APPENDICES

APPENDIX A: Assessment Package

1. Demographic Information Form
2. Relationship Status Questionnaire
3. Screening for Somatoform Disorders (SOMS)
4. Dyadic Adjustment Scale (DAS)
5. MOS 36-Item Short-Form Health Survey (SF-36)
6. Positive Feelings Questionnaire (PFQ)
7. Hamilton Depression Interview Schedule (HAM-D)
8. State-Trait Anxiety Inventory (STAI) -- Sample
9. Beck Depression Inventory (BDI-11) -- Sample

Pre-Session Assessment

The SHARE Study

Synthesizing
Health
And
Relationship
Enhancement

Marital and Family Therapy Program
Wake Forest University School of Medicine
Department of Psychiatry and
Behavioral Medicine

Relationship Status Questionnaire

1) Please indicate your current **marital status** (Check one letter only):

a) _____Married and living together
Date of marriage: _____
Month/Year

b) _____Married but living apart (Separated but not legally)
Date of marriage: _____
Date of separation: _____
Month/Year

c) _____Legally separated
Date of marriage: _____
Date of separation: _____
Month/Year

d) _____Divorced
Date of divorce: _____
Month/Year

e) _____Widowed
Date of spouse's death: _____
Month/Year

f) _____Never Married

2) If you are not married but are currently in a relationship please indicate which description best describes that relationship (Ccheck one letter only):

Not Living Together

a) _____Casually dating (I date other people as well)
When this relationship began: _____
Month/Year

b) _____Seriously dating (I do not date other people)
When this relationship began: _____
Month/Year

c) _____Engaged, but not living together
When this relationship began: _____
Month/Year

Living Together

d) _____Not engaged and living together
When this relationship began: _____
Month/Year

e) _____Engaged and living together
When this relationship began: _____
Month/Year

Background Information

This section asks questions that describe some general characteristics about you. This information helps us understand general characteristics of the people who have completed the survey.

(1) Birthdate: _____

(2) Female_____ Male_____

(3) Number of times you have been married:

0 ____ 2 ____ 4 ____

1 ____ 3 ____ 5 or more ____

(4) Number of times you have been divorced:

0 ____ 1 ____ 4 _____

2 ____ 3 ____ 5 or more _____

(5) Number of times you have been widowed:

0 ____ 2 ____ 4 ____

1 ____ 3 ____ 5 or more ____

(6) Approximate current income of self and spouse combined:

1 - 9,999 ____

10,000 - 19,999 ____

20,000 - 39,999 ____

40,000 - 59,999 ____

60,000 - 74,999 ____

75,000 or above ____

(7) What is your ethnic or cultural background?

1. European-Caucasian ____

2. African American ____

3. Hispanic-Latino ____

4. Asian-American/Pacific Islander ____

5. Native American-American Indian/ Alaskan Native ____

6. Other _____ ____

SOMS

Please answer whether you have temporarily or continuously suffered from the listed symptoms in the **past 2 years**. Only consider symptoms for which no clear causes have been found by physicians and have affected your well-being.

In the **past 2 years**, I have suffered from the following complaints:

1. Headaches	**YES**	**NO**
2. Abdominal pain	**YES**	**NO**
3. Back pain	**YES**	**NO**
4. Joint pain	**YES**	**NO**
5. Pain in the legs and/or arms	**YES**	**NO**
6. Chest pain	**YES**	**NO**
7. Pain in the anus	**YES**	**NO**
8. Pain during sexual intercourse	**YES**	**NO**
9. Pain during urination	**YES**	**NO**

10. Nausea	**YES**	**NO**
11. Bloating	**YES**	**NO**
12. Discomfort in and around the upper abdomen and chest	**YES**	**NO**
13. Vomiting (excluding pregnancy)	**YES**	**NO**
14. Regurgitation of food	**YES**	**NO**
15. Hiccough, or burning sensations in chest or stomach	**YES**	**NO**
16. Food intolerance	**YES**	**NO**
17. Loss of appetite	**YES**	**NO**
18. Bad taste in mouth or excessively coated tongue	**YES**	**NO**
19. Dry mouth	**YES**	**NO**
20. Frequent diarrhea	**YES**	**NO**
21. Discharge of fluids from anus	**YES**	**NO**
22. Frequent urination	**YES**	**NO**
23. Frequent bowel movements	**YES**	**NO**

24. Palpitations	**YES**	**NO**
25. Stomach discomfort or churning in stomach	**YES**	**NO**
26. Sweating (hot or cold)	**YES**	**NO**
27. Flushing or blushing	**YES**	**NO**
28. Breathlessness (without exertion)	**YES**	**NO**
29. Painful breathing or hyperventilation	**YES**	**NO**
30. Excessive tiredness or mild exertion	**YES**	**NO**

31. Blotchiness or discoloration of the skin **YES** **NO**

32. Sexual indifference (loss of libido) **YES** **NO**
33. Unpleasant sensations in or around the genitals **YES** **NO**

34. Impaired coordination or balance **YES** **NO**
35. Paralysis or localized weakness **YES** **NO**
36. Difficulty swallowing or lump in throat **YES** **NO**
37. Loss of voice **YES** **NO**
38. Urinary retention **YES** **NO**
39. Hallucinations **YES** **NO**
40. Loss of touch or pain sensation **YES** **NO**
41. Unpleasant numbness or tingling sensations **YES** **NO**
42. Double vision **YES** **NO**
43. Blindness **YES** **NO**
44. Deafness **YES** **NO**
45. Seizures **YES** **NO**
46. Memory loss **YES** **NO**
47. Loss of consciousness **YES** **NO**

For Women:			**For Men:**	
48. Painful menstruation	**YES**	**NO**	53. Erectile or ejaculatory	
49. Irregular menstruation	**YES**	**NO**	dysfunction	**YES NO**
50. Excessive menstrual bleeding	**YES**	**NO**		
51. Continuous/frequent vomiting during pregnancy	**YES**	**NO**		
52. Unusual vaginal discharge	**YES**	**NO**		

The following questions refer to your symptoms. If no symptoms were present, please skip these questions and continue with question 64.

54. How often did you see a doctor because of your symptoms in the past 2 years?

____Not at all ____1-2 times ____3-6 times ____6-12 times ____More than 12 times

55. Was the doctor able to find the specific cause for your symptoms?
YES N0

56. When the doctor told you that there were no detectable causes
of your complaints, could you accept this as a fact?
YES N0

57. Have the symptoms affected your well-being severely?
YES N0

58. Have the symptoms affected your daily activities
to a great extent (family, work, or recreational activities)? **YES N0**

59. Did you take medicine because of your symptoms?
YES N0

60. Did you ever have panic attacks where you had extreme feelings
of anxiety and numerous physical symptoms, which disappeared
minutes or hours later?
YES N0

61. Did your symptoms appear only during panic attacks
(e.g., anxiety attacks)?
YES N0

62. Did your first symptoms begin before the age of 30?
YES N0

63. How long have you had these symptoms?
____Less than 6 months ____6-12 months ____1-2 years ____More than 2 years

64. Are you afraid or are you convinced that you have a serious disease, even though the physicians have failed to find a sufficient explanation for your symptoms?
YES N0

65. If Yes, Have you had this fear or belief for more than 6 months? **YES N0**

66. Does your pain preoccupy you? **YES** **N0**

67. If Yes, has this pain preoccupied you for at least 6 months?
YES **N0**

68. Do you believe that you have some defect in your appearance, even though others do not share this opinion?
YES **N0**

Relationship Discussion Questionnaire

We are interested in how you typically respond to problems in your relationship (that is, problems that are between you and your partner).

Please rate each item on a scale of 1 (=Strongly Agree) to 9 (Strongly Disagree).

1) When discussing a relationship problem I usually try to keep the discussion going until we settle the issue.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
2) I usually express my feelings about our relationship to my partner.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
3) I usually keep my feelings about our relationship private and do not share them with my partner.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
4) When I become aware of a problem in our relationship I usually do not say anything about it.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
5) I am the kind of person who generally feels comfortable discussing relationship problems.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
6) When my partner wants to talk about a relationship problem, I am usually ready to do so as well.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
7) I usually become silent or refuse to discuss a relationship problem further if my partner pressures or demands that I do so.	Strongly Agree 1 2 3 4 5 6 7 8 9 Strongly Disagree
8) When my partner wants to talk about a relationship	Strongly Strongly

problem, I usually try to get out of the discussion.	Agree Disagree 1 2 3 4 5 6 7 8 9
9) When I become aware of a problem in our relationship I usually try to start a discussion of that problem.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
10) I am the kind of person who generally does not feel comfortable discussing relationship problems.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9

Relationship Discussion Questionnaire	
We are interested in how <u>your partner</u> typically responds to problems in your relationship (that is, problems that are between you and your partner). Please rate <u>each item</u> on a scale of 1 (=Strongly Agree) to 9 (Strongly Disagree).	
11) When I want to talk about a relationship problem, my partner usually tries to get out of the discussion.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
12) My partner usually expresses any feelings about our relationship to me.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
13) My partner is the kind of person who generally feels comfortable discussing relationship problems.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
14) When my partner becomes aware of a problem in our relationship my partner usually tries to start a discussion of that problem.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
15) When discussing a relationship problem my partner usually tries to keep the discussion going until we settle the issue.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
16) If my partner and I are discussing an important relationship issue, my partner usually tries to keep discussing it even if it seems we are beginning to become emotional.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
17) My partner usually keeps feelings about our relationship private and does not share them with me.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
18) My partner is the kind of person who generally does	Strongly Agree Strongly Disagree

not feel comfortable discussing relationship problems.	1 2 3 4 5 6 7 8 9
19) When my partner becomes aware of a problem in our relationship my partner usually does not say anything about it.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9
20) When I want to talk about a relationship problem, my partner is usually ready to do so as well.	Strongly Agree Strongly Disagree 1 2 3 4 5 6 7 8 9

Dyadic Adjustment Scale

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

1 Always Agree	2 Almost Always Agree	3 Occasionally Agree	4 Frequently Disagree	5 Almost Always Disagree	6 Always Disagree

Handling family finances	**1**	**2**	**3**	**4**	**5**	**6**
Matters of recreation	**1**	**2**	**3**	**4**	**5**	**6**
Religious matters	**1**	**2**	**3**	**4**	**5**	**6**
Demonstrations of affection	**1**	**2**	**3**	**4**	**5**	**6**
Friends	**1**	**2**	**3**	**4**	**5**	**6**
Sexual relations	**1**	**2**	**3**	**4**	**5**	**6**
Conventionality (Correct or proper behavior)	**1**	**2**	**3**	**4**	**5**	**6**
Philosophy of life	**1**	**2**	**3**	**4**	**5**	**6**
Ways of dealing with parents or in-laws	**1**	**2**	**3**	**4**	**5**	**6**
Aims, goals, and things believed to be important	**1**	**2**	**3**	**4**	**5**	**6**
Amount of time spent together	**1**	**2**	**3**	**4**	**5**	**6**
Making major decisions	**1**	**2**	**3**	**4**	**5**	**6**
Household tasks	**1**	**2**	**3**	**4**	**5**	**6**
Leisure time interests and activities	**1**	**2**	**3**	**4**	**5**	**6**
Career decisions	**1**	**2**	**3**	**4**	**5**	**6**

1 All The Time	2 Most of the Time	3 More often Than not	4 Occasionally	5 Rarely	6 Never

How often do you discuss or have you considered divorce, separation, or terminating your relationship?	**1**	**2**	**3**	**4**	**5**	**6**
How often do you or your mate leave the house after a fight?	**1**	**2**	**3**	**4**	**5**	**6**
In general, how often do you think that things between you and your partner are doing well?	**1**	**2**	**3**	**4**	**5**	**6**
Do you confide in your partner?	**1**	**2**	**3**	**4**	**5**	**6**
Do you ever regret that you married or lived together?	**1**	**2**	**3**	**4**	**5**	**6**
How often do you and your partner quarrel?	**1**	**2**	**3**	**4**	**5**	**6**
How often do you and your partner "get on each other's nerves"?	**1**	**2**	**3**	**4**	**5**	**6**

1 Every Day	2 Almost Every Day	3 Occasionally	4 Rarely	5 Never

Do you kiss your partner?	**1**	**2**	**3**	**4**	**5**	
Do you and your partner engage in outside interests together?	**1**	**2**	**3**	**4**	**5**	

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

1	2	3	4	5	6
Never	**Less than once a month**	**Once or twice a month**	**Once or twice a week**	**Once a day**	**More Often**

Have a stimulating exchange of ideas	**1**	**2**	**3**	**4**	**5**	**6**
Laugh together	**1**	**2**	**3**	**4**	**5**	**6**
Work together on a project	**1**	**2**	**3**	**4**	**5**	**6**
Calmly discuss something	**1**	**2**	**3**	**4**	**5**	**6**

These are some things that couples sometimes agree and sometimes disagree about. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks by circling yes or no.

