predictive value and external validity of the model. It should verify both the steps of the model and the relation between the presence or absence of the steps and good or poor independent outcomes. Coders, blind to outcomes, use the observational cues of the steps to examine this new sample (Pascual-Leone et al., 2014).

The validation phase is conducted on a sample of cases presenting the task problem under study (e.g., in our case, coparenting dissatisfaction). The cases also need to be contrasted according to independent variables as some cases report positive development after therapy and others do not. For example, in their task analysis study, Zuccarini et al. (2013) selected nine couples who resolved their attachment injury according to their therapist, an independent judge, and to self-report questionnaires on attachment injury, and nine couples who did not. This contrast allowed the researchers to test the ability of the model, measured based on the measurement developed in the first phase, to discriminate between cases with good and poor outcomes. Coders should thus find that cases with good therapy outcomes presented the steps of the model whereas cases with poor therapy outcomes did not (Pascual-Leone et al., 2014). When selecting a measure of therapy outcome, several approaches and instruments may be considered such as self-report questionnaires or observation. Observational data have been broadly overlooked despite their relevance for the study of couple functioning and couple therapy (Friedlander et al., 2019; Wampler & Harper, 2017). To our knowledge no previous task analysis combined the observation of the in-session process and the evaluation of therapy outcomes through observational data.

Observational Data

Using observation to evaluate pre–post therapy development appears valuable to both research and clinical practice. First, it offers the opportunity to assess couples' interactions, which is relevant to understanding therapeutic changes and couples' functioning (Feinberg et al., 2009; Friedlander et al., 2019). Collecting observational data allows assessment of the couple's immediate behaviors within their real context. It thus focuses on data with an important external validity whereas questionnaires focus on the internal validity of the measured construct (Kerig & Baucom, 2004).

In contrast to questionnaires, observational methods provide evidence of change that is not only dependent on the partners' and the therapist's reports and perceptions (Wampler & Harper, 2017). Observational data may reflect changes that partners did not perceived because of their limited ability to observe their own communication (Hahlweg et al., 2004).

Furthermore, observational data relies on independent judges who are not subject to social desirability (Oka et al., 2015). Self-report questionnaires may be biased by social desirability as partners may tend not to report behaviors that are perceived as undesirable (Oka et al., 2015; Shapiro & Gottman, 2005). Observational data also provide information on interactions and behaviors in a specific moment and within a specific context, whereas questionnaires assess overall perception and attitudes of each partner that may not reflect their actual behaviors (Wampler & Harper, 2017). To complete questionnaires, partners have to look back or forward in time (Wampler & Harper, 2017). The data collected through observation and self-report questionnaires may not reflect one another (Oka et al., 2015). In this study, we focused primarily on observational data to contrast our cases. Indeed, observations of couple's interactions as outcomes are more time-consuming than self-report questionnaires but provide a more complete and direct approach to evaluating the couple's relationship or their development over therapy.

Present Research

In this study, we focus on couples of parents as they are largely overlooked within couple therapy research. Studies generally do not specify the inclusion of parents within their samples and predominantly focus on romantic distress (e.g., Doss et al., 2015; Woldarsky Meneses & Greenberg, 2011). However, couples of parents should be considered as a specific subgroup of couples because becoming parents transformed their relationship. Parents are bound not only by their romantic engagement but also by the responsibilities they share as coparents. Parents are thus engaged in a romantic relationship as well as in a coparenting

relationship (Talbot & McHale, 2004). Coparenting encompasses the level of support and solidarity between the adults responsible for the care and upbringing of children (McHale & Lindahl, 2011). The coparenting relationship may create concerns related to, for example, parents' desire to find harmony in coparenting and to work effectively in the care and upbringing of their children. These concerns may influence the quality of the romantic relationship (e.g., Cho et al., 2020) and induce issues related to functioning as both parents and partners. Indeed, research has broadly shown the impact of the coparenting relationship on couple's functioning (e.g., Cho et al., 2020; Morrill et al., 2010), but also on the whole family well-being (e.g., Lam et al., 2018; Schoppe-Sullivan et al., 2016).

