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Acceptance promoting and hindering interactions in Integrative Behavioral Couple Therapy

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ACCEPTANCE PROMOTING AND HINDERING INTERACTIONS IN INTEGRATIVE BEHAVIORAL COUPLE THERAPY

A clinical dissertation submitted in partial satisfaction

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Doctor of Psychology

by

Laura D. Wiedeman

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Kathleen Eldridge, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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This dissertation has been a labor of love that is as much a reflection of my hard work as it is a reflection of the wealth of support and encouragement I received in the process. I am tremendously grateful for Dr. Kathleen Eldridge's willingness to provide both caring guidance and expert insight throughout each step required to complete this dissertation. Through this dissertation, she has provided training in analyzing couple therapy from a research perspective, while also offering excellent training in the art and science of conducting couple therapy. Thank you, Dr. Eldridge, for going above and beyond in order to open doors and provide training that has assisted me in developing specialized clinical practice in working with couples; this is a gift I will treasure.

I am also extremely appreciative of the feedback and support offered by my dissertation committee members: Dr. Joy Asamen, for her particularly detailed feedback and for always making herself available should I need to discuss difficult aspects of my dissertation and methodology; Dr. Mia Sevier, for her expert consultation during the development of the dyadic coding system and her enthusiasm for this study; and Dr. Dennis Lowe, for his expert knowledge of couple dynamics and for introducing me to the art of couple therapy within his Marriage and Family Therapy course. I thank Dr. Andrew Christensen for allowing me to use his data and for both his kindness and assistance related to my development as a couples therapist. In addition, I am grateful for the seven couples in this study who so bravely allowed their vulnerabilities to be videotaped and analyzed; I have learned so much from you. I would also like to thank Dr. Susan Hall for her continual involvement in and encouragement of my professional endeavors. I would not be where I am today without her mentorship.

To my family and friends, I am in awe of your continual patience and excitement for me throughout my journey to become a psychologist. To my wonderful friends, particularly Ani, Karina, and Kasey, thank you for the laughter and empathy that has made graduate school one of the most rewarding experiences I have had. I would also like to thank my grandparents, Bubbie & Zaide, for always making sure to tell me how proud they are and how much they love me. A special thank you to my grandfather Frankie, whose unconditional love has made me into the person I am today.

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Last, my gratitude for my husband, Sean, goes beyond what words could capture. His unwavering loyalty, emotional support, and belief in me have kept me grounded and allowed me to excel on the path to achieving my dreams. This dissertation is dedicated to you, as it could not have been completed without you.

VITA

LAURA DAVIDOFF WIEDEMAN

EDUCATION

2007-present **Pepperdine University**, Los Angeles, CA
Doctoral Degree in Clinical Psychology (Psy.D.), Expected in May 2012
- Graduate student in good standing in APA-accredited doctoral program in clinical psychology at Pepperdine University's Graduate School of Education and Psychology
- *Clinical Competency Examination*: Passed June 2009
- *Dissertation Title*: Acceptance Promoting and Hindering Dyadic Interactions in Integrative Behavioral Couple Therapy
- *Dissertation Final Oral Examination*: Passed October 6, 2010

2005-2007 **Pepperdine University**, Los Angeles, CA
Master of Arts in Clinical Psychology with Emphasis in Marriage & Family Therapy, May 2007

2003-2004 **University of Sussex**, United Kingdom
- Year-long study abroad program

2001-2005 **University of California at San Diego**, San Diego, CA
Bachelor of Arts in Psychology, June 2005
- *Phi Beta Kappa*

CLINICAL TRAINING EXPERIENCES

2010-2011 **Cedars-Sinai Medical Center, Department of Psychiatry and Behavioral Neurosciences**, Los Angeles, CA
Neuropsychology Assessment Extern, supervised by Enrique Lopez, Psy.D.
- Administered, scored, interpreted, and wrote six diagnostic assessments, cognitive screening batteries, and comprehensive psychological and neuropsychological assessments to children and adults diagnosed with a wide range of psychiatric and medical illnesses (e.g., stroke, dementia, traumatic brain injury). Patients were referred from inpatient, intensive outpatient, and outpatient units. Generated comprehensive treatment recommendations and provided follow-up care as warranted.
- Received weekly individual and group supervision from licensed supervisor and postdoctoral fellows.
- Other responsibilities included attending weekly Grand Rounds lectures; completing scheduling and billing paperwork; and consulting with psychiatrists, social workers, and other interdisciplinary staff members.

2009-2010 **Greater Los Angeles VA Healthcare System – Sepulveda Ambulatory Care Center and Nursing Home**, North Hills, CA