Being too tired for sex	**YES**	**NO**
Not showing love	**YES**	**NO**

The numbers on the following line represent different degrees of happiness in your relationship. The middle number, "happy", represents the degree of happiness of 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**

Which *one* 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 it does.
____ I want very much for my relationship to succeed, and will do all I can to see that it does.
____ I want very much for my relationship to succeed, and will do my fair share to see that it does.
____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
____ It would be nice if it succeeded, but I refuse to do any more that 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.

Feelings Questionnaire

Below is a list of questions about various feelings between couples. Answer each one of them in terms of how you *generally* feel about your partner, taking into account the last few months. The rating you choose should reflect how you *actually* feel, not how you think you should feel or would like to feel. Please answer each question by choosing the best number to show how you have generally been feeling in the past few months. Choose *only one number* for each question.

1	2	3	4	5	6	7
Extremely Negative	**Quite Negative**	**Slightly Negative**	**Neutral**	**Slightly Positive**	**Quite Positive**	**Extremely Positive**

1. How do you feel about your partner as a friend to you?	**1 2 3 4 5 6 7**
2. How do you feel about the future of your relationship?	**1 2 3 4 5 6 7**
3. How do you feel about having made a commitment to your partner?	**1 2 3 4 5 6 7**
4. How do you feel about your partner's ability to put you in a good mood so that you can laugh and smile?	**1 2 3 4 5 6 7**
5. How do you feel about your partner's ability to handle stress?	**1 2 3 4 5 6 7**
6. How do you feel about the degree to which your partner understands you?	**1 2 3 4 5 6 7**
7. How do you feel about your partner's honesty?	**1 2 3 4 5 6 7**
8. How do you feel about the degree to which you can trust your partner?	**1 2 3 4 5 6 7**

The following nine items are in the form of statements rather than questions. Please complete them in the same manner, remembering to base your responses on how you *generally* feel about your spouse, taking into account the last few months.

1	2	3	4	5	6	7
Extremely Negative	**Quite Negative**	**Slightly Negative**	**Neutral**	**Slightly Positive**	**Quite Positive**	**Extremely Positive**

1. Touching my partner makes me feel…	**1 2 3 4 5 6 7**
2. Being alone with my partner makes me feel…	**1 2 3 4 5 6 7**
3. Having sexual relations with my partner makes me feel…	**1 2 3 4 5 6 7**
4. Talking and communicating with my partner makes me feel…	**1 2 3 4 5 6 7**
5. My partner's encouragement of my individual growth makes me feel…	**1 2 3 4 5 6 7**
6. My partner's physical appearance makes me feel…	**1 2 3 4 5 6 7**
7. Seeking comfort from my partner makes me feel…	**1 2 3 4 5 6 7**
8. Kissing my partner makes me feel…	**1 2 3 4 5 6 7**
9. Sitting or lying close to my partner makes me feel…	**1 2 3 4 5 6 7**

MOS 36-Item Short-Form Health Survey

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
   (Put appropriate code in box)

☐
1 = Excellent
2 = Very Good
3 = Good
4 = Fair
5 = Poor

2. Compared to one year ago, how would you rate your health in general now?
   (Put appropriate code in box)

☐
1 = Much better now than one year ago
2 = Somewhat better now than one year ago
3 = About the same as one year ago
4 = Somewhat worse now than one year ago
5 = Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does *your health now limit you*, in these activities? If so, how much? Check *one* box per category.

	Yes, Limited A Lot	**Yes, Limited A Little**	**No, Not Limited At All**
a. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing **one** flight of stairs	☐	☐	☐

f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking **more than one mile**	☐	☐	☐
h. Walking **several blocks**	☐	☐	☐
i. Walking **one block**	☐	☐	☐
j. Bathing or dressing yourself.	☐	☐	☐

4. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *as a result of your physical health?*

	YES	NO
a. Cut down on the **amount of time** you spend on work or other activities?	☐	☐
b. **Accomplished less** then you would like	☐	☐
c. Were limited in the **kind** of work or other activities	☐	☐
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	☐	☐

5. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems*, such as feeling depressed or anxious?

	YES	NO
a. Cut down on the **amount of time** you spend on work or other activities?	☐	☐
b. **Accomplished less** then you would like	☐	☐
c. Didn't do work or other activities as **carefully** as usual	☐	☐

6. During the *past 4 weeks*, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(Put appropriate code in box)
1 = Not at all
2 = Slightly

☐

3 = Moderately
4 = Quite a bit
5 = Extremely

10. How much *bodily* pain have you had during the *past 4 weeks?*
(Put appropriate code in box)

☐

1 = None
2 = Very mild
3 = Mild
4 = Moderate
5 = Severe
6 = Very Severe

11. During the *past 4 weeks*, how much did *pain* interfere with your normal work (including both work outside the home and housework)?
(Put appropriate code in box)

☐

1 = Not at all
2 = Slightly
3 = Moderately
4 = Quite a bit
5 = Extremely

12. These questions are about how you feel and how things have been with you *during the past 4 weeks.* For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the *past 4 weeks*. Check *one* box per category.

	All Of the Time	**Most of the Time**	**A Good Bit of The time**	**Some Of the Time**	**A Little of the Time**	**None of the Time**
a. Did you feel full of pep?	☐	☐	☐	☐	☐	☐
b. Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
c. Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

g. Did you feel worn out?

h. Have you been a happy person?

i. Did you feel tired?

13. During the *past 4 weeks*, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?

(Put appropriate code in box)

1 = All of the time
2 = Most of the time
3 = Some of the time
4 = A little of the time
5 = None of the time

14. How **TRUE** or **FALSE** is each of the following statements for you? Check one box per category

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people					
b. I am healthy as anybody I know					
c. I expect my health to get worse					
d. My health is excellent					

Thank you for your
Participation in
The SHARE Study.

Your contribution
is important to us.

Structured Interview Guide for the Hamilton Depression Rating Scale
(HAM-D)

Name_____ Subject #_____
Date_____ Score_____
Circle: Pre-Session Post-Therapy Session
Post-Session

Overview: "I'd like to ask you some questions about the past week. How have you been feeling since last (day of week)? Have you been working?" IF NOT: "Why not?"

*Leave item "Depressed Mood" until end of interview in order to give the subject the opportunity to "spontaneously" communicate these feelings. If there is still uncertainty at the end of the interview, then proceed with the prompts.

Question Ratings	Score
What was your mood been like this past week ? Sad? Hopeless? Worthless? Helpless? In the last week, how often did you feel____? Everyday? All day? Have you been crying at all? If scored 1-4, ask: How long have you been feeling this way?	DEPRESSED MOOD: (sadness, hopeless, helpless, worthless) 0-absent 1-indicated only on questioning 2-spontaeouly reported verbally 3-communicated non-verbally, i.e., facial expression, posture, voice, tendency to weep 4-virtually only; this is spontaneous verbal and non-verbal communication

Question Ratings	Score
Have you been especially critical of yourself this past week, feeling you've done things wrong, or let others down? IF YES: What have your thoughts been? Have you been feeling guilty about anything that you've done or not done? Have you thought that you've brought this sickness (or depression) on yourself in some way? Do you feel you're being punished by being sick?	FEELINGS OF GUILT: 0-absent 1-self reproach, feels he has let others down 2-ideas of guilt or rumination over past errors or sinful deeds 3-present illness is a punishment 4-hears accusatory or dununciatory voices and/or experiences threatening being hallucinations

Question Ratings	Score
This past week, have you had any thoughts that life is not worth living, or that you'd be better off dead? What about having thoughts of hurting or even killing yourself? IF YES: What have you thought about? Have you actually done anything to hurt yourself?	SUICIDE: 0-absent 1-feels like life is not worth living 2-wishes he were dead or any thoughts of possible death to self 3-suicidal ideas or gestures 4-attempts at suicide

Question	
Ratings	Score
How have you been sleeping over the last week? Have you had any trouble falling asleep at the beginning of the night? (Right after you go to bed, how long has it been taking you to fall asleep?) How many nights this week have you had trouble falling asleep?	INSOMNIA EARLY: 0-no difficulty falling asleep 1-complains of occasional difficulty falling asleep, i.e., more than ½ hour 2-complains of nightly difficulty falling asleep

Question	
Ratings	Score
During the past week, have you been waking up in the middle of the night? IF YES: Do yo get out of bed? What do you do? (Only go to the bathroom?) When you get back to bed, are you able to fall right back asleep? How many nights do you feel your sleeping has been restless or disturbed this week?	INSOMNIA MIDDLE: 0-no difficulty 1-complains of being restless and disturbed during the night 2-waking during the night- any getting out of bed (except to void)

Question	
Ratings	Score
What time have you been waking up in the morning for the last time, this past week? IF EARLY: Is that with an alarm clock or do you just wake up on your own? What time do you usually wake up (that is, before you got depressed)?	INSOMNIA LATE: 0-no difficulty 1-waking in early hours of morning but goes back to sleep 2-unable to fall asleep again if gets out of bed

Question	
Ratings	Score
How have you been spending your time this past week (when not at work)? Have you felt interested in doing _____, or do you feel you have to push yourself to do them? Have you stopped doing anything you used to do? IF YES: Why? Is there anything you look forward to? AT FOLLOW-UP: Has your interest been back to normal?	WORK AND ACTIVITIES: 0-no difficulty 1-thoughts and feelings of incapacity, fatigue, or weakness related to activities, work or hobbies 2-loss of interest in activities, hobbies, or work- by direct report of the patient or indirect listlessness, indecision, or vacillation (feels he has to push self to work or be active) 3-decrease in actual time spent in activity or productivity (in hospital, pt. spends less than 3 hrs/day in activity- chores, group)

4-stopped working because of present illness

Question

Ratings	Score
Rating based on observation during interview	RETARDATION: (slowness of thought and speech; impaired ability to concentrate; decreased motor activity) 0-normal speech and thought 1-slight retardation at interview 2-obvious retardation at interview 3-interview difficult 4-complete stupor

Question

Ratings	Score
Rating based on observation during interview	AGITATION: 0-none 1-fidgetiness, playing with hands, hair, etc. 2-moving about, can't sit still, 3-handwringing, nail biting, hair-pulling, biting of lips

Question

Ratings	Score
Have you been feeling especially tense or irritable this past week? Have you been worrying a lot about little unimportant things, things that you wouldn't ordinarily worry about? IF YES: Like what, for example?	ANXIETY PSYCHIC: 0-no difficulty 1-subjective tension or irritability 2-worrying about minor matters 3-apprehensive attitude apparent in speech 4-fears expressed without questioning

Question

Ratings	Score
In the past week, have you had any of these physical symptoms? Read list, pausing for response (physiologic concomitants of anxiety). GI-dry mouth, gas, indigestion, diarrhea, cramps, belching, CV-heart palpitations, headaches,	ANXIETY SOMATIC: 0-absent 1-mild 2-moderate 3-severe 4-incapacitating

RESP-hyperventilating, sighing, urinating frequently,
sweating.