Despite the importance of coparenting in the family literature, little research has addressed coparenting changes within couple therapy. Exploring coparenting processes within couple therapy seems essential to gaining a better understanding of how coparenting changes unfold within couple therapy and to what extent they can drive changes at different levels of couple and family functioning. Therefore, we focused our investigation on coparenting process within a specific couple therapy for parents, the Integrative Brief Systemic Intervention (IBSI). This therapy approach particularly addresses the importance of articulating work on both the romantic and the coparenting relationships within systemic couple intervention (Darwiche et al., 2021). Consequently, it presumably produces changes in both relationships. In this study, we focused on couples' changes related to the coparenting relationship even though couples also worked on and potentially resolved their romantic issues within IBSI sessions. More precisely, we focused on the process that unfolded when parents resolved their coparenting dissatisfaction within the IBSI.

In this study, we conducted a preliminary validation of a task analysis project investigating in-session change in IBSI. The discovery phase of the task analysis project was conducted previously and presented elsewhere (Eira Nunes et al., 2021). In this previous

study, we intensively analyzed six couples undergoing IBSI who reported coparenting dissatisfaction. We selected three couples who successfully overcame their dissatisfaction over the course of therapy and three who did not. Analysis of these six couples (discovery phase) resulted in a model of change derived from the observation of the process through a specific lens, based on IBSI clinical assumptions and relevant empirical literature (Buehlman et al., 1992; Oppenheim & Koren-Karie, 2002). The model comprised six steps: awareness of coparenting dissatisfaction, reflection on negative coparenting dynamics, insightfulness, innovation, validation, and coparenting we-ness. As part of the task analysis, we developed a rating system of the above steps. This system described the observational cues that characterized each step and therefore corresponded to the essential criteria on which to judge if a couple was displaying a specific step of the model.

Objectives. In this study, we aimed to expand upon the previous discovery phase to conduct a preliminary verification of the applicability and relevance of the resulting model of resolving coparenting dissatisfaction to discriminated between outcomes in two contrasting cases undergoing IBSI. According to the task analysis method, the verification of the model should be based on a sample of couples presenting good and poor outcomes on an independent measure (Pascual-Leone et al., 2014). As that independent outcome measure, we selected the development of interaction quality (interaction quality improved for one couple and worsened for the other) as assessed through videotaped discussions about coparenting agreement and disagreement. We focused on independent observational measures as they appeared more clinically relevant (Kerig & Baucom, 2004), less likely to be biased, and more likely to detect therapeutic changes (Oka et al., 2015).

We hypothesized that the couple that improved their interaction quality after therapy would present the six steps of the model whereas the couple that worsened their interaction after therapy would not.

Method

Participants

This contrasting case study was part of an ongoing randomized controlled trial evaluating the efficacy of IBSI and was supported by the Swiss National Science Foundation (Grant SNF 159437). All couples were the parents of at least one child under 16 years old and requested couple therapy. From the available RCT sample of 37 couples of parents who had completed IBSI, we selected two contrasting cases based on their observational measures of interaction quality. To protect the couples' identities, names and personal information were changed.

The bonding couple. The first couple, Kate (38 years old) and Alan (39 years old), had been together for 12 years. They had two daughters of 7 and 10 years old. Alan also had a 14-year-old son from a precedent marriage that spent a weekend every 14 days with them. Before starting therapy sessions, the couple reported having relational difficulties for five years. Kate and Alan were consulting because they felt their children were invading their romantic relationship. According to Kate, it was difficult to feel close to her husband while he failed to support her with the children and was barely engaged in coparenting decisions. For Alan, the main issue was his perception that Kate's overinvestment in her parental role weakened her commitment to their romantic relationship. He wished their romantic relationship could be a strength and a resource in their coparenting difficulties.