Pre-Intern in three rotations

1. Partial Hospitalization Program/Psychosocial Rehabilitation and Recovery Center (PHP/PRRC; Aug-Dec), *supervised by Frederick Martin, Psy.D.*
   - Conducted short-term, recovery-oriented individual psychotherapy for patients with chronic mental illness and co-facilitated a weekly Social Skills Training group based on Dr. Alan Bellack's model.
   - Participated in interdisciplinary treatment team meetings focused on patient treatment planning and transitioning the program from a PHP to a PRRC.
2. Chemical Dependency Treatment Unit (CDTU; Jan-Apr), *supervised by Sylvia Boris, Ph.D.*
   - Performed individual and group therapy for Veterans with addictions and dual-diagnosis, co-facilitating five to six groups per week. Group therapy topics included the 12-step program, substance dependency recovery and maintenance, spirituality, emotions management, and comorbid PTSD/substance use.
   - Attended weekly interdisciplinary treatment team meetings comprised of psychologists, psychiatrists, social workers, nurses, and an occupational therapist.
3. Outpatient Mental Health (OPMH; May-Aug), *supervised by Steven Ganzell, Ph.D. & David Schafer, Psy.D.*
   - Facilitated three outpatient psychotherapy groups for Veterans presenting with diagnoses of PTSD, depression, anxiety, co-morbid medical problems, and grief/loss. OPMH group topics included "Vietnam Veterans with PTSD" and "Combat Remorse."
   - Received introductory training in conducting evidence-based group therapy for PTSD utilizing Acceptance and Commitment Therapy, as well as Existential, Cognitive-Behavioral, and Psychodynamic/Jungian theoretical influences.

Also participated in the following year-long training activities:

- Long-Term Individual and Group Therapy Patients: Maintained two long-term individual patients, one long-term couples therapy patient, and led a long-term co-morbid PTSD and addictions group.
- Primary Care Evaluations: Conducted brief diagnostic evaluations and made appropriate referrals for patients in a primary care walk-in clinic.
- Psychodiagnostic and Neuropsychological Testing Seminars: Attended a weekly one-hour psychodiagnostic testing seminar and a two-hour neuropsychological testing seminar, which included review of commonly used tests, norms, supervision for active testing cases, and review of report writing. Participation in these seminars culminated in the administration, scoring, interpretation, and writing of four integrated assessment evaluations, as well as conducting feedback sessions with the patients and significant family members.

2008-2009 **University of Southern California Student Counseling Center**, Los Angeles, CA

Pre-Doctoral Practicum Therapist, supervised by Karin Sponholz, Ph.D. & Kelly Greco, Psy.D.

- Conducted individual outpatient therapy with university undergraduate and graduate students, maintaining a caseload of five to eight short-term patients, one long-term patient, and one intake evaluation per week. Common presenting problems included adjustment disorders, depression, anxiety, stress management, relationship problems, low self-esteem, grief/loss, and childhood sexual abuse.
- Served as a process observer in a year-long therapy group for master's level therapists in training, in which responsibilities included observing, writing, and presenting a weekly description of group therapy process dynamics to group leaders and members.
- Participated in campus outreach activities, including events during Eating Disorders Awareness Week and visited various student organizations to provide information on the student counseling services.
- All training activities involved collaboration with an interdisciplinary team of social workers, crisis counselors, psychologists, and psychiatrists.
- Attended weekly didactics on multicultural counseling, crisis management, psychiatric consultation, and campus outreach.

2007-2008 **Union Rescue Mission: Pepperdine Mental Health Clinic**, Los Angeles, CA

Pre-Doctoral Practicum Therapist, supervised by Aaron Aviera, Ph.D. & Stephen Strack, Ph.D.

- Provided short and long-term individual psychotherapy to previously homeless, adult men enrolled in a long-term residential rehabilitation program in Los Angeles' Skid Row area. Maintained a caseload of five to six individual patients per week.
- Utilized Psychodynamic, Cognitive Behavioral, and Existential therapies with patients suffering from chronic Axis I and Axis II disorders, as well as significant environmental stressors, legal problems, financial hardship, and histories of physical and sexual abuse.
- Administered, scored, interpreted, and composed multiple testing reports based on brief cognitive or personality assessments.
- Received year-long testing didactics and group supervision from VA staff psychologist Stephen Strack, Ph.D., which focused on the administration and interpretation of the MCMI-III and MMPI-2.
- Conducted intake interviews, participated in regular case presentations, and provided crisis assessments and follow-up care as needed.

2006-2007 **South Bay Center For Counseling**, El Segundo, CA

Marriage & Family Therapist Trainee, supervised by Susan Michael, Psy.D., LMFT, & Priscilla Pascual, LMFT

- Provided short and long-term individual psychotherapy and for children, adolescents, and adults. Common presenting problems included mood and anxiety disorders, grief, and family discord. Maintained a weekly caseload of four to six individual patients.
- Conducted intake evaluations for every patient, made referrals to adjunctive services, and collaborated with social workers as necessary.
- Skills such as conducting intake evaluations, developing the therapeutic alliance, and case conceptualization from Psychodynamic and Family Systems perspectives were emphasized.

SUPERVISORY EXPERIENCES

2010-2011 **Pepperdine University Community Counseling Clinic**, Los Angeles, CA

Lead Pre-Doctoral Therapy Peer Supervisor, supervised by Aaron Aviera, Ph.D.

- Supervise the clinical work of one first-year and five second-year psychology doctoral students working at the Pepperdine University Community Counseling Clinic and the Union Rescue Mission on Los Angeles' Skid Row. Supervision responsibilities include weekly one-hour individual meetings with supervisees and review of clinical notes, intake reports, audiotapes, and videotapes of therapy sessions.
- Answer questions for first-time peer supervisors on supervision issues and crisis management when the primary supervisor, Dr. Aviera, is unavailable, and complete organizational and administrative tasks to assist the primary supervisor.
- Co-lead at least two case conference meetings for eight first-year psychology doctoral students at Pepperdine University Community Counseling Center.