How much have these things been bothering you this past week: (How bad have they gotten? How much of the time, or how often have you had them?)
Note: Do not rate if clearly due to medication (example: dry mouth and imipramine)

Question

Ratings	Score
How has your appetite been this past week? (What about compared to your usual appetite?) Have you had to force yourself to eat? Have other people had to encourage you to eat?	SOMATIC SYMPTOMS GASTROINTESTINAL 0-none 1-loss of appetite but eating without encouragement 2-difficulty eating without urging

Question

Ratings	Score
How has your energy level been this past week? Have you been tired all of the time? This week, have you had any back aches, headaches, or muscles aches? This week, have you felt any heaviness in your limbs, back, or head?	SOMATIC SYMPTOMS GENERAL: 0-none 1-heaviness in limbs, back, or head. Backaches, head aches, muscle aches. Loss of energy and fatigability. 2-any clear-cut symptom

Question

Ratings	Score
How has your interest in sex been this week? (I'm not asking about performance but about your interest in sex- how much you think about it). Has there been any change in your interest in sex (from when you were not depressed)? Is it something you've thought about much? IF NOT: Is that unusual for you?	0-absent 1-mild 2-severe

Question

Ratings	Score
In the last week, how much have your thoughts been focused on your physical health or how your body is working (compared to your normal thinking)? Do you complain much about how you feel physically? Have you found yourself asking for help to do things you could really do yourself? IF YES: Like what, for example? How often?	HYPOCHONDRIASIS: 0-not present 1-self-absorption (bodily) 2-preocupation with health 3-frequent complaints, requests for help, etc. 4-hypochondriacal delusions

Question

Ratings	Score
Have you lost any weight since this (depression) began? IF YES: How much? IF NOT SURE: Do you think your clothes are fitting looser on you? AT FOLLOW UP: Have you gained any of the weight back?	LOSS OF WEIGHT: 0-no weight loss 1-probable weight loss associated with present illness 2-definite (according to patient) weight loss

Question

Ratings	Score
Rating based on observation during interview	INSIGHT: 0-acknowledges being depressed and ill, OR not currently depressed 1-acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, ect. 2-denies being ill at all

Question

Ratings	Score
This past week, have you been feeling better or worse at any particular time of day- morning or evening?	DIURNAL VARIATION: A. Note whether symptoms are worse in morning or evening. If no diurnal variation, mark none: 0-no variation or not currently depressed. 1-worse in the AM

2-worse in the PM

IF VARIATION: How much worse do you feel in the (morning or evening)? IF UNSURE: A little bit worse or a lot worse?	B. When present, mark the severity of the variation: 0-none 1-mild 2-severe

Question	Ratings	Score
In the past week, have you ever suddenly had the feeling that everything was unreal, or you were in a dream, or cut off from other people in some strange way? Any spacey feelings? IF YES: How bad has that been? How often this week has that happened?	DEPERSONALIZATION AND DEREALIZATION (such as feelings of unreality and nihilistic ideas): 0-absent 1-mild 2-moderate 3-severe 4-incapacitating	

Question	Ratings	Score
This past week, have you felt that anyone was trying to give you a hard time or hurt you? IF NOT: What about talking about you behind your back? IF YES: Tell me about that.	PARANOID SYMPTOMS: 0-none 1-suspicious 2-ideas of reference 3-delusions of reference and persecution	

Question	Ratings	Score
In the past week, have there been things you've had to do over and over again, like checking the locks on the door several times? IF YES: Can you give me an example? Have you had thoughts that don't make sense to you, but that keep running over and over in your mind? IF YES: Can you give me an example?	OBSESSIONAL AND COMPULSIVE SYMPTOMS: 0-absent 1-mild 2-severe	

Total 21-Item Score:_____

State-Trait Anxiety Inventory
SAMPLE

Beck Depression Inventory-II
SAMPLE

APPENDIX B

Institutional Review Board Protocol and Approval

IRB Research Protocol
Virginia Polytechnic Institute and State University
Emotion Focused Couples Therapy as a Treatment of Somatoform Disorders: An Outcome Study

Stephanie R. Walsh, Ph.D. Candidate and Bud Protinsky, Ph.D.

I. Purpose

The purpose of this study is to test Emotion Focused Couples Therapy as a treatment of somatic symptoms in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder. This study will also examine whether or not relationship satisfaction, quality of life variables, and comorbid symptoms of anxiety and depression will improve in patients with Somatoform Disorders who receive this type of couples psychotherapy.

Recent attention has been given to Somatoform Disorders after being labeled a "crisis" in health care (Barsky & Borus, 1995; p. 1931). Somatization has been described as "a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them." (Lipowski, 1988, p.1359). Somatizaton has become a problem in Western culture as many people with unexplained medical symptoms seek help for conditions that cannot be seen or detected by conventional medicine, driving up health care costs through the prescribing of unnecessary medicines, surgeries, lab tests, and procedures (Lipowski, 1988).

Conservative estimates suggest that 10-15% of primary care patients experience Somatoform Disorders (Spitzer, Williams, Kroenke, 1994; Kellner, 1985) while one study reported a 25% prevalence rate of Somatoform Disorders in primary care settings (Kirmayer & Robbins, 1991). Many patients, estimates ranging from 30-60%, experience somatic symptoms but seldom find medical relief from them because they can't be medically explained (Stuart & Noyes, 1999).

When medical pathology can't be detected, somatic patients are often referred for behavioral health treatment. Psychological treatment including cognitive-behavioral individual and group therapy have been used to treat individuals with unexplained medical symptoms ranging from facial pain to irritable bowel syndrome. These therapies, compared to symptom monitoring alone, have received support for their effectiveness in reducing symptoms of pain, depression and anxiety that are commonly associated with Somatoform Disorders (Harrison, Watson, & Feinmann, 1997; van Dulmen, Fennis, & Bleijenberg, 1996; Blanchard & Malamood, 1996). At present, no marital or couples psychotherapy has been studied in the context of treating Somatoform Disorders. Therefore, the purpose of this study is to see whether or not Emotion Focused Couples Therapy is an effective treatment in the reduction of somatic symptoms.

The couples who participate in this study will be randomized into a treatment group and a 12 week wait list control group. The primary hypothesis in this study is:

1. Somatic symptoms will improve in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder after the 12 week EFCT treatment compared to couples on a 12 week wait list.
2. Participants will have greater relationship satisfaction after the 12 week EFCT treatment than participants on a 12 week wait list.

Following are the secondary hypotheses in this study:

1. Individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder will have improvement in quality of life after the 12 week EFCT treatment compared to couples on a 12 week wait list.
2. Comorbid anxiety symptoms in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder will decrease after the 12 week EFCT treatment compared to couples on a 12 week wait list.
3. Comorbid depressive symptoms in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder will decrease after the 12 week EFCT treatment compared to couples on a 12 week wait list.

Inclusion/Exclusion Criteria

Forty couples where one partner meets the DSM-IV criteria for Somatoform Disorder or Undifferentiated Somatoform Disorder will be recruited to participate in this study (APA, 1994). To participate in the study couples must be living together. Same-sex couples and people of all ethnic groups are welcome to participate in this study. There are relationship problems for which EFCT is not the indicated treatment and these will be reasons to exclude couples from this study. Couples will be ineligible for participation if there is physical violence, severe verbal abuse, or active substance abuse problems. Couples will be excluded from the study if one or both of them is having suicidal ideation with a plan and intent to carry it out.

II. Procedures

The duration of treatment will include eight total sessions of EFCT. There will be four weekly sessions of EFCT followed by two bimonthly sessions for a total treatment time of 12 weeks. If the couple or therapist must miss a weekly session, the session can be delayed but the total number of sessions will remain at eight. The treatment cycles will begin in February of 2001and continue through December of 2001. Volunteer therapists in the SHARE Clinic (Synthesizing Health And Relationship Enhancement) in the Department of Psychiatry and Behavioral Medicine at Wake Forest Medical School will provide the therapy and include two master's level MFT interns, one doctoral intern, and three psychiatric residents.

At the screening session, there will be a conjoint interview to confirm that medically unexplained symptoms exist in one of the partners and that both parties are committed to couples therapy and exclusionary conditions are not present. In addition, suicide risk will be assessed. If either member of the couple has active suicidal ideation with a plan and/or intent, they will be excluded from the study and referred for other appropriate treatment. They will be provided complete information about the study and alternative treatments will be discussed. Written informed consent will then be obtained if they remain interested. At this time, the participants will be informed of their treatment group designation as randomly assigned (treatment group or 12 week wait-list control group).

Each person will then separately be interviewed to determine diagnoses of Somatoform Disorder or Undifferentiated Somatoform Disorder according to the criteria offered in the *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)* (APA, 1994). If both partners meet the criteria for Somatoform Disorder or Undifferentiated Somatoform Disorder, one partner will be randomly selected to be the index patient. While one person is having the interview, the other will complete the SHARE assessment package (Appendix A) that will consist of:

1) Demographic information
2) Relationship status information
3) Dyadic Adjustment Scale (Spanier, 1976)
4) State-Trait Anxiety Inventory (STAI; Spielberger, 1966)
5) MOS Short Form Health Survey (SF-36; Ware & Sherbourne, 1992)
6) Screening for Somatoform Disorders (SOMS; Reif, Hiller, & Fichter, 1995)
7) Beck Depression Inventory II (BDI-II, Beck, Steer, & Brown, 1996)
8) Hamilton Depression Rating Scale (HDRS; Williams, 1988)

A structured interview guide will be used to administer the Hamilton Depression Rating Scale (HDRS; Williams, 1988). Once the interview and assessment package are completed, the first of eight EFCT psychotherapy sessions will be scheduled.

The EFCT sessions will be 50 minutes in length. To provide less variability, the treatment will be designed for 4 weekly sessions followed by 4 bimonthly sessions. EFCT has nine steps which include (Johnson, 1996):

1) Delineate the conflict issues between the partners
2) Identify the negative interaction cycle
3) Access unacknowledged feelings underlying interactional positions
4) Reframe the problem(s) in terms of underlying feelings

5) Promote identification with disowned needs and aspects of self
6) Promote acceptance by each partner of the other partner's experience,
7) Facilitate the expression of needs and wants to restructure the interaction based on the new understandings,
8) Establish the emergence of new solutions
9) Consolidate new positions in the couple relationship

After the eighth session of EFCT, the couple will be scheduled for their post-treatment follow up and will be conducted one week after the treatment. At follow-up each subject will complete the assessment package individually.

III. Benefits and Risks

Possible benefits from participating in this study include that subjects may experience fewer somatic symptoms and have greater relationship satisfaction. Other benefits subjects may experience include having fewer symptoms of anxiety or depression. A possible risk is that participants may experience discomfort during the EFCT sessions or after as they think about challenging or difficult life events.

IV. Anonymity

All information will remain confidential and no identifying information will be included in any presentations or publications resulting from this research to protect confidentiality and anonymity. All study materials will be maintained in a locked filing cabinet in the principal investigator's research office.

V. Compensation

The participants will not receive any monetary compensation for their participation in this study. However, participants will receive free couples psychotherapy and may experience fewer troublesome health symptoms and greater relationship enhancement as a result of their participation.

VI. Freedom to Withdraw

Participation in this study is completely voluntary. The participants are free to withdraw at any time without adversely affecting their relationships with the researchers, Virginia Tech, or Wake Forest University School of Medicine.

VII. Approval of Research

This research protocol is in the process of being approved by the Virginia Tech Institutional Review Board for Research Involving Human Subjects, the Wake Forest University School of Medicine Institutional Review Board, and the final approval of the Dissertation Chair who is overseeing this study.

