

COMMON AND MODEL-SPECIFIC FACTORS: WHAT MARITAL THERAPY
MODEL DEVELOPERS, THEIR FORMER STUDENTS, AND THEIR CLIENTS SAY
ABOUT CHANGE

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Common and Model-Specific Factors: What Marital Therapy Therapists, Their Students,
and Their Clients Say About Change

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ABSTRACT

Meta-analytic reviews of decades of comparative efficacy psychotherapy research consistently reveal that all tested models of marriage and family therapy (MFT) work, and they generally work equally well. Researchers have hypothesized that this may be due to factors common across models responsible for change. Despite a sizable body of common factors literature in psychology, such research in MFT is still in its infancy. The purpose of this study is to contribute to the development of a theory of common factors responsible for change in MFT. Semi-structured, open-ended qualitative interviews were conducted with three different MFT model developers (i.e., Dr. Susan M. Johnson, Emotionally Focused Therapy; Dr. Frank M. Dattilio, Cognitive Behavioral Therapy; and Dr. Richard C. Schwartz, Internal Family Systems Therapy), Dr. Johnson and Dr. Schwartz's former students, and each of their former clients who had terminated therapy successfully. Transcripts were coded using the grounded theory techniques of open coding, axial coding, and relational statements. Coding was done utilizing a constant comparative method in which data were simultaneously analyzed and coded. Common factors fell into two main categories of model-dependent factors and model-independent factors. Factors within the model-dependent category include those aspects of therapy

that are directly informed by the therapist's model. Model-dependent categories include common conceptualizations, common interventions, and common outcomes. Factors within the model-independent category include general aspects of therapy that are not directly related to the therapist's model. Model-independent categories include client variables, therapist variables, the therapeutic alliance, therapeutic process, and expectancy and motivational factors. Each model-dependent and model-independent category has several subcategories. Results are discussed in both model-specific and common factors conceptualizations. A sequential model outlining how model-dependent factors appear to combine to produce therapeutic change while being mediated by model-independent variables is proposed. The findings are integrated with the current common factors literature in psychology and MFT. Clinical, training, and research implications are discussed.

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Chapter I

Introduction

For decades, marriage and family therapy (MFT) researchers have attempted to discover if psychotherapy works, and if so, why. Recent meta-analytic reviews of decades of comparative effectiveness research reveal two consistent findings. First, marriage and family therapy works. The average person receiving marital therapy is better off than 84% of the untreated sample (for marital *and* family therapy, 65%), and improvement is generally sustained over a long period of time (Shadish & Baldwin, 2002). In fact, marital therapy has a larger effect size (the usual standardized measure of outcome of treatments) than coronary bypass surgery for angina and electroconvulsive therapy for depression (Shadish & Baldwin, 2002). Second, these impressive results generally hold true regardless of the therapeutic model employed or, with a few exceptions, the presenting problem being treated (Shadish & Baldwin, 2002). These MFT findings generally parallel the individual psychotherapy literature.

Researchers have established three main hypotheses to explain these findings. First, perhaps "...there are differences [between models], but they are too "fine grained" to be teased out by extant research methods or the research questions we are asking" (Sprenkle, 2002, p. 20). Significant differences in effectiveness may exist between models, but current research methodologies may not be sophisticated enough to distinguish these differences. This is a plausible hypothesis, as to date some treatments have been shown to work better for some clients (e.g., systematic desensitization for certain phobic disorders; Asay & Lambert, 1999; Lambert & Ogles, 2004). While similar

findings may emerge in the future, it is unlikely that any one model will be able to claim universal superiority over all other models (Sprenkle & Blow, 2004a).

Second, various models may achieve similar results, but through different change mechanisms (Lambert & Ogles, 2004). This is also a plausible hypothesis, and more light will be shed on it as process research – research aimed at uncovering *why* and *how* models work – increases in popularity. Many MFT researchers believe, however, that most models share key change mechanisms (Henggeler & Sheidow, 2002; McFarlane, Dixon, Lukens, & Lucksted, 2002), and that these shared mechanisms are responsible for enough of the variance in outcome to render model-specific mechanisms largely clinically insignificant (Sprenkle & Blow, 2004a). Future research will address this hypothesis.

Third, and I believe most likely, researchers posit that “in their natural clinical form, there is considerable overlap among the major models of...therapy” (Jacobson & Addis, 1993, p. 88). While models of therapy differ widely in their conceptualization of problems, what the therapist actually does in therapy may be remarkably similar among models. When observing a clinician in action, often the only way to tell which theory is guiding his or her work is by the language used and certain model-specific interventions employed, though each therapist would likely report divergent conceptualizations of the case. Perhaps what Asay and Lambert (1999) said of psychotherapy in general applies equally to MFT: “different therapies embody *common factors* [italics added] that are curative, though not emphasized by the theory of change central to any one school” (p. 29). Though change comes wrapped in different linguistic and conceptual packages, when opened it is likely to look the same regardless of wrapping.

In the larger field of psychotherapy, research aimed at uncovering the common factors of therapy models which account for change has blossomed over the past 15 years (Wampold, 2001), while similar research in MFT is still in its infancy. One recent review (Davis & Butler, 2004) revealed only two empirical inquiries (Butler & Bird, 2000; Blow & Sprenkle, 2001), one theoretical article (Sprenkle, Blow, & Dickey, 1999), one scholarly debate (Sexton & Ridley, 2004; Sexton, Ridley, & Kleiner, 2004; Sprenkle & Blow, 2004a; Sprenkle & Blow, 2004b) and one conference presentation (Wampler, 1997) outlining common factors in MFT. We know very little about common factors unique to MFT.

The next steps for MFT researchers interested in furthering our understanding of common factors include generating hypotheses about what components of different models are common factors responsible for change (Blow & Sprenkle, 2001; Sprenkle & Blow, 2004a; Sprenkle, Blow, & Dickey, 1999; Wampler, 1997), determining if they are necessary and/or sufficient by empirically relating these factors to outcome, understanding how and when they are implemented across various models (and if how and when they are implemented makes a difference), and formulating a theory or model that provides adequate clinical and research guidance. The end result could be a meta-theory of change in MFT which would point clinicians, researchers, and educators to what needs to happen when helping people change. In MFT, however, we are a long way from complete development of any one of these goals, let alone all of them. Clearly, we have much to learn about common factors in MFT.

Given the neophytic state of common factors research in MFT, an inductive, qualitative research approach seems well suited to further our current understanding of

common factors. An open-ended, inductive, qualitative approach to collecting and analyzing data can reveal aspects of common factors of change that may be overlooked by quantitative methods (Moon, Dillon, & Sprenkle, 1990). Even pantheoretical explanations of common factors (Lambert, 1992) may miss potential common factors if their initial inductive theorizing is not informed by inductively driven research. A qualitative researcher can search inductively for common factors from the lived experience of the clients rather than deductively forming hypotheses then seeking to confirm these hypotheses. The qualitative researcher starts at the ground level – where the change is occurring – and inductively searches for clues related to change. This increases the likelihood that the hypotheses formed and theories derived from such an analysis will be in accordance with the lived experience of clients in therapy.

To date, there are no known published studies investigating common factors of change in MFT from a purely inductive, qualitative approach. Most qualitative studies investigating couple change in MFT (Christensen, Russell, Miller, & Peterson, 1998; Helmeke & Sprenkle, 2000; Wark, 1994) are peripherally related to common factors in that they inductively explore various aspects of the change process, but none specifically investigate common factors in MFT. The purpose of this study will be to address that void by inductively contributing to a theory of common factors in MFT by interviewing former clients of prominent model developers in MFT that met their goals in therapy, as well as former clients of the students of model developers. I will use techniques from grounded theory methodology (Strauss & Corbin, 1998) to search for commonalities and differences in the therapy experience among the interviewees. Former clients of model developers in MFT will be chosen to ensure that they received theoretically “pure”

therapy (or at least as theoretically pure as model developers practice their therapy). In addition, former students of the model developers and their former clients will be interviewed to increase transferability of the findings.

Such a study will be able to inform the common factors literature in several ways. First, if there are commonalities across the experiences of the clients, these commonalities could tentatively be construed as common factors related to outcome. Second, if there were theory-specific differences between clients, this may shed light on the unique contributions of that model. Regardless of the findings, such a study will further our understanding of the similarities and differences in the change process across diverse models of therapy.

In the next chapter, I will examine what we know about common factors in psychology in general and MFT specifically. I will present this information in the context of the history of common factors in psychology and MFT. Chapter Two will also highlight key points on both sides of the common factors debate. Next, I will explore different research methods for furthering our understanding of common factors in MFT. I will also discuss the suitability of this study to meet those goals. Following that will be a section discussing the various theoretical approaches of the participants in this study. I will review what each theoretician believes leads to change and how he or she goes about implementing that change. Chapter Three will be devoted to the methodology of the study, including the role of the researcher. Chapter Four will include the results of the interviews and the theory of common factors derived from them. Chapter Five will include theoretical, clinical, and research implications from the findings of the study as well as my reflections on my experience interviewing the model developers.

Chapter II

Literature Review

Before an understanding of common factors in MFT can be established, it is helpful to understand the history of common factors in psychology. The following section will provide a history of the common factors position, as well as its current status in individual psychology. Following that will be a section discussing the current status of common factors in MFT.

A History of Common Factors Research and Theory

The Move to Establish Model Effectiveness

In the 1950s and 1960s, British psychologist Hans Eysenck strongly criticized mental health professions for their ineffectiveness (Bergin & Lambert, 1978). He claimed that approximately two thirds of clients diagnosed as *neurotic* improved after two years of treatment. The same proportion of clients, he claimed, improved in the same amount of time without treatment. This repeated criticism put the mental health disciplines on the defensive, triggered numerous heated debates and instilled a crisis of confidence in many therapists (Hubble, Duncan, & Miller, 1999).

Around the same time, many therapists began testing the effectiveness of their models. Highlighting the competitive atmosphere that such research induced, Bergin and Lambert (1978) noted that, “Presumably, the one shown to be most effective will prove that position to be correct and will serve as a demonstration that the ‘losers’ should be persuaded to give up their views” (p. 162). Therapists began to be categorized primarily by which theory they ascribed to, and, to some extent, how effective that theory had been shown to be. The focus was on demonstrating that one model (and, by implication, the

therapists that ascribe to that model) was better than another. Those who ascribed to a theory shown to be effective could pat themselves on their back, while all others either had to establish similar data for their model or defend themselves on other grounds. Either way, therapists began to be defined in relation to the debate.

The trend of providing empirical support for a model's effectiveness has gained considerable momentum over the past fifteen years, fueled largely in recent years by a growing emphasis on accountability by managed health care (Asay & Lambert, 1999). In 1993, a special task force within Division 12 of the American Psychological Association (APA) was formed "at the request" of a leading cognitive-behavioral therapist. Their purpose was to "disseminate important findings about innovations in psychological procedures" (Chambless, 1996; *Task Force Report on Promotion and Dissemination of Psychological Procedures*, 1993, p. 1). Psychologists argued that "patients...have a right to safe and effective treatment" and that it was unethical to fail to develop a list of effective treatments for specific disorders (Wilson, 1995, p. 163). The establishment of this Task Force further divided the field, with proponents of the Division 12 Task Force gladly posting the effectiveness of their models, while others noted that, "However well intended these efforts may be, they scream of scientific or theoretical arrogance" (Asay & Lambert, 1999) or painting by numbers (Silverman, 1996).

Unanticipated Results of the Move to Establish Model Effectiveness

As the number of studies demonstrating the effectiveness of different models mounted, some researchers began to conduct meta-analyses of these studies. A meta-analysis allows a researcher to compile the results of numerous studies and produce an "effect size." An effect size is a standardized statistic that shows how far away the mean

of the test group is from the mean of the control group (Shadish & Baldwin, 2002). In summarizing the findings of the most comprehensive (N=475 studies) meta-analysis of the time, Smith, Glass, and Miller (1980) made the following surprising statement:

“We did not expect that the demonstrable benefits of quite different types of psychotherapy would be so little different. It is the most startling and intriguing finding we came across. All the psychotherapy researchers should be prompted to ask how it can be so. If it is truly so that major differences in technique, count for so little in terms of benefits, then what is to be made of volumes devoted to the careful drawing of distinctions among styles of psychotherapy? And what is to be made of the deep divisions and animosities among different psychotherapy schools?” (p. 185)

To date, every major meta-analysis within psychology and MFT has reached the same conclusion: While therapy works better than no therapy at all, no one model of therapy has been shown to be differentially effective relative to other effective models, especially when confounding variables are controlled (Sprenkle & Blow, 2004a). This is likely the most robust finding in all of psychotherapy research (Sprenkle & Blow, 2004b). Naturally, there was strong resistance to these findings, especially on the part of those who had previously enjoyed the status of “effective” therapist. Nevertheless, these findings left the psychotherapy field with some very difficult questions to answer. What were plausible explanations for these findings? If these findings are true, *why* does psychotherapy work? What is common among the models that do work that accounts for

change? Possible answers to these questions were found in the earlier parts of the century.

The Rise of the Common Factors Movement

About twenty years prior to the beginning of these movements, Saul Rosenzweig (1936) noted that “besides the intentionally utilized methods and their consciously held theoretical foundations there are inevitably certain *unrecognized factors* in any therapeutic situation – factors that may be even more important than those being purposefully employed” (p. 412). This claim was largely ignored, however, until much of the comparative efficacy research began showing little if any differences between models. Though originally written by Rosenzweig (1936), Luborsky, Singer, and Luborsky (1975) are often credited with publishing the dodo bird verdict, in which they commented on the state of comparative efficacy research by saying that all models have won and must have prizes. This claim further ignited the passion with which many sought to establish the effectiveness of their models.

Jerome Frank, in all three editions of *Persuasion and Healing* (1961, 1973; Frank & Frank, 1991), furthered the common factors hypothesis by searching for links between psychotherapy and other activities designed to bring about healing. In the third edition, Frank and his psychiatrist daughter Julia made the claim that therapy in all its various forms should be thought of as a single entity (1991). They proposed the following explanation of their view:

“Two such apparently different psychotherapies as psychoanalysis and systematic desensitization could be like penicillin and digitalis – totally different pharmacological agents suitable for totally different conditions.

On the other hand, the active therapeutic ingredient of both could be the same analogous to two aspirin-containing compounds marketed under different names. We believe the second alternative is closer to the truth” (p. 39).

Frank and Frank (1991) went on to identify four features common to all effective therapies: (a) an emotionally charged confiding relationship with a helping person; (b) a setting that is judged to be therapeutic, in which the client believes the professional can be trusted to provide help on his or her behalf; (c) a therapist who offers a credible rationale or plausible theoretical scheme for understanding the patient’s symptoms; and (d) a therapist who offers a credible ritual or procedure for addressing the symptoms.

Near the same time Frank and Frank (1991) published the third edition of their book, Michael Lambert (1992) published a highly influential article in which he proposed the following four pantheoretical factors as being responsible for all of the outcome variance in psychotherapy: (a) extratherapeutic change, responsible for 40% of the variance; (b) therapeutic relationship, responsible for 30% of the variance; (c) expectancy or placebo effects, responsible for 15% of the variance; and (d) model-specific techniques, responsible for 15% of the variance. Though Lambert’s findings are unfortunately often misquoted as being mathematically derived, in reality they are educated estimates (Lambert, personal communication, 2002).

According to Lambert (1992), extratherapeutic change is termed to be the factors that are a part of the client (e.g., ego strength, psychological mindedness),

as well as part of the environment (e.g., fortuitous events and social support). The therapeutic relationship consists of the bond between the therapist and client, and, in effective therapy, is characterized by attributes such as love, empathy, warmth, and encouragement of risk taking. Techniques refer to those interventions that are unique to specific models (e.g., reframing, behavioral modification, etc.).

Expectancy refers to the improvement that is attributed to the client's expectation that he or she will improve as a result of coming to therapy.

More recently, Wampold (2001) uses the four dimensions proposed by Frank and Frank (1991) as a framework for what he calls a contextual model of psychotherapy, which he contrasts with a medical model of doing therapy. His meta-analytic work stands as one of the most convincing empirical arguments for common factors, as he demonstrates that these four variables can explain about 70% of the outcome variance in therapy. Furthermore, his meta-analysis suggests that at most, 8% of the outcome variance is accounted for by the unique contributions of various models (a percentage much smaller than the previous estimate of 15%; Lambert, 1992). Twenty-two percent of the variance of outcome was unexplained. Wampold's meta-analysis is particularly important because he only includes studies that directly compared two bona-fide treatments to each other, rather than the common effectiveness studies in which a treatment is compared to a less-respected or treatment as usual condition. Additionally, Wampold includes a review of component analyses, or studies which measure the differences in outcome based on adding or subtracting key components of a model

(e.g., empathic attunement in Emotionally-Focused Therapy, EFT; Johnson, 2004).

Proposed Common Factors in Psychology

Lists of common factors began to become increasingly common around the early 1980s. Generally, most lists fit into two categories: narrow or broad. Narrow conceptualizations of common factors focus on nonspecific aspects of various treatment models (e.g., changing the way clients see things, such as externalizing in narrative therapy or collaborative empiricism in cognitive therapy; Sprenkle & Blow, 2004a). The broad conceptualization (Lambert, 1992) highlights common factors that are unique to the treatment setting, such as client, therapist, relationship and expectancy variables.

The two lists that received the most widespread attention were the previously mentioned works of Frank and Frank (1991) and Lambert (1992). Today, most researchers use one of these two aforementioned frameworks as a guide for conducting research (Hubble et al., 1999), even though neither list was mathematically derived.

The empirical support for Frank and Frank's (1991) and Lambert's (1992) theoretical claims are growing. The results of Wampold's (2001) meta-analytic work attribute 70% of the outcome variance in psychotherapy to Frank and Frank's four categories of common factors.

Additionally, since the publication of Lambert's article (1992), a relatively large amount of research has generally supported his claims (Asay & Lambert, 1999). Specifically, the quality of the therapeutic relationship is often a significant

predictor of outcome in many studies (Horvath & Greenberg, 1994; Luborsky, 1994). The notion of client variables as a common factor receives support from the spontaneous remission literature. Many people improve from various disorders on their own through relying on their own creativity to find solutions to their problems, mobilize available resources, and come up with solutions independently from the therapist (Lambert & Bergin, 1994). Furthermore, researchers have cited the finding that level of therapist experience consistently has no significant relationship with outcome as evidence that the client is the primary vehicle of change (Tallman & Bohart, 1999).

Numerous studies from several disciplines offer evidence that clients improve (albeit to varying degrees) simply if they expect to. Lambert, Weber, and Sykes (1993) summarized the effects of the placebo effect on outcome from numerous studies in percentage improvement rates. Their findings suggest that the average client undergoing a placebo treatment is better off than 66% of the no-treatment control group. Much of client improvement can be attributed to their expectations for that improvement. However, placebo effects seem to be less powerful for clients with severe disorders and in studies where more experienced therapists are used (Barker, Funk, & Houston, 1988).

The History of Common Factors in MFT

Now that a larger context of common factors in psychology has been established, it is necessary to understand how common factors in MFT have developed within that context. In 1997, Wampler noted that, "Outcome research in marriage and family therapy has largely ignored the research literature on common factors underlying effective

psychotherapy” (p. 10). Since Wampler’s claim, research focusing on common factors in MFT has increased, though the state of research on common factors in MFT is woefully inadequate when compared to individual psychology (Davis & Butler, 2004). If MFT is indeed a discipline with something unique to offer, it is reasonable to hypothesize that there are factors unique to MFT that are responsible for change (Sprenkle et al., 1999).

Despite the research findings in individual psychology, MFT has historically been resistant to focusing on similarities rather than differences among models (Sprenkle & Blow, 2004a). MFT founders were trying to establish the distinctness and credibility of our field around the same time that Hans Eysneck was leveling his criticisms on the mental health field in general (Nichols & Schwartz, 2001). As a necessary first step in the formation of a new discipline, MFT leaders placed strong emphasis on the differences between systemic and linear approaches to working with mental health problems. Supreme importance was placed on the unique systemic theoretical conceptualizations of MFT (Watzlawick, Beavin, & Jackson, 1967). Inevitably, MFTs developed different models underneath the larger umbrella of systems theory. The early model developers were very charismatic, and quickly gathered a following of clinicians who assumed largely without question that if their therapy were effective, it was because of the techniques taught them by the developer of their favorite model. This trend was particularly strong in the first 30 years of MFT as the field was trying to establish itself.

The trend of focusing on differences rather than similarities among models still continues today in various forms, such as attempts to empirically establish the effectiveness of one model over another, the continued popularity of charismatic model developers on the workshop circuit (Sprenkle & Blow, 2004a), and the emphasis on

teaching models in MFT programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE; Davis & Butler, 2004; Nichols & Fellenberg, 2000).

Additionally, many MFT's expend great emotional effort developing and/or mastering their preferred model, and acknowledging that much of what makes their model work is common to other models as well may be too difficult. Perhaps Frank (1976) said it best: "Little glory derives from showing that the particular method one has mastered with such effort may be indistinguishable from other methods in its effects" (p. 47). The field of MFT also has an unfortunate history of not being influenced much by research (Nichols & Schwartz, 2001; Sprenkle & Blow, 2004a). At least in the early days, the field grew based largely on its intuitive or emotional appeal. As Sprenkle et al. (1999) note, "It was possible (and regrettably still is) for a highly charismatic individual to create a model of family therapy, find success on the workshop circuit, and obtain book contracts with reputable publishers to promulgate the model, without offering an iota of evidence for its efficacy beyond personal testimony" (p. 330). Following a model with emotional appeal is more enticing than focusing on the commonalities of models that may make them effective. Whatever the reason, MFT has only recently begun to acknowledge common factors.

Proposed Common Factors in MFT

Douglas H. Sprenkle and Adrian J. Blow (2004a; 2004b; Sprenkle et al., 1999) have been the primary contributors to the literature concerning common factors unique to MFT. Family therapist Barry Duncan and his colleagues (Duncan & Miller, 2000; Hubble et al., 1999; Miller, Duncan & Hubble, 1997) have also contributed a great deal to the

research on common factors, though their research has focused mostly on factors in psychology rather than MFT.

In the first article specifically outlining common factors unique to MFT, Sprenkle et al. (1999) review the MFT research literature as it relates to Lambert's (1992) four proposed categories, then added five categories of common factors that they believe are unique to MFT. These categories are: (a) relational conceptualization; (b) expanded direct treatment system; (c) the expanded direct therapeutic alliance in MFT; (d) behavioral, cognitive, and affective common factors in MFT; and (e) privileging of client's experience. In a more recent article Sprenkle and Blow (2004a) revised their views of common factors unique to MFT by replacing Lambert's (1992) fourth "model-specific techniques" category with a narrowly defined category labeled "nonspecific treatment variables" (p. 123) that include behavioral regulation (changing the doing), cognitive mastery (changing the viewing) and emotional experiencing (affective experiencing/regulation) as subcategories. They further revised their view by limiting the factors unique to MFT to a) relational conceptualization; b) expanded direct treatment system; c) the expanded direct therapeutic alliance in MFT. The models used in this study were chosen in part because they fit these categories that seem unique to MFT. This is true even of IFS. Even though an IFS therapist meets with individuals, he or she is systemic in that he or she focuses on isomorphic relationships between the client's internal and external systems. This is in contrast to psychological theories designed for the treatment of individuals that typically do not deliberately focus on systemic elements of the client's life.

In describing factors unique to MFT, Sprenkle and Blow (2004a) describe “relational conceptualization” (p.124) as the tendency for MFTs to describe problems in relational terms rather than from stemming within the person. MFTs pay close attention to many systems influencing a client’s life, and treat those systems as if they are present in the room even if they are not. This conceptualization, they propose, is unique to MFT and may account for some of the outcome variance.

The “expanded direct treatment system” (Sprenkle & Blow, 2004a, p. 124) refers to the fact that most MFT’s prefer to work with as many members of the system as possible. The tendency to deliberately bring in as many people as possible, at least during some phase of the treatment, is a hallmark of most MFT models and may be responsible for some of the outcome in MFT. This claim has been echoed by other researchers (Davis & Butler, 2004). Interestingly, many of the current postmodern approaches deemphasize meeting with more than one person (Gergen, 1994). This approach has been criticized as not being family therapy (Minuchin, 1998). Unfortunately, there is no research that distinguishes differences in outcome between systemic therapy with more than one person in the room and systemic-informed therapy with one person, regardless of whether or not that therapy is postmodern.

The “expanded therapeutic alliance” (Sprenkle & Blow, 2004a, p. 124-125) refers to the tendency for an MFT to form an alliance with each member of the system, the system as a whole, and subsystems within the system. These alliances are used to further treatment goals, and their deliberate formation to that end is unique to MFT.

A moderated common factors approach to MFT. Sprenkle and Blow (2004a) outline the state of the art of common factors research in MFT with what they call a

moderated common factors approach. Their moderated approach differs in several ways from a traditional common factors approach. First, Sprenkle and Blow do not support the “dodo bird verdict” (Luborsky et al., 1975; Rosenzweig, 1936) that suggests that one model is as good as another, but posit that “*among effective psychotherapies* [emphasis added] there are relatively small overall differences in treatment outcome, particularly when key confounding variables are controlled” (p. 115). For example, they note that using EFT is not the same as using tarot cards.

Second, Sprenkle and Blow (2004a) do not disparage treatment models, as some proponents of common factors have done in the past. Instead, they note that treatment models are necessary for common factors to work in that they provide a framework within which common factors can operate. Having a theory to guide a clinician’s work is a prerequisite for common factors to be able to work (Frank & Frank, 1991).

Third, some common factors researchers have posited that, since models do not matter, the quality of the therapeutic relationship must be both a necessary and sufficient condition for change (Patterson, 1984). Sprenkle and Blow (2004a) disagree, noting that while they “...do believe that the therapeutic relationship is a highly significant factor in treatment outcome, our approach argues that there is a much larger array of common mechanisms of change that should be studied as well” (p.115).

Fourth, Sprenkle and Blow (2004a) do not adopt the rather dim view of clinical trials research that other common factors researchers do (Duncan & Miller, 2000; Wampold, 2001). While they do believe that clinical trials researchers typically ignore common factors when designing their study, and that there are significant concerns with traditional clinical trials research, they believe that such methods can be a very useful

tool in furthering our understanding of common factors. For example, a clinical trials researcher could easily include numerous measures of hypothesized common factors (e.g., strength of the therapeutic relationship, certain pre-existing client variables, etc.) and see if those variables had any influence on outcome along with the various models being tested. Such research, they propose, would be more useful than a simple comparison of models on outcome.

Finally, Sprenkle and Blow (2004a) do not believe that common factors have to involve a rigid either/or approach. Instead, "...there are probably types of problems, clients, circumstances, and therapists for which a particular model is especially well suited. A moderate common factors position allows for some added benefit from specific factors but argues that the common factors have not been accorded their rightful place within family therapy" (p. 115). They do not prematurely discount the possibility that future research may reveal that some treatments work better for some clients in some situations with some problems (Paul, 1967).

Critiques of the Common Factors Approach in MFT

Now that a picture of the history and current state of common factors has been discussed, a look at critiques of the common factors approach is necessary to understand the purpose of the present study. The small common factors literature in MFT has been met with recent challenges (Sexton, et. al., 2004; Sexton & Ridley, 2004). Sexton et al. (2004) begin their argument by acknowledging that, "...the basic premise of the position is probably correct: There are central and common factors that contribute to successful outcomes that cut across seemingly different theoretical and practice models" (p. 134).

Despite their agreement with the core hypothesis of common factors, Sexton et al. (2004; Sexton & Ridley, 2004) raise the following concerns with the movement: (a) Is there research support for common factors?; (b) Do common factors integrate research into practice?; (c) Do common factors provide an adequate theoretical or conceptual foundation to explain the processes or mechanisms of change?; (d) Do common factors advance theory development?; (e) Do common factors provide the guidance necessary for clinical work?; and (f) Can common factors serve as the basis of clinical training (pp. 135-141)?

Sexton and his colleagues (2004; Sexton & Ridley, 2004) contend that the answer to all of the above questions is “no”. Although they offer different arguments for each point, a central theme of each argument is that common factors are too simplistic to move the field’s understanding of the change process forward. For example,

“...the *current articulation* [italics added] of the common factors perspective is seriously lacking as a comprehensive theoretical foundation to MFT. In our opinion, this is due to the oversimplification of the complex client change processes, the interactional dynamics between client and therapist, and the change mechanisms inherent in the common factors perspective...Thus, *in their current articulation*, [italics added] common factors can never provide a theoretical platform for further theoretical or research development. This is not to say that further development of these ideas might not result eventually in theory development. However, it is to say that the oversimplification inherent in

common factors will need to be replaced by a more accurate representation of the complexity of MFT” (Sexton et al., 2004, p. 140).

The current articulation of common factors in MFT consists of less than 10 articles (Davis & Butler, 2004), almost all of which are characteristic of the early stages of theory formation. Practically all that exists in the MFT common factors literature at this point are tentative lists of common factors (Blow & Sprenkle, 2001; Davis & Butler, 2004; Sprenkle et al., 1999; Sprenkle & Blow, 2004a) and articles providing an overview of the common factors literature in individual psychology and calling for MFT researchers to devote more attention to common factors (Duncan, Miller & Sparks, 2003; Miller, Duncan & Hubble, 1997; Wampler, 1997).

Thus, Sexton et al. (2004; Sexton & Ridley, 2004) are probably right. A student with no clinical training other than in the *current MFT* common factors literature (not including the relatively extensive individual psychology common factors literature from which MFT borrows) could probably not sit down with a client and do much better of a job than they could with no training at all. However, that is a reflection of the current state of the MFT common factors research, not the overall promise of the research should it be further developed. As Sprenkle and Blow (2004b) note in their reply to Sexton et al. (2004), “We never suggested the common factors approach to be a finished or completed product, as they seem to imply, and we hope to contribute to the on-going development of the approach” (p. 153). Should the common factors movement in MFT be further developed, it would likely provide the benefits that Sexton et al. (2004) acknowledge it would:

“Without question, finding a common core of factors to explain successful therapy would be a major breakthrough. This finding would simplify practice, training, and research. It would unify the theoretical schools of MFT, which often compete against one another and find themselves in contentious struggles. In essence, it would serve as a shorthand explanation for the complexity of practice and the diversity of clients, settings, and the sometimes disparate research findings” (p.131).