The struggling couple. The second couple, Victoria (45 years old) and Roger (44 years old), had been together for 23 years. They had two daughters of 5 and 8 years old, and the younger daughter had ADHD. The couple sought help after ten years of relational difficulties. Their initial request for therapy appeared global. They reported encountering various difficulties and distancing within their relationship related to lack of time for their romantic relationship, miscommunication, strong emotional reactions, unspoken tensions, and

exhaustion from parenting. Parenting difficulties were quickly brought into the picture by the couple.

Treatment

Both couples underwent IBSI: seven sessions for Kate and Alan (the bonding couple) and six for Victoria and Roger (the struggling couple). All sessions were audio- or videotaped. IBSI is a manualized brief couple intervention for parents (Carneiro et al., 2012). It is integrative as it relies on the systematic articulation of therapeutic work on the coparenting and romantic relationships. It is brief as it generally comprises six sessions of 1—1.5 hr each over six months. The brief framework implies setting concrete objectives achievable within the timeframe of the therapy. In IBSI, therapists are free to choose their techniques from various systemic models such as the structural, strategic, and transgenerational models (Bowen, 1984; Haley, 1963; Minuchin, 1974).

IBSI is characterized by three main therapeutic principles (Darwiche et al., 2021): therapist aims to (a) engage partners as romantic partners and as a coparenting team from the start of the therapeutic process; (b) support the parents in increasing their awareness regarding their children's behavior and emotional experiences when facing their parents' conflicts; and (c) work on the spill- and crossover effects between coparenting and romantic relationships (i.e., explore how negativity or positivity spills from one relationship to the other or from one partner to the other).

Procedure

Couples were assessed before starting therapy and after the end of therapy. Several measures were taken through self-report questionnaires and videotaped discussions. The videotaped discussions were conducted by the research team at the consultation center or at the couple's house. Couples were asked to talk about agreement and disagreement in their coparenting relationship for 10 minutes (i.e., two discussions of five minutes). Based on

observational data, we selected two contrasting couples from the available RCT sample (37 couples): one that improved its interaction quality and another that did not (see the Analytic Plan for selection procedure). To further support this selection, we compared pre–post changes on observed interaction quality to pre–post changes on self-report coparenting support. Finally, we analyzed the couples' therapy sessions according to the model of resolving coparenting dissatisfaction previously developed (Eira Nunes et al., 2021).

Instruments

Interaction quality. Based on videotaped discussions realized before and after therapy, we assessed the couples' interaction quality according to a coding system synthesizing several scales used in other studies (e.g., Baker et al., 2010; McHale et al., 2001). This coding system evaluates the frequency, quality, and intensity of 10 interaction variables, such as endorsement, agreement, competition, and defensiveness, on a Likert scale ranging from 1 to 10. We used principal component analysis (Cazes, 2004) to summarize the 10 interaction variables into one principal component corresponding to interaction quality.

A team of three independent coders (two researchers in psychology and one master student in psychology) was engaged in coding. Interrater reliability was controlled on 25% of the total sample of videotaped records. The computation of Krippendorff's alpha (Krippendorff, 1980) revealed a good reliability of .81 on average for the 10 variables (from $_{ordinal}\alpha = .71$ to $_{ordinal}\alpha = .90$). Coefficients were calculated with the irr package (Version 0.84.1: Gamer et al., 2019) on R software (R Core Team, 2013).

Coparenting support. Coparenting support was assessed with the Parenting Alliance Measure (PAM; Abidin & Konold, 1999). This 20-item self-report questionnaire assessed coparenting support before and after therapy. Composite scores range between 20 and 100, with higher scores corresponding to higher coparenting support. For our total sample, the internal consistency of the measure was excellent ($\alpha = .95$ for both mothers and fathers).