2009-2010 **Pepperdine University Community Counseling Clinic**, Los Angeles, CA

Pre-Doctoral Therapy Peer Supervisor, supervised by Aaron Aviera, Ph.D.

- Supervised the clinical work of two first-year psychology doctoral students working at the Union Rescue Mission on Los Angeles' Skid Row. Supervision responsibilities include weekly one-hour individual meetings with supervisees and review of clinical notes, intake reports, and audiotapes of therapy sessions.
- Co-lead two case conference meetings for eight first-year psychology doctoral students at Pepperdine University Community Counseling Center.
- Attended didactic training in competency-based supervision by Edward Shafranske, Ph.D. and Carol Falender, Ph.D.

RESEARCH EXPERIENCES

2009-present **Pepperdine Applied Research Center (PARC)**, Los Angeles, CA
Primary Research Assistant, supervised by Kathy Eldridge, Ph.D. & Susan Hall, J.D., Ph.D.

- Assisting with the publication of research activities, including conducting literature reviews and co-authoring publications. Current paper topics in preparation include patient perceptions of the integration of religiosity/spirituality assessment into clinical practice, therapist attitudes regarding integration clinical assessment measures into clinical practice, and advancing the use of the practitioner-scholar within therapy training clinics.

2007-2009 **Pepperdine Applied Research Center (PARC) / Clinic Advancement, Research and Training (CART)**, Los Angeles, CA
Project Coordinator, supervised by Kathy Eldridge, Ph.D. & Susan Hall, J.D., Ph.D.

- Coordinated the creation of a research center within Pepperdine University's three community counseling training clinics, intended to enhance the quality of practitioner-scholar training for masters and doctoral-level therapists by training therapists to integrate assessment measures into clinical practice, while simultaneously using these questionnaires to create an ongoing research database. Assessments included measures of symptoms, stages of change, working alliance, religiosity/spirituality, and social support.
- Facilitated communication and task completion among three clinic directors, two faculty members, numerous graduate and research assistants, and other departments.
- Enhanced integration of assessment measures into clinical practice through creation of a detailed scoring and interpretation manual for each measure used, in addition to designing an ongoing chart auditing system to ensure that questionnaires were administered according to the clinic and research protocol.
- Created a biannual assessment questionnaire of therapist's experiences with the integration of measures into clinical practice and conducted quantitative and qualitative analyses of the resulting data, which led to an annual review and update of policies and procedures.
- Managed over $11,000 of expenditures and enhanced the clinic library through researching and creating a list of evidence-based treatment manuals and resources for therapists, and subsequently purchased over 100 new books for the counseling centers.
- Created a library of couple and family assessment measures that included summarized psychometric properties, norms, and procedures for using each measure, to be used in future research and clinical practice.

2004 **University of Sussex, Biological & Clinical Psychology Research Department**, England
Research Assistant, supervised by Martin Yeomans, Ph.D.

- Assisted with two research studies, the first of which involved recruiting participants and administration of eight 30-minute sessions over four weeks to test the effects of caloric density and portion size on flavor preferences and learned satiety. The second study involved conducting laboratory sessions with participants that measured the influence of mood, as induced by three types of television programs, on food intake in women who had varying levels of eating restraint and disinhibition.

POSTER PRESENTATIONS

Wiedeman, L. D., Eldridge, K., & Christensen, A. (November, 2010). Creating a dyadic coding system for studying change processes within Integrative Behavioral Couple Therapy. Poster accepted for presentation at the American Association of Behavioral and Cognitive Therapies, San Francisco, CA.

Wiedeman, L. D., Eldridge, K., & Christensen, A. (June, 2010). Acceptance promoting interactions in Integrative Behavioral Couple Therapy. Poster presented at the World Congress of Behavioral and Cognitive Therapies, Boston, MA.

TEACHING EXPERIENCES

2007-2011 Teaching Assistant, *Professional Ethics and the Law*
Graduate School of Education and Psychology, Pepperdine University

2007-2011 Teaching Assistant, Ph.D., *Ethical, Legal, and Professional Issues*
Graduate School of Education and Psychology, Pepperdine University

2007-2011 Teaching Assistant, Ph.D., *Psychopathology*
Graduate School of Education and Psychology, Pepperdine University

2006 Teaching Assistant, *Individual and Family Development: A Life-Cycle Approach*
Graduate School of Education and Psychology, Pepperdine University

COMMUNITY PRESENTATIONS AND GUEST LECTURES

Wiedeman, L. D. (2010, November). *Unified detachment interventions within Integrative Behavioral Couple Therapy*. Pepperdine University, Los Angeles, CA

- Presentation to master's-level students enrolled in a marriage and family therapy course

Wiedeman, L. D. (2010, September). *Ethically competent assessment and management of suicide.* Pepperdine University, Los Angeles, CA

- Guest lecture for doctoral and masters-level law and ethics courses

Wiedeman, L. D. (2009, April). *Overview of Integrative Behavioral Couple Therapy: Theory, interventions, and research*. Mount St. Mary's College, Los Angeles, CA
- Guest lecture for masters-level students in a marriage and family therapy course

Wiedeman, L. D. (2009, January). *Conducting suicide assessments: A comprehensive, ethically responsible guide*. Pepperdine University, Los Angeles, CA
- Presentation for masters-level psychology students in a law and ethics course