Advancing our Understanding of Common Factors

Thus we come to the purpose of the present study. The main purpose of this study is to empirically advance our theoretical conceptualization and clinical operationalization of common factors in MFT. Given that the common factors literature in MFT is still in very early stages of development, I utilized qualitative methodology to explore common factors. Specifically, I interviewed former marital/relationship clients of model developers in the field that terminated therapy successfully and asked them what helped them change. I also interviewed the therapists to get their view on how their clients changed. I also interviewed a former student of two of the model developers and their former clients. I used analytic induction and constant comparative methods from grounded theory (Glaser, 2001; Glaser, 1993; Glaser & Strauss, 1967) to analyze the transcripts to see if the clients say that similar things helped them change, and if so, what those things were. Such findings provide an empirical base on which to build a theory of common factors.

This study is the sole MFT study to date that investigates the change process of clients receiving therapy from a theoretically distinct source (i.e., MFT model

developers) as well as a source potentially more transferable to average practice (i.e., students of model developers) in an effort to inform the common factors literature. More detail of the specific methodology of the study is provided in chapter three.

Qualitative methodology is particularly well suited for developing a line of inquiry because it utilizes an inductive approach to data collection and analysis (Glaser, 2001; Glaser, 1993; Glaser & Strauss, 1967). An open-ended, inductive approach to data collection and analysis is often preferred in early stages of theory development because it helps ensure that the information gathered is not limited by the questions asked, as is the case in deductive, quantitative approaches. If I were to utilize a deductive, quantitative approach at this phase in the theory development, the information I gathered would be directed entirely by what I thought was important, which could miss important aspects of the change process that clients might identify. Instead, I approach the clients and therapists with an open mind, asking broad, open-ended questions that allow them to describe their experiences at length. There is no right or wrong answer to the questions I ask, as I do not know beforehand what I will find.

Three model developers or prominent MFT's that work primarily from a specific theory have agreed to participate in this study. They are Dr. Susan M. Johnson (one of the founders and current leader of emotionally focused therapy; EFT), Dr. Frank M. Dattilio (a current leader of cognitive behavioral marital therapy, CBMT, and a former student of Aaron Beck, the founder of cognitive therapy), and Dr. Richard C. Schwartz (the founder of internal family systems; IFS). Each of these model developers were also asked to identify a former student that would be willing to participate in the study, though Dr. Dattilio's student was unable to locate any clients that would participate in the study. In

order to provide a context within which to interpret their interviews as well as the interviews with their clients, the next section will focus on what each of these clinicians believe leads to change.

How People Change: Perspectives From Four Diverse MFT Theories

Johnson (1996) proposes three sets of questions that every theory must provide answers to in order to be of any practical use to a therapist. They are: (a) What is happening here? What is the problem? What is the target of intervention? (b) What should be happening here? What is healthy functioning? What is the goal of treatment? (c) What must the couple do to change the problem and move towards a healthier relationship? How can the therapist foster this change? (p. 17) I have found these questions to be useful in organizing my own thinking about different theories, so I will use each of these categories to guide my discussion of what each theory proposes as leading to change.

Emotionally Focused Therapy

An EFT therapist (Greenberg & Johnson, 1988; Johnson, 2004) views relationships through an attachment theory lens (Bowlby, 1988). According to attachment theory, human beings seek a lasting relationship with an irreplaceable other that provides a *secure base* or *safe haven* from which they may explore the world. Every person has a strong need to be accepted and loved, and in a secure relationship each person is emotionally accessible and responsive to these needs. These needs are referred to as *attachment needs* (Johnson, 2004). The extent to which a person is able to provide a secure base for others (including the self) in adult life is heavily influenced by the type of attachment they had with their parents or caregivers growing up. These early interactions

lead each person to be either *securely attached* (in which the self is viewed as basically loveable, and capable of responding to other's attachment needs), *anxiously attached* (in which the lovableness of the self and the legitimacy of attachment needs is uncertain, rendering dependency on someone else dangerous), or *avoidantly attached* (in which others are not trusted and are not depended on). Each style comes with characteristic emotional displays when an attachment bond is threatened.

In EFT (Johnson, 2004), emotions are seen as a signal of attachment needs. If the attachment bond is threatened, a person will respond emotionally in an attempt to restore the attachment bond. "Emotional expression organizes interactions and communicates inner states to others. *It is the music of the attachment dance* [italics in the original]" (Johnson, 1996, p. 22). When someone cries, it is an invitation to be comforted. If this invitation is refused, they may get angry and criticize their spouse. In EFT, this anger is seen as an attempt to get the partner to be more emotionally accessible; it is a protest to being abandoned emotionally. Sadly, this *secondary* emotional response of anger gets them less of what they need – comfort and reassurance.

What is the problem and target of intervention? To an EFT therapist, problems arise when each partner is not responsive to the other's attachment needs. Negative interactional cycles result, in which partner's behavior gets them less of what they need. For example, if the person in the previous example was a wife crying to her husband, she would perceive his unresponsiveness as evidence that he did not care about her. She would react to this perceived abandonment with anger. The husband would want to protect himself from fears of rejection and failure to meet his wife's needs, so he would withdraw. His withdrawal would scare the wife more, which would increase her

attacking, which would increase the husband's sense of inadequacy and lead to him withdrawing more. Thus, each person's behavior ensures that they do not get what they want the most – a secure bond with their partner. The target of intervention, therefore, is the attachment-based emotional experience, expression, and responsiveness of each member of the couple.

What is healthy functioning? What is the goal of treatment? To an EFT therapist, a couple achieves healthy functioning when each partner is able to express their attachment needs in terms of soft, primary emotions and respond to their partner's expression in a way that promotes a secure base. "It is clear when the therapy process is complete, because the couple is able to exit from negative cycles in the session, to sustain emotional engagement, and to be accessible and responsive to each other" (Johnson & Greenberg, 1995, p. 130).

What must the couple do to change the problem and move towards a healthier relationship? How can the therapist foster this change? An EFT therapist focuses on experientially evoking attachment-oriented emotions, then reprocessing those emotions in a way that they are more likely to get their needs met from their partner. For example, the therapist may say to the wife, "I wonder if it must be terribly scary to see your husband not hold you when you cry." If the wife agrees, the therapist may say, "Could you express that fear to your husband?" The therapist proceeds through each partner's emotional experience, reframing the harsh, secondary emotions such as anger or withdrawal as softer, primary emotions and has the couple express them to each other. As the couple does this, they begin to see each other differently, feel emotionally safer around each other, and respond to each other's needs more appropriately.

Cognitive-Behavioral Marital Therapy

A cognitive-behavioral marital therapist (CBMT) is concerned with behavior, the consequences that maintain that behavior, and the cognitions associated with that behavior (Dattilio, 2001). Behavioral aspects of CBMT has its roots in classical conditioning (Pavlov, 1932), in which an unconditioned stimulus like food, which leads to an unconditioned response like salivating, is paired with a conditioned stimulus. Over time, the conditioned stimulus alone results in the unconditioned response. Principles of operant conditioning (Skinner, 1953) also had a large influence on the development of CBMT. "Operant" refers to any behavior that is voluntary (e.g., arguing), as opposed to involuntary or reflex behavior (e.g., salivating). In operant conditioning, behavior is maintained by its consequences. Behaviors that elicit positive reinforcement are likely to be repeated; those that are punished or ignored are likely to be extinguished.

The stimulus-response-stimulus chain (S-R-S) is a staple of assessment and intervention in operant conditioning. For example, a husband is late arriving home from work (stimulus) and is met with by angry wife (response) to which he responds by retreating to the television (response). A behavioral therapist would focus on extinguishing the anger by having the working spouse arrive home on time and rewarding the kind behavior this elicited from the spouse, or by changing his response when he arrived home late until he found a response that did not elicit anger. This becomes far more complicated, however, when expanding the view to take into account the entire day's interactions. When doing this, it is easy to see how a stimulus can also be a response, and vice-versa.

Cognitive aspects of CBMT have their roots in cognitive therapy (Beck, 1976; Ellis, 1962). Cognitive therapy is concerned with automatic thoughts based on arbitrary inferences about others and one's own behavior. These automatic thoughts are shaped by a person's schemas – core beliefs about how the world functions (Dattilio, 2001). To use the previous example to illustrate the blend of cognitive and behavioral aspects, the husband comes home late from work (stimulus) to which the wife thinks “If he loved me, he'd come home on time” (arbitrarily inferred automatic thought). This thought leads to anger (response), to which the husband thinks “I can never please my wife, so why try” (automatic thought) and plops down in front of the television (stimulus).

What is the problem and target of intervention? To a CBMT therapist, the problem is the behavior the clients wish to be rid of, and the cognitions associated with that problem. The targets of intervention are consequences of the behavior and the cognitions surrounding the behavior (Dattilio, 1998).

What is healthy functioning? What is the goal of treatment? CBMT therapists recognize that families will inevitably have problems, and therefore place a strong emphasis on increasing their ability to cope with problems (Gottman, 1994). A family is healthy if it can maintain a healthy aspect of positive to negative behaviors (a 5:1 ratio to be exact; Gottman & Silver, 1999), have good problem solving and communication skills (Jacobson & Christensen, 1996), and understand the influence their automatic thoughts have on their behavior and are capable of modifying those thoughts and those of other family members (Dattilio, 2001).

What must the couple do to change the problem and move towards a healthier relationship? How can the therapist foster this change? A couple must learn the skills

necessary to achieve healthy functioning, and it is the therapist's responsibility to ensure they learn them. The couple must be able to understand the importance of CBMT concepts and be able to implement them on their own at home. The therapist's role is to explain the concepts so the clients understand them, then, through in-session practice, numerous techniques, and homework, ensure they can implement CBMT principles on their own (Dattilio, 2002).

Internal Family Systems Theory

IFS was developed primarily by Dr. Richard Schwartz (1995; Breunlin, Schwartz, & Mac Kune-Karrer, 2001; Goulding & Schwartz, 1995) in an attempt to merge systems thinking with intrapsychic processes and larger cultural and political issues (Nichols & Schwartz, 2001). In addition to borrowing ideas from intrapsychic psychology, it borrows systemic concepts from structural, strategic, experiential, psychodynamic, and Bowenian theories. According to IFS, the human mind is divided into several different "parts" that follow the same systemic rules of relating to each other that groups of people do (Breunlin et al., 2001). Using a "parts" lens, IFS provides the systemic therapist a familiar map to a client's intrapsychic world.

Though everyone has parts to their mind, people struggling with mental and emotional difficulties have parts that, for some reason, are relating in an extreme way to other parts of the mind. People who have experienced some form of trauma in their lives (from mild to severe) form three different parts – exiles, managers, and fire fighters (Goulding & Schwartz, 1995). *Exiles* are the parts of the mind that are hurt in some way and are subsequently rejected and abandoned by other parts of the mind because of their shameful state. *Managers* live in fear of the exiles; it is their role to keep the exiles

exiled, both for the good of the exiles and the good of the system. Managers use tools such as obsessions, compulsions, reclusiveness, somatic complaints, depressive episodes, hyper-alertness, passivity, and emotional detachment to keep the exiles in their place. Managers are like parentified children in a dysfunctional family – scared, suffering, and neglected yet desperately trying to hide their suffering for the sake of the system. *Fire fighters* are supposed to numb the negative feelings in the system no matter what the cost. They achieve this through activities such as self-mutilation, drugs and/or alcohol, binge eating, excessive masturbation, or promiscuity. They are called into action by the managers when an exile tries to escape, though once the exile is contained the manager immediately attacks the fire fighter for being out of control, indulgent, and weak.

Everyone's mind also contains a *self* that is different from the parts (Breunlin et al., 2001). Once differentiated from the parts (i.e., separated from their feelings and thoughts), the self is capable of standing *meta* to the parts and leading with compassion, confidence and vision. The self is fully equipped to lead once it has been differentiated from the parts; it does not need further development by the therapist.

The person's internal as well as external systems both strive for balance, harmony, and leadership (Breunlin et al., 2001). The same rules that govern the person's internal systems govern their external systems, so change in one will trigger change in the other.

What is the problem and target of intervention? To an IFS therapist, the systemic effect of intrapsychic parts acting in an extreme way (as outlined above) is the main problem. When a person has parts that try to deny or disown each other, internal conflict

is sure to result. The target of intervention is their intrapsychic parts and their relationships among each other.

What is healthy functioning? What is the goal of treatment? A healthy person has parts that understand and accept each other, and fully allow each other to perform their unique roles when needed. The self is fully in charge of directing the parts. The goal of treatment is to help the parts communicate with, understand, and accept each other without behaving in an extreme way.

What must the couple do to change the problem and move towards a healthier relationship? How can the therapist foster this change? Since the client's internal and external worlds comprise one large system, and change in one will effect change in the other along similar lines, the IFS therapist carefully assesses each of these systems and decides whether to proceed with an individual, couple, or family. Regardless of which level of the system the therapist chooses to work with, he or she must get the client(s) to understand, accept, and fully embrace all their parts. The therapist borrows techniques from many different schools of family therapy to achieve this, from experiential "empty chair" techniques to narrative re-storying to paradoxical interventions.

Chapter III

Methods

In this chapter I will first outline the research questions that guided this study. I will then discuss the elements of grounded theory methodology (Glaser, 2001; Glaser, 1993; Glaser & Strauss, 1967) that I used in this study, and their unique fit for answering the questions I am asking. I will provide detail concerning the therapists, clients, and methods of data collection and analysis. The chapter will end with a discussion of my own role as the researcher, including what I believe leads to change and how that may influence the data analysis.

Research Questions Guiding This Study

Specific questions that were asked during the interviews are found in the semi-structured interview protocol (appendix C). The following research questions guided this study:

Client Perspective on Change

1. What do the clients say helped them change?
2. Do the clients of different therapists report that similar things helped them change, different things, or some combination of the two?
3. If there are similarities in what the clients of different therapists say helped them change, do their comments follow the current common factors framework? If so, how?
4. If the client's comments do not follow the current common factors framework, in what ways do they differ from the current framework?

5. If the clients report that different things helped them change, are these differences model-specific, random, or some combination of the two?
6. Are there differences between the model developers and their students in terms of what their clients say helped them change? If so, what are those differences?

Therapist Perspective on Change

7. What does the therapist say helped their clients change?
8. When discussing what helped their clients change, do different therapists report similar things, different things, or some combination of the two?
9. Do the therapists' comments suggest evidence of common factors concepts intermingled with their theoretical conceptualizations of change? If so, what particular elements get mentioned?

Co-construction of Change

10. How did the therapist and client make sense of the change together?
11. Does the therapist have a sense of what their client would say helped them change? If so, how did they arrive at these opinions?
12. Does the client have a sense of what their therapist would say helped them change? If so, how did they arrive at these opinions?

The answers to these questions could further the theoretical conceptualization and operational development of common factors in MFT.

Using Grounded Theory to Study Common Factors in MFT

Grounded theory methodology (Glaser, 2001; Glaser, 1993; Glaser & Strauss, 1967) is well-suited for a study of common factors because the notion of common factors

suggests that there is a theory within the existing theories that begs to be discovered. Something is common among the theories of therapy that helps people recover from a multitude of problems, but we know little about what it is. Grounded theory offers a systematic approach to inductively and deductively analyze raw data from clients discussing what helped them change. Unlike most qualitative approaches, however, grounded theory also deductively tests the tentative conclusions reached during the research process by weighing new data with existing categories inductively derived from existing data to see if the categories continue to fit. This unique mix of deductive and inductive inquiry makes grounded theory a good fit for studying an area where there is a promise of a theory in waiting.

In this regard, grounded theory is different from its qualitative counterparts. In contrast to similar approaches which focus on explaining the subjective meaning-making process of an event (e.g., phenomenology) or culture (e.g., ethnography), grounded theory seeks to find meaning in the data, but then to combine this meaning into discrete categories which are then conceptually linked together to form a theory. For example, a phenomenological approach to research focuses on describing a client's experience of the phenomenon of change. A grounded theory researcher would gather the descriptive account of change as a phenomenological researcher would, but would continue on in an effort to draw theoretical linkages between different conceptually linked categories derived from the description. The end result would be a theory of why change occurred, not solely a description of what occurred.

A researcher using pure grounded theory (Strauss & Corbin, 1998) starts with no assumptions about the data – he or she starts from the ground up. In this study, however, I

have several assumptions about the data (i.e., there are factors common across models responsible for change), which assumptions precluded me from being able to utilize grounded theory in its entirety. Though I did not use a pure form of grounded theory, I did use several data collection and analysis techniques from grounded theory (e.g., constant comparative method, analytic induction, open coding, and axial coding) to answer my research questions. However, it was not appropriate to use grounded theory in its entirety for this study. I will refer to those grounded theory methods I used hereafter as a “modified grounded theory.”

Rationale for Selection of Participants

Discovering whether or not there are similarities in the change process as reported by clients who received theoretically distinct yet clinically transferable (i.e., generalizable) therapy was the main objective of this study. Such an objective makes critical case sampling (Patton, 2002) an ideal method for recruiting a sample. Patton (2002) describes a critical case as, “a statement to the effect that “if it happens there, it will happen anywhere,” or vice versa, “if it doesn’t happen there, it won’t happen anywhere...if that group is having problems, then we can be sure all the groups are having problems.” (p. 236). In other words, if common factors are found in the experiences of clients receiving theoretically distinct therapy, then they will likely be found in clients of other therapists utilizing the same models.

In critical case sampling, critical cases (i.e., clients who received theoretically distinct yet clinically transferable therapy) are purposefully sought using whatever means of recruitment is most likely to secure participation in the study. Many researchers use snowball or chain sampling to secure critical cases. In snowball or chain sampling, “[the

researcher asks] well-situated people: “who knows a lot about _____? Whom should I talk to?” (Patton, 2002, p. 237) and proceeds to recruit the recommended people for participation in the study. I utilized snowball sampling to secure critical cases by asking various members of my committee if they knew any MFT model developers that they thought would be willing to participate in this study. Six model developers were contacted, and four agreed to participate. Later, one of the initial four declined to participate. Additional efforts to recruit another model developer also failed, bringing the total number of model developers to three. The model developers were asked to provide the names of former students whom they believe would participate, and they were contacted in a similar manner via email. All model developers located former students that were willing to participate.

Client Selection

Dr. Schwartz, Dr. Dattilio, Dr. Johnson and one of their former students were each asked to recruit a couple to participate in the study. The therapists were given details about the study, as well as a link to the online consent form (see appendix G), to give to their clients. The therapists were then asked to have their clients sign a release of information and return that release to me. Several therapists mentioned that they would prefer that they just give me the names and telephone numbers of clients that had agreed to participate and I could get the release of information and fax it back to them. I followed this procedure with all of the clients. One couple was contacted initially via email (see appendix B), and the others were contacted initially via telephone. They were each emailed a link to an online informed consent form (see appendix G) which they filled out. I also faxed or mailed each client a release of information (see appendix F) and

instructed them to fill it out and return it to me. Upon receipt, I faxed the completed release of information to the therapist and set up an appointment for an interview with both the couple and the therapist.

Initially, therapists were asked to recruit a couple that had terminated successfully within the past year and with whom they had primarily used the model the therapist is associated with. All of the therapists except for Dr. Schwartz and Ms. O'Neil (Dr. Schwartz's former student) were able to locate a couple that fit that criteria. Dr. Schwartz and Ms. O'Neil were only able to locate an individual that had been primarily working on couple issues. Additionally, Dr. Schwartz's client was still occasionally coming in for therapy about once a month. Since working with an individual on couple issues is an approach theoretically consistent with IFS, I proceeded with those interviews. Dr. Dattilio was unable to recruit any couples that fit the criteria exactly, so I interviewed a couple whom he was still seeing about once every three weeks and would soon be finished with therapy. Dr. Dattilio's two students he referred were unable to locate any clients that were willing to participate in the study, so they were excluded from the study.

Clients

Three couples and two individuals working primarily on relationship issues participated in the study, bringing the total number of client participants to eight. Each participant chose an alias by which they were referred in the interviews and the dissertation. Demographic data for each of the couples is below and in table 1. All client names are pseudonyms.

Dr. Schwartz's client is named William Andrews. He saw Dr. Schwartz for about three years, and was seeing him about once a month when I interviewed William.

William sought therapy with Dr. Schwartz due to internal conflict he was having over the fact that he had fallen in love with a woman other than his wife of 18 years. William decided to pursue a divorce. He is Caucasian, is 42 years old, and has a Ph.D.

Ms. O'Neil's (Dr. Schwartz's former student) client is named Bridgette. She and her husband, Mohammed, are both 38. Her husband did not participate in therapy or the interview, though he did participate in homework exercises that Ms. O'Neil gave Bridgette. Bridgette is Caucasian and Mohammed is Arab. Bridgette has a B.S. and Mohammed has two B.A.'s, and they both completed some Master's degree work. At the time of the interview they had been married for two years and had dated for almost two years before their marriage. Bridgette had been in therapy with Ms. O'Neil for 6.5 years, and had ended therapy in August 2004. Bridgette initially sought therapy for help dealing with the ending of a previous relationship.

Dr. Dattilio's clients are named Geller and Tiffany. Both are Caucasian and have been married for 17 years and known each other for 19 years at the time of the interview. They had been in therapy with Dr. Dattilio and Marianne Dattilio, (the spouse of Dr. Frank Dattilio and co-therapist with him on the case), for 15 months and were finishing up their work in therapy when I interviewed them. Geller is 41 and has a bachelor's degree. Tiffany is 39 and has an associate's degree. They sought therapy for help with difficulties communicating.

Dr. Johnson's clients are named Cassandra and Paul. They declined to provide demographic information beyond their race, which is white. They had been in therapy with Dr. Johnson for approximately 18 months at the time of the interview, and were planning on seeing Dr. Johnson one or two more times, though it had been several

months since they last saw her. They initially sought therapy because Paul was suffering from depression and they were experiencing marital distress.

Pseudonym	Client ID (Nomenclature)	Therapist	Age	Race	Education	Years in Relationship	Months in Therapy
Charles	EFT~ST~CL~H	Dr. Makinen	77	White	J.D.	15	5
Louise	EFT~ST~CL~W	Dr. Makinen	49	White	B.S.	15	5
Cassandra	EFT~DV~CL~W	Dr. Johnson		White			18
Paul	EFT~DV~CL~H	Dr. Johnson		White			18
William	IFS~DV~CL	Dr. Schwartz	42	White	Ph.D.	18*	36
Bridgette	IFS~ST~CL	Ms. O'Neil, MSW	38	White	B.S.	4	78
Geller	CBT~DV~CL~H	Dr. Dattilio	39	White	B.S.	19	15
Tiffany	CBT~DV~CL~W	Dr. Dattilio	41	White	A.A.S.	19	15

* William went through a divorce during therapy and began a new relationship. He had been in that relationship for about one year at the time of our interview.

Dr. Makinen's (EFT~ST) clients are named Charles and Louise. Charles is 77 and Louise is 49. At the time of the interview they had been married for fifteen years. They were in therapy with Dr. Makinen for five months and had terminated therapy six months prior to the interview. Charles has a J.D. and Louise has a B.S. They sought therapy due to conflicts over Louise's choice to take antidepressant medication. Charles was strongly opposed to the choice.

Client Nomenclature

I developed a client nomenclature system to facilitate identification of quotes during the coding and writing process. Nomenclature for each client is in table 1. The first three letters of the nomenclature identify the modality (e.g., EFT). The second two

letters, preceded by a dash, indicate model developer (DV) or student of a model developer (ST). The third two-letter set indicates that the person is a client (CL). The final one-letter set indicated husband (H) or wife (W). So, EFT~DV~CL~W indicates the wife in Dr. Johnson's couple. Since the IFS clients were individuals, there is no fourth letter set. For example, Ms. O'Neil's (Dr. Schwartz's former student) client is IFS~ST~CL.

Therapists

Therapists were selected based on their either being an MFT model developer, a current leader of a model in MFT, or a former student of the same. Therapists were contacted via email from my dissertation committee chair, Dr. Fred P. Piercy. A copy of the email is found in appendix A. The email described the study in detail. Therapists were asked to contact at least one of their former marital or family clients who meet three criteria: 1) they are judged by the therapist to have successfully completed therapy within the past year; 2) the primary treatment modality was that with which the therapist is affiliated; and 3) they did not seek treatment with the therapist based on their model. Model developers were then asked to recruit a student who they had trained within the past year who still practiced therapy using the model the developer is associated with. Former students were contacted via telephone or email. I explained the study and their role in it to them as I did to the model developers. Dr. Dattilio provided me with the names of the only two former students who fit my criteria (he had not been doing much training lately), but neither of them were able to recruit any clients. After seeking permission from my dissertation committee, they were excluded from the study. Ms. Beth O'Neil, MSW, is Dr. Schwartz's former student. Dr. Judy Makinen is Dr. Johnson's

former student. Additionally, Marianne Dattilio served as a co-therapist with him periodically throughout therapy with their clients. Since both Dr. Frank Dattilio and Marianne Dattilio primarily used CBT, she was not interviewed.

Data Collection

Each couple was asked to participate in a 30-60 minute open-ended audiotaped telephone interview. Each client was interviewed individually. A qualitative interviewer (Seidman, 1998) gathers the most information when he or she does not adhere to a rigid interview protocol. Rather, a less structured interview guided by general questions often elicits richer data (Patton, 2002). Therefore, the interviews were guided by the broader research questions discussed previously. See appendix C for a copy of the interview protocol. In an effort to better understand client (Tallman & Bohart, 1999) and therapist (Najavits & Strupp, 1994) variables affecting change, I asked what they, their therapist and their spouse did that helped them change. To better understand the co-construction process at work between the client and therapist, I explored how the therapist and client discussed the change process with each other. In general, I asked the therapists the same questions that I ask the clients. See appendix D for a copy of the therapist interview protocol. I transcribed approximately one-third of the interviews. After signing a confidentiality agreement and completing training, four undergraduate students transcribed the remaining audiotapes in preparation for data analysis. The audiotapes and hard copies of the transcripts were kept in a locked filing cabinet. The soft copies of the transcripts were kept on my computer in a password-protected file. I also kept a journal of my impressions of possible themes during and after each interview which was also included in later data analysis.

Analysis

Primary concerns many researchers have with qualitative research are issues of trustworthiness, credibility, and transferability (Erickson, 1986). To what extent does the data actually reflect the client's experience? How do researchers account for the impact of their biases on the data? How do readers know if the study's findings relate to the circumstances of others? These issues were addressed in part by using the constant comparative method of data analysis (Strauss & Corbin, 1998). In this methodology, data are simultaneously coded and analyzed, with themes from each new interview informing the themes from previous interviews, and themes from previous interviews informing subsequent interviews. Several additional steps (see Table 2) were taken throughout the procedure to ensure trustworthiness, credibility, and transferability.

First, I independently read the transcripts and journal in an *open coding* procedure. Strauss and Corbin (1998) describe open coding as “the analytic process through which concepts are identified and their properties and dimensions are discovered in data” (p. 101). In other words, I “broke apart” the data and put it back together as I read through the transcripts and searched for broad categories of what contributes to change. This initial open coding was done on paper copies of the transcripts, with categories being noted in the margins. This initial coding took approximately forty hours. As I read more transcripts, I deductively searched for information to support the categories that were emerging from the data, and inductively searched for overlooked data to form new categories. I completed the second round of open coding by going through each interview again, this time entering the data into NVivo, a qualitative analysis software program. In this program quotes from each interview were placed into

categories (i.e., themes) and tentative subcategories. This process took about thirty hours. I reached *saturation* – the point when no new categories or subcategories emerge from the data – after about 10 interviews. During this process I also made notes about possible relationships between categories and subcategories for the next stage of coding.

After I finished open coding I began *axial coding*. Strauss and Corbin (1998) define axial coding as “the process of relating categories to their subcategories, termed ‘axial’ because coding occurs around the axis of the category, linking categories of the level of properties and dimensions” (p. 123). Axial coding involves further refining the broad categories by defining its subcategories and explaining how the subcategories are linked to the categories. I read through the codes several times during this stage. The coding in this stage was done exclusively in NVivo.

At this point I addressed trustworthiness by having two other master’s-level MFT students read 30% of the transcripts in an open coding procedure. Each of the students read the same interviews, and both found mostly the same themes that I did. Any differences served primarily to further refine the subcategories that I had found.

Following this stage, I returned to the data to make *relational statements*. Strauss and Corbin (1998) say the following about relational statements: “We call these initial hunches about how concepts relate *hypotheses* because they link two or more concepts, explaining the what, why, where, and how of phenomena” (p. 135). Relational statements specify how the categories are linked theoretically. I continued in this endeavor until I reached saturation.

Throughout the coding I looked for themes as well as differences within couple dyads, within therapist/couple dyads, and across all couple and therapist/couple dyads.

Since my focus was on identifying themes common among models, a primary focus of coding was across models.

To further enhance credibility, trustworthiness, and transferability, I looked through the dual lenses of theory specificity and common factors when analyzing the transcripts. When appropriate, the data are reported in such a way that readers can see the verbatim operational definition of the concept, the model-specific explanation of the concept, and the common-factors explanation for that concept side by side (see appendix E). In this way, I respectfully report – side by side – model specific and common factor explanations of change. This will allow the reader to consider dual processes of making sense of change across three distinct theories, with both the developers of the models and their clients, as well as second-generation proponents of the same models and their clients.

I encountered a difficulty related to reinforcing stereotypes when I wrote clinical examples to illustrate principles I discussed. Namely, I realized that it is impossible to write a clinical example that does not exclude some group of people, be they a minority or majority group. Writing case examples are inherently problematic in this regard. My solution was to write clinical examples that would resonate with the largest possible audience (i.e., the demographic majority), though I realize that in doing so I may exclude minorities. I regret this inevitable necessity, and hope that readers will be sensitive to my dilemma.

I further sought to establish trustworthiness, credibility, and transferability through providing numerous quotes to clarify each category and subcategory so the reader can decide for himself or herself if he or she agrees with my conclusions.

Additionally, utilizing the constant comparative method and *triangulation* – the process of using more than one source (e.g., researcher) to analyze the data – helped ensure the minimization of researcher bias. Another method is to explicitly discuss what I believe leads to change so that readers can know my own biases along with accompanying procedures I will use to assure that my results are not simply a reflection of my own biases. Such a discussion is the focus of the next section.

Role of the Researcher

The patterns and themes that I will see in the data will inevitably be colored by my preferences, beliefs, and past experiences. My challenge as a qualitative grounded theory researcher is to minimize the effects of my preferences on the reporting of the data. The data needs to reflect as closely as possible what the participants say. To aid the reader in determining the extent I have achieved that goal, I will discuss my beliefs about change in therapy.