According to the Jacobson and Truax method (1991), we computed both the clinical cut-off and the reliable change index (RCI). Using our data for the clinical dataset and Delvecchio et al. (2015) data for the nonclinical dataset, we found a cut-off at 80.39 for mothers and at 82.65 for fathers. Scores below these cut-offs were considered to reflect clinical distress. The RCI based on our RCT sample was of 9.22 for mothers and 8.91 for fathers, and changes in pre- to post-therapy scores equal to or greater than the RCI were considered clinically significant.

Analytic Plan

Preliminary analysis on interaction quality. As a preliminary analysis, we conducted a non normalized principal component analysis (Cazes, 2004) on the various interaction variables presented above. We used the FactoMineR package (Le et al., 2008) on R software (R Core Team, 2013). We conserved the variance of each variable and therefore assessed their respective contribution to the principal component (unstandardized data). The principal component analysis aimed to summarize 10 interaction variables into a principal component. We based our analyses on the pre- and post-therapy data of 37 couples. We were able to identify one principal component for each discussion that explained between 46% and 57% of the variance. This principal component contrasted positive interaction variables (e.g., agreement and endorsement) with negative interaction variables (e.g., defensiveness and competition). Therefore, couples who improved their interaction quality moved towards a higher score on the principal component.

Selection of the two couples. We then selected two couples that had developed in opposite ways after therapy. One couple improved their interaction quality in the two discussions from pre- to post-therapy whereas the other worsened their interaction quality. To contrast our two couples, we selected couples respectively presenting the largest positive (bonding couple) and negative deltas (struggling couple) between pre- and post-therapy scores

on the principal component. Selecting two extreme cases may allow us to capture how their experience of therapy was so different. Table 1 presents the *z-scores* of each couple's pre- and post-therapy interaction quality in the discussions about coparenting agreement and disagreement. Negative z-scores signal lower interaction quality (high levels of negative interaction variables) compared with the whole group and positive z-scores signal higher interaction quality (high levels of positive interaction variables) compared with the whole group. To further support observational data, we also explored self-report data on coparenting support. In the preliminary results section, we compared results from self-report questionnaires with results from observation of videotaped discussions.

Table 1.

Z-Scores of Interaction Quality for Each Coparenting Discussion at Pre- and Post-Therapy

	Agreement			Disagreement		
Couple	Pre	Post	Delta	Pre	Post	Delta
Bonding couple	0.33	1.12	0.79	-0.50	0.80	1.30
Struggling couple	1.36	-0.30	-1.66	0.79	-0.12	-0.91

Note. Numbers in the table correspond to the z-scores of the couples' interaction quality according to the coparenting discussion (agreement or disagreement) in time. Deltas correspond to the difference between pre- and post-therapy z-scores.

Qualitative analysis of sessions. Following the task analysis method, we first verified that both couples presented the problem state under study. In this study, the problem state that couples had to present is coparenting dissatisfaction. Coparenting dissatisfaction was signaled by one partner expressing negative emotions regarding the coparenting relationship and/or the other coparent's behaviors or attitudes. Not all couples undergoing IBSI express coparenting dissatisfaction, and, by extension, they may not experience the process under study. Identification of coparenting dissatisfaction during therapy sessions was thus a prerequisite for a couples' inclusion in our contrasting case analysis.

Two independent coders, blind to outcomes, assessed the therapy sessions of both couples for the presence or absence of the six steps of the model of resolving coparenting dissatisfaction: awareness of coparenting dissatisfaction, reflection on negative coparenting dynamic, insightfulness, innovation, validation, and coparenting we-ness. One coder was a researcher in psychology (first author) and the other was a psychotherapist specialized in systemic couple therapy. Only the second coder was blinded to the model of resolving coparenting dissatisfaction when coding sessions. The first coder watched the therapy sessions and identified 42 segments (24 for the bonding couple and 18 for the struggling couple) related to the model of resolving coparenting dissatisfaction. Coding was based on a coding manual that operationalized each step into observational cues (Eira Nunes et al., 2021). On all segments, coders achieved an agreement of 77%; agreement for the struggling couple (68%) was lower than for the bonding couple (83%). Coders resolved all disagreements to obtain consensus on every coded segment.