Davidoff (Wiedeman), L., Campos, K., & Pezeshkian, A. (2008, May). *Empowerment and self-esteem: Embracing our strengths*. Viewpoint High School, Calabasas, CA
- Presentation for 70 ninth grade high school students, as part of a community outreach project

Davidoff (Wiedeman), L., (2006, November). *Assessing and discussing risky behavior with adolescent clients*. Pepperdine University, Los Angeles, CA
- Taught a clinical skills development workshop for masters-level students

Davidoff (Wiedeman), L., (2006, October). *Clinical implications of attachment theory*. Pepperdine University, Los Angeles, CA
- Taught a clinical skills development workshop for masters-level students

Davidoff (Wiedeman), L., (2006, September). *Using genograms in psychotherapy*. Pepperdine University, Los Angeles, CA
- Taught a clinical skills development workshop for masters-level students

HONORS AND AWARDS

2007-2010	Glen and Gloria Holden Scholarship, *Pepperdine University*
2007-2008	Conrad N. Hilton Foundation Fellowship, *Union Rescue Mission*
2007	Chancellor's Distinguished Graduate Student Honoree, *Pepperdine University*
2005	Phi Beta Kappa Honor Society, *University of California, San Diego*
2004	Golden Key International Honor Society, *University of California, San Diego*
2004-2005	Provost's Honors, *University of California at San Diego*
2002-present	PsiChi, The National Honor Society in Psychology
2001-2002	Provost's Honors, *University of California at San Diego*

PROFESSIONAL AFFILIATIONS

2010-present	Association for Behavioral and Cognitive Therapies, *Student Affiliate*
2010-present	International Society for Traumatic Stress Studies, *Student Affiliate*
2008-present	Los Angeles County Psychological Association, *Student Affiliate*
2006-present	American Psychological Association, *Student Affiliate*

ABSTRACT

Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1998) is an evidence-based couple therapy that facilitates the development of emotional acceptance to improve relational satisfaction. IBCT's efficacy has been demonstrated up to five years post-therapy (Christensen, Atkins, Baucom, & Yi, 2010), yet less is known about what couples actually do in therapy that alleviates distress. The current study expands upon previous investigations of the relationship between individual change processes and treatment outcome in IBCT in two main ways: first, through utilizing a dyadic lens (rather than an individual emphasis), and second, through a qualitative, discovery-oriented methodology that focuses on the interactions believed to promote or interfere with IBCT's change mechanism, emotional acceptance. The first component of this study involved the development of a dyadic rating system for interactions among couples in therapy that may directly serve to enhance partner acceptance (e.g., partner one vulnerability + partner two validation) or interfere with the potential for acceptance (e.g., partner one vulnerability + partner two criticism). This global coding system was generated based on theoretical literature, past research, expert consultation, clinical judgment, and observation of videotaped IBCT sessions. The second component of the study involved observation and analysis of six sessions per each of the seven selected couples that participated in IBCT's original outcome study (Christensen et al., 2004); these couples were classified into growth (n=4), no growth (n=1), or decline (n=2) categories based on the amount of emotional acceptance the couple reported between pre-treatment and 26 weeks. Results revealed that all couples engaged in multiple acceptance promoting and interfering interactions, typically initiated by vulnerability or aversive

partner behaviors, and that the meaning of these interactions were unique to the emotional context of the couple. Growth couples tended to maintain an open, respectful, and often humorous interactional style, whereas no growth and decline couples appeared to maintain an accusatory, defensive stance and sarcastic or belittling humor. Future research should continue to employ a dyadic, qualitative approach to understanding the change processes that occur within couple therapy. Additional research implications and clinical recommendations are provided.

Chapter 1

Introduction

Relationship distress is extremely common and is connected to emotional, behavioral, and physical problems in adults and their children (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Christensen & Heavey, 1999; Jacobson & Addis, 1993; Johnson & Lebow, 2000; Pinsof, Wynne, & Hambright, 1996; Shadish & Baldwin, 2005; Snyder, Castellani, & Whisman, 2006). The high rates of distressed couples suggest a pressing need to understand how to help improve relationship satisfaction within couple therapy. While multiple evidence-based couple therapies exist, little is known about the processes within these therapies that lead to change. This dissertation focuses on examining the processes of change within integrative behavioral couple therapy (IBCT; Jacobson & Christensen, 1998; Christensen & Jacobson, 2002), which emphasizes both emotional acceptance and behavioral change. Specifically, this dissertation will explore interactions within couple therapy in order to understand the relationship between acceptance promoting interactions (IBCT's theorized process of change) and growth or decline in emotional acceptance (IBCT's mechanism of change).

Evidence-Based Couple Therapies

Over the past few decades, five forms of couple therapy have emerged as evidence-based treatments for relationship distress (Baucom et al., 1998; Christensen, 2010; Snyder et al., 2006). While shown to be effective in reducing relational distress and increasing marital satisfaction, these forms of couple therapy have also demonstrated contributions to improvements in individual psychiatric disorders such as depression,

agoraphobia, sexual disorders, alcoholism, and schizophrenia (Baucom et al., 1998; Snyder et al., 2006).