VIII. Biographical Sketch of Investigators

A. **Principal Investigator:**

Stephanie R. Walsh, Ph.D. Candidate
Marriage and Family Therapy Program
Dept. of Human Development
College of Human Resources and Education

Virginia Polytechnic Institute and State University

I am currently in the process of completing a Medical Family Therapy Residency/Internship at Wake Forest University School of Medicine in Winston-Salem, North Carolina. I have completed all of the required coursework at Virginia Tech and have passed the Preliminary Examination prior to residency. My past research experience includes conducting three qualitative studies, one of which was my master's thesis. At present, I am a project manager for a research study on cardiac illness at Wake Forest University School of Medicine and am a team data collector for a supervision study, both of which employ quantitative methods.

B. **Secondary Investigator:**
Dr. Bud Protinsky, Dissertation Chair
Director, Marriage and Family Therapy Program
Dept. of Human Development
College of Human Resources and Education

Dr. Protinsky is currently serving as the Dissertation Chair for this research and will be following each step of the proposed study. His research background is diverse as he has chaired several dissertation studies and has conducted research using both quantitative and qualitative methodologies. Dr. Protinsky is a clinical member and approved supervisor of the American Association for Marriage and Family Therapy. He received is Ph.D. in Marriage and Family Therapy from Florida State University and completed his post-doctoral work at Georgetown University Medical Center, Philadelphia Child Guidance Clinic, the Family Therapy Institute of Washington D.C., and the Long Island Society for Clinical Hypnosis. Dr. Protinsky is a Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, and Licensed Professional Counselor.

Emotion Focused Couples Therapy as a Treatment of Somatoform Disorders: An Outcome Study

Wake Forest University School of Medicine
IRB Protocol Form

February 16, 2001

I. Description of the background, purpose, hypothesis, and significance of this research, benefit to the patient, improvement of medical knowledge, etc.

The purpose of this study is to test Emotion Focused Couples Therapy as a treatment of somatic symptoms in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder. This study will also examine whether or not relationship satisfaction, quality of life variables, and comorbid symptoms of anxiety and depression will improve in patients with Somatoform Disorders who receive this type of couples psychotherapy.

Recent attention has been given to Somatoform Disorders after being labeled a "crisis" in health care (Barsky & Borus, 1995; p. 1931). Somatization has been described as "a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them." (Lipowski, 1988, p.1359). Somatizaton has become a problem in Western culture as many people with unexplained medical symptoms seek help for conditions that cannot be seen or detected by conventional medicine, driving up health care costs through the prescribing of unnecessary medicines, surgeries, lab tests, and procedures (Lipowski, 1988).

Conservative estimates suggest that 10-15% of primary care patients experience Somatoform Disorders (Spitzer, Williams, Kroenke, 1994; Kellner, 1985) while one study reported a 25% prevalence rate of Somatoform Disorders in primary care settings (Kirmayer & Robbins, 1991). Many patients, estimates ranging from 30-60%, experience somatic symptoms but seldom find medical relief from them because they can't be medically explained (Stuart & Noyes, 1999). When medical pathology can't be detected, somatic patients are often referred for behavioral

health treatment. Psychological treatment including cognitive-behavioral individual and group therapy have been used to treat individuals with unexplained medical symptoms ranging from facial pain to irritable bowel syndrome. These therapies, compared to symptom monitoring alone, have received support for their effectiveness in reducing symptoms of pain, depression and anxiety that are commonly associated with Somatoform Disorders (Harrison, Watson, & Feinmann, 1997; van Dulmen, Fennis, & Bleijenberg, 1996; Blanchard & Malamood, 1996). At present, no marital or couples psychotherapy has been studied in the context of treating Somatoform Disorders. Therefore, the purpose of this study is to see whether or not Emotion Focused Couples Therapy is an effective treatment in the reduction of somatic symptoms.

According to a leading couples therapy researcher, the central nervous system becomes overwhelmed in times of relational distress (Gottman, 1994). Physiologic differences among individuals exist in levels of tolerance of emotional reactivity and nervous system arousal. It may be that couples do not have the ability, due to the over arousal of the nervous system, to express emotional concerns within the relationship. Further, individuals may have difficulty sharing their emotions with their partner or may not have the skills to address relationship issues directly, which may lead to the development of somatic symptoms as a means to gain emotional connection and empathy. Because EFCT has demonstrated its effectiveness in changing rigid interactional patterns in couples (Johsnon & Talitman, 1997; Johnson & Greenberg, 1995; Johnson & Greenberg, 1985a; 1985b), EFCT will be used in this study to change couple interaction patterns around somatic symptoms.

The couples who participate in this study will be randomized into a treatment group and a 12 week wait list control group. The primary hypothesis in this study is:

3. Somatic symptoms will improve in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder after the 12 week EFCT treatment compared to couples on a 12 week wait list.
4. Participants will have greater relationship satisfaction after the 12 week EFCT treatment than participants on a 12 week wait list.

Following are the secondary hypotheses in this study:

4. Individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder will have improvement in quality of life after the 12 week EFCT treatment compared to couples on a 12 week wait list.
5. Comorbid anxiety symptoms in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder will decrease after the 12 week EFCT treatment compared to couples on a 12 week wait list.
6. Comorbid depressive symptoms in individuals with Somatoform Disorder or Undifferentiated Somatoform Disorder will decrease after the 12 week EFCT treatment compared to couples on a 12 week wait list.

Possible benefits from participating in the EFCT treatment include that subjects may experience fewer somatic symptoms and have greater relationship satisfaction. Other benefits subjects may experience include having fewer symptoms of anxiety or depression.

II. Inclusion and exclusion criteria for subjects.

Forty couples where one partner meets the DSM-IV criteria for Somatoform Disorder or Undifferentiated Somatoform Disorder will be recruited to participate in this study (APA, 1994). To participate in the study couples must be living together. Same-sex couples and people of all ethnic groups are welcome to participate in this study. There are relationship problems for which EFCT is not the indicated treatment and these will be reasons to exclude couples from this study. Couples will be ineligible for participation if there is physical violence, severe verbal abuse, or active substance abuse problems. Couples will be excluded from the study if one or both of them is having suicidal ideation with a plan and intent to carry it out. Patients with suicidal ideation will be asked about the severity and type of thoughts they may be having in addition to the plans (if any) they have considered. If a plan has been considered, they will be asked "What has prevented you from following through with that plan?"

All participants will receive information about safety precautions and procedures to follow in the event that a subject becomes imminently suicidal. In particular, all participants and their partners will be advised to remove or secure potential means of attempting suicide, particularly firearms, from their homes at the inception of the study. In addition, each participant will receive a laminated wallet size card listing the emergency phone numbers for the study therapists, the principal investigator and staff, and the WFUBMC general telephone number to reach the psychiatrist-on-call. Participants and their families will be able to reach study staff or the psychiatrist-on-call on a 24-hour basis. All contacts outside of regularly scheduled sessions will be documented in writing by study staff or the psychiatrist-on-call.

In the event a participant becomes imminently suicidal, crisis intervention precautions and procedures will be used as described by Marsha Linehan, Ph.D. (Linehan, unpublished manuscript, University of Washington, 1996). If a participant is imminently suicidal and refuses to sign a written safety contract agreeing to no self-harm with the therapist, the participant will be removed from the study protocol and will be referred and admitted for inpatient hospitalization. My supervisor, Dr. Wayne Denton has admitting privileges to the inpatient psychiatric unit that will be used if needed.

Participants will be recruited for this study from a variety of sources. a) There are existing referral streams into the Department of Psychiatry and Behavioral Medicine that go through the Referral & Intake Coordinators. The coordinators will be informed as to the existence and purposes of this study. If people call to inquire about services and identify that they are seeking treatment for relationship discord and unexplained medical symptoms, the Referral & Intake Coordinators will have the option of presenting the study to them. b) Potential clinical referral sources within the medical center and in the community will also be informed about this study and potential participants can be directly referred to the study. Potential clinical in-house referrals include primary care clinics such as Family Medicine, Internal Medicine, Employee Assistance Program, the Women's Health Center of Excellence, the Outpatient Psychiatry Department Clinic, the Marital and Family Therapy Clinic, and departmental faculty. Potential community referrals may include area members of the North Carolina Association for Marriage

and Family Therapy who will receive letters informing them of this study and external primary care clinics who have referred patients to the Marriage and Family Therapy Clinic.

Participant recruitment will be over 12 months.

III. Detailed description of procedures to be carried out on subjects.

The duration of treatment will include eight total sessions of EFCT. There will be four weekly sessions of EFCT followed by two bimonthly sessions for a total treatment time of 12 weeks. If the couple or therapist must miss a weekly session, the session can be delayed but the total number of sessions will remain at eight. The treatment cycles will begin in February of 2001and continue through December of 2001. Volunteer therapists in the Marriage & Family Therapy Clinic at Wake Forest Medical School will provide the therapy and include two master's level MFT interns, one doctoral intern, and three psychiatric residents.

At the screening session, there will be a conjoint interview to confirm that medically unexplained symptoms exist in one of the partners and that both parties are committed to couples therapy and exclusionary conditions are not present. In addition, suicide risk will be assessed. If either member of the couple has active suicidal ideation with a plan and/or intent, they will be excluded from the study and referred for other appropriate treatment. They will be provided complete information about the study and alternative treatments will be discussed. Written informed consent will then be obtained if they remain interested. At this time, the participants will be informed of their treatment group designation as randomly assigned (treatment group or 12 week wait-list control group).

Each person will then separately be interviewed to determine diagnoses of Somatoform Disorder or Undifferentiated Somatoform Disorder according to the criteria offered in the *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)* (APA, 1994). If both partners meet the criteria for Somatoform Disorder or Undifferentiated Somatoform Disorder, one partner will be randomly selected to be the index patient. While one person is having the interview, the other will complete the SHARE assessment package (Appendix A) that will consist of:

9) Demographic information
10) Relationship status information
11) State-Trait Anxiety Inventory (STAI; Spielberger, 1966)
12) Relationship Discussion Questionnaire (RDQ; Denton & Burleson, 1999)
13) MOS Short Form Health Survey (SF-36; Ware & Sherbourne, 1992)
14) Screening for Somatoform Disorders (SOMS; Reif, Hiller, & Fichter, 1995)
15) Hamilton Depression Rating Scale (HDRS; Williams, 1988)
16) Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996)
17) Dyadic Adjustment Scale (DAS; Spanier, 1976)

A structured interview guide will be used to administer the Hamilton Depression Rating Scale (HDRS; Williams, 1988). Once the interview and assessment packages are completed, the first of eight EFCT psychotherapy sessions will be scheduled.

The EFCT sessions will be 50 minutes in length. To provide less variability, the treatment will be designed for 4 weekly sessions followed by 4 bimonthly sessions. EFCT has nine steps which include (Johnson, 1996):

10) Delineate the conflict issues between the partners
11) Identify the negative interaction cycle
12) Access unacknowledged feelings underlying interactional positions
13) Reframe the problem(s) in terms of underlying feelings
14) Promote identification with disowned needs and aspects of self
15) Promote acceptance by each partner of the other partner's experience,
16) Facilitate the expression of needs and wants to restructure the interaction based on the new understandings,
17) Establish the emergence of new solutions
18) Consolidate new positions in the couple relationship

After the eighth session of EFCT, the couple will be scheduled for their post-treatment follow up and will be conducted one week after the treatment. At follow-up each subject will complete the assessment package individually.

Couples who are randomly assigned to the 12 week wait list group will complete the prescreening treatment session and will then be given an appointment for the post-wait-list assessment session to be held 12 weeks after the baseline testing. At this time, the couples will complete the same instruments that were given at the prescreening session. Following this, they will receive 8 sessions of EFCT and will then complete the third and final testing session.

All information will remain confidential and no identifying information will be included in any presentations or publications resulting from this research. All study materials will be maintained in a locked filing cabinet in the principal investigator's research lab.