Results

In the result section, we first present our preliminary results regarding changes in interaction quality. We then report the main results related to the verification of our model. We thus provide a detailed description of the steps that were present for both contrasting couples.

Preliminary Analysis on Interaction Quality

The bonding couple. Partners improved their interaction quality from before to after therapy for both coparenting agreement and disagreement discussions (see Table 1). More precisely, they shared a more similar perspective regarding their children's needs, were more affectively connected when exchanging about their children's chores and education (Baker et al., 2010), and expressed increasing approval of their mutual parenting practices (McHale et al., 2001) at post-therapy. Partners also displayed less competition for the role of child expert

(Baker et al., 2010), less defensiveness, and less perceived pressure to change as they showed decreasing tendencies to ward off criticism or protect themselves in the discussion (Gordis et al., 1996), and they put less implicit or explicit pressure on their partners to change their behaviors or personality (Sevier et al., 2004).

Self-report data corroborated the observed improvement. The couple reported coparenting support below the clinical cut-offs before therapy—Kate's score of 52.00 was below the cut-off of 80.39 and Alan's score of 29.00 was below the cut-off of 82.65. However, their scores increased after therapy, surpassing the clinical cut-off (Kate = 81.00; Alan = 94.00). Their pre–post change was also clinically significant as they respectively exceeded the RCIs of 9.22 for the mother and of 8.91 for the father.

The struggling couple. In contrast, the struggling couple moved from positive to negative interaction quality on the coparenting discussions (see Table 1). This couple displayed a good interaction quality before therapy when discussing coparenting agreements and disagreements. However, after therapy, the quality of their interactions declined. In contrast to the bonding couple, the struggling couple demonstrated less agreement, shared emotion, and endorsement than before therapy. After therapy, they shared fewer similar perspectives regarding their children's needs and appeared less emotionally connected and less supportive of each other's interactions with the children. Their interactions were also characterized by more defensiveness, competition, and pressure on their partner to change.

Regarding their perception of coparenting support, self-report data revealed that Victoria's scores remained in the normal range as the score was above the clinical cut-off of 80.39 before therapy and did not significantly change from pre- to post-therapy (pre-therapy score = 88.00; post-therapy score = 85.00). On the other hand, Roger's report of coparenting support revealed clinical distress before therapy, with a PAM score of 75.00 below the clinical cut-off of 82.65. However, after therapy, he reported a clinically significant

improvement as his score surpassed the clinical cut-off (post-therapy score = 90.00), with an increase of 15.00 (RCI of 8.91). For this couple, self-report data did not reflect the decrease that we detected in the observational data based on the videotaped discussions.

Qualitative Analysis of Sessions

In the next sections, we illustrate each step displayed by the bonding couple and the struggling couple. Coders looked for the presence and absence of the steps of the model from Sessions 1 to 7 for the bonding couple and from Sessions 2 to 6 for the struggling couple. At the end of the next section, Table 2 offers an overview of the results.

The bonding couple. Kate and Alan expressed their coparenting dissatisfaction within the first therapy session. Kate deplored Alan's impatience toward their children and his lack of engagement in coparenting.

In the first session, shortly after Kate expressed her dissatisfaction, both partners were able to display some *awareness of their coparenting dissatisfaction* and thus were both engaged in exchanges about the concrete aspects of Kate's coparenting dissatisfaction. They clearly identified the behaviors that were the source of dissatisfaction and the efforts that they should make. Kate also expressed her wishes and expectations in relation to their coparenting issues.

In Sessions 2 and 3, the couple continued exploring their coparenting issues. More particularly, in Session 2, some observational cues of *coparenting we-ness* were identified but some important criteria were not met. Kate referred to the couple as a coparenting team and highlighted their ability to be flexible and adjust to each other. However, she also outlined the need for coparenting changes to achieve a long-term balance and truly be a coparenting team. She was thus relying on future changes to identify herself as part of a coparenting team. Moreover, coparenting we-ness implies the engagement of both parents and Alan was not

significantly involved in the exchanges. Session 3 was characterized by discussions about Alan's son (Kate's stepson).