My Beliefs About Theory

The primary purpose of a theory is to guide the clinician through the maze of information presented to him or her by a family and to use that information to help them achieve healthier functioning. A theory provides answers to the following questions every clinician must answer when seeing a family: 1) what information should I focus on and why; 2) what patterns and redundancies are present in this information; and 3) how will changes in the information I focus on lead to healthier family functioning? The usefulness of a theory is determined by the extent to which it answers the above three questions. While the answers to these three questions vary among theories, I believe that in general the behaviors that flow therefrom are much more similar than different. I

believe that different theories use different language to describe remarkably similar processes, and that the differences which do exist are primarily at the conceptual rather than the operational level. Different theories exist primarily for the benefit of different therapist preferences and styles. Factors that actually help clients change is found to some degree in most theories. I believe that the things a therapist does that elicit change are common across theories, and that therapists would benefit from asking what they believe some of these factors are.

I believe that change follows certain principles. These principles constitute a “golden thread” that is in place every time an individual or a system makes a lasting change. These principles are true independent of their observation and/or quantification by clinicians or researchers; they are not socially constructed. Every time a person makes a lasting change, some or all of these principles are involved. I believe that all MFT theories touch to some degree or another on these principles, though no one theory completely encapsulates all principles necessary for change. I believe that the common factors line of research is the closest our field has come to discovering these principles, which is why I am so interested in the movement.

In summary, I believe that no one theory is “the truth” per se, but rather each contains elements of universal principles of change. A therapist will be maximally effective when he or she uncovers the common factors of change that operate across theories and uses these to inform his or her therapy. Rather than aimlessly drifting through therapy, an effective therapist will be fluent in many different theories which he or she will move between as the situation requires.

Table 2

Methods of improving credibility, trustworthiness, and transferability.

Credibility: How readers can know if the results are consistent with the data collected.	Trustworthiness: How readers know if the researcher’s findings can be trusted.	Transferability: How readers know if the study’s findings relate to the experiences of others.
<ul style="list-style-type: none"> • Triangulation of data <ul style="list-style-type: none"> • Couple interview data quoted in text • Therapist interview data quoted in text • Using three researchers to analyze the data • Couple and therapist rate therapy as successful • Constant comparative method of data analysis • Analytic induction • Discussion of researcher bias • Analyzing and reporting through dual lenses of theory specificity and common factors 	<ul style="list-style-type: none"> • Triangulation of data <ul style="list-style-type: none"> • Couple interview data quoted in text • Therapist interview data quoted in text • Using three researchers to analyze the data • Couple and therapist rate therapy as successful • Constant comparative method of data analysis • Analytic induction • Discussion of researcher bias • Analyzing and reporting through dual lenses of theory specificity and common factors 	<ul style="list-style-type: none"> • Triangulation of data <ul style="list-style-type: none"> • Couple interview data quoted in text • Therapist interview data quoted in text • Using three researchers to analyze the data • Couple and therapist rate therapy as successful • Reporting unique client characteristics and the possible resultant effects on the data • Utilize model developers as well as their students as sources of data • Discussion of researcher bias • Analyzing and reporting through dual lenses of theory specificity and common factors

He or she will search for patterns and redundancies in the information presented to him or her, and will always be asking how these contribute to family functioning. In doing this, he or she will be mindful of the commonalities across theories that he or she believes are necessary for change to occur. I believe that once we lay aside our theoretical rivalries and truly understand what it is about therapy that helps people change, that we will see dramatic improvements in the effectiveness of our work as MFTs.

Having said that, I believe that the facts are always friendly. It could reasonably be construed that I will find common factors in this study no matter what, and that my search will not be inductive at all given my pre-conceived beliefs about change. In truth, my zeal lies in discovering how people change rather than in proving one line of thinking over another. I will report the changes people make, the model-specific operations that therapists believe led to that change, and the common factors conceptualization of that explanation. In other words, I will institute methods that support multiple lenses to understanding change rather than a rigid “either-or” approach.

My Theoretical Preferences

I consider myself to be an integrative therapist. I have a good working understanding of most MFT theories, and prefer to adapt the theory to the client rather than vice-versa (Piercy, 1984). My choice of theory is determined by client needs. Though I do use many different theories in my work, I typically rely on what I loosely term psychodynamic and attachment-oriented approaches (Greenberg & Johnson, 1988; Kerr & Bowen, 1988; Scharff & Scharff, 1987), experiential (Satir, 1988), and communications oriented (Watzlawick et al., 1967) approaches unless client needs dictate otherwise. I typically prefer experientially oriented approaches such as EFT, though I will use cognitive or insight oriented approaches such as CBT or Bowenian therapy equally as comfortably.

Chapter IV

Results

Overall, the data fell into two broad categories: *model-dependent* themes and *model-independent* themes. Model-dependent themes are elements of therapy that are directly informed by the therapist's model. They are elements of therapy that would not be there if the therapist was not using a model, such as the way they conceptualized the case. If a therapist did not have a model, he or she would have no way of conceptualizing the case. Model-dependent themes do *not* imply that specific elements of a model are more important than those of another model.

Model-independent themes are those elements of therapy that are more general in nature and are not directly related to the model, such as the therapeutic relationship or therapist and client attributes. Each of the three categories had several subcategories. Model-independent themes fell into the following five categories: 1) therapist variables; 2) client variables; 3) the therapeutic alliance; 4) therapeutic process; and 5) expectancy and motivational factors. Each category had several subcategories.

Therapy seemed to roughly progress through the stages of conceptualization, intervention, and then outcome. Model-dependent and model-independent themes were found throughout each of those three stages of therapy, though those themes will be discussed primarily in the model-dependent section.

In this chapter I will discuss all of the categories and subcategories found during data analysis. I will begin with discussing the model-dependent categories and subcategories, followed by a discussion of the model-independent categories and subcategories. In the final section I will present a model that synthesizes the categories,

detailing how the categories and subcategories are all related to each other relative to change in therapy. Model-specific and common factors will be discussed throughout.

Model-Dependent Themes

Model-dependent themes are those themes that are directly informed by the therapist's theory, such as the way problems are conceptualized, interventions that are crafted that address those problems, and elements of health that signal the couple is ready to terminate therapy. There are no themes unique to one model that was "better" than similar themes of other theories used in the study. Similar outcome was achieved by all models. See Table 3 for a list of model-dependent categories and subcategories.

Therapist's Common Conceptualizations

The first category in which model-dependent themes were found is common conceptualizations. Each therapist had a conceptualization of their client's presenting problem that was informed by their model. They had a clear view of what the problem was and how it came to be. While much of the conceptualization was model-specific, there were three main areas of overlap: 1) family of origin influences on their current relationship; 2) current interactional cycles that resulted from prior family of origin experiences; and 3) affective, behavioral, and cognitive dysfunctions learned in the family of origin that perpetuated the current interactional cycle. See table 3 for a summary of common conceptualizations.

<p>Table 3 <i>Model-dependent categories and subcategories.</i></p>
<p>Therapist’s common conceptualizations Family of origin influences on current behavior Cognitive, affective, & behavioral elements of interactional cycles</p> <p>Client’s common conceptualizations</p> <p>Co-construction of the problem conceptualization</p>
<p>Common interventions</p> <p>Raising awareness of the cycle and each individual’s role in it Slowing down the process Standing meta Encourage personal responsibility</p> <p>Use of metaphor</p> <p>Family of origin as a context for the cycle</p> <p>Altering the cycle Emotional regulation Cognitive reframing Behavioral shifts</p>
<p>Common outcomes</p> <p>Softening Client’s awareness of the cycle and their own role in it Softening of thoughts Softened behavior Softened affect/emotional regulation</p> <p>Making space for the other Support of partner’s autonomy Confidence Slowing down Personal responsibility</p>

Family of origin influences on current behavior. At least one therapist from each model viewed their client’s problems as stemming from experiences in their family of origin. Dr. Dattilio described the following:

“Geller was a very controlling individual, I mean ridiculously controlling. He’s very successful for a young guy in [business]. He just was a pain in

the ass. He had a father who really never accepted him and was always putting him down. Even when he first took Tiffany to meet his father he looked and he said, “She’s a sharp girl. What the hell is she doing with you?” That kind of thing. His mother...made up the difference. This kind of set up a [spoiled attitude] with him... A lot of my time was focused on helping Geller deal with his feelings about being rejected and that went back to his childhood, and the [things] his wife did that sometimes reminded him of the way his father [acted].”

When describing Tiffany’s (i.e., Geller’s wife) role in the marital distress, Dr. Dattilio said, “It’s interesting – her mother was very condescending and she ended up marrying a male version of her mother.”

Dr. Johnson mentioned that, “[My clients] grew up in an Eastern-European culture which I know quite well and where I don’t think they had a very supportive environment to grow up in.” She went on to describe how, because of their family of origin and cultural issues, her clients did not learn to be emotionally available and responsive to each other. Dr. Makinen’s (EFT~ST) clients were having difficulties agreeing on the wife’s use of prescription medication to treat her depression. The husband strongly disagreed with using medication to treat depression, and spent a great deal of time and energy trying to dissuade his wife. In describing what she saw as Dr. Makinen’s perception of the presenting problem, her client said,

“Because he had bad experiences with medication in his past. Thirty or forty years ago...he had a bad experience with his mother when she was

ill and dying; psychiatric medications had made her catatonic and helped lead to her death.”

Ms. O’Neil (IFS~ST) also conceptualized her client’s current problems as stemming from her family of origin:

“...her family of origin and childhood had a lot of trauma in it, [so] she developed some very vigilant parts. [She had some] very...significant protective parts. And then around that she...developed some very entrenched caregiver parts that focused everything outward... She was the youngest in the family; she had...about six or seven siblings, and she...felt like she had to be the success story...”

Interactional cycles: cognitive, behavioral, and affective elements. Most of the clinicians in this study conceptualized how their client’s family or origin influenced their current situation in terms of interactional cycles. Most therapists looked at how each spouse’s behavior, thoughts, and emotions influenced those of their partner’s, and vice-versa. See table 4 for examples of interactional cycle concepts. For example, Dr. Dattilio described how the wife’s passive behavior influenced her husband’s behavior: “...one of the things that she learned is that she unwittingly was enabling her husband to be more and more like her mother all the time and wasn’t even aware of it.” He explained the controlling husband’s part in the cycle this way:

Table 4 <i>Common conceptualizations: Family of origin experiences.</i>		
Verbatim explanation of change	Theory specific explanation of change	Common factors explanation of change
<p>Dr. Johnson (EFT): “I don’t think [my clients] had a very supportive environment to grow up in.”</p> <p>Dr. Dattilio (CBT): “Geller deal[t] with... [his childhood feelings of] being rejected...and the way his wife [acted] sometimes reminded him of the way his father [acted].”</p> <p>Ms. O’Neil (IFS): “She had been...sexually molested by her brother...and...her mother had a fairly significantly abusive part...”</p>	<p>EFT: Family of origin experiences form a person’s attachment style – a set of beliefs about whether or not the “self” is lovable. Different attachment styles have unique characteristic emotional displays that serve the function of maintaining a level of emotional distance the person is comfortable with. Insecurely attached couples simultaneously seek and fear emotional closeness.</p> <p>CBT: Family of origin experiences form a person’s scripts and schemas – core beliefs about the world and themselves in relationships. Behavior and emotion in relationships is driven by the cognitions that form their schemas. People will arrange their relationships in a way that reinforces their schemas.</p> <p>IFS: Internal “parts” form as a result of early trauma. These parts are always characterized by extreme emotions, behavior, and thoughts. A part’s primary function is to protect the “self,” though as a person grows older the parts interfere with the establishment of healthy relationships.</p>	<p>Early life experiences shape the way a person acts, thinks, and feels in adult intimate relationships. These feelings, thoughts, and behaviors can serve to establish a close, nurturing relationship or to distance and alienate. Dysfunction in one aspect (i.e., affect behavior, or cognition) will be associated with dysfunction in the others.</p>

“He met Tiffany and really led her around by the nose, to the point where she started realizing she didn’t like her life with him. She’s a black belt in karate...and that really built a lot of her confidence. She became more confident... and he became more insecure. ”

Dr. Johnson described her client’s interactional cycle this way:

They just want[ed] their partner to change and their partner to be more loving and accepting. They [didn’t] really see how they create the negative cycles in the relationship. They don’t see the relationship as a whole. I think they were both feeling very cut off from each other. [They felt] very alone, like they couldn’t count on each other at all. I think that had a lot to do with William getting depressed...They would sometimes both attack, but basically their negative cycle is that he would sort of shoot and run and withdraw.”

Most therapists also identified maladaptive affect, behavior, and cognitions/beliefs as the three elements that perpetuated the dysfunctional interactional cycles. The following quote from Ms. O’Neil (IFS~ST) is characteristic of cognitive aspects of her client’s cycle:

“...she was interpreting behaviors in a negative. Her perception out of the lens of these parts [perceived] behaviors in a way that reinforced those beliefs of those negative parts. [This] didn’t really allow...her to have any access to his [or her] self...”

SD: It was affecting how she treated him...?

CL: And how she felt treated by him.”

Dr. Dattilio illustrates a focus on cognitive, behavioral and affective elements of the cycle as he describes his conceptualization of the husband's part in the relationship problems:

“...a lot of the work had to do with...really getting him to reexamine his thinking about what entitled him to [violate his wife's] space. Most of the time it was his own insecurity – [it] needed to be constantly reassured. If he had it in his mind that they were going to be intimate that night and things just didn't work out right,...and he'd be all revved up about it. [If] something...happen[ed] where the kids were sick and it would shoot a hole in the plans, Tiffany just kind of rolled with it and said, 'that's life.' He would pout and be a prick about it. They were really alienated, just fighting all the time... He was almost like a child. She had to learn to stop giving in to that. The other end of it was to teach him what to do with his own insecurity and his volatility.”

Not surprisingly, there were some model-specific differences in which of the three elements different therapists emphasized, with EFT clinicians focusing more on affective elements while the CBT therapist focused more on behavioral and cognitive elements. IFS therapists seemed to focus on all three elements equally. Interestingly, however, most of these differences were relatively slight; therapists from each model frequently mentioned affective, behavioral, and cognitive/beliefs elements as contributing to their client's current dysfunctional interactional cycle despite their model's emphasis on one element over the others. For example, despite her model's focus on affective elements,

Dr. Makinen (EFT-ST) mentions her focus on the cognitive and behavioral elements that perpetuated her client's cycle:

“I think he needed to hear about the impact that his ranting, as they both called it, had on her and [how it] resulted in her withdraw and distancing from him, which set his anxiety and his beliefs that it was the medication causing her to withdraw.”

Even though CBT emphasizes cognitive and behavioral aspects of interactional cycles, Dr. Dattilio acknowledges also paying attention to affective elements of the cycle:

“A lot of my time was focused on helping Geller deal with his feelings about being rejected [which] went back to his childhood, and the way his wife did [things] that sometimes reminded him of the way his father [acted]. He needed to process that emotionally.”

The fact that the different therapists focus on elements outside the usual scope of their model is somewhat of a surprise, as EFT strongly emphasizes affective elements of interactional cycles (Johnson, 2004) and CBT strongly emphasizes cognitive and behavioral elements (Dattilio & Epstein, 2003). The IFS literature seems to slightly favor the emotional and cognitive elements over the behavioral (Breunlin et al., 2001).

Possible explanations for this focus on elements of interactional cycles outside of a model's scope will be discussed in chapter five, as well as implications of this overlap for clinical practice.

Table 5 <i>Common conceptualizations: Interactional cycles.</i>		
Verbatim explanation of change	Theory specific explanation of change	Common factors explanation of change
<p>Dr. Johnson (EFT): “They would sometimes both attack, but basically their negative cycle is that he would sort of shoot and run and withdraw.”</p> <p>Dr. Dattilio (CBT): “She had to learn to stop giving in to [her husband]. The other end of it was to teach him what to do with his own insecurity and his volatility.”</p> <p>Ms. O’Neil (IFS): “[...her part was making her interpret] behaviors in a negative... Which then didn’t really allow...her to have any access to his self or her own [self].</p>	<p>EFT: Becoming emotionally vulnerable enough to establish an intimate relationship is too scary, so insecurely attached people will maintain emotional distance by harsh, secondary emotions. These emotions invite the same from their partner, and serve to emotionally alienate both partners from each other.</p> <p>CBT: People interact with others in a way that reinforces the beliefs that constitute their core schemas. If these schemas contain irrational beliefs about relationships, interactional cycles will form that perpetuate those beliefs.</p> <p>IFS: One person’s parts – which are inherently emotionally reactive – tend to elicit their partner’s parts, which are also emotionally reactive. The goal is to have the client’s self – which is inherently calm – guide communication rather than the parts.</p>	<p>Each partner’s thoughts, feelings, and behaviors both influence and are influenced by those of their partner’s. Distressed couples will form an interactional cycle in which each partner’s dysfunctional cognitions, affect, and behaviors are reinforced. If partner’s thoughts, feelings, and/or behaviors are modified, the cycle will shift from destructive to healing. Shift in one aspect will lead to shifts in the others.</p>

Therapist's Model-Specific Conceptualizations

Other than family of origin influences on current interactional cycles, there was little overlap between how therapists utilizing different models conceptualized their cases. All of the therapists spoke the language of their model very clearly as they described how they conceptualized their client's problems. The EFT therapists spoke at length about attachment, the CBT therapist spoke about the interplay between cognitions and behaviors, and the IFS therapists talked about parts. This comment by Dr. Schwartz is illustrative of the theoretical clarity used by the therapists when I asked them to describe how they conceptualized the case:

“Well, [I conceptualized his case] the way I conceptualize most cases, which is to get to know the parts of him that were at war inside and bring forth more of what I call his “self” so that he had a better sense of what he wanted to do with this situation and with the rest of his life... In the process of doing that [I needed to help him] do a lot of healing with the parts that were in such turmoil.”

Model-specific aspects of each therapist's conceptualization followed the more detailed discussion of how the different models conceptualize problems in chapter two.

Clients' Conceptualizations

Clients' conceptualization of the presenting problem varied widely. Practically all of the clients mentioned something quite narrow and vague, such as, “my husband is too controlling,” “we just can't communicate,” or other similar issues familiar to therapists. In fact, the *lack* of any common theme to their initial complaints was in and of itself the

only consistent theme. When thinking about change, the lack of any commonalities to initial client complaints is meaningful, as it may evidence the very reason they are in therapy: they do not have an adequate way of thinking (i.e., a model) to explain how they got into their problem and what they can do to get out of it.

Co-Construction of Problem Conceptualization: The Adoption of a Model

The co-creation of a problem conceptualization, or the extent to which a therapist provides a model that the client views as a credible explanation for their problems (i.e., the model fits their experience), is another common factor in this study. The co-construction of the problem conceptualization is evidenced in this study most by the change in the client's problem definition as therapy progressed. When asked to reflect on their view of the problem when they first sought help, the client's responses were varied and often vague. However, clients tended to adopt the therapist's conceptualization of their problem after they had been exposed to it in therapy (several factors may influence this, as discussed in the final section of this chapter). See table 5 for a summary of co-construction of the problem definition concepts.

There was no evidence of a "co-construction" in that the therapist's conceptualization of the problem was not as open to influence by the client's conceptualization as the client's was by the therapist. That is, the client was influenced much more by the therapist than the therapist by the client in this regard. The co-construction consisted of the therapist offering an explanation for their problem, and the client accepting or rejecting it (in this case, of course, all clients accepted it). The effects of wholeheartedly adopting the therapist's model are illustrated by IFS~DV~CL when he said, "There's absolutely no way that I would have been in a place of this kind of internal

clarity...if I hadn't been working with this kind of model or something like it as [fervently] as I had."

Once the clients adopted the therapist's conceptualization of their problem (a willingness to do so is a common factor discussed later), the client's conceptualization followed the same themes as outlined above for the therapists (i.e., family of origin influences, interactional cycles, model-specific conceptualizations). For example, after being exposed to the therapist's conceptualization of the problem, CBT~DV~CL~W described how her family of origin experience affected her current interactional cycle with her husband:

"So after seeing Marianne [Dattilio] individually there were quite a few things about [how] my upbringing...affected...my ability to communicate...and how I react to different things. [For example,] my husband has a very strong personality. How I react to [his personality] was one of the issues. So I worked with Marianne individually, and I became much more aware of my tendencies as it related to the marriage and interacting with Geller."

Prior to beginning therapy, she described her goals more vaguely:

"...we were obviously experiencing some marital issues. I would say the primary goal was to improve our communication; to reduce the level of stress in the marriage."

Table 6 <i>Brief examples of the co-construction of the problem definition.</i>		
Problem definition	Representative Quotes	Common Factors Explanation
Client's Conceptualization	<p>Tiffany (CBT client): "...the primary goal was to improve our communication; to reduce the level of stress in the marriage."</p> <p>Bridgette (IFS client): "[I] had so much anger and so many controlling behaviors... I need[ed] to alleviate that whether it's for the good of my relationship or the good of myself"</p> <p>Louise (EFT client): "...[we wanted to] break some barriers that my husband [and I] were having about communicating... about the depression I was experiencing "</p>	Each client's conceptualization of their problem reflected a lack of any unifying themes or concepts (i.e., a model) that could help guide them from dysfunction to health. Descriptions of problems were vague and suggested that clients did not know what to do.
Co-construction of the Problem Definition	<p>Paul (EFT client): "[I needed to make myself vulnerable because] the other party will not shoot at a fragile person – at a person who is reasonable, who is openly willing to share emotions."</p> <p>Bridgette (IFS client): "I...get into a part and get very extreme when...argument[s] would come up."</p> <p>Tiffany (CBT client): "I felt a lot of times that because his tendency to be so strong and controlling came across in the marriage that he didn't respect me...and...as a result...I become withdrawn and I will go with the flow... we were becoming increasingly polarized."</p>	Client's adopted the therapist's conceptualization of the problem provided that conceptualization fit the client's experience of the problem, the therapist was viewed as credible, and it was presented in a way that minimized resistance. Client's initial chaos began to be replaced with the therapist's order (i.e., their model), which gave the client's hope that they could change.

EFT~DV~CL~H illustrates how initial vague goals were replaced with a model-specific conceptualization of their problem once therapy had begun. When asked to describe their initial goals, he said they wanted to, "[Be] able to see things from different

perspectives. Our ultimate goal was to better the relationship. That was the ultimate goal.” Later, he showed his familiarity with EFT and emotional elements of interactional cycles by stating that, in order for them to improve they needed to become more vulnerable, “Because...the other party will not shoot at a fragile person, at a person who is reasonable, who is openly willing to share emotions.”

Common Interventions

The second model-dependent category is common interventions. The therapists in this study used their model-informed conceptualization of the problem to drive their interventions. Therefore, the areas of overlap in their interventions are quite similar to the areas of overlap in their conceptualization. There was, however, a great deal more overlap in their interventions than in their conceptualization. Many of their interventions were couched in the conceptual language of their model but, pragmatically, looked very similar across models.

Raising Awareness of the Cycle and Each Individual’s Role in it

The interactional cycle – one of the common conceptualizations – was also a primary focus of intervention for therapists in each of the three models. Therapists’ intervention into the interactional cycle followed roughly the same pattern across the three models: 1) raise awareness of the interactional cycle by *slowing down the process*; 2) help each partner be aware of their role in it by learning to *stand meta* to themselves; and 3) and help them adopt a healthier stance by *encouraging personal responsibility*. The temporal sequencing of these events was not always clear, nor did it seem that each step happened in isolation. At times it seemed that each step co-occurred with the others. Additionally, dysfunctional aspects of the client’s *family of origin* were used throughout

each of these steps to provide a context for their current difficulties. Rather than dwelling on the past, each model focused on altering patterns learned in their family of origin in the present. See table 6 for a summary of concepts related to raising awareness of the cycle.

Slowing down the process. The first step in altering the interactional cycle was to slow down the process. This was done in several ways, including structuring the amount of time each client talked, helping each partner listen to their partner rather than jumping to conclusions and helping clients see their partners differently. This increased awareness seemed to help couples slow down and begin to explore other possibilities for their current difficulties. Louise (EFT~ST~CL~W) describes how Dr. Makinen helped them slow down their pursue/withdraw pattern:

“At the beginning particularly I [would] withdraw [when] he would be starting his...formal arguments... I would just sit back and think, “Oh yes I have heard this before.” And then over time...Judy wouldn’t let him go on that long and [she would] say, “Look at Louise, what’s going on here? Why do you think she is being quiet?” and that sort of thing... [She] point[ed] out something he might not have been aware of himself and [tried] to help him not interrupt. [She] put a meaning on my behavior that was different than what he was putting on it.

SD: ...did that help you engage more in the discussion?

CL: Yes I think it did.”

Dr. Makinen reiterated this goal when I asked her what she did to help them reach their goals: “First of all was to get him to kind of slow down and to actually hear her.” Each of

the therapists reported similar attempts to slow down the process in an attempt to bring awareness to the interactional cycle.

Standing meta. Once clients had slowed down the process, therapists helped them stand meta, or outside of, themselves. Therapists used several different techniques to facilitate this process, such as reframing their partner's behavior or intent. One of the most common methods was to encourage the clients to explore alternative explanations for their partner's actions, as evidenced by CBT~DV~CL~W:

“One of the things that Marianne [Dattilio] taught me to do is step back and say, ‘What am I doing here that I can do differently that might make the outcome of this more positive? Maybe he’s reacting to me because he was brought up a certain way. Maybe my behavior isn’t the best right now and I’m contributing to the escalation of whatever it is that’s going on.’ So for me that really works because I’ll step back and say, ‘Okay, maybe I did something or said something that was really interpreted in a bad way.’”

Her husband described how he began altering their interactional cycle by learning to stand meta when I asked him to describe what was happening when therapy seemed to be the most productive:

CL: “We were communicating better and seemed to *step outside ourselves* [italics added] and listen to what the other was saying.

SD: To step outside yourself; tell me more about that.

CL: Well, it’s easy when you are in any kind of conflict...to take strictly your side and think in terms of where you’re coming from and draw conclusions. It’s not easy to find out what the other person’s perspective is and where they are coming from... From my perspective it seemed like we

both were shutting down and not allowing the other person to get their point across. We were too busy trying to force our point across and get [our] view through. And you're trying so hard to get them to realize it and understand it. But the other person is not openly listening...because they're hearing their own things and putting up their own shield."

Perhaps the most creative intervention designed to help a client stand meta to themselves was used by Dr. Makinen (EFT~ST). The husband of the couple she was working with tried very hard to convince his wife to stop taking anti-depressants. He talked a lot about this and would not let his wife share her feelings on the matter. When Dr. Makinen tried to interrupt him, he thought she was siding with the wife and got upset. Here is how she handled it:

"So I said to him... 'We could tape the sessions and then what you can do is you can take the tape home and listen to it. You might find that useful.' ...That was very powerful because he got to hear himself and the impact he had on her and how she shut down. And when they came back [for] the next session I asked them what that was like and he was just blown away by that... I think that helped make a big, big difference."

The husband echoed Dr. Makinen when I asked him how he had changed: "Certainly [I learned to] listen more. You know, I realized [that] listening to a tape recorder...I guess I realize that I talk too much." Learning to stand meta helped the client's realize their own role in their relationship problems.

Table 7

Common interventions: Raising awareness of the cycle and each individual's role in it.

Common Interventions	Representative Quotes	Common Factors Explanation
Slow Down the Process	<p>Louise (EFT client): "...[over time...Judy wouldn't let him go on that long and [she would] say, "Look at Louise, what's going on here? Why do you think she is being quiet?" and that sort of thing...Pointing out something he might not have been aware of himself and [try] to help him not interrupt."</p> <p>Bridgette (IFS client): "[my therapist] kept inviting me back to where I was instead of letting me run forward."</p>	Therapists focused on helping each client be aware of their role in the cycle and change their stance in it. They did this by: 1) slowing down the process; 2) helping clients stand meta to themselves and their partner; and 3) encouraging personal responsibility in changing their stance in the cycle. Metaphors were often used to help clients keep a "picture" of the cycle in their minds as they worked on altering the cycle inside and outside of therapy.
Stand Meta to Themselves and Their Partner	<p>Geller (CBT client): "We were communicating better and seemed to step outside ourselves and listen to what the other was saying."</p> <p>Charles (EFT client): "Certainly [I learned to] listen more... I realized [when] listening to a tape recorder...that I talk too much."</p>	
Encourage Responsibility in Changing Their Stance in the Cycle	<p>Ms. O'Neil (IFS student): "That's what we're working at is the ability to notice when it's a part and then to be able to...see if there is enough critical mass of self either with one person or between the [couple] that we can have a different response in relationship to these parts instead of really letting them run the show."</p> <p>Tiffany (CBT client): "One of the things that [my therapist] would work with me on was asserting myself initially...rather than store, store, store, and then explode, or let it magnify and then distort."</p>	

Encourage personal responsibility. Slowing down the process and helping clients stand meta alone were not enough. Once clients had done this, therapists helped clients take personal responsibility for their role in the cycle. There was no one technique used to do this; instead, it was more directly or indirectly encouraged in the language that the therapists used with their clients. Dr. Dattilio discusses an instance in which he helped the husband be aware of his role in the interaction by slowing down the process, helping the husband stand meta to himself, and directly encouraging him to take personal responsibility to act differently:

“For example, one time they were on vacation and she decided she wanted to go get gas in the car before the next day... He said, ‘We’ll get it on the way home.’ And she said, ‘No, I want to get it now...’ He was just being a real jerk [thinking], ‘Why does she have to go get it now? She’s dissing me.’ I said, ‘Look, what are some of the alternatives that may be going on? Yeah maybe she’s dissing you because you’re a big pain in the ass. What else might it be?’ And I get him to think, ‘Well I don’t know.’ I said, ‘Well did you ever think she just needed a little time out and wanted to take a drive for herself and get her head together.’ ‘No I didn’t think about that.’ [I said,] ‘Ask her and see if that might have been.’ He asked her and she said ‘That’s exactly the reason. I just needed a little time to myself.’ I told him all people do that. So now he says, ‘Yeah, I can see that I don’t know why I’m being such a dick.’ I said, ‘Well...I think that’s the juvenile child in you who stamps his foot and wants what he wants.’

You know what, you're a big boy now and you're married, you're a dad and have a wife and you need to knock that off."

The onus to change was not just on the husband in this couple. CBT~DV~CL~W mentioned how her therapist helped her see her side in the interactional cycle and take personal responsibility for changing it: "One of the things that Marianne [Dattilio] would work with me on was asserting myself initially right when I feel the need to do it rather than store, store, store, and then explode, or let it magnify and then distort." Dr. Dattilio implied his emphasis on personal responsibility in exiting the cycle in his work with his clients when he said that he tried to: "...[teach] him how to contain himself, and...[teach] her not to fall back into the same pattern and not to give into him. [This] was a major task."

Using IFS "parts" language, Ms. O'Neil described how she raised awareness of the cycle by slowing down the process, helped her client stand meta to herself, and encouraged personal responsibility in interacting differently. She would have her client, Bridgette, go home and practice with her husband:

"We'd...identify parts...of [each] person. Bridgette would identify [a] vigilant part, and then Mohammed would say what part comes up for him around that vigilant part, and then Bridgette would say what part comes up for her around his part that reacts to that vigilant part. [We would]...do a little sequencing.