The specific evidence-based couple therapies are a diverse representation of humanistic, psychodynamic, cognitive, behavioral and acceptance-oriented therapies. First, *emotionally focused couple therapy* (EFT; Greenberg & Johnson, 1988) is rooted in attachment theory and has the goal of helping partners to develop more secure attachment bonds within a relationship (Johnson, 2008). Therapists accomplish this restructuring through facilitating the expression of underlying emotions involved in the couple's interaction patterns, which allows for a new, healing emotional experience between partners to occur in the here-and-now (Greenberg, James, & Conry, 1988; Johnson & Greenberg, 1988). Second, *insight oriented marital therapy* (IOMT; Wills, Faitler, & Snyder, 1987; Snyder & Wills, 1989) relies on an examination of the unconscious and unresolved emotional processes that contribute to conflict within the couple (Wills et al., 1987). The goal of IOMT is to use probing, reflecting, and affective reconstruction to uncover and explain the unconscious feelings, beliefs and expectations partners have for one another, and to work this through on a conscious level. Ultimately, this process enables the couple to interact in a mature, autonomous manner (Snyder & Wills, 1989).

A third evidence-based couple therapy, *cognitive behavioral couple therapy* (CBCT), relies on the basic premise that both emotional and behavioral responses to relational events are impacted by information processing errors (Baucom, Epstein, LaTaillade, & Kirby, 2008). Therapists work to correct these distorted cognitive appraisals and maladaptive beliefs within a relational context, focusing on the interpretation and evaluation of one's partner's behavior (Baucom et al., 2008). Through

evaluating one's own automatic thoughts, assumptions, and relationship expectations, the behaviors, cognitions and emotions that are associated with relationship quality also improve (Baucom et al., 2008).

Fourth, *traditional behavioral couple therapy* (TBCT; Jacobson & Margolin, 1979), also known as *behavioral marital therapy*, focuses on facilitating behavior change through the use of behavioral exchange strategies. TBCT assumes that by learning behavioral skills (e.g., communication and problem-solving), couples will decrease the frequency in which they engage in negative behaviors and increase the frequency of positive behaviors, therefore reducing relationship distress (Doss, 2004; Jacobson & Christensen, 1998).

Last, *integrative behavioral couple therapy* (IBCT; Jacobson & Christensen, 1998) is an evidence-based couple therapy that primarily focuses on the development of emotional acceptance, with a secondary emphasis on behavioral change. The emphasis on emotional acceptance represents a shift from former behavioral approaches that are consistent with other third-wave behavioral therapies. For example, within acceptance and commitment therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) and dialectical behavior therapy (Linehan, 1993), acceptance is utilized within individual therapy as a way to recognize and acknowledge one's experience without judgment or blame. IBCT expands the notion of individually oriented acceptance to focus on emotional acceptance within the dyadic context of a couple.

There are two dimensions of acceptance within IBCT; first, acceptance entails letting go of the struggle to change one's partner, and second, it involves using problems to create intimacy rather than to exacerbate distress (Jacobson & Christensen, 1998).

Through increased understanding of common interactional patterns and the emotional experience of one's partner, differences may no longer be viewed as intolerable. Additionally, IBCT suggests that these differences are not the problem; it is the emotional reactivity to these differences that creates distress. Through focusing on the emotional context occurring within common interactional patterns, the therapy aims to facilitate the development of a new perspective on a couple's interaction and a deeper understanding of one's partner (Jacobson & Christensen, 1998). As a result of this deeper understanding and emotional intimacy, behavioral change may occur based on a genuine, natural desire by one or both partners (also known as contingency shaped behavior), rather than through compliant rule-following typically emphasized in TBCT (also known as rule-governed behavior; Jacobson & Christensen, 1998). In this manner, fostering emotional acceptance may facilitate naturally generated, contingency shaped changes, both of which interact to increase marital satisfaction.

There are two predominant acceptance promoting strategies within IBCT that aim to change the emotional context in which problems are experienced (Jacobson & Christensen, 1998). The first strategy involves *empathic joining*, which emphasizes the expression and clarification of one's emotional experience. As part of empathic joining, therapists assist each partner in gaining self- and other-awareness as self-disclosure of underlying emotions increases, while a therapist simultaneously encourages empathic, compassionate, and validating partner responses (Jacobson & Christensen, 1998). Within empathic joining, the therapist works to reframe what the couple may view to be problematic to instead be understandable, even inevitable emotional reactions to the couple's differences; through this reformulation, couples can focus more on the

emotional context rather than the problematic behaviors (Jacobson & Christensen, 1998). Thus, the therapist normalizes the conflict as understandable differences between two people and provides a non-blaming explanation for each partner's behavior, so that these differences can be experienced more compassionately (Jacobson & Christensen, 1998).

IBCT's second acceptance promoting strategy, *unified detachment*, is designed to help couples engage in an intellectual analysis of their problem behaviors (Jacobson & Christensen, 1998). Through this intellectualized viewpoint, couples gain insight into consistent patterns or themes within their relationship and learn to discuss problems in an externalized manner (e.g., referring to the problem as an "it" rather than a "you"). This detached perspective is useful for describing the couple's typical interactional process (e.g., patterns, themes) and serves to counteract blaming or accusatory statements (Jacobson & Christensen, 1998). Through having an increased understanding of interactional patterns without use of blame or accusation, couples begin to experience problems differently. Instead of engaging in repetitive conflictual interactions, couples can recognize their destructive patterns and unite against them, creating the opportunity for a new type of interaction to occur.