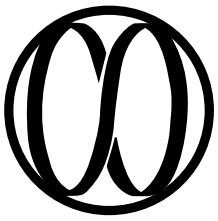
IV. Describe the scope of the study and how the sample size was determined.

Statistical analyses will estimate mean changes in the number of somatic symptoms, relationship satisfaction, quality of life, symptoms of depression, anxiety symptoms, and relationship roles from the pretreatment and posttreatment scores from the treatment group and wait-list control group. Post-test scores on the SOMS, QMI, SF-36, STAI, HDRS, and RDQ will be compared with pre-treatment scores to assess for statistically significant change. Statistical significance of differences between the treatment group and the wait-list control group will be determined by t-tests. Analyses of covariance (ANCOVA) will be used to assess for statistical significance of difference between pretreatment and posttreatment scores for all subjects.

At present, no standard deviation has been established for the EFCT intervention. The sample size for this study was determined from a previous randomized control trial that used EFCT as an intervention for distressed married couples and included a sample size of 40 couples (Denton, Burleson, Clark, Rodriguez, & Hobbs, 2000).

Data entry, management, and analyses will be conducted using the SPSS statistical software package.

SHARE Study Advertisement



Wake Forest University Baptist

MEDICAL CENTER

COUPLES NEEDED For SHARE Study
(Synthesizing Health & Relationship Enhancement)

The purpose of this research study is to test couple's therapy as a treatment of chronic medical conditions of one spouse or partner. Free psychotherapy study treatment of unexplainable chronic medical conditions such as headache, chronic fatigue, fibromyalgia, irritable bowel syndrome and pelvic pain will be offered to those who qualify. Study related psychotherapy treatment is provided in the Department of Psychiatry at Wake Forest University School of Medicine. For more information, contact Stephanie Walsh at (336) 716-4281.

APPENDIX C

PARTICIPANT INFORMED CONSENT (Virginia Tech)

Couples Therapy for the Treatment of Health Problems and Relationship Enhancement: The SHARE Study

Purpose

You have been invited to participate in the SHARE study that stands for "Synthesizing Health And Relationship Enhancement". This is a research study on the treatment of health problems and relationship enhancement with couples therapy. The purpose of this study is to determine if couples therapy is helpful for improving relationship and physical health problems. It has been found previously that couples therapy is generally helpful for relationship problems but whether it is also helpful for health problems is not known.

Procedure

The therapy you will be receiving is commonly used to help couples with their relationship problems. A Marriage and Family Therapy Intern or a Resident in Psychiatry will be your therapist and the couples' therapy sessions will be 50 minutes in length. Your participation in this study will include participating in the SHARE clinic for 12 weeks, and participating in a pre-treatment interview and an interview after the treatment has been completed. Your participation in this research is voluntary and you are free to not participate if you so wish. Your choosing not to participate will not effect your treatment at the Wake Forest University School of Medicine or any affiliation you may have with Virginia Tech. Further, you will not be charged any clinical fees for this therapy.

The only difference from usual treatment is that you will be asked to complete some questionnaires before and after the couple's therapy. This will require your being present for approximately 90 minutes before you begin the couples therapy treatment and 90 minutes after the entire treatment has been completed. You will not be compensated financially for this time. As stated above, you will not be charged for this service. The questionnaires will ask you about: a) background information (e.g., how long you have been married, if you have been married

before, etc.) b) feelings of depression, anxiety, and other symptoms that can go along with them, c) the level of happiness with your relationship, d) your communication with your partner, and e) your physical health. When therapy ends I will contact you by telephone to schedule the final interview session.

Possible Benefits and Risks

The potential benefits to you from participating in this study are that you might feel more satisfied with your relationship and may have less physical health symptoms after completing the therapy. A potential risk to your participating would include that you may experience discomfort during or after the therapy sessions as you think about challenging or difficult life events.

Anonymity

Your participation in this study is confidential. A clinical record will be kept in the routine manner and will be confidential except as provided by law or with your written request to release records. The research questionnaires will be kept separately in a research file. This file will also remain confidential and will be kept locked in a filing cabinet in a locked room. Your responses to the questionnaires will not be shared with anyone else in your family. Any results of this study which are made public or are published will not include any information that would allow you to be identified to protect your anonymity.

In choosing to sign this form, it means that you have agreed to participate in this study and have read all of the information included in this form. It also means that you have asked questions and addressed concerns you may have about this study with the principal investigator. Your participation is voluntary and you are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigators, Virginia Tech, or Wake Forest School of Medicine. You will be given a copy of this agreement to keep.

Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and by the Department of Human Development and Wake Forest University School of Medicine.

"I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent."

_____ Date: _____
Participant Signature

_____ Date: _____
Participant Signature

_____ Date: _____
Witness

Should I have any questions about this research or its conduct, I may contact:

Investigator: Stephanie Walsh, MS, LMFTA
(336) 716-0135

	Swalsh@wfubmc.edu
Faculty Advisor:	Bud Protinsky, Ph.D. (540) 231-6782 Hprotins@vt.edu
Departmental Reviewer:	Joyce Arditti, Ph.D. (540) 231-5758 Arditti@vt.edu
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Participant Informed Consent (WFU)

Couples Therapy for the Treatment of Health Problems and Relationship Enhancement: The SHARE Study

Purpose

You have been invited to participate in the SHARE study that stands for "Synthesizing Health And Relationship Enhancement". This is a research study on the treatment of health problems and relationship enhancement with couples therapy. The purpose of this study is to determine if couples therapy is helpful for improving relationship and physical health problems. It has been found previously that couples therapy is generally helpful for relationship problems but whether it is also helpful for health problems is not known. Your total involvement in the study will be 4-8 months depending upon which treatment group you will be randomized to.

Procedure

The therapy you will be receiving is commonly used to help couples with their relationship problems. A Marriage and Family Therapy Intern or a Resident in Psychiatry will be your therapist and the couples therapy sessions will be 50 minutes in length. Your participation in this study will include participating in the SHARE clinic for 12 weeks, and participating in a pre-treatment interview and an interview after the treatment has been completed. Your participation in this research is voluntary and you are free to not participate if you so wish. Your choosing not to participate will not effect your treatment at the medical center. Further, you will not be charged any clinical fees for this therapy and you will be given information on what to do in the event of a clinical emergency.

A clinical record will be kept in the routine manner, as for all patients in our department, and this record will be confidential except as provided by law or with your written request to release records. The research questionnaires will be kept separately in a research file. This file will also remain confidential and will be kept locked in a filing cabinet in a locked room. Your responses to the questionnaires will not be shared with anyone else in your family. Any results of this study which are made public or are published will not include any information that would allow you to be identified.

A difference from usual treatment is that you will be asked to complete some questionnaires before and after the couple's therapy. This will require your being present for approximately 90 minutes before you begin the couples therapy treatment and 90 minutes after the entire treatment has been completed. You will not be compensated financially for this time. As stated above, you will not be charged for this service.

Another difference from usual treatment is that there will be two treatment groups. One group will begin treatment right away while the other group will wait 12 weeks before starting treatment. You will be randomly assigned (like the flip of a coin) to one of the two groups when you enter the study.

The questionnaires will ask you about: a) background information (e.g., how long you have been married, if you have been married before, etc.) b) feelings of depression, anxiety, and other symptoms that can go along with them, c) the level of happiness with your relationship, d) your communication with your partner, and e) your physical health. When therapy ends I will contact you by telephone to schedule the final interview session.

Possible Benefits and Risks

The potential benefits to you from participating in this study are that you might feel more satisfied with your relationship and may have less physical health symptoms after completing the therapy. Some people, however, do not find the therapy to be helpful. A potential risk to your participating would include that some people find they feel more upset after therapy sessions.

You may ask any questions you have before deciding whether to participate in this study. Your participation is entirely voluntary and you are free to withdraw from the study it at any time you should wish without penalty. If you do withdraw, you still be welcome to be treated in our department and at this medical center. If you decide not to participate in this study, I will provide you a referral to another clinician who will be able to provide treatment for you.

If you have future questions regarding this research, you may contact:

Wayne H. Denton, M.D., Ph.D. or
Stephanie R. Walsh, M.S.
Department of Psychiatry & Behavioral Medicine
(336) 716-0135

If you have concerns regarding your clinical care that you would prefer not to discuss with us, you may contact:

Patient Relations
Wake Forest University Baptist Medical Center
(336) 713-2273

If you have questions regarding your rights as a research participant, you may contact:

Chair, Institutional Review Board,
Office of Research
Wake Forest University School of Medicine
(336) 716-4542

"I have read both sides of this consent form and voluntarily agree to participate in the research project called 'Couples Therapy in the Treatment of Relationship and Physical Health Problems'. I understand that I may withdraw from this study at any time that I wish."

_____	_____
Signature of Subject	Date
_____	_____
Signature of Subject	Date
_____	_____
Signature of Person Administering Consent	Date

APPENDIX D

SHARE Study Treatment Manual

SHARE Principal Investigator: Stephanie Walsh, MS
Treatment Manual: Wayne H. Denton, MD, PhD

Marital & Family Therapy Program
Department of Psychiatry & Behavioral Medicine
Wake Forest University School of Medicine
Medical Center Boulevard
Winston-Salem, NC 27157

SHARE Treatment Manual

This manual on the research and clinical experience of the team and, especially, the following texts:

Greenberg, L.S. & Johnson, S.M. (1988). Emotionally focused therapy for couples. New York: Guilford.

Johnson, S.M. (1996). The practice of emotionally focused marital therapy: Creating connection. New York: Brunner/Mazel.

I. Introduction

Steps of EFT:
1. Delineate the conflict issues between the partners
2. Identify the negative interaction cycle
3. Access unacknowledged feelings underlying interactional positions
4. Reframe the problem(s) in terms of underlying feelings
5. Promote identification with disowned needs and aspects of self
6. Promote acceptance by each partner of the other partner's experience
7. Facilitate the expression of needs and wants to restructure the interaction based on the new understandings
8. Establish the emergence of new solutions (cycles)
9. Consolidate new positions

(Greenberg & Johnson, 1988; Johnson, 1996).

II. Protocol for the Emotion Focused Couples Therapy Intervention

A. General comments on use

B. Initial Session: EFT Assessment

The clinical EFT assessment can usually be accomplished in one session. In some cases, it may need to be completed in session 2.

1) Joining/Introductions
2) What brings you here?
    - Allow the couple to decide who will speak first
    - Allow speakers to speak with minimum interruption but don't allow to go on too long before hearing from other partner
    - It is important at this stage that both partners have complaints as this is where their investment in therapy will be
    - Listen especially for:
        - Relational problems (defn: a problem that cannot be conceptualized without two people – such as arguing, or poor communication)
        - How their complaints may be connected (e.g., one partner complains that the other won't talk while the second partner complains that the other nags)
        - Complaints involving the depression
    - Continue to ask if they have any other complaints until they say that they have mentioned them all.
    - You need to find a problem that both clients and you can agree on as problems to work on. Sometimes this is easy - for example, if both present that the problem is "arguments". At other times their complaints may be different (e.g., "she is too critical", "he is too

nonresponsive"). In this latter case, the complaints are often complimentary and so can be "weaved together". For example, "when these situations come up you feel that she is too critical and you feel that he is too nonresponsive".

- There may be situations where you just can't find any common ground on what problem you will be working on. For example, if he says his goal is to work out the marriage and she says here goal is to separate. Hopefully, the screening process will have removed these types of situations but it is possible that they will not have.
- All three (including yourself) must agree on the problem. There may be times where the couple agrees on the problem but you can't accept it. For example, partner A might say that the problem is partner B's temper and partner B might agree that the problem is their temper. You, on the other hand, may clearly see that partner A plays a significant role that neither partner is accepting and that will have to be addressed for treatment to be successful. In this case, continue to listen carefully for any subtle complaints that partner B might make against partner A and you might be able to expand the definition of what the problem is. If you remain stuck at this point, you can continue with the remainder of the steps but

- Before you move on, summarize the complaints that you have heard and make sure both parties give some type of agreement that you have accurately heard what their complaints are.