SD: And what often happens in that is...it...separates the parts from the self more, is that it?

CL: Yes...eventually if people own their own parts, you can bring more levity to it. Ultimately, we have some of these parts in our life. ...We're not going to necessarily erase these parts, but our relationship to these parts and our partner's relationship to these parts is going to change. That's what we're working at is the ability to notice when it's a part and then to be able to...see if there is enough critical mass of self...either with one person or between the two of you that we can have a different response in relationship to these parts instead of really letting them run the show."

Use of Metaphor.

Several clients reported that their therapists provided a metaphor of the cycle that was helpful in remembering their role in it. Dr. Johnson's clients spoke of "being in a tank, shooting at each other," or "warriors hiding behind armor and shooting at each other." They mentioned that this helped them keep the cycle and their role in it in mind as they focused on becoming more vulnerable. Dr. Dattilio's clients spoke of a "table" metaphor that helped the wife remember that she was responsible for doing her part (i.e., being two of the four legs), but she couldn't do her husband's part (i.e., the other two legs). This helped her be responsible for her own emotions in an argument rather than her husbands.

Family of Origin as a Context for the Cycle

At least one therapist and client from each model frequently referenced dysfunctional affect, behaviors, or cognitions learned in the client's family of origin or previous relationships as the source of their role in the cycle. Current interactional cycles

were “pitched” as the fruit of these early influences. However, time was not spent blaming the past. Rather, clients were encouraged to explore new ways of interacting in the here and now; the family of origin was simply used as a context for the origin of their current difficulties. This seemed to provide a credible explanation for what was happening in their relationship and a backdrop for their work at altering the cycle. CBT~DV~CL~H described how their families of origin were the backdrop for their work:

“Look, I need to know why I feel this way and why don’t I feel more special... She comes from one background and one way of being brought up with different parents and different set of siblings and I’m coming from a different scenario and its like night and day. She’s working on her demons and I’m working on my demons and then together with ourselves it’s better.”

Dr. Schwartz mentions his focus on his client’s past as being in the background of their work together:

“What took place was he was able to focus on and heal a lot of his emotions from the past, and...listen inside himself rather than focusing on trying to change everything outside himself. [This continued until] the point where he got more clarity about the dilemma he was in and how to handle that.”

Altering the cycle

The methods used by each therapist to alter the cycle were largely model-specific. Each therapist focused on helping their clients understand what was “underneath” or

“driving” their stance in the cycle (much of this work had already been done or was taking place as they explored family of origin influences), but they largely focused on model-specific elements of the cycle as they did this. For example, EFT therapists focused largely on emotional elements perpetuating the cycle, while the CBT therapist focused largely on cognitive and behavioral elements of the cycle. IFS therapists seemed to focus on all three aspects equally (though they seemed to slightly favor emotional and behavioral aspects as they talked about parts feeling and behaving in extreme ways). Though each therapist primarily favored the element that their model focused on, each therapist did focus on behavioral, cognitive, and emotional elements as they altered the cycle (implications of which element is focused on is discussed in the final section of this chapter). See table 7 for a summary of how therapists altered the cycle using emotional, behavioral, and cognitive elements.

Emotional regulation. Using model-specific language, at least one therapist from each model commented on the importance of their client’s ability to learn to recognize and regulate their emotions in order to alter the cycle. In model-specific language, they all mentioned that clients need to shift from being emotionally reactive to being emotionally responsive to their partner, but each therapist had different ways of getting their clients there.

The EFT therapists focused directly on processing primary (as opposed to secondary) emotions as a means of altering the cycle. Dr. Johnson’s client mentions this in response to being asked what about therapy helped her the most:

“CL: Just talking about how... I see certain things and how I felt in certain situations. [There were] lots of things where...my husband was

very surprised that I could feel like that, or very surprised that he never thought of such feelings.

SD: He didn't know what was going on inside of you?

CL: No.

SD: And Sue helped you be able to...

CL: To express those feelings.

SD: What was the experience like for you Cassandra doing that?

CL: It was like learning something new. It was learning a new technique – a new life approach actually, [learning] how to deal with your own feelings instead of expressing anger and frustration. I tried to talk deeper about how I feel in certain situations.”

Her husband had this to say about learning to regulate his emotions:

“[I learned] how to talk about [my] feelings in a non- threatening way. [I learned to] not dust out [my] anger or anything like that, but to talk about how [I] feel – that I feel hurt, that I feel whatever – [talk about] my feelings without accusing the other person... That's...the difference; before we were able to talk about feelings in a way that we accused each other. Now...we talk about...how [we] feel in the situation without accusing the other partner. That's the difference.”

Table 8 <i>Common interventions: Altering the cycle</i>		
Common Interventions	Representative Quotes	Common Factors Explanation
Emotional Regulation	Paul (EFT client): “Before [therapy] we were able to talk about feelings in a way that we accused each other. Now the difference is...that...each of [us] talk about how [we] feel in the situation without accusing the other partner.”	Once clients were aware of the cycle and their role in it, therapists helped the clients know how to change in order to initiate a healing interactional cycle. Therapists accomplished this by helping clients regulate their emotions, reframe cognitions, and shift behaviors. Though therapists from each model focused on certain aspects more than the others (e.g., EFT focused on emotion more, and CBT focused on cognition and behavior more), all therapists focused on each of the three aspects in helping their clients exit destructive interactional cycles. Shifts in one aspect almost always co-occurred with shifts in the others, and almost always achieved the same end of helping the clients exit the destructive cycle and begin a healing cycle.
Cognitive Reframing	Tiffany (CBT client): “[Therapy taught me to]...step back and say, ‘What am I doing here that I can do differently that might make the outcome of this more positive? Maybe he’s reacting to me because he was brought up a certain way. Maybe my behavior isn’t the best right now and I’m contributing to the escalation of whatever it is that’s going on.’ ... I’ll step back and say, ‘Okay, maybe I did something or said something that was really interpreted [poorly].”	
Behavioral Shifts	Bridgette (IFS student): “[Beth told me that] when you’re washing the dishes and you’re worrying about “What’s out there that needs to be done and what about this application and what about this form, what about this messy house.” [Then] is the best time to climb in bed and read a book or take a bath, because then [I] gain perspective [and can talk with my husband calmly again].	

EFT therapists were not the only ones to focus on emotional regulation as a means of altering the cycle. Dr. Dattilio also focused on regulating emotion as a means of altering the cycle, though he went about it differently. He believed that change would come more quickly if you focused on the cognitions that preceded the emotions:

“[I] don’t ignore emotion; emotion is very important. [I just] don’t feel that emotional processing in and of itself is enough to get people to change and [I] think you can move a little quicker if you can get right to the antecedents, which is a lot of the cognition. A lot of my time was focused on helping Geller deal with his feelings about being rejected and that went back to his childhood and the way his wife did things that sometimes reminded him of the way his father [acted]. He needed to process that emotionally. Mediating it cognitively helped him really turn that around rather than focusing on the affect.”

SD: It gave him something concrete to focus on and change, would that be fair?

FD: Correct.”

This illustrates a fundamental difference between the two models: EFT proposes that focusing on emotion is the most important in-road to the cycle and should be the target of intervention; CBT proposes that cognitions are the most important in-road, as they provide the client something they can “do.” They both pay close attention to emotion, but they each do something different with it. An IFS therapist helps clients regulate their emotion by encouraging them to speak from “self,” which is more calm, rather than an emotionally reactive “part.” Regardless of the model, the therapist helps

the clients recognize their partner's angry, secondary emotions as a cue to respond with softer, primary emotions (though CBT and IFS therapists would not use those terms). Whether each stance makes a difference in outcome in this study is discussed in the last section of this chapter.

Cognitive reframing. Each of the therapists focused on reframing attributions that each partner made about the other that perpetuated the cycle. The intent that one partner attributed to the other's actions was often seen as contributing to the dysfunctional interactional cycle and thus became the focus of intervention. Interventions aimed at altering these cognitions include exploring other alternatives to their spouse's behavior, as evidenced by Dr. Dattilio in a previously mentioned quote:

“What are some of the alternatives that may be going on? Yeah, maybe she's dissing you because you're a big pain in the ass. What else might it be?’ [I'd] get him to think, ‘Well I don't know.’ I said, ‘Well did you ever think she just needed a little time out and wanted to take a drive for herself and get her head together.’ [He said,] ‘No I didn't think about that.’ [I said], ‘Ask her and see if that might have been.’ He asked her and she said ‘That's exactly the reason. I just needed a little time to myself.”

Consistent with his model, Dr. Dattilio also had his clients monitor their self-talk outside of the session, recognizing and challenging those beliefs that perpetuated the cycle:

“[I use] homework...to [help them] take a look at monitoring what they tell themselves and how they get themselves wound up and upset and

engage in [negative] interactions. So it's a lot of monitoring of self talk and identifying where there [are] distortions [in] what they tell themselves [that] gets themselves emotionally wound up and [leads them to] engage their spouse in a lot of negative interactions. [It helps] them restructure [their] thinking. I have them write down [their self-talk] and I go over it when they come back. So one of the things we did was have them identify distortions and then talk about how they were guilty of engaging in those distortions."

Dr. Makinen (EFT~ST) deliberately changed her client's interpretations of his own behavior. He was making sexual advances towards his wife late at night when his wife was trying to sleep, which was causing a lot of distress in the marriage. In an effort to help him switch his role in the cycle, Dr. Makinen reframed his desire as a temptation. Since he was very religious, viewing his behavior as a temptation provided him a new avenue of dealing with his behavior:

"That was...redefined as a temptation...for me. I just realized that that was temptation, and I just...say a prayer everyday and I...think of that particular situation and say, 'God, please visit that temptation and help me not be tempted here and to break away from her and go over to my side of the bed.'"

As a result of his efforts and Dr. Makinen's reframe, he was able to take the lead in forging a more satisfying sexual relationship with his wife.

Dr. Johnson reframed marital conflict as an opportunity to grow, which may have given her clients a reason to continue working on their relationship:

“[I tell them to] give your partner the benefit of the doubt, and sometimes that’s very hard to do. The bottom line is you have to do that if you’re going to build a real deep basis of trust. You also have to do it if you’re going to repair rifts because...rifts are inevitable in any relationship. It’s actually when you have a fight or a rift when the repair is often the place where the relationship really starts to grow. It’s the repair process where the relationship starts to grow. I mean, in a way you don’t know anyone until they’ve disappointed you and you’ve had a big fight with them. Then you can go from there.”

Ms. O’Neil used an activity she called “parts mapping” that drew attention to her client’s cognitions:

“I usually take...art paper and give people markers and they begin to [draw] particular parts... I’ll have them put some of the core beliefs of the parts down. [They’ll write] a couple sentences, [such as]. “People are untrustworthy” or whatever the part believes. And then we kind of look at who else is in that. It’s kind of like drawing the internal family only certain parts kind of have certain parts around them.”

While each attempted to alter cognitions, therapists utilizing different models seem to do this differently. An EFT therapist seems to challenge their cognitions experientially in the course of an enactment or by using a reframe, and usually in the context of emotional processing. A CBT therapist seems to directly challenge client’s cognitions didactically, whereas an IFS therapist seems to simply call attention to the

cognition and lets the client choose what to do with it. Whether these differences make a difference is discussed in the final section of this chapter.

Behavioral shifts. As expected, Dr. Dattilio focused on directly altering behavior that perpetuated the dysfunctional cycle more than the IFS or EFT therapists. He spent some time teaching communication skills. Despite this, altering behavior was still an area of interventive overlap among the three theories. Therapists from each model tried, in some fashion, to get their clients to behave differently. For example, Ms. O’Neil saw that her client got stressed easily; this led her to have a short temper with her husband, which set in motion a negative interactional cycle. Beth gave her homework designed to alter this cycle by engaging in self-care when she started to get stressed, which had this effect:

“[Beth’s exercises]...helped a lot... [She would say,]... ‘Ok, when you’re washing the dishes and you’re worrying about what’s out there that needs to be done and what about this application and what about this form, what about this messy house.’ When it’s...like that, as hard as it is to do, [it] is the best time to climb in bed and read a book or take a bath, because then you gain perspective.

SD: So when you’re so overwhelmed that’s the time...

CL: To take a break. The time that you’re least compelled to take a break is the most necessary time to take a break.

SD: And be able to recognize that and to...

CL: And interrupt it.”

Both EFT therapists focused on altering behavior with the intent of altering the cycle. Dr. Makinen had her clients structure their at-home interaction by setting a time

limit on how long they could talk about an issue. The husband tended to keep talking about an issue until the wife could no longer stand it and she would withdraw. Setting a time limit helped the wife be able to re-engage in the discussion and it helped the husband regulate his emotions – he got more excited the longer he talked. One of the ways Dr. Johnson encouraged her clients to behave differently was by “taking more risks with each other at home.” This intervention was aimed at shifting emotions, but was directed at changing their behavior as a means of changing their emotional experience. In fact, *taking risks* was an element of changing behavior that most of the therapists urged their clients to do.

Model-Specific Interventions

One of the most surprising findings of this study was how easy it was to tell what model a client’s therapist used by listening to the language the clients used. The EFT clients spoke about identifying, accessing and expressing primary emotions. The CBT clients spoke about maladaptive cognitions and behaviors. The IFS clients spoke about parts (in fact, each IFS client had a very difficult time when I asked them to explain how they changed to a lay person unfamiliar with IFS language). In other words, each therapist adhered closely to his or her model, both conceptually and operationally. EFT therapists helped their clients regulate their emotions by processing primary emotions. The CBT therapist helped his clients regulate their emotions in part by focusing on the cognitions that preceded the emotions. IFS therapists helped their clients regulate their emotions by providing a framework with which to understand them. So, while they all used model-specific conceptualizations and interventions to do so, they all focused on largely the same thing.

Common Outcomes

The third model-dependent category is common outcomes. All of the clients in this study ended up experiencing remarkably similar changes at the conclusion of therapy. There were more commonalities in this category than in either the common conceptualizations or common interventions categories.

Softening: “Just Give up Your Pride and Show Your Softer Side”

A statement from EFT~DV~CL~H summarized a shift that most of the clients experienced when he said that he learned to, “Just give up [his] pride and show [his] softer side.” CBT~DV~CL~H said it this way: “It’s just time to...step outside [myself] and think of her.” IFS~ST~CL simply said, “We both stopped trying so hard to change the other person.” Each client reported a softening towards themselves and their partner. They voluntarily abandoned their previously harsh, critical view of their partner (and in some instances, themselves) in favor of a more patient, loving approach. When faced with an event that previously would have triggered a harsh response, angry emotions, and critical thoughts, they instead acted, felt, and thought more “softly”. They were able to exit on their own what previously would have become a negative interactional cycle.

It is one thing to soften; it is another for a client to know what to do once they have softened. Clients reported not only having a change of heart, so to speak, but also reported knowing what to do once they had softened to carry those changes into actual different ways of interacting with each other. The first element of softening I will discuss, then, is being aware of the cycle and their role in it. Following that section will be sections devoted to cognitive, affective, and behavioral changes that were associated with softening. Though I will discuss changes in affect, behavior, and cognition separately, in

reality changes in one aspect always co-occurred with changes in the other two aspects. In other words, one person did not experience a softening of cognition without also experiencing a softening of behavior and emotion, etc. Each client emphasized shifts in some elements more than others, depending on which model they received, but they all mentioned a shift in each element. For example, shifts in behavior and cognition in EFT tended to follow shifts in emotion, since EFT focuses on emotion. The same pattern was true with cognitions and behaviors in CBT. IFS seemed to focus on cognition and affect more than behavior.

“If you’re not getting enough intimacy, don’t start whining that you’re a sex-starved wretch.” Client’s awareness of the cycle and their own role in it. A softening in behavior, affect and cognition seemed to be both preceded and accompanied by an awareness of the cycle and their own role in it and a willingness to take responsibility for changing that role (which responsibility is a common client attribute I will discuss later). In order to abandon their stance once they had softened, they had to be aware of what that stance was and how it was contributing to the relationship problems. CBT~DV~CL~W described how she and her husband have both come to this awareness:

“It’s very easy to fall into my old patterns of behavior. I have to constantly be thinking, ‘Okay, how am I supposed to react in this situation?’ or, ‘What’s the most productive way to react or deal with this.’ But it’s coming more naturally now because I’m doing it more frequently, and we’ve noticed a tremendous decrease in the amount of turbulence.

SD: Okay. So you sort of stand back from yourself in these situations and choose, and...it comes naturally now, more so than it used to?

CL: Much more naturally now. I mean, it still requires effort and if our level of stress in our household for whatever reason – holidays or whatever – increases, [our tendency] to fall back into our old behaviors, both of us, is very quick. But now, we even commented the other day, the awareness level is so much greater that we can almost see it coming now. And when you can see it coming and you're aware that you're headed in a direction that you don't want to go it's much easier to intercept... We have to step back and say, "Okay, if this is not a good time, let's calm down and come back to it, table it, whatever." It's the awareness of it. [That's] really the word that I'd [use to] describe [it] – the awareness of it."

Her husband made very similar comments about his awareness of the cycle and his role in it.

EFT~ST~CL~H also became aware of his role of the cycle in which he would pursue sexual intimacy and his wife would withdraw as a result of his pursuing, which would increase his pursuing and so on. He evidenced this awareness by saying, "It concerns me that I was a good part of the problem in that I was bothering her too much about this and not leaving it alone, and not trusting God to handle it, the whole problem... If you're not getting enough intimacy, don't start whining that you're a sex-starved wretch."

IFS~DV~CL used parts language to describe his ability to see his role in relationship problems:

"...when I'm with my fiancé I'll say, "You know, I'm clearly not in self right now; I know I'm in some kind or worried anxious part, but this is

what I'm feeling." Then at least she knows...that [my comments are] colored by a particular kind of perspective because it's...the nature of that part."

Softening of thoughts. As would be expected from the CBT model's focus on the role of cognition in marital problems, Dr. Dattilio's clients mentioned shifts in thinking more than the other clients; several of these examples are evident in previous quotes. However, at least one client from each model mentioned that their thoughts had changed as a result of therapy. When a client's thinking shifted, shifts in behavior and affect either co-occurred or soon followed. Cognitions were shifted using several interventions, including reframes (used in all models), direct didactic challenges of thoughts deemed irrational (used primarily in CBT), indirect experiential challenges (used primarily in EFT) and non-directive, inductive processing (used primarily in IFS). Shifts in thought included attributing different intent to their partner's actions, as evidenced by EFT~DV~CL~H's mention that, "the way [my] partner behaves is not necessarily how she wants to behave...so give her the benefit of the doubt." EFT~ST~CL~W mentions that her partner's perception of her behavior has shifted: "He doesn't raise the issues that we have hammered to death and sort of agreed to disagree on. Or if he does and I say, "I don't feel strong enough to talk about this," he respects that and doesn't see me as putting [him] off or being defensive." This "softer" attribution to the intent behind their partner's actions – the refusal to take their partner's actions at face value – allowed them to treat each other more kindly, which shifted the interactional cycle.

IFS~ST~CL mentioned that her thoughts changed as she repeated the questions she had heard Ms. O'Neil, her therapist, repeat over and over in therapy. Beth would ask

her, “Who is that? How old is that part? When did [you] first remember having this feeling?” As a result of the alternative cognitions this exploration brought to surface, IFS~ST~CL mentioned that when she interacted with her husband, “I was able to actually [say], ‘Okay, this is a part of his,’ and actually sit back with curiosity and try to learn more about that part, rather than just responding rapid-fire back with one of my parts.” In other words, when an argument started with her husband she had explored alternative beliefs about the conflict enough to be able to exit the cycle on her own without becoming emotionally reactive. Beth, her therapist, explained her client’s shift in cognitions this way: “So I think that as time went on she began to open more to his lightness. [She began to] not see it as him avoiding situations or not taking her seriously, [which] was a kind of a pattern that was in her previous relationship that we were aware of. It got in the way of intimacy for her.”

Softened behavior. For each client, harsh, defensive behavior was replaced with softer, more loving behavior. This was one of the most pervasive findings, perhaps because the very notion of change implies that your behavior will be different in some way. Rather than simply behaving differently, this shift in behavior seemed to reflect a deeper shift in the way the clients felt about the relationship. Each partner abandoned their critical stance in the interactional cycle for a softer, more nurturing stance. Again, this change did not occur in isolation; it was accompanied by shifts in cognition and affect.

This abandoning of their harsh stance in the relationship is evidenced by EFT~DV~CL~W when I asked her what advice she would give other couples that she learned in therapy: “Do not [accuse] each other. Talk about your own feelings without

accusing the other person...Never threaten your partner. Never accuse your partner of anything or threaten him.” EFT~ST~CL~W mentioned that, “I think I am slower to jump to conclusions. I’m a better listener...I am able to...not become defensive and not react emotionally – I just listen.” CBT~DV~CL~W mentioned that her behavior has changed: “When we enter into an argument now, and actually it has decreased tremendously, we try to avoid the slinging of personal insults. ‘You’re this way, you’re that way.’” She went on to say, “It’s such a concerted effort to modify behavior. It’s very easy to fall into my old patterns of behavior. I have to constantly be thinking, ‘Okay, how am I supposed to react in this situation?’ or, ‘What’s the most productive way to react or deal with this?’ But it’s coming more naturally now because I’m doing it more frequently and we’ve noticed a tremendous decrease in the amount of turbulence.” Her husband echoed her efforts to change behavior: “When I think she’s hostile or nasty now I don’t come back and blast her. [Instead] now I ask what’s wrong. And then she’ll tell me ‘Hey you didn’t have to say that or do that’. Then I say ‘Geez I didn’t even realize, I’m sorry.’ Then it seems to deflate the whole thing.”

Also, EFT and CBT therapists focused a lot more on trying to directly change behavior – either hand-in-hand with emotional processing or alone – than did IFS therapists. IFS therapists were more indirect in that they would simply explore different “parts” and their relationship to each other in the session and largely let their clients decide on their own what to do differently. EFT and CBT therapists were more directive about how the couple should interact differently. For example, Dr. Johnson encouraged her clients to “take risks at home” with each other. Similarly, Dr. Dattilio showed his clients different communication skills.

Softened affect/emotional regulation. Another key way in which couples exited their negative interactional cycles was by shifts in the way they expressed emotion. Before therapy was successful couples tended to match harshness with harshness. Success began to be marked when soft expressions of emotions elicited the same from their partner. Couples were better able to regulate their emotions; they were less emotionally reactive, which made it easier for their spouse to be the same, replacing defensiveness with emotional accessibility.

Not surprisingly, this change was more readily visible in EFT clients, since EFT therapists made the focus on this emotional processing their entry point into altering the cycle. A simple statement about the role of emotional expression in altering the cycle from EFT~DV~CL~H is characteristic of several statements from the EFT clients: “I think what was crucial was that [Dr. Johnson] was able to make us share our inner emotions. That shows [our] vulnerability, [so] then the other person takes a look back and maybe shares her vulnerability. That would work for us.”

What was surprising was the finding that CBT and IFS clients also mentioned an increased ability to regulate their emotions as a significant event in rebuilding their relationships. Using IFS “parts” language, IFS~DV~CL mentioned how he learned to regulate his emotions:

“I’d talk to a part, and Dick would say, ‘Okay, ask that part to step back.’ And I’d [say], ‘Okay, let’s...see who else is there,’ [then] another part comes up [and] you ask that part to step back. I’d start getting to know several of my parts, and...I’d start to see the difference between exiles and managers, and then over time I did start to see the difference between any

part and self. And that was really primarily experiential because self has an energy and a calm about him that none of the parts have, because all of the parts...have a...prevailing emotion whether it's rage or sadness or anxiety or whatever and the managers are pretty uptight.”

In non model-specific terms, his process of finding his “self” was accompanied by learning to regulate his emotions. The focus on finding his “self” seemed to help him stand back from himself – to stand meta to himself in the cycle – and choose a calmer response to a situation that previously would have made him anxious. He provides an example of this change:

SD: “You say you’re less thrown by people close to you when they get upset, and that sort of thing?”

CL: Exactly. And that’s certainly been the case in my work relationships. I mean, sometimes work relationships can be difficult, and I’ve had to learn how to have a healthy level of disagreement with my closest work colleagues. I’m the [director of an organization] and the executive director is my closest colleague. We don’t always see eye to eye, [but] I’m not always trying to make him happy now and he’s not always trying to make me happy now, and it’s good. I think the organization is growing as a result.”

CBT clients had similar experiences with learning to regulate their emotions.

CBT~DV~CL~W mentions how she was able to alter their interactional cycle by learning to regulate her emotions and re-engage with her husband:

“...I noticed from his end he’s expressed that he felt I was more cool, resistant and aloof. I did withdraw an awful lot because I was always so busy reacting to what he said that once I could assert myself and say, ‘I don’t agree with that. I don’t feel that way,’ I felt better about myself; I felt stronger, and I wasn’t hostile towards him. I didn’t feel hostility because I was able to say, ‘Look! I don’t agree,’ and not worry that he would either disown me or not love me anymore, or worry about the consequences of disagreeing with him. And those were the little successes that clicked for me.”

Unlike EFT therapists, Dr. Dattilio helped the wife regulate her emotions by focusing on the cognitions associated with the affect. He mentioned that he focused on the beliefs that were associated with the emotion (e.g., “he will disown me if I upset him”).

Slowing down, standing meta, and taking personal responsibility helped CBT~DV~CL~H regulate his emotions in interactions with his wife. Prior to therapy, he viewed his wife’s hostility as a cue to respond with the same. As a result of therapy, he viewed her hostility as a cue to respond with kindness, to which she responded with the same. He said:

“[Now] when I think she’s hostile or nasty...I don’t come back and blast her. [Instead] I ask, ‘What’s wrong?’ And then she’ll tell me ‘Hey you didn’t have to say that or do that’. Then I say ‘Geez I didn’t even realize, I’m sorry.’ Then it seems to deflate the whole thing.”

The process of viewing anger as a cue to respond with love and concern is a hallmark of EFT, and is congruent with the goals of IFS. An EFT therapist accomplishes this goal by

processing emotions. A CBT therapist helps clients regulate their emotions by focusing on altering cognitions triggered by certain behaviors. An IFS therapist does it by encouraging the calmer “self” to respond to a partner’s emotionally reactive “part.” Since clients from all three models reached similar outcomes, perhaps which aspect a therapist chooses to focus on is more a matter of therapist preference and client fit as long as the therapist helps the clients regulate their emotions. This will be discussed more in chapter five.

Making Space for the Other

The second major category of outcome is *making space for the other*. Several clients strongly emphasized the point that EFT~ST~CL~W did when asked what she learned in therapy about nurturing relationships. She simply said, “give each other space.” Maturana (1992, November) describes violence as “...holding an idea to be true such that another’s idea is wrong and must change.” Conversely, he describes love as “opening space for the existence of another.” His definitions of violence and love fit nicely with a shift experienced by the clients in this study.

In most couples, one client shifted from insisting that their partner change to supporting their spouse’s autonomous development. Their partner shifted from being submissive to more confident and independent. Several subcategories emerged as a result of this systemic shift. Shifts in this area seemed to be deeper than shifts in their interactional cycles. Shifts in their interactional cycles could be thought of as first-order change (Watzlawick, Weakland, & Fisch, 1974), or a change in the way their relationship “looked.” Shifts in the “making space for the other” category could be thought of as second-order change (Watzlawick, Weakland, & Fisch, 1974), or shifts at a deeper level

that influences how the relationship “looks.” In other words, clients did not only shift what they did, but they shifted who they were as a person.

Changes in this category reflect shifts in clients’ stance towards their partner and towards how they felt about themselves. The subcategory primarily related to a shift in their stance towards their partner is *support of partner’s autonomy*. The subcategories primarily related to a shift in their stance towards themselves are *confidence*, *slowing down*, and *personal responsibility*. As with previous subcategories, the subcategories in this category are interdependent; change in one often brings about or co-occurs with change in another. For example, a shift of how a client views themselves affects their partner, and changes in a client’s stance towards their partner still affects the way the client feels about themselves as a result of their partner treating them differently. Each of these subcategories is discussed below.

Support of partner’s autonomy. Several clients (usually the husband) in this study began therapy as very controlling. CBT~DV~CL~H described himself at the outset of therapy this way: “[I] was...a very jealous type of person that [was] insecure. I want[ed] to...keep her down or keep her with me.” His therapist, Dr. Dattilio, described him this way: “Geller was a very controlling individual, I mean ridiculously controlling...He would just do ridiculous things, to the point where she would be in the bathroom and the door would be locked and he’d get a screwdriver and open it up so he could go in and talk to her. [Things that were] just a complete violation of her space.” Dr. Dattilio mentioned that this was causing a rift in his client’s marriage; as the wife became more independent, the husband became more jealous and controlling. Similarly, EFT~ST~CL~H was also controlling at the beginning of therapy, as was IFS~ST~CL.

As therapy progressed and each client began to see their partner and themselves differently, they replaced their controlling stance with a more accommodating stance.

They made space for their partner to grow according to their own desires.

CBT~DV~CL~H discusses the change he experienced:

CL: “[I] was...a very jealous type of person that [was] insecure. I want[ed] to...keep her down or keep her with me. But I found that my wife needed to grow and needed to do several different things...to fulfill herself. I guess not only to say it’s ok to do; really it’s none of my business to say no anyway. But the bottom line is to...encourage her and to help nurture [her desires] in some way. [Now I try] to help her to go ahead and achieve those goals that she’s looking for. Not talk her out of it but say, “If that’s something you really want to do then do it and go for it.”

SD: Give her some autonomy and be supportive?

CL: Exactly, and I [was not] always that way... I make enough money for both of us, [so I thought she didn’t] need to work. [I’d] sort of bottle her up and that’s not what she needed. Now she’s all over the place.

(laughs) I have to throw the fishing line out now...no, I mean she’s really happy and that’s what makes her go.”

He mentioned how he decided to change. Dr. Dattilio had told him that “if he didn’t get with the program, she’s going to leave.” This was CBT~DV~CL~H’s response:

“I was afraid of losing her. [I realized] it’s either you get with the program or she’s going to leave...Its just time to do that and step outside [my]self and think of her. And I don’t know if I always did; I always thought I was

thinking of her, but I wasn't. I was thinking about myself. It was ok thinking about her as long as it didn't interfere with me. But once it became something that could interfere with me, well, then that was a different story. And now I'm just trying to go with what she wants as long as it doesn't hurt me. Like she said, 'I didn't hurt you. As long as it doesn't hurt you what difference does it make?' And she's right."

His wife acknowledged his change, mentioning that he was a lot more accepting of her feedback and her wishes.