Couple Therapy Outcome Research

Couple therapy outcome research involves randomized clinical trials that include some assessment of marital satisfaction/distress, marital status, and pre- to post-treatment improvements. Multiple RCTs have demonstrated that couple therapy is effective at reducing marital distress (Baucom et al., 1998; Johnson & Lebow, 2000; Pinsof et al., 1996; Snyder et al., 2006). However, there is evidence to suggest that these improvements only last approximately six months to one year after therapy, as studies

have shown one- to two-thirds of couples demonstrating deterioration up to four years post-treatment (Christensen & Heavey, 1999). In fact, research has shown that less than half of the couples that receive therapy are able to make and maintain treatment gains over the long-term (Jacobson & Addis, 1993).

IBCT was created, in part, to address these less than ideal long-term results. Through the largest randomized clinical trial of couple therapy conducted to date, Neil Jacobson and Andrew Christensen examined the overall and comparative effectiveness of IBCT and TBCT based on a sample of 134 seriously and chronically distressed couples randomly assigned to one of these two treatments (Christensen et al., 2004). Results demonstrated that couples in both treatments made clinically and statistically significant improvements, with 70% of IBCT couples and 60% of TBCT couples showing reliable improvement or recovery (Christensen et al., 2004). Analysis of the trajectory of change during treatment revealed that TBCT couples tended to make the most improvement at the start of treatment, but would plateau towards the end of therapy, whereas IBCT couples made steady gains across treatment (Christensen et al., 2004).

Assessments were conducted every six months for two years post-treatment, then every six months to a year until couples reached five years post-treatment (Christensen et al., 2010). Data gathered from these assessments revealed that immediately after therapy ended, an initial deterioration period occurred for the majority of couples; however, the 14 week deterioration period for IBCT couples was found to be shorter than the 22 week deterioration period for TBCT couples (Christensen, Atkins, Yi, Baucom, & George, 2006). Two years post-therapy, 68% of IBCT couples and 60% of TBCT couples were classified as improved or recovered; in fact, for couples that did not improve in therapy,

55.6% of IBCT couples and 21.4% of TBCT couples demonstrated improvement during the two years post-therapy. Five years post-therapy, 50% of IBCT couples and 45% of TBCT couples were classified as recovered or improved (Christensen et al., 2010). Interestingly, couples classified as clinically recovered at five years were more likely to report continued use of IBCT behaviors (e.g., empathizing with one's partner) than couples classified as unchanged or deteriorated (Christensen et al., 2010). Overall, it appeared that couples still married five years post-treatment were able to make and maintain gains in marital satisfaction, as compared to their pre-treatment satisfaction levels (Christensen et al., 2010).

Couple Therapy Process Research

Although research has evaluated the effectiveness of couple therapy, researchers and clinicians have continually expressed a need for more research on couple therapy processes and mechanisms of change (Beutler, Williams, & Wakefield, 1993; Christensen et al., 2010; Christensen, Baucom, Vu, & Stanton, 2005; Doss, 2004; Greenberg, 1999; Heatherington, Friedlander, & Greenberg, 2005; Johnson & Greenberg, 1988; Johnson & Lebow, 2000; Pachankis & Goldfried, 2007; Snyder et al., 2006; Woolley, Butler, & Wampler, 2000). Process research involves exploration beyond the outcome question of whether couples change in order to study how and why change occurs. This form of inquiry is well suited for investigating the course and specific determinants of client change both in-session and over the course of treatment (Christensen et al., 2005; Pachankis & Goldfried, 2007), and can also help to clarify the similarities and differences between diverse treatments (Nock, 2007). In addition, process research is an appropriate methodology for examining how specific treatments

work for a particular individual, couple, or group of people, consistent with the American Psychological Association's (2006) recommendation that future research identify common and specific factors related to mechanisms of change for diverse populations.

In addition to being informative for researchers and theorists, process research has direct implications for clinicians. Process research can result in descriptions of specific client and therapist behaviors that are exhibited during couple therapy, explanations for how these behaviors relate to the course and outcome of therapy, and how interventions or treatments can be helpful for a diverse array of clients (Beutler et al., 1993; Christensen et al., 2005; Greenberg, 1999; Jacobson & Addis, 1993; Pinsof et al., 1996). This information is highly valuable to clinicians, as it informs both what is likely to be helpful for a particular client within a therapy session and a conceptual understanding of how these useful components relate to overall treatment. Using the results of process research to disseminate information regarding client change processes, mechanisms, and the course of treatment, therapists can more effectively utilize evidence-based practices when working with distressed couples.

Despite the informative nature of process studies, few investigators have conducted this form of research (Heatherington et al., 2005; Snyder et al., 2006; Woolley et al., 2000). There are many potential reasons why researchers might hesitate to engage in process research. First, the methodology can be very labor intensive and time consuming, making it difficult to use with large samples, which impacts the generalizability of the findings (Llewelyn & Hardy, 2001; Woolley et al., 2000). Second, determining the units and categories for analysis is often a complicated and subjective task (Llewelyn & Hardy, 2001; Woolley et al., 2000). A third reason may involve the

lack of a clear methodological guide for how to conduct process research (Greenberg, 2007). Furthermore, there seems to be a misconception that process research only relates to specific episodes within therapy as opposed to providing information about the whole treatment (Doss, 2004; Greenberg, 2007). Removing the misconception that process and outcome research are mutually exclusive will allow for the integration of these two types of research, leading to more informative and effective studies of therapeutic change (Doss, 2004).