3) Begin to track the cycle of behavior surrounding the complaint and depressed behavior
   - You want considerable detail about exactly what the cycle of behavior surrounding the problem is like. You may need to ask, for example, "say everything is alright and, then, as you look back, what might be the first thing that happens that would be the start?" Usually, it will be someone saying something, a look, etc. You then want to find out in detail what each person's response is. You can ask people directly or ask one of them what the other's response is. "When you might say that, what would his usual response be?".
   - You want to check back and forth to make sure that both of them are agreeing with the other's recounting of the events. "Does that sound familiar?" (after the partner has talked about what might be said). In nearly every case, the disagreements one person might have with the other's comments will be minor. You want to restate it so that both of them will agree. Check out frequently, "Does that sound familiar," "Is that right,", "Would you agree."
   - There may be exceptions to the cycle, but there will always be a usual way that it proceeds and this is what you are interested in. "So, sometimes he says ……., but usually what he does is ……, is that right?"

- Minor variations can be incorporated into the later reframe (e.g., "sometimes this happens and sometimes this happens").
   - You may or may not begin to hear about underlying emotions at this point in the therapy – do not need to press too much for this at this point as the clients may not feel safe enough yet to reveal much of their internal emotional experience.
   - The cycle will usually be an initiate-avoid pattern. The other pattern that might be obtained is an overresponsible-underresponsible pattern.

4) Obtain relationship history

- How did you meet?
- What attracted you to each other?
- You are especially interested in personal (non-physical) attributes
- Track relationship history up through marriage/point of commitment
- When did the problems begin?
- Does this correspond with any developmental changes? (e.g., birth of a child, death in the family, loss of job, etc.)

5) Ask about goals for therapy
   - Ask: "What are you hoping will be different when you are finished coming here?"
   - Be sure to hear from both partners.
   - The goals will generally be the inverse of the complaints (for example, if the complaint was "arguments", then the goals may be "to get along")
6) Assess commitment

- Say: "Couples come to this clinic for different reasons. Some couples come because they want to try and work on their relationship, others come because they want to get out of their relationship and want help in doing so, and some come not sure if they want to work on their relationship or get out of it. I am wondering which of these positions might best describe where you are at?"
    - Note: It is important to ask if they want to *work on* the relationship and not ask if they want to *stay in* the relationship. They may imagine *staying in* the relationship as it is and, since it is distressed, this may not be a desirable option. The thought of *working on* the relationship may seem less threatening and a prospect that is easier for them to agree on.
- If both say they want to work on it, then you can move on.
- It is unlikely after the screenings that either will say they want out of the relationship. You may find some people who will say that they are not sure if they want to work on it or not. Since they have had the motivation to go through the screening process, it is likely that this is a statement of safety. To say that one wants to work on the relationship is a first step of vulnerability that one or both partners may be reluctant to make. It is important that both partners "ante up" at this step and state that they are desirous of working on the relationship. Therefore, if one or both of them says that they are uncertain about working on the relationship then you will need to apply gentle pressure with questions such as the following:
    - "Can you tell (the partner) some of the pros and cons you are considering in deciding whether to end this relationship?"
    - "Can you tell (the partner) some of the pros and cons you are considering in deciding whether to work on the relationship?"
    - Ask the other person how they are feeling to hear that their partner say that they are not sure if they want to work on the relationship or not.

With these questions, the reluctant partner will usually say that they *do* wish to work on the relationship and you can move on.

You should carry out this step even if you feel positive that the couple does want to work on their relationship. Part of the reason is that this step is an *intervention* as well as an assessment.

Verbally acknowledging that one wants to work on the relationship is sometimes the first step in increasing vulnerability. Hearing that the partner is committed to work on the relationship can begin to slightly increase optimism in the other partner.

- If you feel uncomfortable asking about commitment when it seems obvious this is what the couple wants, you can preface your questions with the comment, "I think I know the answer to this but let me ask anyway…"

In the unlikely event that you come across a couple where one or both partners just is unwilling to commit to working on the relationship, go ahead and complete the remaining tasks of this session and ask *both* of them to think about whether they wish to work on the relationship or not. Usually this will lead any remaining reluctant persons to go ahead and commit to therapy. You can then take the videotape of this session to supervision before supervision.

7) Present the reframe

- This is a new description of the problem using the circular cycle of interaction obtained in task 3 described above including any underlying emotions that may have been elicited as well.
- The cycle should include both partners complaints in a connected manner.
- You should present the cycle in their own words as much as possible and as their perceptions.
- In delivering the reframe, you should pay attention to volume of your speaking, rate of speech, use of hand gestures, etc. in order to increase the impact of the delivery.
- It is important that the reframe be presented in such a way as to have impact, that it will get the couple's attention.
- The delivery of the reframe should usually be set up with a comment such as, "OK, I have been asking you a lot of questions and, now, I would like to give you some feedback as to what seems to have been happening between the two of you. Listen to this and see if I seem to have been hearing you correctly."
- For example, with the classic initiate-avoid pattern with the woman as the initiator, "So, what happens Jane is that you become aware of a situation that you feel needs to be discussed and bring this up with Bill and, Bill, somehow in the way she brings this up you feel attacked and like you aren't going to be able to please her and you have come to find that it seems the best way to deal with this situation is just to say nothing - Jane, you then begin to feel panicked that he won't even talk about this situation in your relationship and begin to wonder if he even cares so you try harder to get him to talk about it - Bill, you then find yourself claming up even more - You try harder (Jane) until you get to the point where you said it was better to get any response from him, even if an angry one, then to hear nothing. This all ends with you (Bill) either leaving the house or maybe just going down to the basement.
- As you are delivering the reframe, the couple should be nodding and giving other signs of agreement that you have captured what happens between them correctly. If not, you should check with them what is not fitting and you can adjust the reframe as you are delivering it.
- At the completion of the reframe delivery, you should formally check with them to see if they agree
- "Does this seem to capture what has been happening between you?"

8) Contract for therapy

- The couple has already agreed to participate in the study but it is good, clinically, to have them reaffirm their commitment to participate in the process of therapy.
- You should avoid the use of jargon and use, instead, common language. It is best to use their own words as much as possible.
- "You have both talked about wanting to work on …… This is the type of problem that couples come here to work on. If you are still wanting to continue, I would be glad to work with you towards accomplishing the goals of …… Is that still something you would like to do?
- Remind them that you will be meeting weekly for four sessions and then every two weeks for four additional sessions.
- Tell them that at the end of the fourth session you will be taking stock of how the sessions are going – "At the end of the fourth session, I will be taking stock with you how the sessions are going. If you are satisfied with how it is going we may just continue in the same manner. If it seems we are missing something then we may want to make some changes for the second half of the sessions."
- An important part of the contracting is to invite the clients to give you feedback if they are unhappy with how therapy is going.
    - "As we are going along, it is possible that you may find yourself unhappy with something that is happening in these sessions. My intention is that these sessions should be helpful to you so, if you find that they are not, I would like to invite you to tell me about it. It may be that I have been unaware of something or insensitive to something and we can often correct whatever it is and continue on at that point."

- It may or may not occur that one of the partners will ask you something about "what type of therapy is this," or "what model of therapy will this be," or in some way try to engage you in a technical discussion about the therapy. Try to answer such questions without jargon – try to tie it in to what they have already been telling you, using their words if possible. For example, you could say "what we will be doing is to try and understand how you are reacting to each other and how we can change what is happening between you so that (you can have fewer of the 'big blow out' arguments, feel closer to each other, etc.)

- Confirm date and time of next appointment.
- Begin to set up the homework. As with the reframe, you want to have impact with your delivery of the homework.
- "In a minute I want to give you some homework, if you would be willing to accept it - but first, let's make our next appointment."

9) Homework

- The homework should be the last part of the interview that you leave them with.
- Give them the "observe homework" - this asks each partner to observe for their part of the cycle and what *they* (not their partner) do when that scenario begins to replay.
- "OK, before we go, I would like to give you some homework - if you would be willing to accept it - since we are just starting off, this will be an easy assignment because I am not

going to ask you to do anything new - what it would involve would be that, between now and the next time we meet, I would like for you, Jane, to watch for those times where you become aware of a concern involving Bill and you are to observe how you respond in those situations. Your part of the homework, Bill, would be that when Jane brings a concern up with you, you are simply to observe how you respond."

- Confirm their willingness to participate in the homework - "would you be willing to do that?"
- Check with them to see if they understand the homework.
    - "Let me see if I have communicated well, could you tell me what I have asked you to do"?
    - Sometimes clients will have heard you tell them to change their behavior.
        - "You said that if he comes home late I'm just supposed to not say anything about it!"
- The delivery of the homework should be the end of the session - don't let them begin to answer it. You can tell them that you want some "fresh examples" for next time.
- You may have couples ask "what if it doesn't happen in the next week?" You should ask them about how often it occurs and it may be that it is less than once per week. In that case, you can respond with seriousness "well, maybe this will be one of the weeks". This will usually provoke some surprise or humor. You can tell them that "if this does not occur in the next week, I have some other things we can talk about".

C. Early working phase: (Approximately sessions Two through Four)

Each session should generally start with a question to the effect "what has it been like being together since we met?" Often, people will respond that they have been "busy" and have had little time together. In that event, you can ask them what it has been like when they *have* been together. People will usually respond with an assessment to the effect that there have been "ups and downs". Other times they may say that everything has been fine or that it has been bad. These three scenarios will be discussed below:

I. "Ups and downs".

If people report that the quality of the time since the last meeting has been variable, it is important to start with hearing about the "ups" or positive aspects. They may wish to begin immediately discussing the negatives but you can tell them "I will want to hear about that, but first I would like to ask you to tell me about the "ups". If you start with the negatives, this sets a negative tone in the session and it is usually not possible to go back to the positives later. If you start with the positives, this sets an encouraging tone to the session and, when you later discuss the negatives, it tends to be done more constructively.

You can ask, "what have the ups/good times/etc. been?". You will then hear them out. Listen especially for changes in the cycle - e.g., that an initiator toned down their pointing out of problems, or that an avoider remained present and listening. If there were changes in the cycle, this is important and you will want to spend sufficient time processing and

discussing this. Each partner may attribute the improvement to change in behavior on the part of the other - this can be later linked in a new reframe of the cycle.

You can ask the other person what it was like for them when this change occurred. Let them talk as long as they can about any positive feelings they had about it and reflect these feelings back to them. They may respond that they were not even aware of the change. You don't want to let this be a discouragement to the spouse who made the change so you need to respond quickly with a comment such as "so this happened so naturally that you weren't even aware of it - are you glad that it happened?"

They may act as if the "ups" of the week were no be deal - "we usually have a week like that - the big blow ups don't occur that often." In this case, ask how often the problematic event is likely to happen. You can then respond, "so, to go a week without this is no surprise/no big deal/etc.". They will agree and you should then just go on. Do not try to convince them that this was significant.

If the "ups" represent a change in the cycle you will want to spend more time on this than if it was apparently more of a coincidence. Likewise, the more significant the change - the more time you will want to spend on it. After thoroughly covering the positives, you should go on to processing negative experiences below.

II. The week was all positive

This should be processed as with the section above on dealing with the "ups" that occur in a week. Again, this may just be a coincidence if the problematic event does not occur that often or it may represent a positive change. Later in the course of therapy, after change has begun occurring, this particular scenario is more likely to occur than at the start of therapy and this is dealt with further below in the section on Sessions 5 and 6.

III. Negative events - The basic EFT working session intervention

Process with one partner →
Check out response of other partner →
a) if accepting: expand
b) if defensive: process
Repeat

There is a basic series of steps in dealing with the problem/s that couples bring to therapy and this constitutes the heart of EFT. To give a preview, this involves processing one partner's emotional reactions to the cycle then processing the other partner's emotional reaction to what they have been hearing. This tends to involve Steps 5, 6, and 7 of EFT.