EFT~ST~CL~H experienced a similar shift, as he described his fervent pre-therapy efforts to get his wife to stop using anti-depressants as "a bit of a pipe dream." He conceded that, "I can't be sure that she [would] have been worse without them, you know, who knows? No one knows." His wife mentioned that, "he doesn't raise the issues that we have...agreed to disagree on. The husband mentioned that he now tries to listen and "...talk – don't be afraid of ideas. Just ask questions and get a better handle on how the person feels and why they feel like that." This was a major shift for him. The husband in the couple gave up trying to change his wife and instead let go of the desire to control as his wife made the choices she thought best. She summarized one of the major ways in which she and her husband changed: "You don't want a clone of yourself... Once you've married him don't expect [that you] can change him. You married a whole person – an adult person. Both of you will change, but not necessarily the way you think. Be okay with it."

IFS~ST~CL mentioned a similar shift from being controlling to, "...patience, or space. [I was] more able to sit with... 'don't know.' The ambiguity [felt] more...wide

open and hopeful, rather than restrictive...Some of the less urgency...is that we both stopped trying so hard to change the other person. Also...we both developed [a] greater acceptance [of each other].”

Confidence. As the controlling spouse eased up and the submissive spouse re-engaged, both partners seemed to enjoy an increased sense of self-confidence. The submissive spouse was able to freely say what was on his or her mind without fear of retribution from his or her partner. This seemed to lend legitimacy to the client’s opinions, which bolstered their self-confidence, as evidenced by CBT~DV~CL~W’s comment:

“What I have to do...is [to] develop confidence in what my feelings and my opinions and my beliefs are... I’m a strong person to a certain degree, but I will question if there’s a stronger personality present...and that comes from my background.”

This increase in confidence was not limited to her marriage:

“...the beauty of it is [the confidence is] not just with my husband. It’s with my friends, and I’m stronger in what I feel and what I’m thinking. I’m not afraid to voice [my opinions] and I don’t bottle things up and get annoyed as much. So the beauty of it is that not only is it great in the marriage but it’s helping me with other people...I don’t worry as much now about whether or not people are going to like it...I’m not as eager to please as I used to be and therefore I’m not as stressed out.”

Her husband mentioned that he was still working on figuring out “why I don’t feel more special,” but that he had made a lot of progress and that he is “...a little more laid back

when it comes to things. I'm trying to let things roll off my back a little bit more. I'm not so quick to jump and get so edgy and controlling. Hopefully I'm not as controlling as I was before." Dr. Dattilio sums up how he thought they were able to open up space for each other:

"I think they were emboldened...to be able to use their own resources. [They] recogniz[ed] that each of them had desires and they had legitimate concerns about what they wanted in the relationship and they learned to give each other what they needed...I guess in essence they learned more healthy ways to fulfill each others' needs."

IFS~ST~CL also experienced a shift in her self-confidence in relationships as a result of therapy. This is part of what she said when I asked her what the three most important things she learned in therapy about maintaining a healthy relationship:

CL: "And then the biggie, the most important one, is [that I learned] compassion for self, which also increases compassion for others. So many times we can...have this compassion for others and be so self-unforgiving and then you realize after you start developing compassion for yourself, how much more your compassion for others actually increases. You thought you were exhibiting all this compassion, but it becomes deeper, richer, more authentic when you really have it for yourself... [I learned to] forgive [myself] and ...instead of hating one of [my] parts [I] develop[ed] an understanding of where...that part came from and [that my part is] really neat she's not as horrible as you think."

She noticed that as she relaxed and stopped trying to control her husband both she and her husband gained more confidence. IFS~DV~CL and some of the EFT clients reported similar changes. For example, EFT~ST~CL~H said that therapy had indirectly helped him become “more social.”

Slowing down. The process of making space for their partner involved both partners slowing down their process. Before entering therapy, most clients were trying to change their situation. The harder they tried to change, the worse things seemed to become. Consequently, each client’s efforts to make things change had a certain hurriedness or anxiety to it. Some clients were trying to force their partner to change, some were engaging in compulsive behaviors, and so on. At the end of therapy, each therapist mentioned that their clients had slowed down and relaxed in their efforts to change things outside of them. Using EFT terms, Dr. Johnson mentioned that her clients went from attacking their partner to, “...a more secure attachment than they had ever had in...their lives. They were able to look at their vulnerabilities [and] move into a place where they could tell each other their deepest needs and feelings and be responsive to each other.” Ms. O’Neil (IFS~ST) said that her client was, “Just more free to enjoy her life and not have so many worries that really weren’t very grounded.” Dr. Schwartz said he thinks his client is, “...much less anxious in general, less stressed; I think he feels a lot more confident...”

Clients from each model mentioned similar changes. As CBT~DV~CL~H put it, “I’m a little more laid back...I’m not so quick to jump [or]...edgy and controlling.” His wife said that, “little things aren’t bothering us as much.” IFS~ST said that when therapy was over, “I was able to laugh more. I was able to see the humor in things...on my

own... Also, when I was doing the work, I could engage in Mohammed's humor instead of [saying], 'Stop joking with me. This isn't funny. This is really serious.'

The clients seemed to abandon their attacking stance for a more curious stance towards their partner. EFT~ST~CL~H, who had previously been controlling, mentioned that after therapy he was able to, "Listen...I mean really listen. Don't sort of look off into space. Look into the person's eyes. Try to feel their feeling. Understand why they're saying what they're saying."

Personal responsibility. Making space for their partner involved clients taking personal responsibility for their stance in the relationship. Previously, they were caught up in blaming their partner for the relationship problems. As they grew in self-confidence and slowed down, they also adopted a greater responsibility for their experience in the relationship. As they stopped worrying about their partner's behavior and focused on their own, they began to open up space for their partner's autonomy. They stopped demanding that their partner change and instead focused on how they could change, regardless of what their partner did.

IFS~ST~CL uses parts language to describe how she took personal responsibility and began to open up space for Mohammed, her husband, when I asked her how she is different with him now:

"I could lighten up easier...I could sit there patiently and listen instead of reacting. Basically when his parts would come up, I could be more in self. I really worked at...being more centered and in self. And I could just kind of sit and listen and nod instead of jumping."

She went on to say that Mohammed began to open space for her once she did for him.

EFT~ST said that when the husband saw the effects of his controlling behavior on his wife, and his wife started to re-engage with her husband, he, "...[took] responsibility for his blaming everyone else, the doctors, the medication, [etc.]." CBT~DV~CL~H said that now when he is involved in an argument, he, "...[tries] to look back and think, 'it obviously starts with you'. [I try] to look at [myself] before [I] worry about her."

Taking personal responsibility is the last subcategory of the model-dependent themes, or themes directly informed by the therapist's clinical model. Model-dependent themes include common and model-specific factors in therapist's conceptualizations, interventions, and outcomes, each with several subcategories.

The focus of the next section is to describe the model-independent themes that I found in this study. Model-independent themes are those themes that are not directly related to the therapist's model. They are themes that are inherent in the nature of the therapy process itself, and would be present in therapy regardless of which – if any – model the therapist utilized.

Model-Independent Themes

Model-independent themes fall into the following categories: 1) therapist variables; 2) client variables; 3) therapeutic relationship; 4) therapeutic process; and 5) expectancy and motivational factors. Each category has several subcategories. Each of these themes and their subcategories will be discussed below. Following this section will be a section devoted to explaining how the model independent and model dependent factors combine to bring about change in therapy. A summary of model-independent themes can be found in table 9.

Therapist Variables

Common therapist characteristics are the first model-independent category. Though each therapist had a unique personality and style, several common themes emerged as I asked the clients in this study to describe their therapists.

Patience: respecting client's pace. Each therapist showed a respect for the client's pace of change by being patient with the change process. The therapists moved therapy along, but they did not push clients to go faster than they were comfortable. The clients led the pace of therapy. EFT~DV~CL~W alluded to Dr. Johnson's patience when she said that it was about halfway into their therapy (which lasted approximately 18 months)

<p>Table 9 <i>Model-independent categories and subcategories.</i></p>
<p>Therapist variables Patience: Respecting client's pace Caring Yet Firm and Boundaried Culturally and Religiously Sensitive</p>
<p>Client variables Humility Commitment and hard work Psychologically/systemically aware</p>
<p>The therapeutic alliance Isomorphism Mutual trust and respect</p>
<p>Therapeutic process Structure/flow balance Neutrality Repetition Collaboration and accommodation Safety</p>
<p>Expectancy and motivational factors Faith in the referral source Perception of the therapist as competent Fit of the model Motivational beliefs and experiences</p>

before she and her husband started to connect. Dr. Dattilio exhibited the same patience as his clients were in therapy for about 15 months, much of which was slow going.

Taking a long-term perspective of her client's change process helped Ms. O'Neil demonstrate patience with her client's pace. She said:

“...it was very repetitive. [We did the same things] over and over and over again. And there's times when you're doing that when you [think], ‘You know, this is really habitual.’ ...As a therapist you [think], ‘Well, you know, who knows?’ ...you have to kind of have the perspective [that] it may not be in this lifetime... It wasn't really clear to me, Sean, where we would get to in this lifetime.”

Bridgette mentioned that as Ms. O'Neil modeled patience, Bridgette was more able to be patient with herself:

“...I could go on and on about things Beth did to help therapy be productive. The first picture that came to mind...is her sitting there so extremely patient... [She was] patient in the short run and in the long term. So she could be very patient if in a session I was just flooded with parts or extremely compartmentalized or something like that; she could so patiently work with that and not get frustrated. She would be very patient in just the matter of a session. [She was] also extremely patient with a long grief process...when I was...saying, ‘It's been...months, isn't this enough?’ She'd [say], ‘No, grief goes on...’ I would be impatient with that, and she would be hanging in there saying, ‘This is what it is.’”

Caring yet firm and boundaried. Each client knew that their therapist cared about them, although “caring” did not always look the same. When one thinks of a “caring” therapist, images of a very soft, warm, empathetic, Rogerian-type of therapist often come to mind. This was not always the case in this study. Once each client knew their therapist cared about them, each therapist asked them to take a lot of risks and make difficult changes. Each therapist would lovingly push them to do difficult things. This was usually done in the context of a warm, soft approach, though at times this involved taking a deliberate firm and direct stance, as was the case with Dr. Dattilio. He said that he “was very hard on [his male client]. I was very direct; probably the way he wanted his father to be, but in a loving way.” This direct approach can be seen in previous quotes in this dissertation. Though to an outsider this deliberate stance may seem uncaring, it had its intended effect of joining therapeutically, as CBT~DV~CL~H notes when I asked him to describe Dr. Dattilio:

“Like with Marianne [Dattilio] you can see a warmth with her; I don’t feel a warmth with [Dr. Frank Dattilio]. I think [he] is more detached. He’s a nice guy, don’t get me wrong, but I don’t see the same warmth that she has. He’s not a nurturer; he’s [more] fatherly. He... slaps me around and says, ‘you need to knock it off and knock it off now.’ Unless he feels that’s what I need, therefore he tailors it that way. I find him more fatherly [and] stern. I [did] find him to be...understanding and empathetic. I’m not saying he’s some asshole or something like that. I like him and I’d go back to him, but he’s not soft by any means.”

Dr. Dattilio matched his “stance” to what he perceived the client needed, and he was right. While his stance changed, the overall principle did not: connect with clients in the way that they most need and encourage them to take the risks necessary to improve their relationship.

Dr. Makinen (EFT~ST) illustrated the same principle but took a different approach to her clients. Her clients had been to a therapist previously, and the therapist directly challenged the husband’s strong opposition to his wife’s antidepressant medication. This direct challenge made the husband dig his heels in even more. Dr. Makinen took a different approach by establishing a relationship with both clients and then firmly but gently pushing each partner to change. Judy [EFT~ST~CL~W] described the effect this stance had on her and her husband: “[Dr. Makinen is] very good at...the facilitation role without coming on very strong in a way that I wouldn’t want to challenge her or disagree with her.” Both partners in this case responded well to Dr. Makinen’s gentle but firm approach.

Another element of being caring was being well-boundaried. Therapists were able to show their care for their clients while at the same time maintain healthy boundaries. IFS~ST~CL mentions how her therapist balanced caring with boundaries:

“She had amazing boundaries. On a few occasion over the six years I distinctly remember...times when tears came [to] her eyes. And yet it was never one of those things like, “I need to take care of my therapist,” because she had the most amazing boundaries and the most solidness.”

Culturally and religiously sensitive. Therapists were aware of and responsive to cultural and religious diversity when it was present in therapy. This strengthened the

therapeutic relationship, and allowed therapists to do work with – instead of against – these important areas of their client’s lives. Dr. Johnson said that her clients, “...grew up in an Eastern-European culture which I know quite well and where I don’t think they had a very supportive environment to grow up in.” Her familiarity with the culture allowed her to remain present with the couple when they would escalate: “...perhaps this didn’t put me off because I’m European too so I felt at home with it, but at times they would both attack. I felt like that that was a cultural thing. I sort of knew it and it didn’t really put me off...Growing up in Europe I kind of knew the territory.” Her inclusion of culture in the therapy sessions was apparent as her client’s often framed their difficulties with being emotionally vulnerable as having cultural roots.

Bridgette’s (IFS~ST~CL) husband, Mohammed, was from Jordan, which presented the couple with several cultural issues to be juggled. For example, when he found out that she had been sexually abused by her brother, he could not understand why she still talked to him; in his culture, he would have been forever banned from the family. Similar issues arose around an abortion Bridgette had had several years ago, as well as her decision to cremate her mother’s remains. Bridgette summed up Beth’s competency in helping her navigate these issues simply by saying, “she’s very culturally aware.”

Religion played a large role in Charles and Louise’s (EFT~ST~CL~H&W) therapy. Dr. Makinen was comfortable with discussing the couple’s religious beliefs in therapy. Religion was such a factor in their sessions that when I asked her to describe her relationship with them, she described herself as a “pastoral care facilitator.” As Charles mentions, being comfortable with the couple’s religious beliefs was vital to the success of therapy: “She went along with the idea enthusiastically of starting every meeting with a

prayer. She was the leader in prayer. I believe that I'm with my present wife because of prayer." He went on to say that, "The therapy...helped me see how important prayer was. If I hadn't been seeing a [Christian] counselor that wouldn't have happened..." Louise had this to say about the effect of Dr. Makinen's inclusion of the couple's religious beliefs in the therapy session:

"...[my husband's] faith is very important to him. After he became comfortable and sensed that faith was also important to [Dr. Makinen] it seemed [to lend] an enormous amount of credibility to her. He was much more accepting of her interventions or assistance...and willing to engage at...that level."

Since none of the difficulties that clients sought therapy for directly involved gender issues, the data do not support drawing conclusions about the therapist's appreciation for gender issues. It seems reasonable to assume, however, that an effective therapist would also be sensitive to gender issues should they be present in therapy.

Client Variables

Common client characteristics are the second model-independent category. This category and its subcategories was one of the most pervasive, clear and distinct themes of the entire study. As such, I believe that it has a great deal to do with outcome (an idea discussed further in chapter five). Client variables seemed to be both *static*, such as psychological/systemic awareness, and *malleable*, such as willingness to take personal responsibility, commitment, and willingness to risk/be vulnerable. Each of these variables will be discussed in detail below.

Humility. A person who is humble is often thought of as weak or vacillating. That is not the definition of humility that fits the clients in this study. Rather, clients in this study showed their humility by acknowledging from the outset a shared ownership of the problem and its resolution (i.e., willingness to take personal responsibility). Furthermore, they were willing to change once they became aware of their part in the relationship problems (i.e., willingness to risk/be vulnerable).

Tiffany (CBT~DV~CL~W) mentioned that both she and her husband had a willingness to take personal responsibility for the problem and its resolution:

“We had the desire as a couple to make improvements, and we were both open enough to listen to where we needed to improve. And that’s very difficult to do, because it’s easy to always say it’s the other person’s fault and that I’m perfect and you’re the one that’s flawed (laughing)...Both of us have been willing to take a good look at who we are and where our insecurities and immaturities brought problems to the marriage.”

Geller, her husband, echoed her willingness to take personal responsibility:

“From the beginning I’ve tried to [take responsibility]. When he first sat down with us I tried to do that and say ‘Look, obviously I have a big part in this; it’s a 50/50 thing,’ and she did the same. She would listen and take input to what he said and what Marianne [Dattilio] said... I think that we both are taking responsibility for what’s going on.”

Charles (EFT~ST~CL~H) demonstrated his willingness to take personal responsibility when he said, “...it concerns me that I was a good part of the problem in that I was bothering her too much about this and not leaving it alone, and not trusting

God to handle it.” Once they were shown ways that they were contributing to the problem, they abandoned those ways for a healthier stance in the relationship regardless of how strongly they had been defending their position beforehand. This phenomenon is called “softening” in this study, and will be discussed in more detail later. For example, EFT~DV~CL~W said of her husband, “Well...for all his strong feelings and strong opinions I think there was humility. I can learn; I don’t have all the answers.”

In addition to being willing to take personal responsibility, clients showed their humility by being willing to take risks and make themselves vulnerable to their spouse and the therapist. Paul (EFT~DV~CL~H) discussed his and his wife’s willingness to take risks for the benefit of the relationship:

CL: “But it’s very, very, very difficult [to be vulnerable] in the heat of discussion, my goodness.

SD: Yeah, it takes a lot of risk, I would imagine.

CL: That’s what she tried to [get us to] learn [was] how to take risks with each other. And we had homework; we were supposed to take some risks with each other...And many times...we didn’t do it...because it was so terrifying. We were standing in our tanks against each other. But [we realized that taking risks] is necessary.”

He went on to say that they were both willing to, “...really take off our arms during the session and basically practice what [Dr. Johnson] teaches.” Dr. Johnson noted the value of this when I asked her what it was about the couple that helped them change: “They got engaged in the process [and] we had a good alliance... They stayed engaged [and] they

were willing to fight for their relationship...They got engaged in the therapy process; engaged with me. Literally, that's what makes the difference."

When asked what it was about her that made therapy successful, Bridgette (IFS~ST~CL) said, "...I'm extremely authentic; I take risks." William (IFS~DV~CL) said that,

"...I really let my guard down [to the therapy process]; not only with the person I was having this relationship with, but I also really let my guard down in therapy. [I figured that] if you don't let your guard down in your therapy session, what's the point of being there? But I found that I had to make myself very vulnerable, and in this model I really...had to re-experience the hurt of my exiles so that I could bring them home and have them feel safe."

Commitment and hard work. Commitment and a willingness to work hard were other client common factors. Almost every therapist and client identified commitment and hard work as a central theme in the successful outcome of therapy. Clients were committed to the therapy process. Most clients were in therapy for well over a year; several were in therapy for multiple years. William (IFS~DV~CL) echoed most client participants' devotion to therapy when he said, "I never trusted that the therapy wouldn't work – I just didn't know what it was going to look like on the other side."

Clients were also committed to their relationship, as evidenced by EFT~ST~CL~W:

CL: "Well, there was never in my mind any question of leaving the marriage. This was never an option and I suppose that I was willing and

interested and motivated to find a way to work this out and get through this.

SD: So there was a commitment there?

CL: Yes.

SD: Leaving wasn't an option – you were going to work it out one way or another?

CL: That's right, and also being stubborn and passive [or] resistant wasn't an option. I wasn't just going to tough it out and live with this tension until he left or something. We had committed to each other and I could just visualize coming through this..."

When I asked what it was about him that helped therapy work, Geller (CBT~DV~CL~H) said that,

"It's doing the work that's necessary to make it work. ... [My wife] was [committed] and so was I. That's a good word – "committed" – we both were very committed to it. So when they told us what to do and told us the techniques, [then] that is what we did. [We did] the best we could; some of them don't apply and some of them aren't comfortable for us, but we tried to do the best we could."

Tiffany, Geller's wife, summed up their commitment to the marriage by simply saying, "We're not quitters."

Psychologically/Systemically aware. In addition to being humble and committed, clients were also psychologically and/or systemically aware and intelligent. They were able to grasp abstract concepts that represented their psychological and systemic

difficulties and use those abstract concepts to guide their change. Humility and commitment are malleable client characteristics, meaning that if a client does not come into therapy with them they can possibly be fostered by the therapist. Conversely, psychological/systemic awareness seems to be a more static trait. Clients either have it (or are capable of having it once it is presented) or they don't. In this study, all of the clients were psychologically and systemically aware.

There were no quotes that said, in effect, "I am psychologically and systemically aware." Rather, their awareness was reflected in their ability to grasp the abstract concepts that were presented to them, reflect on them, and use them as a guide to change their experience in the relationship. It is quite possible, however, that clients who are not psychologically and systemically aware can still be helped. The therapist simply may need to alter their stance with these clients. For example, there is research suggesting that lower SES clients prefer more direct, concrete approaches than their higher SES counterparts (Cline, Mejia, Coles, Klein, & Cline, 1984).

The Therapeutic Alliance

Nearly every therapist and client emphasized the importance of the therapeutic alliance. Most of the therapists mentioned that establishing a caring relationship with their clients was a necessary precursor to working effectively together. When asked how he was able to help his clients change, the first thing Dr. Dattilio said was, "by establishing a rapport." When asked what it was about her clients that helped them change, Dr. Makinen (EFT~ST) said, "They were very easy to align with. It was very easy to build rapport with them because they were...very open. I think if you can build a

really good alliance with both partners, you're going to see shift. ... I think it's really down to the alliance."

The quality of the alliance was a product of a blend of therapist and client variables. For example, if therapists were committed to their client's well-being, and clients were open and willing to risk, the result would be a good therapeutic alliance. So, while this section focuses on the *indicators* of the therapeutic alliance, the reader should bear in mind that the therapeutic alliance was a product of the therapist and client variables discussed earlier. The main components of the therapeutic alliance are isomorphism and mutual trust and respect.

Isomorphism. In each case, the therapeutic alliance served as a model for the client's relationship. Attributes that the clients needed in order to change were modeled by the therapist. For Dr. Makinen's clients, the husband was controlling and the wife had withdrawn. Dr. Makinen used the therapeutic alliance to model a way out of this cycle by modeling how to set firm limits (for the wife) and how to validate your partner (for the husband):

"...he's very controlling. And when he requested we pray at the beginning of every session he [wanted to] open the prayer, [so] what I did very early on, because I didn't want him to control or manipulate the sessions is set really clear boundaries with him. I said, "Ok this is great, yes I think this is very important that we pray at the end of the session and I think we should take turns."... And so I felt it was very important to take the bull by the horns and also model for his wife how to set some clear boundaries around his behavior. I think that was a really important thing;

otherwise...he would run the sessions. And he really would have been able to manipulate using God and the way he prayed... She chose to opt out of praying at the beginning of the session so we alternated between Charles and myself... I allowed him to pray the way he wanted to pray and I never corrected that either. When it was my turn to pray at the opening of the session I prayed in a way that was validating for both of them. [It came down to] modeling and setting limits – firm limits.”

Dr. Frank Dattilio and Marianne Dattilio used the therapeutic alliance to model a healing relationship for each of their clients. Dr. Frank Dattilio believed that the husband needed to experience a relationship that was very direct yet loving, so he took this approach with the husband:

“I was very hard on him. I was very direct, probably the way he wanted his father to be, but in a loving way. I...gave him a lot of strokes and said, ‘Look man you’ve got so much going for you and you’ve accomplished this, you’ve just got to realize that this doesn’t mean your wife is dissing you when she doesn’t respond and there are other things going on.’ It was a real learning experience for him.”

Marianne Dattilio established a relationship in which the wife could explore what she really felt about things without being rejected. This served as a model for the client. She became more assertive, which helped the couple exit their interactional cycle.

Tiffany (CBT~DV~CL~W) said:

“I’m a strong person to a certain degree, but I will question if there’s a stronger personality present...and that comes from my background. I

didn't develop this, so, naturally I'm going to defer to the stronger [personality], which I married. And I'll just have to be good at...saying, "I feel this way, and that's the way it is, and respect it!" And that's where she came into play, because she did respect me even though she might not agree or whatever. She's never indicated one way or another. She understands and respects that, and that's a huge thing."

Mutual trust and respect. Each therapeutic alliance was characterized by mutual trust and respect. Clients trusted both the therapist and the process of therapy in general. This trust grew as they had more successful experiences in therapy. Clients trusted their therapist as their therapist competently led them out of their pain. For example, Dr. Johnson's clients began to trust her because, as EFT~DV~CL~H said, "When we had a tendency to flare up, even during the session, she had [a] magical power to lead us out of that. It was almost magical." EFT~DV~CL~W said that, "... [We both] trusted Sue from the very beginning." Dr. Johnson mentioned that, "...they trusted me a lot, so they let me work with them on a very refined level at times."

IFS~ST~CL began to trust her therapist when she saw that her therapist could competently deal with the client's "parts" that she was so afraid of. This trust born of competence was isomorphic – the client also began to trust in herself as her therapist helped her experience those parts and effectively deal with them:

CL: "She would really...create that space – that very secluded space – where it was safe to say "Ok, we can go there and we can come back from there within this hour." And I guess I developed more trust in doing that. If I went to a [scary] place I wouldn't get stuck in that space and spiral.

SD: So was it trust in yourself or Beth?

CL: Both, because at first I was having trust in Beth saying, “I can trust you to navigate this in a way where I won’t be a wreck when I walk out of here.” Then I started [to trust myself after I saw that I could do it.]”

Therapists and clients also had a mutual respect for each other. For clients, the development of respect for their therapist seemed to closely follow the development of trust – it largely hinged on successful experiences in therapy. Therapists seemed to develop respect for their clients as they saw them working hard and taking risks in therapy. When I asked Dr. Johnson to choose four or five words to describe her relationship with her clients, she said, “Respect. I really felt like I knew the culture they came from and I knew what it took to take those emotional risks.”

Other times respect developed naturally over a long period of working together. When I asked Ms. O’Neil (IFS~ST) the same question I asked Dr. Johnson above, Beth said, “I would say respect. We really liked each other. I think there was...some level of [a peer-to-peer relationship].”

Therapeutic Process

There were several commonalities across theories in the in-session process. The therapeutic process refers to those elements of therapy primarily related to *structure* and *climate*. Structural elements of the therapeutic process include common ways in which the therapist structured the sessions and his or her interactions with the couple over the course of therapy. Structural elements include structure/flow balance, neutrality, and repetition. Common processes related to climate refer to the “atmosphere” within which

therapy was conducted. Collaboration/accommodation and safety were the main climate categories that emerged from the data.

Structure/flow balance. In general, therapists were careful to strike a balance between structuring the session and allowing the session to “flow.” The therapists were a coach or facilitator – most of the work in therapy was done by the clients, but within the structure that the therapist set up. IFS~DV~CL illustrates this principle well as he discussed what Dr. Schwartz did that helped therapy be productive:

“He actually did very little, but what he did was remarkable. My job in a parts therapy session as I see it was to go in there, tell him a little bit about the external circumstances of my life, get in self, find a part that needed to be talked to, and have self talk to the part. ... But basically what Dick would say, especially at the beginning, was, “No, you’re not in self yet. That’s a part.” Or, he would get me...to get that part to step back. ... So, just very gentle guides like that. Very gentle sort of tweaks of where your attention is that Dick does and then...when a part has aired its issues then...I’d say “Well, what do we do now,” and Dick would suggest, “Well, you could ask that part if it wants to unburden it’s sadness.” ... And Dick will guide me through a couple processes, but I’m doing almost all the work. He’s just there to make sure I’m in the zone of self and to bring in the occasional healing modality as it’s needed.”

The degree of the client’s emotional reactivity was a guide in how much the therapist structured the session. In the previous example, IFS~DV~CL was not very emotionally reactive, so Dr. Schwartz let his client process. When he would start to

become emotionally reactive (i.e., in an extreme part), Dr. Schwartz would structure the session by encouraging him to get in “the zone of self.” Dr. Makinen (EFT~ST) offers another example of this concept. Charles (EFT~ST~CL~H) was quite emotionally reactive when he began therapy, and his wife, Louise, was quite withdrawn. Louise mentioned how Dr. Makinen structured the session:

SD: You mentioned, Louise, that Judy steered the discussion. Can you tell me a little bit more about that? ... In what ways did she steer the discussion?

CL: Well I'm thinking mostly in the terms of the volume. My husband is very eloquent when he gets going and he can get going for awhile and she would gently...try to get back on track or give me a chance to respond. ...

SD: So she stopped your husband long enough so you would be able to say what you had to say?

CL: Yes. At the beginning particularly I was withdrawn and he would be starting his typical formal arguments and I would just sit back and think, “Oh yes I have heard this before.” And then over time...Judy wouldn't let him go on that long and [she would] say, ‘Look at Louise, what's going on here?’”

As Charles became less emotionally reactive (primarily through hearing himself talk so much on the tape recorder as discussed earlier), Dr. Makinen structured the session less and allowed them to interact on their own more.

The way a therapist chooses to structure therapy influences their client's receptivity to therapy. As illustrated previously, Dr. Dattilio was very direct with his clients, largely because that is what he thought they needed and could handle. This approach worked well with them, as it helped the husband stop being controlling, and the wife engage with her husband more. Conversely, Dr. Makinen used a more gentle approach with her clients. Dr. Makinen's client's had gone to a previous therapist that used a direct approach similar to the one Dr. Dattilio used with his clients. This approach did not work well with the husband at all, as he said that, "I started feeling like [leaving my wife] when this previous marriage counselor...said, "You have no choice but to stay with her." I guess she meant morally, given the situation, I had no choice. But, I may have interpreted that the wrong way. I said, "Well, of course I've got a choice. I can leave her."

Neutrality. Therapists maintained a sense of neutrality over the course of therapy. Therapists refused to enter into triangles with a client. This balance held true for the overall course of therapy more than it did on a session-by-session basis. There were periods of time where the work would be focused on one person, but if complaints arose about this excessive focus it was made explicit that it was for the good of the relationship rather than the a case of the therapist choosing sides. Dr. Makinen made this explicit when she had been working with Charles, the husband, for a while. Louise, the wife, said that,

"You know sometimes my husband understood [Dr. Makinen asking him to let me talk] as, 'Oh you're taking her side; you're not listening to me,' but she was able finally [able] with tape recording the sessions [to] show

how much air time he was taking up and that it wasn't at all the case...

She wasn't turning to me for an alternative option – she was giving me another chance to break in.”

Even Ms. O'Neil, who met with an individual rather than a couple, kept the couple relationship in mind and refused to triangulate with her client (the wife). Her client mentions the effect this had on her:

“When I would be working with relationship stuff with [Ms. O'Neil] she never took sides. It's so easy when you're in a one-on-one conversation with someone to side with the person who is sitting in front of you. But she always had...empathy with Mohammad and I simultaneously. ... She would express her sincere like for Mohammad even when acknowledging her disappointment with him and even when validating my disappointment. She could hold the two together at once, which made me feel very safe. I'm not so careful [about complaining about my marriage] because I'm so out there with the stuff. But I do know that when you do that sometimes friends start developing resentment towards your husband that lasts even longer than you yourself have. I didn't have to fear that happening with Beth.