Models for conducting psychotherapy process research. In an effort to address the aforementioned concerns about conducting process research, select researchers have attempted to create a detailed methodological guide for engaging in this form of inquiry (Greenberg, 1999, 2007; Mahrer & Boulet, 1999; Woolley et al., 2000). One example is known as discovery-oriented process research (Greenberg, 1992, 1999, 2007; Mahrer & Boulet, 1999). This type of research usually begins with the selection of specific couples and sessions to screen for an intervention or variable of interest (Greenberg, 2007; Mahrer & Boulet, 1999; Woolley et al., 2000). Once the desired interactions or interventions have been identified, they are described in detailed, meaningful units of analysis that focus on both what the therapist and client do to bring out this occurrence, as well as the outcome of the observed task (Greenberg, 2007; Mahrer & Boulet, 1999). At this point, a coding system is developed to capture the identified processes, which allows researchers to continue to develop and refine the similarities and differences in how the identified processes occur and the task outcome (Greenberg, 2007; Mahrer & Boulet, 1999; Woolley et al., 2000). This analysis can be informed by existing outcome

research while it can also provide useful information to be incorporated into future outcome research.

Given the reciprocally informative nature of outcome and process research, Brian Doss (2004) provided a model for a united framework in which outcome and process research are conducted over time. This model builds on the strengths of both research approaches, offering a guide for an in-depth, clinically informative research sequence that tests, refines and disseminates high quality, effective treatment modalities. As shown in Figure 1, the model starts with the basic idea that in psychotherapy, change processes lead to the occurrence of change mechanisms, which in turn influence the treatment outcome (Doss, 2004).

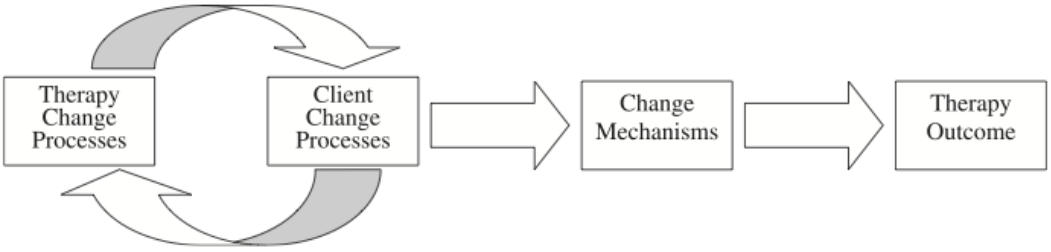

Figure 1: Components of change in psychotherapy. From *Changing the Way We Study Change in Psychotherapy*, by B. D. Doss, 2004, *Clinical Psychology: Science and Practice, 11*(4), p. 369. Copyright 2004 by Brian D. Doss. Reprinted with permission of the author.

Change processes are defined through two dimensions. First, therapy change processes are interventions, directives, or other active ingredients of a treatment (Doss, 2004). Second, client change processes consist of client behaviors and experiences within the therapy (Doss, 2004). Both therapy and client change processes are engaged in a reciprocally influential feedback loop, working together to generate improvements in a treatment's mechanism of change. Change mechanisms are defined as "immediate changes in client characteristics or skills, not under direct therapist control, that are

expected to lead to improvements in the ultimate outcomes of therapy" (Doss, 2004, p. 369). Therefore, both therapy and client change processes influence one another and together lead to the occurrence of a change mechanism within the client, which becomes generalized into the client's daily life and, in turn, influences the overall treatment outcome.

According to Doss' (2004) model, there are four phases involved in the integration of process and outcome research, beginning with the determination of treatment efficacy and then continuing with an examination of change mechanisms, change processes, and refinement of the overall treatment. The first phase, forming a basis to study mechanisms, focuses on outcome research (typically a randomized clinical trial) that determines whether a treatment is effective. If treatment efficacy has been established, the next phase of investigation involves understanding change mechanisms. In this phase, researchers work to operationally define the hypothesized mechanisms of change based on therapist and client report, as well as the underlying theory of the treatment. Before moving on to the next research phase, it is important to test the relationship between the hypothesized change mechanisms and treatment outcome (Doss, 2004).

The third phase of studying change in psychotherapy involves understanding change processes. Once the change mechanism has been established, researchers are tasked with deriving critical client change processes through both qualitative and quantitative methodologies. When an understanding of client change processes has been obtained, an in-depth analysis of the different ways clients experience these change processes in both successful and unsuccessful treatments can occur. Client change

processes will then be related to therapy change processes in order to understand the impact of therapist interventions and general therapy characteristics on the course of treatment (Doss, 2004).

The last research phase is called application of an understanding of change and involves adjusting the treatment based on the previous research findings in order to enhance the treatment's effectiveness (Doss, 2004). Through completing all four phases of this research framework, both researchers and clinicians gain an in-depth understanding of the particular processes involved in successful and unsuccessful therapy. It follows that process and outcome research can be conducted in a unified framework that results in a detailed, descriptive model for effective therapy.