Session 4 could be presented as a key session as many steps of the model were coded. First, in Session 4, the couple engaged in *reflection on their negative coparenting dynamics*. Kate highlighted the actions and reactions that triggered their coparenting dissatisfaction. More particularly, she outlined that, as she was generally more involved with the children, she was triggered by the fact that her husband tended to be less engaged. His approach appeared less effective to her even if she acknowledged that her way might not always be the right way either. Alan recognized that he was less proactive than Kate and validated Kate's view of their coparenting dynamic (i.e., dynamics of *over- and under-investment*). They extended their reflection within the fifth session.

Then, already in Session 3, but mostly in Session 4, Kate displayed *insightfulness*. In Session 3, Kate's insightfulness mainly focused on her stepson's decision to stop coming to their house and the reasons behind this decision. Nonetheless, insightfulness was mostly present in Session 4, as Kate reflected extensively on their children's (stepson included) emotional experience of their negative coparenting dynamic: how they experience Alan's passivity and her overinvestment. For instance, regarding her stepson's decision to take some distance with their family, she tried to understand the reasons behind this decision and how their respective reactions to this decision (Alan's distancing and her requests for more explanations) may have impact his emotional experience (he may have felt left out of their family and pressure by her). She was able to challenge her parenting style and attitude with her stepson as she acknowledged that he may have experienced her desire to be invested and present for him as intrusiveness.

The *innovation* and *validation* steps were also present in the fourth session. Alan was the one primarily engaged in the innovation step, and Kate validated his efforts. Alan revealed

that he was trying to be more involved with the children and had, for example, been sending old family pictures to his older son. He explained that he tried to maintain the connection between them even when they were apart and let his son know that he missed him. This new behavior corresponded to the innovation step and appeared to be a response to Kate's wishes for more emotional involvement from Alan toward their children. Kate validated Alan's new behaviors. Alan continued innovating regarding coparenting through therapy sessions.

By the end of therapy, the couple looked back at their request for therapy and shared their satisfaction regarding their therapeutic journey. They agreed on the improvements that were made even if Kate highlighted the fragility of those changes. They both shared their intention to be careful to maintain a positive dynamic regarding both their coparenting and romantic relationships.

As shown in Table 2, only the *coparenting we-ness* step was not observed in the sessions. Five steps out of six were displayed over the course of therapy.

Table 2

Summary of the Steps Coded in the Two Contrasting Cases

	Bonding couple							Struggling couple				
	S1	S2	S3	S4	S5	S6	S7	S2	S3	S4	S5	S6
Awareness of coparenting dissatisfaction	✓	✓					✓				✓	✓
Reflection on negative coparenting dynamics				✓	✓							
Insightfulness			✓	✓								
Innovation				✓		✓	✓			✓		
Validation				✓			✓					
Coparenting we-ness												

The struggling couple. Coparenting dissatisfaction was identified in Session 2 as in Session 1, the couple mainly talked about their romantic relationship and the lack of time for

the couple. In Session 2, Victoria highlighted that Roger was often unavailable for coparenting tasks such as putting the children to bed and helping children with homework.

From Session 2 to Session 4, before the couple engaged in any step of the model, their interaction was characterized by minimization of the importance of their coparenting issues. For instance, Victoria appeared uncomfortable and nervous when talking about her coparenting dissatisfaction. When the therapist asked Victoria what she expected from Roger in those moments when he was unavailable, she was not able to answer. Both partners tended to change the subject when the therapist tried to explore concrete aspects of their disagreements and dissatisfaction.