SD: You could explore and you knew she wasn't going to hate...

CL: Right, I could go down like, “I'm so angry with him and I'm so hurt by him, let down by him...” And I didn't have to fear [that] in two months when I'm [saying], “I'm so happy to have him,” she would still be stuck with the other.”

Repetition. Repetition was another factor common to the therapeutic process. Both clients and therapists mentioned that they did very similar things over and over again in therapy. If the clients saw what was being repeated as relevant to their problems (a common factor discussed later), the repetition cemented the path to change and helped the clients function on their own. CBT~DV~CL~W, in referring to the communication skills that she repeated with Dr. Dattilio over the course of 15 months, said that, "... [the skills are] coming more naturally now because I'm doing [them] more frequently. We've noticed a tremendous decrease in the amount of turbulence."

Repetition helped clients continue the work of therapy in their daily lives. Ms. O'Neil described her work with her client as being, "very repetitive – kind of over and over and over again." Bridgette, her client, described the effect of this repetition:

CL: "Well, Beth would take me through the IFS process, session after session for years. So, as time went on, I would be able to ask myself the very same questions that she would ask me in therapy when working around parts. It was almost like I could hear her voice in my head, saying things like, "Okay, who is that? How old is that part? When did I first remember having this feeling?" So I was able to internalize the process and employ it on myself just from years of doing it week after week."

Collaboration and accommodation. Therapists fostered an atmosphere of collaboration and accommodation. Instead of refusing her client's request, Dr. Makinen (EFT~ST) accommodated her client's desire to pray to begin each session as long as it was done on her terms. She described this as "meeting they client where they are at." She further accommodated her client's religious beliefs by framing her theory-specific

interventions (e.g., identifying and processing primary emotions) in spiritual terms. She said that the effect of this was,

“...very powerful, very validating because he would talk about how God works in his life. And I was able to understand that and validate his fears and frame it in terms of...spiritual, emotional...terms which [was] less threatening [to him] than just emotional. Because if I just would say [an emotional] word...and say, ‘Is this how you feel,’ he would deny it because that would indicate a sign of weakness.”

Accommodating her client’s beliefs allowed her to avoid a power struggle without having to abandon her theory. As a result, Charles (the husband) was receptive to Dr. Makinen and framed most of the positive change that happened in therapy as resulting from prayer: “The therapy just one more time helped me see how important prayer was. If I hadn’t [have] been seeing a [Christian] counselor...that wouldn’t have happened I don’t think.”

Therapists encouraged collaboration with their clients. Ms. O’Neil explained how she collaborated with her client in using IFS as the treatment method:

“Well, she happened to be one of the lucky candidates that I was seeing when I started the IFS training. But...we had developed enough trust in our relationship that she really is very open, and she trusted me. And I said, ‘You know, I’m taking this training and I’m working with this method,’ ... So I said, ‘How would it be for you if we kind of check this out and see how this feels?’ ... And so she was very open to it.”

Dr. Johnson also fostered a collaborative atmosphere with her clients. Dr. Johnson's clients mentioned reading about EFT in books that Dr. Johnson gave them. I asked about this, knowing that such homework is not a regular part of EFT work. She said, "I tell them as much as they seem to want to know in as simple a way possible. ... I don't "teach" EFT – they experience it – but I encourage collaboration, so if they have questions [I answer them]."

Safety. Most clients mentioned feeling safe when they were with the therapist. This seemed to be largely a product of knowing what to expect in therapy (a factor discussed later) and trusting that the therapist was competent enough to not let things get too overwhelming. CBT~DV~CL~H attributed much of their success to Dr. Dattilio's ability to, "...[create] an atmosphere with two willing partners that were going listen to the techniques that were told."

Safety was also a product of the client's willingness to take risks to be vulnerable. A safe environment resulted as clients risked their emotional safety by making themselves vulnerable and the therapist structured the session in a way that fostered this expression (usually by focusing on having the spouse hear their vulnerable partner differently). EFT~DV~CL~H describes the safety he felt this way: "...Sue...was able to make us understand each other better. She created a non-threatening atmosphere; she encouraged...sharing our vulnerability."

For others, a safe environment resulted from simply knowing that the therapist would respect them. This safety led them to be more open to the process of therapy. EFT~ST~CL~W said that once her husband knew that Dr. Makinen would respect their religious beliefs, "...he become comfortable. [When he] sensed that faith was also

important to her [he lent] an enormous amount of credibility to her and he was much more accepting of her interventions or assistance.”

To Ms. O’Neil (IFS~ST), establishing a safe relationship was a top priority. When I asked her what she thought her client would say helped her change, she said, “I think she’d probably say safety. I think she’d probably say the sense of feeling safe and trusting. I tend to believe this is probably more than just Bridgette. I tend to believe people heal more by the environment we create for them to work with their parts in.”

Expectancy and Motivational Factors

Another common factor across models was the fact that clients expected to get better, saw therapy and their therapist as a tool that would help them get better, and persisted in working towards that goal even when things were difficult. An interplay between several common themes facilitated this expectancy and persistence. These themes are *faith in the referral source, perception of the therapist as competent, fit of the model* and *motivational beliefs and experiences*. Implicit in all of these themes is the client’s perception of therapy as a viable means of helping them with their problems.

Faith in the referral source. Each of the clients in the study was referred to their therapist by someone that they trusted. This had an influence on their expectation that therapy would work. William’s (IFS~DV~CL) girlfriend, who was a therapist, knew of Dr. Schwartz’s work and suggested that William see Dr. Schwartz. William said, “I didn’t ever have any doubts that [therapy] was going to work [because] I totally trusted this person that I was having this relationship with, and she totally trusted Dick. Because of those two levels of trust I trusted that the therapy was eventually going to take me where I wanted to go.” IFS~ST~CL was referred to Ms. O’Neil through a close friend

who was also a therapist. Dr. Dattilio's clients were referred by Tiffany's (the wife) mother. Geller (the husband) said that his mother-in-law saw Dr. Dattilio "in the paper constantly...and suggested he was the top guy around." Tiffany said that her mother's referral gave her confidence that therapy would work. Dr. Johnson's clients were referred to her through trusted friends who were former clients of Dr. Johnson. Dr. Makinen's clients were referred to her through the wife's psychiatrist and her job's Employee Assistance Program (EAP).

Prior to beginning this study, one concern that I had was how to not include only clients who actively sought out their therapist because of their specific model. Presumably, such a population would not generalize to an average client seeking therapy. On the other hand, I wondered if clients who actively sought a therapist with a good reputation were different than a client who simply called the therapist with the nicest ad in the Yellow Pages. As it turns out, each client in this study actively sought a therapist with a good reputation rather than a therapist with a specific model. As EFT~ST~CL~W said, "...we'd rather [be referred from someone we trusted] than go through the Yellow Pages."

Perception of the therapist as competent. Being referred from a trusted referral source seemed – initially at least – to influence the client's perception of the therapist as competent. Clients began therapy assuming that it would work, and their therapist's competence bolstered that assumption. CBT~DV~CL~H described Dr. Dattilio as, "fair, smart...pin-point accurate, and...knowledgeable." EFT~DV~CL~W paid Dr. Johnson the following compliment: "It's just that she is just so gifted. She is a gifted person who is able to intuitively guide you thru difficult situations. I mean with all her knowledge she

has the gift. I don't know of anybody like [her]." When I asked her to describe her therapist, IFS~ST~CL simply said, "I could go on and on about things Beth did to help therapy be productive." Each client had similar things to say about their therapist's competence.

Fit of the model. Clients viewed their therapists as competent largely because they provided a viable explanation of the client's problems (i.e., the model) and – through their non-anxious presence and the fit of the model to the client's problems – gave the clients hope that the therapist had seen this before and could provide a way out. The therapist's model provided structure and order to the client's chaos, which gave the client hope. The model fit their experience. CBT~DV~CL~W described what happened when Dr. Dattilio described their marriage as becoming "increasingly polarized" and explained what he meant in terms of the interactional cycle previously discussed. She said, "...I didn't even realize it until we started in therapy and it was pointed out that [the polarization was] exactly what was happening. And then once it was pointed out to us...it was like, "Wow, that's exactly what's happening and has been for years." She went on to say,

CL: "... [I] have all these feelings trapped inside and [I] know it's not healthy, but how do [I] get beyond that? And that's when I started to think, 'He's identifying all these things that I'm thinking and feeling inside; maybe there's hope that I can get through some of these and feel better.'

SD: Sure. If someone's sort of seen it before...

CL: Right, right. And he's calm about it. It's kind of like, 'This is the way it is,' ...rather than having unrealistic expectations and

misunderstandings, you can say, ‘Okay, this is the way it is.’ I do well with that. I do well with the reality of, ‘Just give it to me the way it is and I’ll deal with it’ kind of a thing.”

Knowing that the therapist was comfortable with the process and had seen “the other side” that the clients could not currently see gave the clients a reason to take the risk necessary to do the work therapy required. Dr. Dattilio said that he saw his task as:

“...orienting them to a model of thinking about how their beliefs interfere with their interactions. [I wanted to] have them become cognizant of these distorted beliefs...[and understand how] they’ve contributed to a lot of tension in the relationship and [then] gather new evidence for restructuring them in a way that would be helpful.”

Dr. Dattilio oriented his clients to his model, but the clients did not know that was what was happening – they did not have a session where he sat down and explained the model to them (at least not that they could remember). Instead, the model was explained through what was focused on in the dialogue between the therapist and clients. This was true of EFT as well. None of the CBT or EFT therapists didactically “taught” their model per se, but rather taught it naturally through the conversations and experiences they had with their clients. Ms. O’Neil (IFS~ST) was the only therapist who explained the theory to her client. Therefore, how the clients learn about the model may not be important, but it does seem important that clients become oriented to a model that gives them a credible explanation for their problems and provides a way out. This allowed them to continue taking the risks necessary to make therapy successful.

Motivational beliefs and experiences. Trusting the referral source, their therapist and the model were the main factors that gave the clients hope that their relationship would improve. Motivational beliefs helped give them a context within which to justify the work of therapy. Each of the clients mentioned having certain beliefs or thoughts that helped them continue working in therapy even when things were difficult. Some of these beliefs were presented by the therapist, often as a reframe to their struggles. Others were beliefs that the client already possessed. For example, both Dr. Makinen and Dr. Dattilio's clients mentioned that because they had children and had been married for so long they wanted to continue the marriage. Regardless of where the beliefs originated, the important factor was that they gave the client a credible reason to resolve their problems in their current relationship no matter how difficult the work became.

One common belief was that going through difficult times successfully would increase their love for each other. IFS~ST~CL said that,

“...with each setback that Mohammad and I had it eventually brought us greater trust and deeper love, even if that didn't take place right off the bat. We would go through struggles with various setbacks, but ultimately we would hang in there, keep communicating, keep trying to be present...And what evolved out of that was great trust that this person will stick through it and deeper love because we've got a better understanding of one another.”

Dr. Johnson proposed a similar belief about working through difficulties in a relationship:

“You’ve got to take emotional risks if you want to create a relationship and you’ve got to be willing to ask for your needs to be met. And give your partner the benefit of the doubt and sometimes that very hard to do. The bottom line is you have to do that if you’re going to build a real deep basis of trust. You also have to do it if you’re going to repair rifts because...rifts are inevitable in any relationship. It’s actually when you have a fight or a rift when the repair is often the place where the relationship really starts to grow. It’s the repair process where the relationship starts to grow. In a way you don’t know anyone until they [have] disappointed you and you’ve had a big fight with them. Then you can go from there.”

Though Dr. Johnson’s clients did not mention this belief verbatim, they did echo the general theme of it several times.

Dr. Dattilio proposed a similar belief in an attempt to prepare his clients for the difficult work that lay ahead. CBT~DV~CL~W recalls, “...they were pretty up-front about it and said, “You’re going to enter some periods where you’re not going to like this.” Her husband said, “...they said to us, it’s going to get worse before it gets better.” This helped them continue on when the work was difficult.

Dr. Dattilio also gave his clients a reason to continue working on their personal issues in their current relationship rather than abandoning it and seeking another relationship, thinking that the second one would be happier. CBT~DV~CL~W said, “Dr. Dattilio said to us, ‘Nobody’s perfect, and no matter what you do what you do and whomever you choose to be with, you’re still going to have your own issues and you’re

going to bring them to the table.’ And that’s why...we both felt that we wanted to do this.” She went on to say, “It wasn’t going to be any better anywhere else...So why not try to improve what we have, because when it’s good, it’s good. [But] when it was bad it was really bad.”

In addition to motivating beliefs, having positive experiences in therapy also helped couples maintain hope. EFT~DV~CL~W said that Dr. Johnson, “...made us talk about our marriage and our feelings...in the session, and we were able to actually to connect right away emotionally... That [experience] gave us new hope; it was very encouraging and positive.” Her husband echoed her when I asked him what happened that led him to start believing things would improve. He said, “I would see the tendency [to improve] every single...visit. I would see that, ‘Yeah if we continue doing this...we will get better. This is the way.’ Every single session was a relief. There were also sessions where I was really looking forward to those sessions because I was able to...share my inner thoughts.”

CBT~DV~CL~W had a similar experience. When I asked her what kept her going when things were tough, she said, “I guess those little successes along the way.” She went on to say that working in therapy was like losing weight: “As the behaviors were changed or modified...and an incident would occur and it worked, that’s when...I would equate [the success] to losing weight. [I’d] get that little bit of success and [think], ‘Wow, this really works!’ ... That’s what gave me the hope.”

How Change Occurs: A Synthesis of Model-Dependent and Model-Independent Themes

So far, this chapter has focused on the results of my open and axial coding procedures. I have outlined each of the categories and their subcategories related to

common factors that emerged from the data. The remainder of this chapter will be devoted to the results of the final data analysis procedure: making relational statements. I will explain how each of the categories and subcategories relate to each other in order to bring about change. As with the rest of the results section, this section was both inductively and deductively derived. Much of this section represents inferences that I drew from the data.

The model-dependent variables are in a sequential order (i.e., common conceptualizations, common interventions and common outcomes). This is in part because such a linear explanation is unavoidable when explaining separate phenomena in writing (i.e., one has to come first, second, and third). It is also in part because, in general, that is how therapy naturally progresses, and that is how the participants in my study described it. Keep in mind, however, that the progression through each of these stages is more circular – one stage informs and is informed by the other. For example, the conceptualization phase is interventive in that it gives the clients hope. Also, there is no distinct line between where the intervention phase ends and the outcomes start; they often co-occur. As I discuss the interaction between elements of each stage and the model-independent themes I will mention the common factor being discussed in italics where relevant. This is to refer the reader to the more detailed discussion of each category and subcategory that has been outlined previously.

Additionally, when interpreting the model it may be helpful to think of the model-dependent categories as potential *moderating* variables. In quantitative research, moderating variables are those variables specific to the model that make it effective. Model-independent categories may be thought of as *mediating* variables. If two couples

receive the same therapy and one couple improves while the other does not, the variables that made the difference are the mediating variables. In other words, they are variables that are “outside” of the model but are still related to the outcome of therapy. A diagram outlining the model derived from the data is presented in figure 1.

The Co-construction of the Problem Definition Phase

At least two phenomena characterize the very beginnings of therapy in this study, and in any instance when a therapist is using a model to inform his or her therapy. First, at some level, the clients were confused as to how to help their relationship (*client conceptualization*). Efforts to change on their own had failed. Second, the therapists in this study had a clear idea of what was “dysfunction” in a couple, what was “health,” and how he or she could get their clients from the former to the latter. They knew how to help (*expectancy and motivational factor*).

Regardless of the model utilized, the therapist begins therapy by searching for cues that signal dysfunction in the couple. For the EFT therapists, these cues could be attachment injuries, secondary emotions, and so forth. For the CBT therapist, these could be irrational thoughts and self-defeating behaviors. For an IFS therapist, these could be extreme emotional reactions to each partner or one’s self. The list could go on endlessly for every MFT model in existence. Though there were several model-specific differences, two common themes characterize the cues MFT’s in this study searched for: 1) family of origin or previous relationship influences on current behavior; and 2) interactional cycles in which those early influences are played out and current problems are perpetuated. The cues they pay attention to will likely be in the context of at least one of these two categories.

Once a therapist starts to notice cues that signal dysfunction, he or she begins to present these to the couple. The couple will begin to adopt the therapist's explanations as an adequate replacement for the chaos that characterizes their current conceptualizations provided that the following conditions exist: 1) the therapist is viewed as credible (*expectancy and motivational factors*); 2) the proposed explanations (i.e., the therapist's model) fit the couple's experience and address issues realistically related to relational health and dysfunction (*expectancy and motivational factor*); 3) the therapist proposes his or her explanations in a way that minimizes client resistance (*therapeutic process*); and 4) the clients are at least somewhat willing to take personal responsibility for their part in the relationship (*client variable*). If any one of these variables is missing, outcome may suffer.

Once the couple adopts the therapist's conceptualization, the clients begin to feel hope (*expectancy and motivational factors*). They will be encouraged that there is a way out of their current situation that is achievable because their therapist has seen it before and is calm about the situation (*expectancy and motivational factor*). The clients begin to "buy" the therapists conceptualization of the problem (*co-construction of problem definition*).

The Intervention Stage

The co-construction of the problem definition is an intervention in and of itself, as it provides clients with hope and the beginnings of a way to make sense of the chaos that has become their relationship. However, more formal interventions follow the initial co-construction of the problem definition phase.

A therapist intervenes by using model-specific and common methods and interventions. Most of their interventions are aimed at altering affective, cognitive, and behavioral elements of the interactional cycle between the two partners (*interactional cycle; common interventions*), though each model emphasizes a different aspect of the cycle. For example, EFT, CBT, and IFS therapists all would notice when a client reacts with anger and attempts to control when their spouse rolls his eyes. They would also notice how these two behaviors likely perpetuate one another, or are at least a small part of a larger cycle of behaviors that perpetuate one another. Each therapist would probably inquire about that in some fashion, and would expect to find that there was some historical root to the affect, behavior, and cognition whether it is in the family of origin or a previous relationship. Perhaps when the husband's mother used to roll her eyes the husband felt dismissed and devalued. Now, when he sees the same behavior, he reacts with anger and tries to get the wife to stop. Perhaps when the wife's father would get angry, her mother would turn her head and roll her eyes in disdain then later talk to the daughter about how weak her father was for getting so angry. In this couple, the behaviors, cognitions, and affect of each couple perpetuate those of the other. So, the cycle would be like the cycle in figure 2 (with an arbitrary starting point).

A therapist from each model will intervene at different levels of the cycle (see figure 1). The EFT therapist would *primarily* focus on how the display of secondary emotion perpetuates the cycle. The husband's anger invites the wife's contempt, and vice-versa. The EFT therapist will fashion interventions aimed at helping each partner identify, own, and express their primary (e.g., hurt and fear) rather than secondary (e.g., anger, contempt) emotions, with the assumption that the expressed primary emotions will evoke

the same from their partner, thus altering the cycle and allowing them to resolve their attachment injuries (Johnson, 2004).

The CBT therapist would *primarily* focus on the automatic thoughts, schemas (i.e., in this case, deep-seated cognitions about relationships) and behaviors that perpetuate the cycle (Dattilio, 2005). He or she would help the clients explore alternative explanations to their partner's behavior, and help each partner explore different ways of responding to each other, which would thus alter the cycle. The IFS therapist (Breunlin et al., 2001) would pay attention *primarily* to cognitive and emotional aspects of the cycle. He or she would help each partner explore the beliefs associated with each "part" that was reacting so strongly to their partner's "part." This would help them explore different ways of interacting with each other.

So, while the entry into the cycle varies across models, they are all focusing on altering an aspect of the cycle. As evidenced in this study, the point of entry – be it cognitive, affective, or behavioral – did not matter in terms of outcome. *A change in one aspect was almost always associated with nearly simultaneous changes in the others.* The curative element may not be which aspect the therapist focuses on or how they intervene; rather, the curative element may be that they systematically focus on altering the cycle.

Regardless of the therapist's entry point into the cycle, most of their interventions serve the following purposes (see figure 1): 1) to slow down the process (*common intervention*); 2) to help the couples stand meta to themselves in the cycle, thus experiencing themselves and their partner differently (*common intervention*); and 3) to encourage personal responsibility by changing their stance in the cycle (*common intervention*).

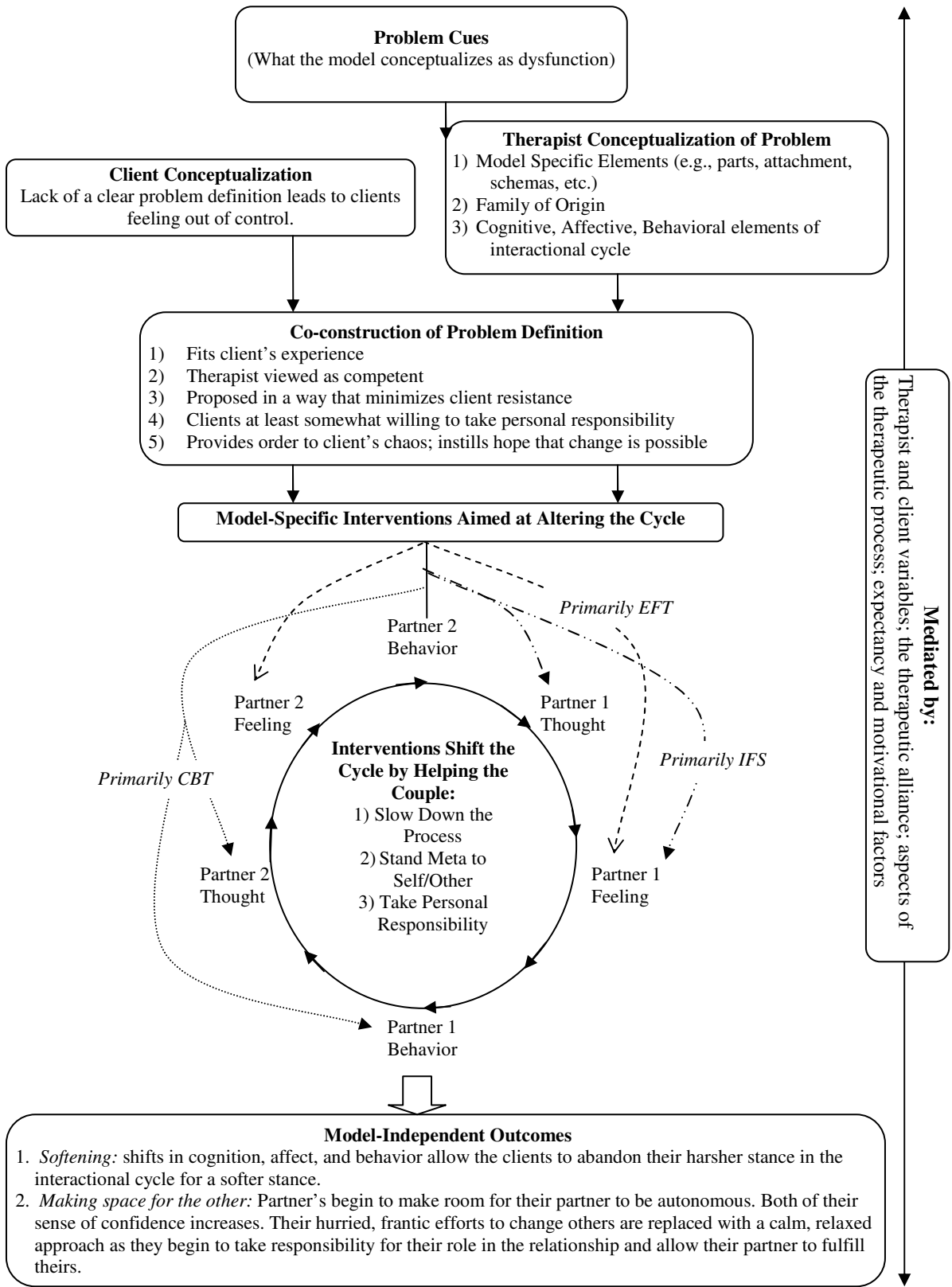


Figure 1: How model-dependent and model-independent themes combine to create change.

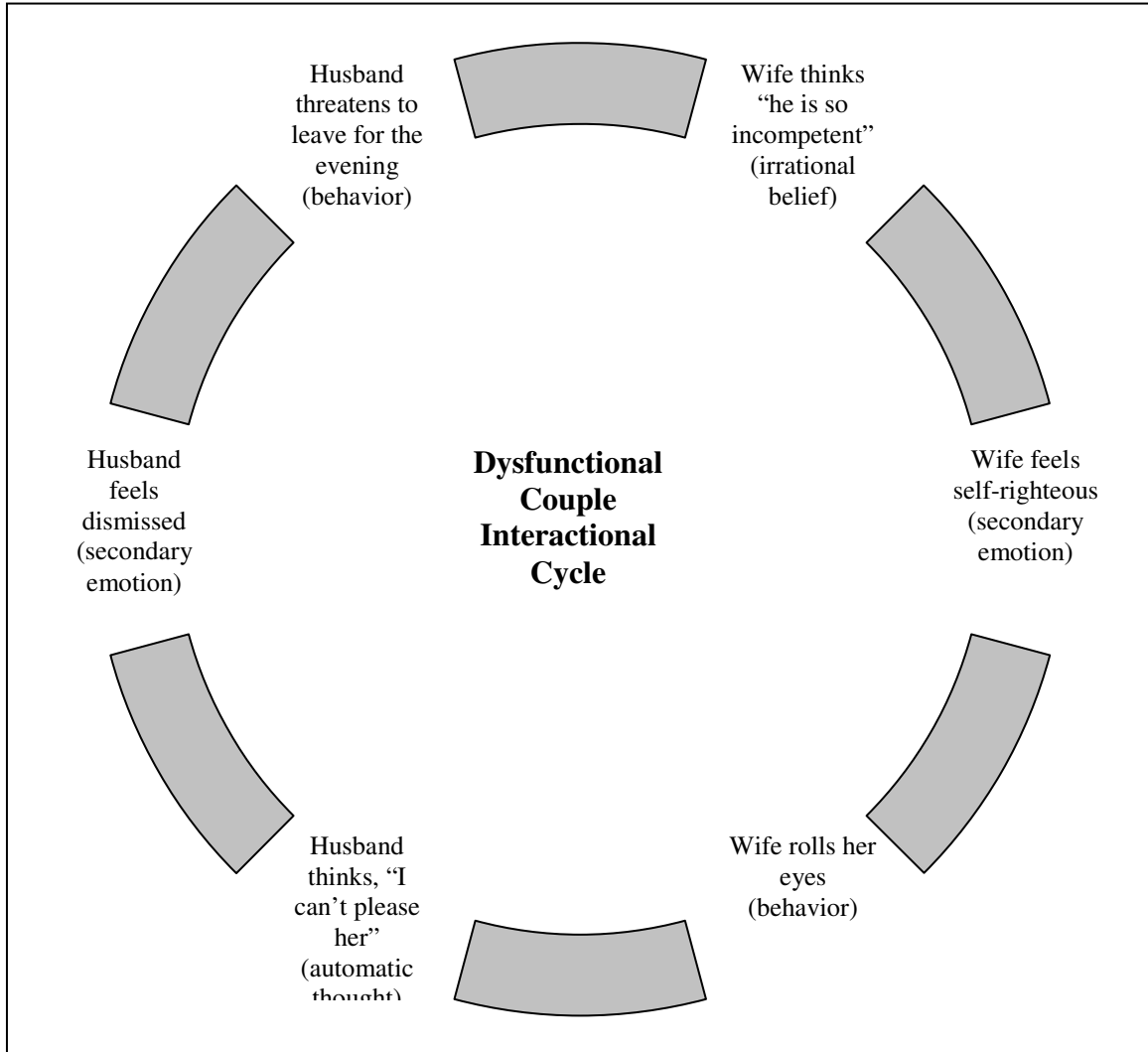


Figure 2: Dysfunctional interactional cycle

Therapists use a myriad of model-specific interventions to facilitate these goals.

Therapists help their clients stand back from themselves by slowing down the process. As couples begin to slow down, they are able to stand meta to themselves in the cycle – to see their own role in the relationship problems, as well as the role of their spouse. Once they can acknowledge their own role in the cycle they are encouraged to take personal

responsibility for changing their stance in the cycle, whether it is via altering affect, behavior, cognition, or some combination of the three.

The success of the above-mentioned tasks is determined largely by the degree to which the clients trust the therapist is acting in their best interest (*therapeutic alliance*), whether or not the therapeutic relationship is isomorphic to the goals of therapy (*therapeutic process*), the safety of the therapeutic environment (*therapeutic process*), the degree to which the process is repeated (*therapeutic process*), the therapist's ability to present interventions in a way that is direct but does not elicit resistance (*therapeutic process*), a client's willingness to accept personal responsibility for their role in the relationship problems and commitment to work on the relationship (*client variables*), and a client's ability to grasp psychological and systemic concepts (*client variable*).

The Outcome Stage

Not surprisingly, the categories that were the target of intervention were also primarily categories in which clients changed. The outcome stage is largely a "fruit" of the intervention stage; it is not clear where one ends and the other begins. Therapists focused on shifting affect, behavior and cognitions in the cycle by slowing down the process, helping their clients stand meta to themselves and their partner, and take personal responsibility for changing their stance in the cycle. As therapists did this, and clients were open to the process, their interactional cycle shifted from being destructive to healing. This change happened regardless of the "entry point" into the cycle that the therapist used (i.e., cognitive, behavioral, or affective). As clients made these changes, they experienced a shift in how they thought, felt, and acted towards their partner (*softening*; see figure 3 for an illustration of a healthy interactional cycle). They began to

be kinder to each other. They replaced attempts to control or withdraw from their partner with nurturing their partner's autonomy. They increased in self-confidence, and their rushed, anxious approach to life slowed down. As they stood meta to themselves and saw themselves and their partner differently, they were able to slow down and stop trying to control each other.