This sequence will usually begin with the partner's presenting a distressing event that has occurred between them. You want to track the sequence of events that occurred - with an ear towards placing it in context of the cycle you identified during the assessment. At this point in the treatment, you will want to begin probing for the clients' underlying

emotional reactions. You must select one person to begin working with. This can be either partner but you may want to choose the person who is more distressed which will usually be the initiator in the couple. You want to bring the emotional experience into the present; into the therapy room. You can do this with questions such as, "Jane, what is happening inside you right now as you are talking about this?", or "what is happening in your gut?", or "how are you feeling as you discuss this?"

Initially, clients often will not directly answer these questions. They will ignore the question, continue talking about what happened, or tell you what they *thought* about the incident (e.g., "I just can't believe that he did that again," "I think that she needs to get help for this"). At this point, beginning therapists sometimes become panicked that therapy is not going as it is supposed to and they will abandon the treatment model and begin doing something else (e.g., offering advice). If you ask the client how they feel and they do not answer you, the solution is to ask again. Sometimes you have to ask repeatedly. You can try to rephrase the question somewhat or cajole the patient but you should ask several times. Usually, once the client sees that you are not going to let the matter drop they answer you.

As you are asking one person about their emotional experience, it is not unusual for the other person to interrupt. This may be to answer for the person you are talking to, to continue talking about what happened, to be critical of their partner, etc. It is important that you block this interruption so that the person you are trying to talk to will see that you are serious about hearing what they have to say and, also, that you are not going to let them off the hook.

Once the person does begin talking about their emotional experience you especially want to listen for "vulnerable" emotions. The first emotion you will usually get is anger. Anger is a safe emotion. While anger is a legitimate emotion, it is not a vulnerable emotion so the person can eventually be asked, "yes, so you were feeling angry - what else were you feeling?" Anger can be a primary emotion, but there are nearly always other emotions that go along with this. Vulnerable emotions would include "hurt", "disappointment", "sadness", "inadequacy", etc. In many cases, the client won't simply come out and tell you that they were feeling "hurt" but they will only let this "slip" out with a brief word or comment. You have to be alert to listen for these "slips" of vulnerable emotions. When you hear one, you will usually need to stop the action and draw attention to what was said so as to amplify it. For example, "so….you say that her comments were hurtful to you?", "…..it made you feel like a little boy." The client may want to deny the vulnerable emotion; if you use their own words then it is harder for them to do so. It is especially important at this point to block the other partner from interrupting.

Some clients are more difficult to draw out then others. As you listen to the client describing a situation, you should put yourself in their shoes and notice your own emotional reaction - this is likely similar to what they experienced. If you are unable to elicit their describing their reactions, it is acceptable to make some tentative suggestions.

This should never be done in the form of telling them what they felt but rather as questions: "As I hear you talking, I am wondering if you might have felt attacked by her comments?", "I don't know if this fits for your, but I would imagine that someone in that situation might have felt abandoned". In some cases, the client will agree with your suggestion. This can then be built on with a follow-up question such as, "Could you say some more about that, about feeling abandoned?" In other cases, the client will disagree with your suggestion. This is alright - they may then come back to tell you how they *were* feeling.

It is important to spend enough time with the client to develop their emotional reactions to the cycle. Again, beginning therapists will sometimes hear one comment and then move on. Spending time with the client to help them talk about how they were feeling helps them in their acceptance of these emotions (Step 5) but, also, while listening - the other partner may be coming to accept how the speaking partner was feeling (Step 6). Five minutes or so may be spent on this process.

While talking with the first partner, you will want to keep an eye on the other partner to try and monitor their reactions. You may observe sadness, disdain, etc. Once you have completed processing these reactions with one partner, you turn to the other partner and ask something to the effect of "what is it like to be hearing what (partner's name) is saying?" You will then usually receive one of two responses: acceptance or defensiveness.

Acceptance (Corresponds to Step 6): Acceptance may be indicated directly by a partner saying something like "I'm sorry that s/he feels ….." or "I never intended him/her to feel like that". In this case you should encourage the speaker to elaborate, e.g., with repeating - "you didn't intend that she should feel hurt."

Acceptance may be accompanied by a "but" - such as, "I'm sorry he feels that way but that is the only way I can get through to him." This is still an indication of acceptance of the other's feelings. You can amplify the acceptance portion, again, by repeating that portion - "You didn't intend that he should feel attacked." This gives the speaker a face-saving way to acknowledge the other's feelings.

Continue to amplify the speaker's acceptance of the other's emotions. In the process, you can begin to explore this person's emotions in the cycle. After completing this, you will then turn to the former speaker and ask what it has been like hearing what the present speaker has been saying.

Defensive reaction: You have been processing Partner A's emotional experience, inquire of Partner B about what it is like listening to what Partner A has been saying and Partner B begins an angry attack - "I can't believe it - that is a bunch of nonsense." You need to intervene quickly in this case as Partner A may have just made themselves vulnerable and will be unlikely to do so again if they are attacked without protection. Your response should be the basic response to all problems in EFT - process emotional reactions. For example, you can ask of Partner B "What is

your own experience of these situations?" - this can then lead to a processing of Partner B's own experience of the cycle that surrounded this event and a temporary ignoring of their lack of acceptance of Partner A's response. After processing Partner B's emotional reactions and providing acceptance of them, you may later be able to soften Partner B's reactions to Partner A's emotional experience through a reframe (Step 4).

Other therapist responses to defensiveness can include: "It is hard for you to see (Partner A) in this way" or "What makes it hard to believe that (Partner A) was feeling (name of emotion)?" There will be a back and forth between the two partner's experience.

IV. Development of new solutions (Steps 7 & 8).
As the couple is processing their emotions they may begin to talk to each other about what they are needing (Step 7) based on their new acceptance of their underlying emotions (Step 5). The assumption in EFT is that as people begin to recognize and accept their own and their partner's emotional reactions

You should not offer any "advice" about how to solve the content problem (e.g., you would not suggest "maybe you can do the checkbook one month and then you do it the next month") but you *can* guide them in developing *process* solutions.

V. "Predicting relapse"
When a couple begins to make progress, you should warn them about relapse. You can say something to the effect "You all are making good changes, but I hope you won't be too discouraged if you find that you also have some setbacks - times where the old pattern comes up again. I tell you this because sometimes when couples have a setback they feel like that have gone all the way back and that they only thought they had been making progress. In fact, what most couples find is that if they get up and brush the dust off of themselves and get back to doing the new things that were working, that they actually had not fallen all the way back after all. So, I hope that you won't have any setbacks but I won't be terribly surprised if you do. In fact, if you do have a setback - it can give you practice on recovering from a setback."

VI. Use of Homework

A) The "observe homework"
As therapy progresses the understanding of the cycle will change or the cycle itself may begin to change. The couple can be asked to observe *their* reactions and behavior in the cycle.

B) "Continue to do what you are doing"
As couples begin to make changes, you may just want to encourage them to continue what they are doing.

C) No Homework
If the couple is making good change, it may not be necessary to give any homework. You can simply end the session by confirming the next appointment time.

D) The "challenge homework" and restraint of change

The challenge homework is reserved for cases where change is not occurring; "stuck" cases. This intervention presents the couple with a challenge: "For things to get better in a relationship it always comes down to both people doing something that does not feel comfortable to them. I can see that for the two of you, if things are going to get better it will come down to you, (Partner A) when you see something between the two of you that needs to be addressed - that you will "tone down" your comments to (Partner B) (you will want to try and use their own words to refer to these behaviors and reactions). For you, (Partner B), it will come down to, when (Partner A) brings something up with you, that you will continue to listen and be present and not 'throw the wall up' (again, trying to use their own words). So, you will each have a 'moment of truth' where you have to make a decision about your relationship moving forward or not - for you (Partner A) the moment of truth will be when you see something that needs to be addressed and deciding how you will bring it up and for you (Partner B) it will be when (Partner A) points these things out and you, in that moment, make a decision about how you will respond. So, I'm not saying what you all should do, I'm just pointing out what I see that will need to happen if progress is going to be made."

D. Late working phase (Approximately sessions Five through Seven)
If there is going to be significant change, this will usually start to occur by around the fourth session (around the time that the weekly sessions end).

Beginning therapists often wonder what to do after they have already processed the cycle in the second session. The answer is that you continue the same process in the succeeding sessions. The differences between the sessions will be: a) that the cycle will be changing and, therefore, what you are processing will be different and b) you will move to deeper emotions. In the beginning of therapy the clients will not feel safe to immediately reveal their most vulnerable emotions (and, in fact, they may not even have sufficient awareness of them to verbalize them if they wanted to). As the sessions proceed, they will hopefully feel increasingly safe to reveal increasingly vulnerable/deeper emotions. This will occur, in part, as they see positive change beginning to occur and have increased optimism about the relationship.

Early in the working phase, the couple may primarily talk to you and talk little to each other. As you proceed further into the sessions you should work towards having the couple talk directly to each other more:

a) You may preface questions with comments such as “Can you tell him….(what it is like when he……)”, “Will you tell her…(your experience when she….)”
b) There may be times where they start to tell you something and you direct them to address the other partner. One partner starts to talk to you and you motion towards their partner and say ‘tell her….”.

If they are talking to each other and what they are talking about is consistent with your goals for the session there is no need to intervene. It is possible that in some of the latter sessions you may say little although there are many cases in which this does not ever happen.

Talking to each other may feel uncomfortable to them and, so, they will resist your efforts. You will ask them to address each other and they will say a word or two to their partner and then turn back towards you. Although it is possible that you were premature in your effort to have them address each other more directly, it is also true that you may *need* to push them beyond their point of comfort. This requires clinical judgment that comes with experience. If they do not comply with your request to address each other and begin talking to you again you may:

a) Repeat yourself – "tell her" – you can use hand gestures (pointing to the other partner)
b) Simply point towards the other spouse perhaps without saying anything
c) In more extreme cases of resistance, you can look away or at the floor so that the person will have no one to speak to except their partner

E. Termination (Session Eight)

As you move into the latter stages of therapy (anywhere between sessions 5 and 7) you may begin to notice that the clients begin to "close off". This helps them to "seal off" their vulnerability as they prepare emotionally for the end of therapy. With other couples, they will continue to work right up until session 8.

By the time of session 8, there is not much more significant new work that is going to be done. They may "seal off" as they know this is the last session. Alternatively, if a new problem or highly conflictual problem begins to come up you will likely not want to initiate work on this since you will not have any follow-up sessions. Session 8 is a time to wrap-up the work that you have done and look towards their future without therapy.

a) You can still begin the session with asking what it has been like being together since the last session. If this is along the general lines of what the previous sessions have been focused on then you can process this as you would in any other session.
b) Termination-specific questions for the couple
   i) "This being our last session, I am wondering what your thoughts are about where you are now as a couple relative to where you were when you first contacted us here?"
   ii) "What have you taken from these sessions?"

   Note: It may be that the couple reports that nothing has changed. These comments should be accepted non-defensively.

   iii) "If you wanted to get back to where you were before you were coming here, what would you each need to do?"

c) You can review with them what change you have seen – try to frame this in terms of the cycle.

d) You can solicit their feedback – "What are your thoughts and feelings about having taken part in our study?", "Is there any feedback that you would give to us or to myself about what has been helpful, what has not been helpful, or any observations you have had about how we could improve what we are doing?"

e) They may or may not ask about what they should do if they feel like they have more work to do. Recommend that they might give this a few weeks as sometimes change continues to occur after the sessions are over. If they continue to feel like they might benefit from further therapy, you can tell them that they can contact yourself or Stephanie Walsh about further treatment through the MFT program or for information about resources outside the medical center.

f) Discuss the follow-up evaluation session.

g) "Predict relapse" – "It is not uncommon that couples at times may fall back on their old patterns – particularly during times of stress. At these times, couples sometimes feel like they are back to square zero and that all of the progress they made has been reversed. In fact, what couples often find is that if they pick themselves up and brush the dust off and get back to doing the things that were working for them while they were coming to the sessions, that they find they begin moving forward again and had not fallen as far back as they thought."

h) You can say your good byes – remind them about the follow-up assessment as they leave.