Despite this dynamic of avoidance and confusion, coders identified the *innovation* step for Roger–this step does not require the engagement of both partners. In Session 4, Roger explained that they had adopted a new coparenting behavior and tried to divide their responsibilities differently. He presented this new behavior as a solution to Victoria's timid complaints about coparenting. Victoria did not validate the innovation. She judged the change too fragile and irrelevant. Therefore, the *validation* step was not coded for this couple.

Near the end of therapy sessions (Session 5), coders identified *awareness of coparenting dissatisfaction.* Victoria and Roger were able to directly address a conflict situation and authentically confront each other with very few withdrawals. Both partners were engaged in the awareness of coparenting dissatisfaction and identified which behaviors of the other parent were upsetting in this situation. Victoria blamed Roger for being selfish and disengaged, while Roger blamed Victoria for being unwilling to compromise and unreasonable.

Globally, over the sessions, Roger appeared active and motivated whereas Victoria was mainly passive and rarely validated Roger's input. At times, she appeared not ready to engage and even resistant to change. By the end of therapy, according to coders' observation

of the process, the couple main improvement was the ability to directly approach difficulties, at least regarding their coparenting issues. They appeared not yet on the same page as, for example, Roger described their relationship as improved with more relief and closeness. He appeared quite positive regarding their therapeutic progress. In contrast, Victoria's perspective was substantially different. She expressed doubt about their progress. She emphasized their difficulties and her remaining dissatisfaction regarding Roger's lack of availability for coparenting as if they were moving backwards.

As shown in Table 2, Roger and Victoria displayed only two steps of the model throughout their therapy sessions.

Discussion

This study aimed to verify the applicability and relevance of the model of resolving coparenting dissatisfaction for discriminating between two contrasting cases. The model was partially verified in this study. Our main hypothesis was that the couple whose interaction had improved after therapy would present the steps of the model whereas the couple whose interactions had worsened after therapy would not. Coding of sessions revealed the presence of five out of six steps of the model for the bonding couple and of two steps for the struggling couple. Only the step of coparenting we-ness was not observed by coders in either case and was therefore not verified in this study. Our findings may signal that couples do not need to identify themselves as part of a new coparenting team (as defined in Eira Nunes et al., 2021) within the therapy sessions to overcome their dissatisfaction. We could postulate that for some couples, such as the bonding couple, this step would be displayed later when coparenting changes had been installed and had deeply modified the coparenting dynamic. Future verification studies should investigate the presence or absence of coparenting we-ness in the therapy sessions of couples who resolve their coparenting dissatisfaction to verify the essential nature of this step for resolving coparenting dissatisfaction. Nonetheless, it is

common that validation studies fail to systematically observe some steps of the model in the resolved cases (e.g., Pascual-Leone & Greenberg, 2007; Zuccarini et al., 2013). For example, Zuccarini et al. (2013) verified the attachment injury resolution model even though some of the couples considered as resolved did not present some of the steps; five steps out of eight were not consistently presented by all resolved couples.

In task analysis studies, unresolved cases frequently present fewer steps than do resolved cases (e.g., Pascual-Leone & Greenberg, 2007) and also present earlier steps of the model (e.g., Zuccarini et al., 2013). In line with this literature, we found that the couple whose interaction quality worsened after therapy presented only two steps of the model: the awareness of coparenting dissatisfaction and innovation steps. We initially postulated these steps would not normally be presented by unresolved couples. Displaying awareness of coparenting dissatisfaction by the end of therapy was identified by coders as a key moment for the struggling couple. Indeed, coders overall impression when watching the struggling couple's sessions was of confusion and lack of focus on the concrete issues. Nonetheless, from the fifth session onwards, the couple's exchanges featured more authenticity. Benson et al. (2012) have identified emotional avoidance as a common target of couple therapy. They highlighted how avoidance may limit the couple's ability to experience emotional intimacy and thus to feel close to each other. Mutually avoidant partners avoid topics that are too emotionally distressing. Consequently, important issues remain unresolved, exacerbating their relational issue and deceasing both partners' satisfaction (Benson et al., 2012). In light of the literature, overcoming their initial avoidance appeared to be an important therapy outcome for this couple. However, this study revealed that this first step of the model did not differentiate our two cases. The main difference was that to achieve deeper changes in coparenting, couples needed to overcome the awareness step at some point. They needed to stop blaming

each other for their dissatisfaction and reflect on their respective contribution to the coparenting dynamic to be able to change further.