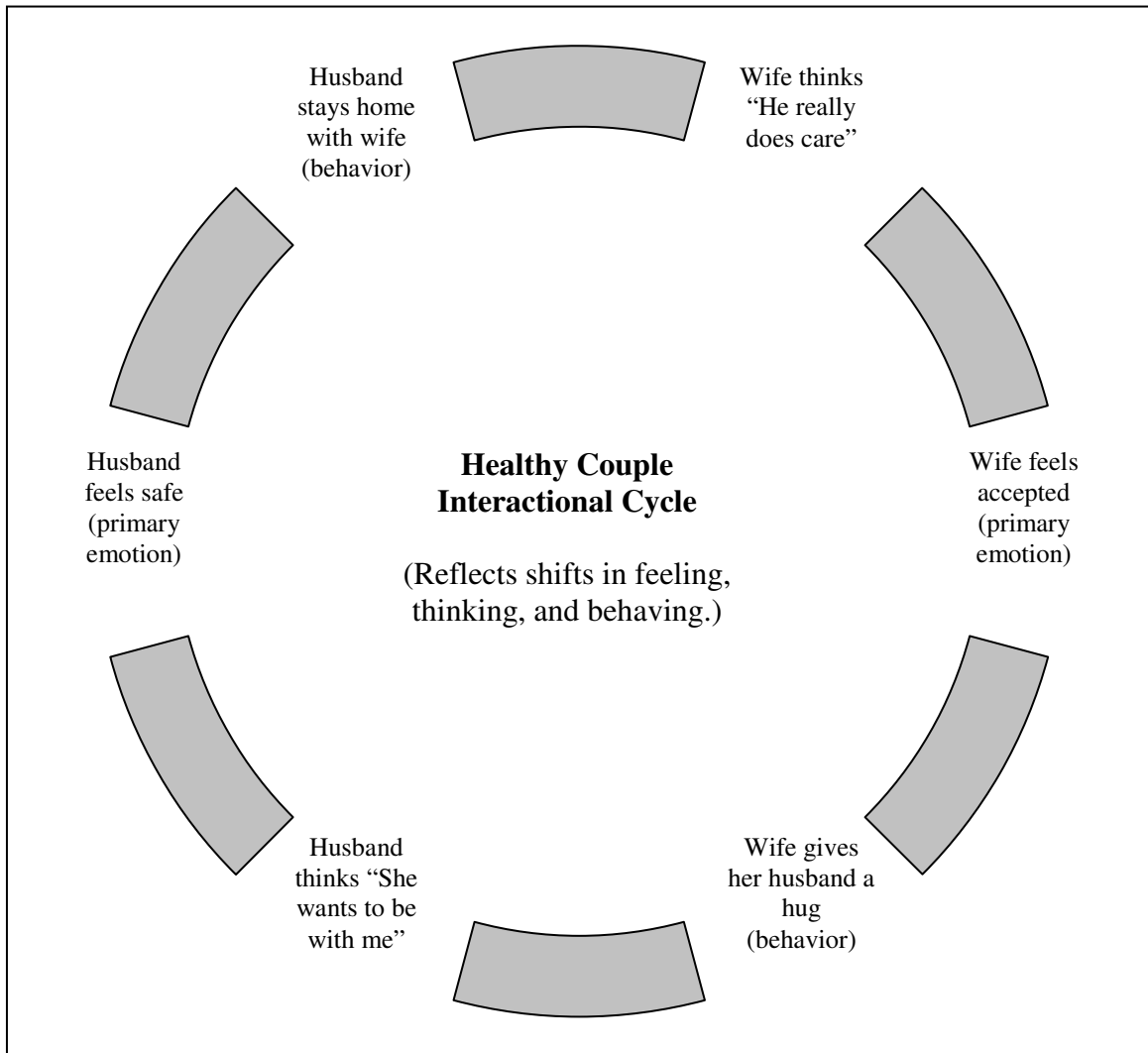


Figure 3: Healthy interactional cycle

Chapter V

Discussion

In this chapter I will discuss the clinical, research, and training implications of this study. I will also discuss how this study informs and expands the current common factors literature throughout this chapter and in a separate section. I will begin by discussing my experience with interviewing MFT model developers.

Reflections on Interviewing the Founders

I was honored that each therapist and client who participated in this study took time out of their busy schedules to talk with me. The model developers in particular took a risk participating in this study, as they each understood that this was a study on common factors. They did not know if my analysis of their interviews would reflect favorably on them or their model. They did not know if I would be respectful of their model, or if I would twist their interviews to further my own agenda. I appreciate the fact that they trusted me, and I attempted to honor that trust by being respectful of their models. Model developers are often criticized by common factors researchers as being solely devoted to furthering their model at the expense of a more comprehensive understanding of change. Regardless of the veracity of those critiques, the model developer's participation in this study on common factors implies their commitment to furthering the field's understanding of change rather than a fervent promotion of one's model at the expense of a broader study of change. I appreciate their integrity in doing so.

Several themes stuck out to me as I interviewed the model developers. First, I was impressed with the model-specific clarity with which they articulated their practice. It was very interesting to hear them describe how their clients changed as their theory says

they should, and then to hear their clients say the same thing. From the interviews, they really do practice exactly as they say they do. It made the practice of therapy as it is portrayed in textbooks seem much more real to me. It was also interesting to interview their former students, who each had a style of practice distinct from the developer's style. Most of them were not as "textbook" in their approach as were their trainers. Both styles worked, which bolstered my faith in the power of a well-trained therapist to effect change in people's lives.

I was also impressed with the passion the model developers had in their work with their clients. It was obvious that they were each invested in helping their clients overcome their problems. Their clients all noted this passion; it seemed to spread throughout the client system. Their clients seemed to feel comfortable with them in large part because the developers believed in what they did so fervently. This passion for their clinical work was evident in the interviews as they would often become excited when they were explaining a concept to me. In some instances it felt like I was being taken on a guided tour of something they had just discovered and were still excited about. I found their excitement for ideas invigorating. It was fun to feel their passion for their clinical work. I believe that their passion is a large part of the reason that their clients in this study improved.

I was struck by the fact that each of the developers mentioned how important they perceived the therapeutic relationship to be. Most of them said that they believed the relationship they establish with their clients is vital to the success of therapy. They mentioned that establishing a therapeutic relationship was on the top of their list of priorities with their clients. They also mentioned how important it was that the clients are

motivated and willing to engage in therapy. They willingly acknowledged that successful therapy was more than having a good model.

Clinical Implications

This study has several clinical implications for couple's therapy. First, this study highlights client's resourcefulness (Duncan, Solovey, & Rusk, 1992). Perhaps clients are more flexible than we give them credit for given that we sometimes insist that we should use one model with all clients. Despite receiving diverse forms of therapy in diverse formats, the clients in this study achieved their goals of establishing a healthy relationship. Which model was used did not seem to have an impact on the outcome of their therapy *as long as the clients viewed the therapist and his or her model as a credible explanation for how they got into their problem and how to get out of it.*

Findings from a study of EFT (Johnson & Tallitman, 1997) support this assertion. In searching for mediators of successful therapy in EFT, they found that "couples most likely to be satisfied after 12 sessions of EFT and at follow-up were couples who made a positive alliance with the therapist and, more specifically, who saw the tasks of EFT, which promote emotional engagement, as relevant to their problem (p. 146)." Outcome was mediated by the therapeutic relationship, and the strength of the relationship was largely determined by the credibility the client's lent to the therapist's problem conceptualizations and interventions. Clients in my study mentioned a similar phenomenon.

Second, this study highlights the importance of having a model for doing therapy. Therapy was helpful largely because the client's chaos was replaced with the therapist's order (i.e., their model). The client came into therapy unable to organize all that was

happening to him or her into anything they could use as a guide out of their difficulties. As Frank (1991) notes, clients coming into therapy are “conscious of having failed to meet their own expectations or those of others, or of being unable to cope with some pressing problem...[and] feel powerless to change the situation or themselves” (p. 35). The therapist provided that order with their model. All other factors equal, a model will be effective if it: 1) orients the therapist to credible aspects of dysfunction; 2) provides a clear definition of a healthy relationship; and 3) provides a clear operational map for how to help a client from health to dysfunction.

If a therapist does not have a model that provides a relevant definition of dysfunction and health and how to help clients from one to the other to guide conceptualization and intervention, he or she will only add to the confusion. Without a model to guide the therapist, the therapist will not know what to attempt to change, how to change it, or how to know when therapy is complete. Replacing one person’s chaos with another’s will not help.

Therapists may find the following questions helpful when thinking about what dysfunction is and what is health when working with their clients: What does this client system need more or less of? What do I believe are the most important things to look for in the first session? How will I know when they are ready to terminate therapy? What will they be able to do (or think, or feel) that they are not now? What interventions can I use to help get them from one to the other?

Proposing that a model is necessary to therapy is in contrast to some proponents of common factors, who claim that, since all models seem to work the same, models are largely irrelevant (Duncan & Miller, 2000). Rather, my approach is consistent with

Sprenkle and Blow (2004b), who propose that models are necessary, as they are the vehicle through which common factors operate. As long as the model fits the above-mentioned criteria, it does not seem to matter *which* model is used, as they all reached similar ends in this study.

Similarly, the model-specific interventions in this study did receive attention by the clients when they were asked what it was about therapy that helped them change. Each client described model-specific things that their therapist did that helped them. Interestingly, however, was the fact that all clients said that *the model-specific interventions helped them in similar ways*. This supports the systemic concept of *equifinality* (Nichols & Schwartz, 2001), or the idea that the same end can be reached through several different means. So, having a clear definition of health seems to be as important to doing good therapy as having a bag of tricks. The bag of tricks is useful – even necessary – but not if the therapist does not know to what end to use them.

Though this study suggests that a therapist be familiar with credible models of therapy, this study also suggests that a therapist should be flexible within those models. A therapist should not lose sight of the ends (i.e., the definition of health) as they focus on the means (i.e., the interventions), and should be willing to abandon the model's means if they are not helping the clients reach desired ends. Dr. Makinen provided a good example of this concept in this study. The husband was having difficulty standing meta to himself in the cycle, where he was pursuing and his wife was withdrawing. She attempted to help him do this by trying to get him to identifying and process primary emotions. When this did not work, she abandoned her model-specific techniques and tape recorded him during the session then had him listen to himself at home. He was amazed at how much he

talked (i.e., he stood meta to himself in the cycle), and altered the cycle by committing to listening to his wife rather than trying to force his point. Dr. Makinen used unconventional means to reach model-congruent ends.

This study also calls attention to variables not related to the model when working with clients. There are several model independent variables that are within the therapist's control, such as therapist attributes (Tallman & Bohart, 1999), the therapeutic process, and his or her role in the therapeutic alliance (Bachelor & Horvath, 1999).

Repetition is another pragmatic clinical implication of this study. Repetition is an important concept in helping people change (Helmeke & Sprenkle, 2000). Many clients in this study mentioned that it was after doing the same things over and over again that they started to change. I have observed in my own therapy and my clinical supervision that therapists will often try a few sessions of one model, then, if that does not work, they will switch to another model and so on. Perhaps this may be useful in some cases or while finding a "fit" between the model, therapist, and clients. This study suggests, however, that patience may be needed more than a new model when change is not happening as quickly as hoped.

This study supports other research that highlights the importance of the beginning stages of therapy. Studies suggest that between 56% to 71% of the outcome variance is attributed to changes made in the early stages of treatment (Fennell & Teasdale, 1987; Howard, Lueger, Maling, & Martinovich, 1993). In this study, many clients' hope that change could happen was bolstered in the initial sessions of therapy as their therapist shared his or her conceptualization of the problem with them. The clients believed that someone had seen their problem before and was still calm about it, so surely there must

be hope. This was affected largely by whether or not the therapist's conceptualization fit the client's experience of their problem, and their perception of the therapist's competence. Their perception of the therapist's competence was influenced by the referral source. Assessing the referral source may be an important piece of information for therapists to gather.

The importance of matching a therapist's directiveness with a client's emotional reactivity is another clinical implication from this study. Butler and Gardner (2003) mention that therapists should provide more structure in therapy when clients are emotionally reactive, then lessen the structure as clients become better able to regulate their emotions and sustain conversations on their own. This study supports that hypothesis. As therapy progressed with most of the couples in this study, the therapist became less and less involved in structuring therapy as the clients grew in their ability to regulate their emotions.

Research Implications

This study has several implications for future couple's therapy research. Comparative efficacy research is at the heart of the common factors debate (Sprenkle, 2002). Proponents of such research claim that it will ultimately show that one model is more effective than the others (Task Force Report on Promotion and Dissemination of Psychological Practices, 1993). Common factors researchers claim that such an approach "screams of scientific or theoretical arrogance" (Asay & Lambert, 1999, p. 23), and that what works about therapy is largely not found in the model per se. To date, meta-analytic reviews of the comparative efficacy literature have failed to show any significant differences among tested treatments (Wampold, 2001). Some common factors

researchers cite these findings as evidence that comparative efficacy research should stop (Duncan & Miller, 2000). Others (Sprenkle & Blow, 2004a; 2004b) suggest that this research could continue, but should be expanded to include a study of variables broader than just model-specific factors (e.g., researchers could use the same study to focus on the relationship between therapist or client variables and outcome).

I believe that this study primarily supports the latter common factors claim. Clients in this study consistently claimed that aspects of the model *did* help them. Future comparative efficacy research could be useful, but only if it is expanded to include more independent variables than the models. The model does seem to be important for outcome, but so do a multitude of other variables such as the model-independent categories in this study. Comparative efficacy research could also include measuring variables such as client and therapist factors, differences in in-session process (Butler & Wampler, 1999), and other variables on outcome. Such an approach could provide a great deal of empirical information about the effect of the interaction of several of these variables on the outcome of therapy.

Much of the research on couple's therapy has focused on which model works the best. The model presented here suggests that a study of how therapy helps people change would be much more comprehensive. In this study I called attention to the importance of understanding common aspects of distressed couples and common aspects of healthy couples. The obvious role of a model is to take a couple from dysfunction to health. *Less obvious, but perhaps more important, is what the model describes as dysfunction and health.* Does the model orient the therapist to dysfunctional aspects of the couple's functioning that really matter? Are the indicators of healthy relationships that the model

uses to suggest that a client is ready to terminate therapy really indicators of healthy relationships? These are empirical questions. It is possible to know, empirically, commonalities of healthy and dysfunctional couples. It is also possible to know the extent to which a model dovetails with this research. Interesting research could be done on the extent to which models orient clinicians to aspects of dysfunction that are relevant, the extent to which the aspects the model describes as health really are aspects of health, and whether or not the model provides adequate direction for how to help a client go from one to the other. Research that focused on common aspects of healthy and dysfunctional relationships could have as much or more clinical relevance as research focusing on whether or not a model works (Davis & Butler, 2004).

A substantial amount of research has already been done in this area (Carrère & Gottman, 1999; Driver, Tabares, Shapiro, Nahm, & Gottman, 2003). Dr. Johnson (1996) has outlined how EFT dovetails with Gottman's research, particularly as it relates to being flooded with negative emotions and constricted expression. Future attempts to delineate how models address empirically established commonalities of distressed couples and facilitate the growth towards health would be useful.

This study provides similar linkages between the models studied and studies of common aspects of healthy and dysfunctional couples (Carrère & Gottman, 1999; Driver et al., 2003). Gottman and Silver (1999) describe criticism (a complaint coupled with an attack on one's character), contempt (e.g., criticism with displays of disgust and hostile humor or sarcasm), defensiveness (i.e., defending one's position), and stonewalling (i.e., withdrawing from an argument) as the four horsemen of the apocalypse for a marriage. When these four elements are found in large degrees in a marriage, the marriage is likely

to end in divorce. Gottman describes “flooding” as another aspect of dysfunctional couples. Flooding occurs when one partner (almost always the male) becomes so physiologically aroused in an argument that he stonewalls; he withdraws and shuts down emotionally. This further enrages the pursuing partner (usually the wife), which increases her pursuing, which increases his flooding and stonewalling, and so forth in a self-perpetuating, negative interactional cycle.

Gottman and Silver (1999) describe a healthy marriage as one where each partner (especially the husband) accepts the other’s influence. Therefore, according to Gottman’s research and the model presented in this study, an effective model would orient the therapist to the four horsemen and help the therapist know how to help the clients abandon the four horsemen for a relationship where each partner was accepting of the other’s influence. This process happened with each of the clients in this study. Each therapist’s model oriented them to the interactional cycle created by each partner’s four horsemen and helped them modify the cycle by creating a shift in how they felt, thought about, or behaved towards their partner. As a result, each partner in this study increased in their respect for each other’s autonomy. They stopped trying to change each other and accepted each other’s influence.

Future process research that identifies and links relational processes to health and dysfunction could facilitate our understanding of the change process. Furthermore, making links between existing research outlining common aspects of healthy and dysfunctional couples and therapy models more explicit could greatly further our understanding of how to use our therapy models to help people change.

Future research into variables that mediate change in therapy would also be useful. The model-independent variables in this study could be thought of as mediating variables. More fine-grained research that investigates how mediating and moderating variables interact to create change would greatly further our understanding of change.

Training Implications

Current COAMFTE guidelines place a strong emphasis on teaching models of therapy. Several authors (Sprenkle & Blow, 2004a; Nichols & Fellenberg, 2000), including myself (Davis & Butler, 2004) have proposed that the teaching of models should be de-emphasized, and be replaced with more instruction on common factors. After finishing this study, I believe that the teaching of models in MFT training programs should be altered rather than de-emphasized. The clients in this model were helped largely because the therapists had a model that provided a roadmap for how to help. Taking away that roadmap and replacing it with only the model-independent variables does not seem warranted. However, the role of model-independent factors is too salient to the success of therapy to be ignored in training. Instead, I believe it would be helpful to alter the way we teach models to more accurately reflect the way models seem to work; namely, as a vehicle of change rather than the sole contributor to change. Currently, individual models often taught as being superior to others, or that the techniques associated with one model are responsible for change in therapy. This study does not warrant such an approach. Instead, this study supports a training approach in which students have a thorough grasp of several models, and can comfortably switch between them as needed. This approach is in contrast to picking one model to master and only using that model with clients.

In addition to being exposed to the role of model-independent factors in therapy, I believe that their study of models should go hand-in-hand with a study of commonalities of distressed and healthy couples. This way, therapists would be able to form a picture of what they think constitutes a dysfunctional relationship, what constitutes a healthy relationship, and how they can help their clients from one to the other (i.e., the model). Neglecting an understanding of health and dysfunction could leave a therapist with a quiver full of arrows, but no knowledge about what to hunt or when to stop hunting.

Whether or not a model “works” or whether it fits empirical concepts of relational dysfunction and health are not the only criterion that should be used to judge the usefulness of a theory. Ethical and moral issues such as sensitivity to issues of diversity, and the propensity of the model to reinforce harmful stereotypes should also be taken into account when evaluating the usefulness of a model. For example, does a model encourage the therapist to value the experiences of each family member equally? Is the model flexible enough to find use with diverse cultures? Answers to these questions are equally as important to evaluating the usefulness of a model as are answers related to efficacy.

Once a therapist understands concepts of relational dysfunction and health, it may be helpful to train therapists in non-model specific techniques that help clients go from one to the other. For example, learning relaxation techniques to help clients regulate their emotions is a technique easily adapted to most models.

Furthermore, therapists’ training could be greatly enhanced by an increased focus on the self or character of the therapist (Asay & Lambert, 1999; Davis, in press). Several themes emerged from the data relative to common therapist characteristics, and the effect

those characteristics had on the therapeutic alliance and in-session process. Educators could focus on helping therapists become more caring, warm, direct, and boundaried to name but a few attributes. I agree with Asay and Lambert's (1999) assertion that, "Changing the emphasis in graduate training toward the development of the therapist as a person who prizes others can only make the enterprise of therapy more valuable, meaningful, and effective" (p. 49).

Therapists' training could also be enhanced by a focus on model-independent variables. Many of the model-independent variables found in this study are in the therapist's control. Others seem to influence the outcome of therapy, and as such warrant being aware of.

I have found – from personal experience and that of my supervisees – that beginning therapists often become preoccupied with the means (i.e., the interventions) when they lose sight of the ends (i.e., the desired outcome). Supervisees often come into supervision searching for techniques to assist with their stuck cases. When I ask them questions such as, "what does the system need more or less of?" in an attempt to help them clarify what is wrong, they are often stuck. They respond similarly when I ask them to describe how they will know when the clients are ready to terminate. Supervisees often seem to lose sight of the big picture and become preoccupied with specific interventions when they are not even sure what the interventions are for. A more clear understanding of health and dysfunction may help with this. They could be taught to view their models as both a means (through the interventions) and an end (through the definitions of health and dysfunction). This may help them become "stuck" less, as they would be able to separate where they were going from what they were going in.

Integration of Findings With MFT Models Not Represented in This Study

Though the themes in this study were derived from three distinct models of MFT, evidence of similar themes exists in other MFT models. This section will focus on similarities between themes in this study and MFT models not included in this study.

Common Conceptualizations: Family of Origin and Interactional Cycles

Several MFT theories other than those in this study use family of origin experiences conceptualize cases. Bowenian approaches (Kerr & Bowen, 1988) focus almost solely on family of origin experiences when conceptualizing cases, as do contextual (Boszormenyi-Nagy, 1987) and object relations (Scharff & Scharff, 1987) therapists. Structural therapy (Minuchin & Fishman, 1981) is also interested in transgenerational issues when working with clients.

The notion of interactional cycles is as old as family therapy itself (Watzlawick, Beavin, & Jackson, 1967). Practically every MFT model incorporates some aspect of interactional cycles into their conceptualization and intervention. Brief therapy approaches such as strategic (Haley, 1976), solution-focused (deShazer, 1988) and Milan systemic (Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. 1978) theories all rely heavily on viewing one partner's behavior in the context of that of their partner. Interactional cycles such as triangles are a central theme of structural therapy (Minuchin & Fishman, 1981).

Common Interventions: Raising Awareness of and Altering the Interactional Cycle

Interventions aimed at raising awareness of the cycle through slowing down the process, standing meta to oneself and one's partner, and encouraging personal responsibility are also common across MFT theories not included in this study. Narrative

externalization of the problem (White & Epston, 1990) serves to help a client slow down their internal and interpersonal processes by helping clients battle the problem rather than themselves or each other. The solution-focused therapist (deShazer, 1988) helps clients slow down and take personal responsibility by helping them search for exceptions to their current problem and encouraging them to re-create those exceptions. From a Bowenian perspective (Kerr & Bowen, 1988), differentiation could be seen as slowing down, standing meta to yourself, and taking personal responsibility to be less emotionally reactive in relationships.

Several theories use cognitive, affective, and behavioral interventions to alter interactional cycles. Narrative (White & Epston, 1990) re-storying could be thought of as altering a couple's cognitions about themselves in relationships. Bowen's concept of differentiation (Kerr & Bowen, 1988) is primarily concerned with helping a person regulate his or her emotions. Strategic (Haley, 1976), Solution-focused (deShazer, 1988), and Milan systemic (Palazzoli et al., 1978) models all focus on problematic cognitive interpretations couple's put on each other's behavior. Experiential therapists (Napier & Whitaker, 1978) focus on processing their client's emotions in therapy.

Integration of Findings With the Current Common Factors Literature

The findings of this study confirm, challenge and expand current common factors theory. I will discuss how this study meshes with common factors literature in psychology and in MFT.

Integration With Common Factors in Psychology

This study generally supports and expands Lambert's (1992) common factors conceptualization in psychology. Lambert's (1992) article is possibly the most frequently cited article in the common factors literature. Lambert attributes the largest part of the outcome variance, 40%, to "extratherapeutic variables." These are events completely outside of the therapist's control. Such events could include job changes, moving homes, formations of new friendships, and so on. In fact, when considering that Lambert also ascribes 30% of outcome variance to the therapeutic relationship, 15% to expectancy or placebo effects, and 15% to model-specific techniques, only 30% of the outcome of therapy can be influenced by the therapist (i.e., 15% for the therapist's half of the therapeutic relationship and 15% for model-specific techniques). Seventy percent of the outcome of therapy is completely outside of the therapist's control!

This study suggests that Lambert's (1992) earlier estimates of the therapist's influence on therapy may be conservative. Though I could not comfortably assign a percentage, all of the clients made it very clear that they could not have achieved the changes that they did without the help of their therapist. Only one client (Bridgette; IFS~ST~CL) attributed some of the change in her life to changes in external events. She and her then-fiancé, Mohammed, had been involved in a long legal battle with the Immigration and Naturalization Services (INS) when he was not allowed back into the country after he had returned to visit Jordan after the terrorist attacks on September 11, 2001. Resolving this legal dispute, coupled with moving to a new city and starting a better job had an impact on the outcome of her therapy. I do not believe that these changes can be separated from therapy very easily. Perhaps Bridgette was able to endure the long battle with INS and secure a better job after their move in part *because* of the

changes she made in therapy. It seems difficult to say what external changes in client's lives are influenced – at least in part – by work in therapy. Every client in this study was quick to give credit to therapy and their therapist, as was IFS~DV~CL when he said, “There's absolutely no way that I would have been in a place of this kind of internal clarity...if I hadn't been working with this kind of model or something like it as [fervently] as I had.”

This study also suggests that therapist's have some control over what Lambert (1992) referred to as expectancy and placebo effects. The referral source, which is outside of the therapist's control, had a great deal to do with whether the clients expected to improve. Once clients began therapy, however, their hope increased a great deal as the therapist provided them with a way of thinking about their problems that provided an explanation for how they got to where they were and what they could do to get out. as previously discussed, clients reported that seeing their therapist not be anxious when they told him or her about their problems gave them hope that someone had seen this before. They trusted that their therapist would be able to lead them out of their difficulties. In short, this study suggests that the therapist may have a great deal more control over the outcome of therapy than previous common factors literature has estimated.

The client variables found in this study seem to be necessary for change to occur. The supremacy of client variables over therapist variables may not be that clear-cut, however, as a poor therapist may thwart even the most motivated client, and a good therapist may be able to motivate an unmotivated client. Having said that, the results of this study generally confirm the viewpoint of Miller, Duncan, & Hubble (1997) that, “the research literature makes it clear that the client is

actually the single, most potent contributor to outcome in psychotherapy” (pp. 25-26). The therapist could have been at the top of his or her game the entire time, and if the client was not willing to change, none of that would have mattered. The fact that each of the clients in this study changed despite receiving diverse models supports this assertion. Dr. Dattilio said it more bluntly:

“FD: I have to tell you though that...people often come in and say, ‘What is your success rate?’ I have to tell them fifty percent. Fifty percent of the people get better and do well. Fifty percent either fail or don’t show up or just go down the drain. That’s about what it is – none of this 90% success rate. That’s bullshit. I mean fifty percent at best.

SD: It sounds to me that a lot of this is on their shoulders, yeah?

FD: Yeah... It’s no different than physical therapy. I was paralyzed...five or six years ago. I had [an operation] and I learned a lot about physical therapy and how important it is. They step on you, and I tell you what – my recovery came as a result as busting my ass. The harder I worked, [the more I overcame]. I...overcame everything. I’m back to where I was. I mean you really have to work your ass off. And if you do, you make head way and if you don’t then you live with what you got.”

This study also confirms the narrow (Hubble et al, 1999; Tallman & Hobart, 1999) and broad (Lambert, 1992) conceptualizations of common factors in psychology. Narrow factors are those aspects of the therapy process common across specific models. Broad factors are factors not directly associated with the model but still related to change, such as therapist and client variables, the therapeutic relationship, and so forth. In this

study, model-dependent factors are similar to narrow factors, and model-independent factors are similar to broad factors. This study expands the detail of each of these categories and proposes a model of how elements of both factors interact to produce change in MFT.

Integration With Common Factors in MFT

This study further confirms, refines, and expands contemporary frameworks of common factors in MFT (Sprenkle & Blow, 2004a). Sprenkle and Blow confirm Lambert's (1992) four categories of common factors as being applicable to MFT as well, and then propose the following three factors as common factors unique to MFT: 1) relational conceptualization; 2) the expanded direct treatment system; and 3) the expanded therapeutic alliance. Each of these categories are discussed in detail in chapter two. This study confirms their "relational conceptualization" category, and further refines this category by outlining what the relational conceptualizations in this study are (i.e., family of origin influences on current affect, behavior, and cognition and the perpetuation of these through interactional cycles).

This study also provides support for Sprenkle and Blow's (2004a) "expanded direct treatment system" and "expanded therapeutic alliance" categories. Even when working with individual clients, the work was always done in the context of the client's relationship with their partner, and was characterized by familiar couple therapy processes (e.g., therapists' refusal to triangulate). This study expands the current MFT common factors literature by providing a conceptual model that proposes how model-dependent factors interact with each other sequentially to bring about change in MFT, and how those factors are mediated by model-independent factors.

This study also sheds more light on the interaction between affective, behavioral, and cognitive factors in MFT (Sprenkle & Blow, 2004a). There has been a debate between two of the models in this study – EFT and CBT – over whether it is more important to focus primarily on cognitive or affective elements of the couple’s experience in an attempt to shift their interactional cycle (Nichols & Schwartz, 2001). Cognitive therapists propose that working on cognitions gives clients something concrete to focus on that they can change, which will in turn change emotions. EFT therapists propose that a client’s emotional experience is a more primary organizing factor in relationships, and should therefore be the focus of intervention. This study suggests that they both may be right. Neither needs to try to change the other’s viewpoint. In this study, changes in one element (i.e., affect, behavior, or cognition) tended to either co-occur with or be closely followed by changes in the other two elements. This is an assertion that could be answered more definitively by future quantitative research.

Sprenkle and Blow (2004a; 2004b) propose what they call a “moderated common factors approach.” This approach was discussed in detail in chapter two. It differs from traditional common factors approaches (Wampold, 2001; Duncan & Miller, 2000) in that it does not disparage the use of treatment models and comparative efficacy research. Ways in which this study supports their views on comparative efficacy research has been discussed earlier. Sprenkle and Blow propose that treatment models are the vehicle through which common factors operate, and as such are necessary components of effective therapy. This study supports their assertion, and provides additional detail into how having a model facilitates the therapy process (e.g., by increasing client’s hope as the therapist’s model-informed conceptualization fits the client’s experience, etc.).

Common factors researchers and proponents of specific models have long debated the utility of treatment manuals (Hubble et al., 1999). Proponents of treatment manuals claim that the manuals are necessary to provide enough detail about the model to allow clinicians to be able to use it competently and to perform research on the model that is reliable and generalizable (Crits-Christoph & Mints, 1991). Common factors researchers claim that treatment manuals inhibit creative processes, and that the change process is too unique from client to client to be put into “cookbook” form. Similar to Sprenkle and Blow’s (2004a; 2004b) moderated common factors approach, the results of this study suggest that both may be right and wrong. The better a clinician knows diverse models, the more freedom he or she will have in therapy. Well-written treatment manuals could only deepen this knowledge. However, to ultimately be useful, treatment manuals should move away from their excessive “cookbook” focus on model-specific interventions and spend just as much focus on the model’s definitions of health and dysfunction.