APPENDIX E: Therapist Forms

SHARE
Synthesizing Health and Relationship Enhancement

INITIAL EVALUATION FORM

Marital & Family Therapy Program
Wake Forest University Baptist Medical Center

Case #: **Date:**

Name	Age	Occupation

Marital/Relationship Status:

- ☐ Married and living together
- ☐ Married and separated
- ☐ Cohabitating
- ☐ Dating/Engaged but not cohabitating

Descriptions of the Relational Presenting Problem(s) (Step 1):
Hers

His

Other information about the relational and health problem(s):

Draw Cycle of Behavior Containing the Presenting Problem (Steps 2 & 3):
Relationship History:

Initial Meeting:

Initial Attraction:
His

Hers

Other Relationship History:

When did problem begin and any associated developmental change:

Client Goals (Step 1):
His

Hers

Commitment Level:

- ☐ Both desire to work on improving relationship
- ☐ One or both partners has decided to end the relationship
- ☐ One or both partners uncertain whether to work on relationship or end it

Reframe Presented to Couple (Step 4):

Therapy Contract:

- ☐ Goals agreed on by couple and therapist
- ☐ Couple informed about mid-therapy assessment after session 4

Homework:

- ☐ Observe Homework (describe below)
- ☐ Continue more of the same
- ☐ No Homework
- ☐ Challenge Homework (describe below)

Next Session:

SHARE
Synthesizing Health and Relationship Enhancement

PROGRESS NOTE

Marital & Family Therapy Program
Wake Forest University Baptist Medical Center

Names: **Case #:** **Date:** **Session # (of 8):**

Content of Session:

Steps of therapy worked on (Process of Session):

Current Cycle of Behavior (Steps 2 & 3):

Any Message Delivered at End of Session (e.g., Reframe [Step 4]):

Homework:

- ☐ Observe Homework (describe below)
- ☐ Continue more of the same
- ☐ No Homework
- ☐ Challenge Homework (describe below)

Next Session:

Curriculum Vitae

STEPHANIE R. BURWELL WALSH
PhD, LMFT

Home Address
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Pfafftown, NC 27040
(336) 923-1071

Work Address
Wake Forest University School of Medicine
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Winston-Salem, NC 27157-1087
Phone: (336) 716-0135
Fax: (336) 716-6830
E-mail: Swalsh@wfubmc.edu

Education

August 1998-May 2002
Ph.D.
Virginia Polytechnic Institute and State University
Blacksburg, VA
Human Development
Marriage and Family Therapy Specialization

August 1996-August 1998
Master of Science
University of Nebraska-Lincoln
Lincoln, Nebraska
Family and Consumer Science
Marriage and Family Therapy Specialization

August 1994-May 1996
Bachelor of Science
University of Nebraska-Lincoln
Lincoln, Nebraska
Family Science

August 1992-May 1994
Bethany College
Lindsborg, Kansas
Special Education

Professional Licensure

September 2000
Licensed Marriage and Family Therapist, NC #876

Professional Membership

September 1999-Present	Collaborative Family Health Care Coalition
October 1996-Present	American Association for Marriage and Family Therapy, Student Member
September 2000- Present	North Carolina Association for Marriage and Family Therapy, Student Member
August 1998-2000	Virginia Association for Marriage and Family Therapy, Student Member
October 1996-1998	Nebraska Association for Marriage and Family Therapy, Student Member

Clinical Experience

July 2000-July 2002	Medical Family Therapy Pre-Doctoral Internship Wake Forest University School of Medicine Department of Psychiatry and Behavioral Medicine Winston-Salem, North Carolina
November 1998-May 2000	Marriage and Family Therapy Pre-Doctoral Practicum The Family Therapy Center of Virginia Tech Blacksburg, Virginia
October 1998-May 1999	Facilitator, Alzheimer and Dementia Caregiver Support Group Virginia Tech Adult Day Services Blacksburg, Virginia
August 1997-August 1998	Medical Family Therapy Intern University of Nebraska Medical Center Department of Family Medicine Omaha, Nebraska
November 1996-August 1998	Family Therapy Trainee The Family Resource Center University of Nebraska-Lincoln Lincoln, Nebraska

Supervision Experience

January 2000-present	AAMFT Approved Supervisor-in-Training, Doctoral Track
July 2000-present	Supervise Residents in Psychiatry and Master's level MFT Interns at Wake Forest University School of Medicine
January-May 2001	Supervised Master's level therapists in the Counselor Education program at Virginia Tech

Research Activities

January 2001	Developed the SHARE Clinic for dissertation data collection (Synthesizing Health and Relationship Enhancement)
January 2001-2002	SHARE Study Research, Therapist Training, and Project Management
September 2000	Clinical Research Investigator/Coordinator Certificate Program Wake Forest University School of Medicine
February 1999	Conducting Effective Focus Groups. Training sponsored by the Center for Academic Enrichment and Excellence, Virginia Tech
July 1998	Master's Thesis "High Achieving Adolescent Females in Nebraska: Understanding Their Success"
August 1996-1997	Graduate Research Assistant University of Nebraska Healthcare Policy Grant
January 1995-1996	Undergraduate Research Assistant University of Nebraska The Family Violence Project

Teaching Experience

July 2000-Present	Psychiatry Residency and Training Program Outpatient Psychiatry Conference and Marital & Family Therapy Clinic Wake Forest University School of Medicine
January 1999-2000	Graduate Teaching Assistant for Associate Dean HR4004 Professional Seminar, Virginia Tech

Awards

The 2001 American Association for Marriage and Family Therapy
Graduate Student Research Award

The 2001 James D. Moran Memorial Thesis/Dissertation Award
Virginia Polytechnic Institute & State University

Outstanding Poster, 2001 North Carolina Association for Marriage and Family Therapy Annual Conference, Durham.
Cox, G.E., Walsh, S.R., Fortner, J., & Benson, K. Applying Emotion Focused Therapy to Couples Treated in a Medical Family Therapy Clinic.

Honorable Mention Poster, 2001 North Carolina Association for Marriage and Family Therapy Annual Conference, Durham.
Walsh, S.R. Women's Narratives of Strength and Resilience in Coping with Fibromyalgia Syndrome: A Thematic Analysis.

Honors

July 2002	Invitee, 5th AAMFT Research Conference, Reno, NV
July 2001	Invitee, 4th AAMFT Research Conference, Reno, NV
July 2000	Invitee, 3rd AAMFT Research Conference, Reno, NV
July 1999	Invitee, 2nd AAMFT Research Conference, Chicago, IL
January 1999-Present	Sigma Phi Omega, National Academic Honor and Professional Society in Gerontology
August 1995-1998	Phi Upsilon Omicron Collegiate Honor Society

August 1995-1998	Kappa Omicron Nu Collegiate Honor Society
August 1996-1998	University of Nebraska-Lincoln Regent's Scholar
August 1992-2000	The Lloyd E. and Katherine S. Winslow Scholarship Recipient

Consulting Positions

October 1998-May 2000	Marriage and Family Therapy Consultant Virginia Tech Cardiac Rehabilitation Program Blacksburg, Virginia
January 1999	Montgomery County Supervised Visitation Program Consultant Blacksburg, Virginia

Professional Activities

October 2000-Present	Sexual Assault Task Force Wake Forest University School of Medicine
October 2000-Present	Women's Health Center of Excellence Preferred Provider Wake Forest University School of Medicine
November 1998-2000	Eating Disorder Task Force Virginia Tech Women's Center

Peer-Reviewed National Presentations

Walsh, S.R. Research Update: Somatoform Disorders. American Association for Marriage and Family Therapy Annual Conference. Nashville, TN, October, 2001.

Woody, R.H., Woody, J.D., Becvar, D.S., Denton, W.H., Jory, B.L., & Walsh, S.R. Understanding Family Therapy Ethics. American Association for Marriage and Family Therapy Annual Conference. Nashville, TN, October, 2001.

Denton, W.H., Walsh, S.R., & Wedemeyer, E.L. Family Therapy as a Health Care Profession. American Association for Marriage and Family Therapy Annual Conference. Denver, CO, November, 2000.

Bleiszner, R., Roberts, J., Viers-Yaun, D.R., & Walsh, S.R. They're at it again: Family Stress and Conflict Reduction Strategies. 21st Annual Southern Gerontological Society Conference, Raleigh, NC, March/April 2000.

Peer-Reviewed Poster Sessions

Walsh, S.R. A Qualitative Study of Fibromyalgia Syndrome in Upwardly Mobile Women. American Association for Marriage and Family Therapy Annual Conference, Nashville, TN, 2001.

Walsh, S.R. Women's Narratives of Strength and Resilience in Coping with Fibromyalgia Syndrome: A Thematic Analysis. The North Carolina Association for Marriage and Family Therapy, Durham, NC, March 2001.

Cox, G.E., Walsh, S.R., Fortner, J., & Benson, K. Applying Emotion Focused Therapy to Couples Treated in a Medical Family Therapy Clinic. The North Carolina Association for Marriage and Family Therapy, Durham, NC, March 2001.

Walsh, S.R., Viers-Yaun, D.R., Bermudez, J.M., & Prouty, A.M. It Takes Two to Pioneer: A Wive's Study of Husbands' Marital Perceptions. American Association for Marriage and Family Therapy Annual Conference. Denver, CO, November, 2000.

Invited Presentations and Poster Sessions

Denton, W.H., & Walsh, S.R. Emotion Focused Couples Therapy. East Carolina University, Greenville, NC, November, 2001.

Denton, W.H., & Walsh, S.R. Fear of Intimacy. The Mental Health Association in Forsyth County, Winston-Salem, NC, September, 2001.

Walsh, S.R., & Flemke, K.R. Women with Fibromyalgia Syndrome: Clinical Themes from Two Case Studies. The Southeastern Symposium on Family and Child Development. Athens, GA, April, 2000.

Walsh, S.R., Viers-Yaun, D.R., Bermudez, J.M., & Prouty, M. Pioneer Marriages: Preliminary Discoveries from a Qualitative Study. The Southeastern Symposium on Family and Child Development. Athens, GA, April, 2000.

Walsh, S.R., & Sparks, J. Making the Most of Marriage as the Nest Empties. Parent's Weekend Workshop, Virginia Polytechnic Institute & State University, March,1999.

Prouty, A.M., Bermudez, J.M., & Walsh, S.R. Play in Family Therapy: Narrative Theory and Play Therapy. Radford University's Counseling Summer Institute, Radford, VA, June, 1999.

Publications

Walsh, S.R. (1998). High achieving adolescent females in Nebraska: Understanding their success. Unpublished Master's Thesis. The University of Nebraska-Lincoln.

Peer Reviewed Journal Articles

Walsh, S.R., & Fortner, J.S. (2002). Coming full circle: Family therapy and psychiatry reunite in a training program. *Families, Systems & Health, 20*, 105-111.

Denton, W.H., Walsh, S.R., & Daniel, S.S. (2002). Evidence-based practice in family therapy: Adolescent depression as an example. *Journal of Marital and Family Therapy, 28,*39-45.

Book Chapters

Denton, W.H., & Walsh, S.R. (2001). Evidence-Based Practice: A New Frontier for Family Therapy and Ethical Practice. In R.H. Woody & J.D. Woody (Eds.), *Ethics in Marriage and Family Therapy: Understanding the 2001 AAMFT Ethics Code.* Washington, DC: American Association for Marriage and Family Therapy.