Regarding the innovation step, innovation without subsequent validation appeared to compromise the couple's resolution. For the couple that did not improve their interaction quality after therapy, the lack of validation after the husband displayed innovation appeared to offset the progress that the innovation should represent in the process under study. Roger explained that both parents had adopted new coparenting behaviors. However, Victoria did not validate this innovation and even refuted the change, presenting it as exceptional and irrelevant. Changes that were not validated failed to contribute to the resolution of coparenting dissatisfaction.

Finally, in both cases, we observed a greater investment on the part of one parent—the mother in the bonding couple and the father in the struggling couple. This imbalance between partners has been previously noted and discussed in the literature, particularly concerning men's engagement in couple therapy (e.g., Englar-Carlson & Shepard, 2005). However, we observed that for the couple that declined after therapy (the struggling couple), the imbalance was accompanied by passivity and a lack of validation from the partner who was generally less invested. She appeared to be uncomfortable and not ready to engage in the process. This passivity was not observed for the couple that improved after therapy, as the wife was more involved, but the husband cooperated and validated her. One parent may be more invested than the other; they may be more engaged in exchanges and adopt new behaviors while the other sits on the sidelines offering occasional validation of the more engaged parent. This imbalance nevertheless may enhance changes for the couple provided that it is not characterized by the motivation and commitment of one partner and the resistance to change of the other.

Limits

The primary limitation of this study was that we described the relation between outcomes and the process under study without considering the potential influence of external factors. For example, children's characteristics or the initial agreement on the therapeutic objectives might have influenced couples' improvement. Given that one of the daughters of the struggling couple presented ADHD, they might have faced specific coparenting challenges (e.g., Cook et al., 2009; Mendez et al., 2015). These challenges support the importance of addressing coparenting within couple therapy but may require further therapeutic work to disentangle their difficulties as parents and as romantic partners. Moreover, the couple appeared to have several therapeutic objectives and to be ambivalent regarding the nature of their issues. These two characteristics may have made it difficult for the struggling couple to work on their difficulties within the brief framework of IBSI (Biesen & Doss, 2013). Future studies should thus investigate potential covariates that may explain differences in outcomes or that may have hindered or facilitated resolution of the coparenting issues.

This preliminary verification study was based on the coding of two judges, one who was blind to the model. The other judge (first author) participated in the discovery phase. Coding might thus have been biased by the coder's expectations regarding the model. However, both coders were blind to the outcome, and the double coding enabled verification of the reliability of the coding of sessions and prevented any further biases.

Conclusion

This preliminary verification study partially confirmed the applicability of the model of resolving coparenting dissatisfaction in two contrasting couples. Based on the model, we were able to differentiate the couple that improved after therapy and the couple that declined. The partners who increased their ability to actively listen to each other, be supportive, find

compromises, and bond over coparenting discussion outside of their therapy sessions also resolved their coparenting dissatisfaction through specific steps of change related to insight and behavioral changes. As we conducted our study on only two cases, we were able to select extreme cases that had developed in opposite ways after therapy. This approach allowed us to discuss how a couple who benefited from therapy and one who did not—at the coparenting level, at least—experienced very different in-session processes. This limited sample allowed in-depth analysis and subsequent hypotheses on the characteristics of the observed processes that were particularly different for each couple and that may have contributed or prevented resolution. Therefore, future studies should extend this first verification of the model on a larger sample to, for example, verify our findings regarding the necessity of coparenting we-ness or of the dependence between the innovation and validation steps.

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