Strengths and Limitations of the Study

As with all studies, this study has several strengths and limitations inherent in its design. One of the main limitations in this study is the client sample. In general, the clients in this study were Caucasian, had a relatively high SES, remained in therapy for a long time, and were well-educated. Although the variables that resulted from the study are likely applicable across a diverse clientele, such a homogeneous sample may limit the generalizability of the results in unforeseen ways. Therapists, educators, and researchers

using the results of this study to guide their work are encouraged to remain open to new data that may be presented by a more diverse clientele.

Additionally, the therapists freely admitted that they chose the clients I interviewed because they did very well in therapy. Though this could be interpreted as these are people so motivated that they would have gotten better going to anyone, I think there are other plausible explanations. The client variables outlined in this study seem to be the main ways in which the uniqueness of these clients contributed to their successful outcomes. Those commonalities (e.g., commitment, hard working, willing to risk) are found across many clients, and if they are not initially, this study also suggests that these attributes can be fostered by the therapist.

Another limitation of this study is the inability to make causal links between any of the variables in the study and outcome. Simply because I found common variables across theories does not mean that these variables are necessarily causally linked to outcome. Christensen, Doss, and Atkins (in press) use the following analogy to illustrate this principle:

“There is a children’s story about how humans first learned to eat meat. In a village by the ocean, where people lived in huts on stilts above the ground, a fire started in a village hut and a pig trapped underneath was burned to death. The villagers came by afterward to look at the poor pig, who had been a favorite pet. One villager bravely put his finger on the pig to see if the animal was indeed dead, his finger got burned, he instinctively put it in his mouth, and he discovered the new and wonderful taste of cooked meat. This lucky fellow with the burnt finger and happy taste buds

encouraged others to stick their finger into the pig and soon the whole village was having a feast. Sometime later the village wanted to enjoy such a meal again, so they naturally tied another pig underneath a hut and burned the hut down!”

In other words, we do not know which variables in this study are truly associated with change, and which are “little bits of superstitious behavior here and there” (Kazdin, 2001, p. 147). A reader could be tempted to infer causality in the relationships between variables that I propose. This question is best answered quantitatively, and is one that I hope researchers will pursue.

Additionally, it could be said that there is a greater chance that any given therapist’s practice of a model (e.g., EFT) looked more like Dr. Johnson’s EFT than it looks like another therapist’s practice of EFT, since most therapists are exposed to Dr. Johnson’s practice sometime during their EFT training. Therefore, a model developer’s clinical practice would be transferable to most clinicians. On the other hand, though a model developer’s therapy has a high likelihood of being theoretically distinct, this very fact may mean that the way they do therapy is not very transferable to other therapists. Since there is no easy answer to this dilemma, former students of the model developers were included in the study in an attempt to provide a more ideal mix of theoretical purity and clinical transferability. The main clinical difference between model-developers and their former students was that the former students seemed to use slightly more flexible in using integrative techniques to reach the therapeutic ends of their model. Dr.

Makinen's use of the tape recorder to help the husband see how much he talked is an example of this.

The degree to which a client selected one of the therapists in this study based on his or her theoretical orientation presents an interesting dilemma. On one hand, if a client selected a therapist in this study based on that therapist's theory, it could be said that that client was different than the average client. Therefore, what they say will not be transferable to other clients, thereby limiting the usefulness of my results. On the other hand, it is possible that the amount of initiative a client shows in learning about his or her therapist prior to deciding to begin therapy with that therapist is a client common factor. Clients that show initiative in selecting a therapist that they believe will "fit" them better are not limited to those seeking help from model developers. Some clients expend a lot of effort learning about various therapists before making a decision; others dial the first therapist they see in the yellow pages. We do not know if clients that vary on this continuum also vary on outcome.

Since each alternative is credible, it seemed premature to foreclose on one or the other. My solution to this dilemma was to ask the therapists to, if possible, recruit clients who had no knowledge of the therapist's model before therapy. If they are unable to locate such a client, they can select whatever client they wish as long as they meet the other criteria. Throughout the interview I monitored the degree to which the clients were familiar with their therapist's model, and inductively searched for what influence that may have had on the change they experienced in therapy. Each client did purposefully seek a therapist that others viewed as competent, though none of them specifically sought

their therapist because of their model. A further discussion of this finding is in the “expectancy and motivational factors” section.

In addition to its limitations, this study also has several strengths. Specifically, the majority of the common factors literature – both in psychology and MFT – has been deductively derived. This is the first study that I am aware of that specifically investigates common factors from an inductive, qualitative perspective. As such, the variables in the study include several subcategories not previously detailed in the common factors literature (e.g., aspects of the therapeutic process). Additionally, the model derived from the study builds on contemporary models of common factors in MFT (Sprenkle & Blow, 2004a) by adding, expanding, and refining current factors. This study also provides additional detail about the relationships between potential mediating and moderating variables in MFT.

Conclusion

As mentioned in chapter two, one of the chief criticisms of the current common factors literature in MFT is that,

“...the *current articulation* [italics added] of the common factors perspective is seriously lacking as a comprehensive theoretical foundation to MFT. In our opinion, this is due to the oversimplification of the complex client change processes, the interactional dynamics between client and therapist, and the change mechanisms inherent in the common factors perspective... Thus, *in their current articulation*, [italics added] common factors can never provide a theoretical platform for further

theoretical or research development. This is not to say that further development of these ideas might not result eventually in theory development. However, it is to say that the oversimplification inherent in common factors will need to be replaced by a more accurate representation of the complexity of MFT.” (Sexton et al., 2004, p. 140)

The current state of the common factors literature in MFT is characteristic of an emergent school of thought, as there are less than a dozen published articles pertaining specifically to common factors in MFT (Davis & Butler, 2004). It is no surprise, then, that the current literature does not represent a comprehensive theory. Sexton et al go on to say that,

“Without question, finding a common core of factors to explain successful therapy would be a major breakthrough. This finding would simplify practice, training, and research. It would unify the theoretical schools of MFT, which often compete against one another and find themselves in contentious struggles. In essence, it would serve as a shorthand explanation for the complexity of practice and the diversity of clients, settings, and the sometimes disparate research findings.” (p.131)

When considering Sexton et al’s critique of the current state of the literature and advice for moving it forward, it is important to consider what type of model would be ideal for serving as a guide for the “complexity of practice and diversity of clients” (p. 131) Sexton and colleagues mention. If a model were too broad, it would not allow a therapist to know what to focus on and when, leaving them lost with only a vague map to guide them. It would be like trying to find your way around New York City with only a map of the major highways in New York State. If the model were too specific, the

therapist could get lost in the details or get too caught up in trying to remember what he or she was “supposed” to be doing, which may stifle their creativity and the natural flow of therapy. It would be like trying to cross the plains with pages and pages of maps that detailed every slight impression of the plain’s surface. By focusing on minutia, the map would be a hindrance rather than a guide. Additionally, a model that was too specific and detailed would by definition not address the complexities unique to each client.

Models that are either so specific that they allow no room for flexibility or are so vague that they provide no direction for complex situations are not helpful to therapists. An ideal model would provide enough detail to allow a therapist to know what he or she could be paying attention to and why at any given time across diverse circumstances, yet be broad enough to allow for conceptual and interventive flexibility with each unique client. I believe that this study moves the field closer to the development of such a theory of common factors by providing a model that is specific enough to guide practice, yet broad enough to capture commonalities among different MFT theories and model-independent aspects of the therapy process. I hope that others will join efforts to further refine common factors theory, research, and training.

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Appendix A

Invitation Letter

Dear Dr. _____

Personal comments in this paragraph, if Fred knows the person well.

I'd like to ask a big favor of you that that won't take much of your time and that will make you very rich. (Okay, the rich part is a lie.) Sean Davis, one of my doctoral students, plans to study what clients of prominent family therapists from different theoretical orientations (and you are one of them) say helped them change. He wants to see how one of your successful clients will describe the change they experienced while working with you, and the reasons for it.

Would you be interested in helping Sean and me out? We would ask you to identify a former client who was successful in achieving their therapy goals. We would prefer a marital/relationship couple, but an individual working on marital issues would be okay too. We will ask you to contact them and see if they would be willing to let Sean interview them for 30-60 minutes about their experience in therapy with you. Sean would also interview you for 30-60 minutes about your perception of what helped your clients change. (If 30 minutes is too long, we will take whatever time you can spare.) If possible, we would prefer interviewing a client who was not very familiar with (insert *whatever their model is*) before they began therapy with you. We will mail both you and your client(s) consent forms to sign and return before the telephone interview, which will take place at a time this summer that is convenient for you.

I think you might enjoy taking part in this study. If you would like, when the interviews are over, and with everyone's permission, Sean will return transcripts of his interviews to you and your clients. This will serve as a reflective opportunity for each of you to learn more about how the other sees the reasons for the successful therapy. With your permission, we will include your name in publications that result from this study. And -- last but not least -- you will be on the Fred-Piercy-owes-me-a-big-favor list. Seriously, I hope you will say "yes" to taking part in this brief but important study.

Thanks, (first name). For now, just hit "reply" and let me know if you will be able to help us out. If you say "yes", Sean will get back in touch with you in a month or two.

Final personal comment here.

My best -- Fred

Appendix B

Letter to Potential Participants

Dear Sir or Madam,

I received your name from Dr. _____, who I understand has contacted you about my study. I am writing to personally invite you to participate in a study designed to help understand how couples who complete therapy successfully were able to change. If you would consider your couple or marital therapy with Dr. _____ a success, then you are qualified to participate in this study. I would like to call and ask you and your partner a few questions about your experience in therapy with Dr. _____. The interview should take between 30-60 minutes, and will be done at a time convenient for you.

Your identity will be kept strictly confidential. I will record and transcribe the interviews, but will use fictitious names of your choice to identify you in all transcripts. You will not be identified in any publications that result from this study. Additional information about the study, in addition to a form to read, sign and return to me if you agree to participate, is attached to this letter. As soon as I receive the form, I will contact you to set up a time for us to talk about what made your therapy with Dr. _____ successful.

Thank you in advance for your willingness to help advance the field of Marriage and Family Therapy!

Sincerely,

Sean D. Davis, M. S.
Marriage and Family Therapy Doctoral Candidate
The Family Therapy Center of Virginia Tech
840 North University City Boulevard
Blacksburg, Virginia 24061

Client Alias: _____

Client Theory: _____

Appendix C

Semi-Structured Client Interview Protocol

1. How would you rate the success of your therapy with Dr. _____ on a scale of 1-10, with 1 being none of your goals for therapy were met and 10 being all of your goals for therapy were met?
2. What were your goals for therapy?
3. What was happening during the times that therapy seemed to be the most productive? That is, how do you explain the success of therapy?
4. What happened that led you to start to believe that your relationship would improve?
5. In what ways are *you* different now as a result of therapy compared to before you started therapy?
6. In what ways is *your partner* different now as a result of therapy compared to before you started therapy? How about your relationship?
7. As you can imagine, therapy helps some individuals and couples and doesn't help others. What characteristics about you helped you be successful in therapy? What characteristics about your partner helped?
8. What, if anything, did the therapist do that helped therapy be productive?
9. What four or five words best describe the relationship you had with your therapist?
10. If you had to write a book for a lay person about the three most important things for maintaining a healthy relationship that you learned in therapy, what would they be?
11. Your particular therapist practices therapy primarily using a specific theory. Did you know that before you started therapy with him/her?
 - a. If so, what impact did the therapist's theory have on your decision to seek therapy with him/her?
 - b. If not, was there a time after beginning therapy that you became aware of his/her theory? How did that happen?
12. What do you think your therapist would say happened in therapy that helped you change?
 - a. How did you come to know what your therapist might say?
 - b. Did you ever discuss what made therapy successful? Talk about that discussion.

Therapist: _____
Therapist Theory: _____

Appendix D

Semi-Structured Therapist Interview Protocol

1. How would you rate the success of your therapy with _____ on a scale of 1-10, with 1 being none of their goals for therapy were met and 10 being all of their goals for therapy were met?
2. What were their goals for therapy?
3. How did you conceptualize this case?
 - a. What needed to happen for them to reach their goals?
 - b. What did you do to facilitate that?
4. In what ways did they change? What would you say brought about that change?
5. What four or five words best describe your relationship with these clients?
6. Were there any changes they made that you would not necessarily have predicted from your theory?
7. If you had to describe how your clients changed to someone completely unfamiliar with your theory, and therapy in general, what would you say?
8. To what extent are these clients like your “average” client? If they are different from the norm, how are they different?
9. What four or five words would you use to describe your clients?
10. What do you think your clients would say happened in therapy that helped them change?
 - a. How did you come to know what they might say?
 - b. Did you ever discuss the reasons for their success? Tell me about that conversation.

Appendix E

Analysis Matrix

Verbatim explanation of change	Theory specific explanation of change	Common factors explanation of change

Appendix F

Release of Information



VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

The Family Therapy Center

Department of Human Development
College of Liberal Arts and Human Sciences
840 University City Blvd., Suite 1 (0515)
Blacksburg, Virginia 24061
(540)231-7201 Fax: (540)231-7209

AUTHORIZATION TO RELEASE INFORMATION

In regard to information about _____,
(name of adult client or minor child)
born, _____,
(date of birth)

I hereby give permission to the staff of the Family Therapy Center of Virginia Tech to
(please check all that apply):

- _ Send confidential records and/or test results to:
_ Discuss confidential records and/or test results w/SD:
_ Receive confidential information (oral and written) from:

(Person or agency)

(Address)

This information is released for the purpose of: _____.

(Signature of client)

(Date)

(Signature of Legal Guardian, if client is a minor)

(Date)

(Signature of witness)

(Date)

This authorization will be in effect for 180 days, unless terminated earlier in writing by the client.

No information sent or received through this authorization may be re-released to any other persons or agency without specific written permission of the client.

Informed Consent

Instructions: Please read this entire web page. If you have any questions regarding any aspect of this study, please contact any of the individuals listed at the bottom of this web page. If you agree to participate in the study, please type your name and date in the box under section 10, "Subject's Permission." Please remember to hit the "submit" button after you have typed in your name. Typing in your name and date and clicking "submit" indicates your willingness to participate in the study.

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

What clients receiving theoretically distinct therapy say helped them change.

Sean D. Davis, M. S., and Fred P. Piercy, Ph.D., Investigators

1. Purpose of Research

The purpose of this study is to determine what it is that couples who have successfully completed (according to the couple and their therapist) a theoretically distinct form of couple therapy say helped them change. The results of this study will provide greater insight into how different therapists' approaches help clients change. Eight couples and their therapists will be interviewed. Therapists will have used one specific theoretical therapy approach when working with the couple. Couples will have sought therapy primarily for relationship distress. The researchers reserve the right to determine suitability for participation in the research project.

2. Procedures

Therapists will be contacted and asked to be interviewed and to recruit former couple's therapy clients that may be willing to be interviewed. Therapists will contact Sean D. Davis with contact information of couples that have agreed to participate, as well as with a signed release of information form from the couple. Each member of the couple will be interviewed separately in a 30-60 minute telephone interview at a time and location of his or her choosing. The therapist will also participate in a 30-60 minute interview at a time and place of his or her

choosing. The interviews will be recorded on audiotape and transcribed. Participants will only be interviewed once.

3. Risks

If at any time during or after participating in the interview you experience psychological discomfort, you may contact the researchers at the number below. Should you have other concerns than those which you feel comfortable disclosing to the researcher, you can contact the Institutional Review Board with those concerns at the number listed below.

4. Benefits

For former clients, many participants in similar research projects report that formally reflecting upon the positive aspects of their therapy experience enhances change above and beyond the progress made in therapy. For therapists, participation in this project will allow you to reflect on how your approach to therapy helped the couple. Answers from both parties will help marriage and family therapists better understand how therapists and clients view the change process in couples therapy. However, no promise of guarantee of benefits has been made to encourage you to participate.

5. Anonymity and Confidentiality

To ensure your responses are anonymous, participants will choose pseudonyms (different names) by which they will be referred to during data collection, analysis, and reporting. All identifying information in the transcripts will be altered. Audio tapes and transcripts from the interviews will be stored indefinitely in a locked filing cabinet when they are not being analyzed. Access to the tapes will be limited to the researchers and, until transcription is complete, to two undergraduate assistants. Future research, if any, which utilizes the transcripts of the interviews will have all identifying information removed. Confidentiality will be broken only in instances of known (or a strong suspicion of) child abuse or if the participant is believed to be a threat to him/herself or others. In these instances, the proper authorities will be notified.

6. Compensation

There is no compensation for participating in this research.

7. Freedom to Withdraw

Subjects are free to withdraw from the study at any time without penalty. Subjects are also free to not answer any questions they do not want to.

8. 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.

IRB Approval Date: 8/6/2004

Approval Expiration Date: 8/6/2005

9. Subjects Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

Former Clients: Participate in an approximately 30-60 minute interview in which you will discuss your experience in therapy. Sign a release of information form as provided by your therapist and return this form to your therapist. Complete this informed consent form by typing in your name in the box under section 10.

Therapists: Participate in an approximately 30-60 minute interview in which you will discuss your experience as the couple's therapist. Recruit former clients for participation in the study. *If so indicated in the initial email contact by Sean D. Davis*, you will also recruit one of your former students who practices therapy primarily from the same model you use for participation in the study. Provide Sean D. Davis with their contact information. Provide former clients a release of information form that you use in your clinical practice and instruct them on how to complete it. Gather the completed form from your former clients and return the it to Sean D. Davis. Provide Sean D. Davis with your former clients' contact information.

10. Subject's Permission

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:

Please type your name and date here, then click "submit" below to indicate your willingness to participate in this study:

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

Investigator: Sean D. Davis, (859) 257-4033, sedavis1@vt.edu

Faculty Advisor and Departmental Head: Fred P. Piercy, (540) 231-4794, piercy@vt.edu

Chair, IRB, Office of Research Compliance, Research and Graduate Studies:
David M. Moore, (540) 231-4991, moored@vt.edu.

Please indicate your willingness to participate in the study by clicking "submit" below.

SUBMIT

Appendix H

Vitae

Sean D. Davis, Ph.D.

Marriage and Family Therapy

2389 English Station Drive, Lexington, Kentucky 40514

(859) 224-0564 seandavis@vt.edu

Education

- Ph.D. Virginia Polytechnic Institute and State University, 2005
Marriage and Family Therapy, COAMFTE Accredited
Chair: Fred P. Piercy, Ph.D.
Dissertation: *Common and Model-Specific Factors: What Marital Therapy Model Developers, Their Former Students, and Their Clients Say About Change*
Committee Members: Scott W. Johnson, Douglas K. Sprenkle, Margaret L. Keeling
Internship: Temporary Faculty in University of Kentucky's Marriage and Family Therapy Program
- M.S. Brigham Young University, 2002
Marriage and Family Therapy, COAMFTE Accredited
Chair: Mark H. Butler, Ph.D.
Thesis: *Common Pitfalls of Beginning Marriage and Family Therapists Utilizing Enactments*
- B.S. Brigham Young University, 2000
Major in Family Science, Minor in Psychology
- A.A.S. Utah Valley State College, 1998
Behavioral Science

Scholarship

RESEARCH AND CLINICAL INTERESTS

Include, but are not limited to:

- Common factors of change in Marriage and Family Therapy
- Process/observational couple interaction research
- The role of theory in Marriage and Family Therapy practice and training

- Conceptualization and operationalization of enactments
- Couple therapy and couple softening process
- Adult survivors of childhood sexual abuse

PEER-REVIEWED PUBLICATIONS

Davis, S.D. (in press). Beyond technique: An autoethnographic exploration of how I learned to show love towards my father. *Qualitative Report*.

Davis, S. D., & Butler, M. H. (2004). Enacting relationships in Marriage and Family Therapy: A conceptual and operational definition of an enactment. *Journal of Marital and Family Therapy*, 30, 319-334.

Davis, S. D., Piercy, F. P., Meszaros, P. S., Huebner, A. J., Shettler, L., & Matheson, J. L. (2004). Female adolescent smoking: A Delphi study on best prevention practices. *Journal of Drug Education*, 34, 295-311.

Huebner, A. J., Shettler, L., Matheson, J. L., Meszaros, P. S., Piercy, F. P., & Davis, S. D. (2004). Factors associated with former smokers among female adolescents in rural Virginia. *Addictive Behaviors*, 30, 167-173.

Huebner, A. J., Shettler, L., Matheson, J. L., Meszaros, P. S., Piercy, F. P., & Davis, S. D. (in press). Examining ethnic differences in predictors of female adolescent smoking in rural Virginia. *Journal of Child and Adolescent Substance Abuse*.

BOOK CHAPTERS

Piercy, F. P., Soekandar, A., Limansubroto, C., & Davis, S. D. (in press). Family therapy with Indonesians. In M. McGoldrick, J. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (3rd ed.). New York: Guilford.

Benningfield, A. B. & Davis, S. D. (in press). Family business consultation: Opportunities for MFTs. In S. M Harris, D. C. Ivey, & R. A. Bean (Eds.), *A practice that works: Alternatives and supplemental strategies to your stand alone therapy practice*. New York: Taylor & Francis.

MANUSCRIPTS SUBMITTED FOR PUBLICATION

Matheson, J. L., Meszaros, P. S., Huebner, A. J., Piercy, F. P., Davis, S. D., & Shettler, L. (2003). Prevalence of cigarette smoking among adolescents in the U.S.: A focus on data for females from four national surveys. Manuscript under review.

MANUSCRIPTS IN PREPARATION

Davis, S. D. *The next step: A conceptual framework for common factors in MFT.*

Fife, S. T., Whiting, J. B., Davis, S. D., & Bradford, K. *Understanding the therapeutic relationship in MFT: A common factors framework.*

Davis, S. D. *Learning to love again: The utility of marital therapy as a treatment for adult survivors of childhood sexual abuse.*

Davis, S. D. *The softening process in couple's therapy: A common factors perspective.*

Davis, S. D., & Butler, M. H. *Common pitfalls of beginning therapists utilizing enactments in MFT.*

PROFESSIONAL PRESENTATIONS—PEER-REVIEWED

Meszaros, P. S., Piercy, F. P., Huebner, A., Matheson, J., Davis, S. D., & Shetler, L., (2003, November). *Female adolescent smoking: A family health concern.* Symposium conducted at the meeting of the National Council on Family Relations, Vancouver, British Columbia.

Davis, S. D. (2004, September). *Softening in couple's therapy: A common factors perspective.* Poster presented at the meeting of the American Association of Marriage and Family Therapy, Atlanta, Georgia.

GRANT WRITING

Davis, S. D. (2003). Dr. Michael Sporakowski Travel Grant. Department of Human Development, Virginia Tech (funded for \$500).

Teaching

COURSES TAUGHT/TRAINING RECEIVED

Supervised Experiential Practice of Marriage and Family Therapy, FAM 787
Sole provider of individual supervision to master's level MFT students; co-instructor of group supervision with Dr. Gregory Brock, University of Kentucky, Fall 2004, Spring 2005

Professional Seminar in MFT: Familial Play Therapy, FS 776
Instructor, University of Kentucky, Spring 2005

Introduction to Family Intervention: Working With Families and Individuals, FAM 360

Instructor, University of Kentucky, Fall 2004, Spring 2005

Human Sexuality: Development of Behavior and Attitudes, FAM 253 (online course)
Instructor, University of Kentucky, Spring 2005

Community Programs in Family Life, HD 4344
Instructor, Virginia Polytechnic Institute and State University, Spring 2004,
Summer I 2004.

Teaching in Higher Education, HD 5984
Virginia Polytechnic Institute and State University, Fall 2003-Spring 2004.
Completed Human Development Department Graduate Student Teacher Training
Courses.

Survey.vt.edu training
Virginia Tech, 2002. Completed online survey software training. Developed and
implemented several online surveys while a student at Virginia Tech.

Teacher's Assistant, Dr. Lenore McWey
Virginia Polytechnic Institute and State University, Fall 2003. Helped prepare
class materials for HD 4344.

Interviewing Skills, MFHD 356
Brigham Young University, 2000-2002. Taught between 1-3 labs per semester.

Teacher's Assistant, Dr. Mark Butler
Brigham Young University, Fall and Winter 2002. Assisted in the preparation of
materials for MFT 563 (Advanced Systems Theory) and MFHD 250 (Theories in
Family Science). Responsibilities include teaching class, preparing handouts,
making tests, and organizing a website.

Professional/Clinical Recognition and Experience

ACADEMIC AWARDS AND HONORS

1999 Winner of a Brigham Young University academic scholarship, a competitive
scholarship awarded to select members of the general student body based on
outstanding academic achievement.

1997 Maintained standing on the high honor roll, Utah Valley State College.

1997 Winner of the Utah Valley State College Behavioral Science departmental scholarship, a competitive, full tuition scholarship awarded to one person each year.

1993 Salutatorian, Escalante High School.

PROFESSIONAL ORGANIZATIONS

2004-present Kentucky Association for Marriage and Family Therapy

2001-present *Student Member*, American Association for Marriage and Family Therapy.

2001-present PREP/ENRICH Certified Counselor.

1999-2000 *Kappa Omicron Nu*, National Honor Society for family, home, and social sciences. Award given for being in top 10% of my class.

1999-2000 *BYU Pre-Marriage and Family Therapy Student Association*, a student organization designed to assist undergraduates in preparation for training in marriage and family therapy. Activities included campaigning for office and attending workshops.

CLINICAL/SUPERVISION EXPERIENCE

2004-present *Marriage and Family Therapy Supervisor in Training*, Family Center, University of Kentucky. Supervision of Master's level Marriage and Family Therapy students in clinical practica. Supervision provided by Gregory W. Brock, Ph.D., AAMFT Approved Supervisor.

2004-present *Marriage and Family Therapist, Intern*, Family Center, University of Kentucky, Lexington, Kentucky.

2004 *Marriage & Family Therapy Supervisor in Training*, Family Therapy Center, Virginia Tech, Blacksburg, Virginia. Supervision of Doctoral Marriage & Family Therapy students in clinical practica. Supervision of Supervision by Scott Johnson, Ph.D., AAMFT Approved Supervisor.

2002-2004 *Marriage and Family Therapist, Student*, Family Therapy Center, Virginia Polytechnic Institute and State University, Blacksburg, Virginia. Divorce adjustment, marital, domestic violence, anxiety, depression, family, adolescent, extramarital affairs, pre-marital, child (325 hours). Supervised by MFT faculty, AAMFT Approved Supervisors.

2002-2003 *Emergency Relief Clinician*, New River Valley Community Services. Provided on-call crisis intervention and psychological evaluations at local jails and hospital emergency rooms.

2000-2002 *Marriage and Family Therapist, Student*, Comprehensive Clinic, Brigham Young University, Provo, Utah. Marital, pre-marital, family, multigenerational, individual, sexual addictions, extramarital affairs, divorce adjustment, paraphilias (500 hours). Supervised by MFT faculty, AAMFT Approved Supervisors.

RESEARCH/PROFESSIONAL WORK HISTORY

2004-present *Temporary Faculty* in the University of Kentucky Marriage and Family Therapy program. Participated in departmental and program faculty meetings, served on the department self-study committee, will participate in new student admissions process, assisted in coordinating the transition from a 3-year MFT program to 2-year MFT program, taught graduate and undergraduate courses, collaborated on research projects with other faculty members.

2003-2004 *Administrative Assistant* for Fred P. Piercy, Ph.D., Human Development Department Head. Responsibilities include preparing departmental promotional materials, conducting orientation meetings with incoming graduate students, and assisting in various administrative tasks.

2003-2004 *Research Team Member* with Scott Johnson, Ph.D., Anna Beth Benningfield, Ph.D. and fellow MFT students. Investigating the effects of various family issues on the stability of family-owned businesses.

2002-2003 *Research Assistant* for Fred P. Piercy, Ph.D. Conducted a Delphi study on factors of a model smoking prevention program for female adolescents. Developed a web-based survey and conducted qualitative telephone interviews with Delphi panelists. Assisted in analyzing data and preparing a manuscript for publication.

2000-2002 *Research Assistant* for Mark H. Butler, Ph.D. Assisted in reviewing manuscripts for publication in peer-reviewed journals.

2000-2002 *Thesis*. Composed, conducted and defended a master's thesis. Published the literature review in *Journal of Marital and Family Therapy*. Preparing the empirical study for submission to publication.

2001-2002 *Research Assistant* for Wendy L. Watson, Ph.D. Designed qualitative interviews to assess beliefs that facilitate or constrain a positive elderly caregiving experience. Supervised the transcription of these interviews.

1998-2000 *Research Assistant*, Brigham Young University, Tamara Heaton, M.S. Reviewed and summarized research articles dealing with stressors faced by in-home caregivers of the elderly. Participated in bi-weekly meetings in an effort to produce a more comprehensive model explaining caregiver's use of resources.

Citizenship/Service

COMMUNITY SERVICE—PRESENTATIONS, LECTURES & PUBLICATIONS

- Davis, S. D. (2004, August). *Common factors in marriage and family therapy*. Article in the Virginia Tech Department of Human Development newsletter.
- Davis, S. D. (2003, September). *Helping your family cope with trauma*. Invited presentation at a community preparedness fair for Radford, VA (2 hours, 30 people).
- Davis, S. D. & Jeffs, R. L. (2003, August). *Finding strength in diversity: Learning to appreciate those we don't understand*. Invited presentation for the Church of Jesus Christ of Latter-Day Saints, Radford, VA (2 hours, 25 participants).
- Davis, S. D. (2003, August). *The destructive cycle of gossip: A Bowenian approach to healthy relationships*. Invited presentation for the Church of Jesus Christ of Latter-Day Saints, Christiansburg, VA (1 hour, 30 participants).
- Davis, S. D. (2003, February) *Parenting difficult teens*. Invited seminar for the Church of Jesus Christ of Latter-Day Saints, Christiansburg, VA (2 hours, 15 participants).
- Davis, S. D. & Rowden, T. J. (2002, August). *Forgiveness in Families*. Online article written for Brigham Young University's *Forever Families* website. Article can be retrieved at http://www.foreverfamilies.net/xml/articles/forgiveness_in_families.aspx?&publication=short
- Davis, S. D. (2001, November). *Enhancing your communication skills*. Invited presentation for United Way, Provo, UT (2 hours, 20 participants).
- Davis, S. D. (2001, October) *Who knew the first year would be so hard: A look at newlywed marital interaction*. Invited presentation for the Church of Jesus Christ of Latter-Day Saints, Provo, UT (1 hour, 30 participants).
- Davis, S. D. (2001, September). *Building resilient children: A look at shame, attachment, and autonomy*. Invited presentation for the Church of Jesus Christ of Latter-Day Saints, Provo, UT (2 hours, 20 participants).

Personal Information

INTERESTS

Hiking
Camping

Fishing
 Biking
 Reading
 Woodworking

REFERENCES

Mark H. Butler, Ph.D.	Anna Beth Benningfield, Ph.D.
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Additional references available upon request