Outcome and Process Research Within IBCT

The next few paragraphs will focus on providing a step-by-step examination of the current status of process and outcome research within IBCT, using Doss' (2004) research framework presented in the previous section. The theoretical model of change in IBCT suggests that acceptance promoting strategies (primarily unified detachment and empathic joining) will result in shared vulnerability, externalization of the problem, and non-blaming, intellectualized discussions about conflictual interactions. These therapy and client change processes are hypothesized to lead to improvements in emotional acceptance, the change mechanism, both within and outside of the therapy sessions. The resulting increase in emotional acceptance is believed to lead to improvements in martial satisfaction, which is the ideal treatment outcome.

Phase one of the unified framework for investigation of the process and outcome of IBCT required treatment efficacy to be established. The largest randomized clinical

trial ever conducted on couple therapy found that IBCT was an effective treatment for chronically and severely distressed couples (Christensen et al., 2004), with treatment gains maintained at two and five years post-treatment (Christensen et al., 2006; Christensen et al., 2010). Since treatment efficacy has been established, phase two required the hypothesized change mechanism to be operationally defined (Doss, 2004). Factor analysis of an empirically validated self-report measure of acceptance assisted in this process, suggesting four components of acceptance were assessed within this self-report measure: affection, closeness, demand, and violation (Doss & Christensen, 2006). This self-report measure was found to be reliable in measuring mechanisms of change in IBCT (Doss & Christensen, 2006). Next, an empirical examination of this hypothesized change mechanism occurred within a study of how changes in behavior frequency, emotional acceptance, and communication relate to changes in relationship satisfaction across treatment (Doss, Thum, Sevier, Atkins, & Christensen, 2005). Increases in emotional acceptance among couples receiving IBCT were significantly related to improvements in marital satisfaction over the course of therapy (Doss et al., 2005), providing the necessary evidence to suggest that IBCT's hypothesized change mechanism is, in fact, related to treatment outcome.

The next step in understanding how change occurs in IBCT would be to examine change processes as part of phase three. Two studies thus far have investigated client change processes within IBCT. The first study entailed a quantitative analysis of whether IBCT leads to different types of communication processes than TBCT (Cordova, Jacobson, & Christensen, 1998). Results indicated that couples that received IBCT engaged in significantly more non-blaming problem discussions and vulnerable

expressions than couples that received TBCT, and that these processes were related to decreases in marital distress (Cordova et al., 1998). The second study examined in-session spousal behaviors that were expected to relate to change for couples in either TBCT or IBCT (Sevier, 2005). The results showed that couples who received IBCT engaged in significantly more acceptance promoting behaviors within therapy sessions than couples in TBCT (Sevier, 2005). However, relationships between acceptance promoting behaviors and treatment outcome were not significant, which the author suggests may have been due to difficulty measuring in-session acceptance (Sevier, 2005). Both of these studies explored the relationship between in-session partner behaviors (e.g., communication, vulnerability) and treatment outcome, but neither study examined the dyadic interaction between the couple, nor the relationship between these dyadic change processes and IBCT's established change mechanism, emotional acceptance.

Current Study

Consistent with phase three of Doss' (2004) framework, the current study aimed to build upon the existing IBCT process and outcome research by gaining a deeper understanding of IBCT's dyadic change processes and established mechanism of change, emotional acceptance. This study expanded upon previous notions of individual client change processes through its focus on the behaviors and experiences within the couple, as the "client" in couple therapy is the couple itself. Based on the theoretical underpinnings of IBCT, these dyadic change processes were examined through a study of acceptance promoting interactions across the course of therapy. In addition, this study addresses the growing need for qualitative change process research focused on the components of

effective treatments (Christensen et al., 2005; Doss, 2004; Greenberg, 1999; Jacobson & Addis, 1993; Johnson & Lebow, 2000; Snyder et al., 2006).

Using the data from the original outcome study (Christensen et al., 2004), acceptance promoting interactions were studied through a discovery-oriented qualitative methodology in order to gain a descriptive, detailed understanding of the dyadic change process that occur in couples who reported growth, no growth, and declines in emotional acceptance across treatment. The following research objectives were proposed:

1. To create a dyadic coding system designed to assess couples' interactions theorized to foster and hinder emotional acceptance within IBCT.
2. To explore the in-session acceptance and hindering promoting dyadic change processes that characterize (a) all selected couples, and (b) couples that experienced growth, no growth, and declines in acceptance.
3. To examine the qualitative similarities and differences in acceptance promoting and hindering dyadic change processes among couples that report various levels of growth or decline in acceptance across treatment.

Chapter 2

Methodology and Procedures

Participants

Participant data in this study were obtained through a data archive from a clinical trial of marital therapy conducted by Christensen et al. (2004), in which 134 heterosexual couples were randomly assigned to receive IBCT or TBCT. To be included in the study, couples had to be legally married, living together, have a high school education, be fluent in English, and be experiencing serious and chronic marital distress. Couples were excluded from the study if domestic violence was occurring or if at least one partner was diagnosed with an Axis I or II disorder that was thought to likely interfere with treatment (e.g., substance abuse or dependency, schizophrenia, bipolar disorder, and various personality disorders).

The 134 couples that qualified after the multiphase screening process were on average in their early 40s (mean age of wives: 41.62 years, husbands: 43.49 years), had a college education, were married for 10 years, and had one child. The majority of participants were Caucasian (wives: 76.1%, husbands: 79.1%), while remaining participants were African American (wives: 8.2%, husbands: 6.7%), Asian or Pacific Islander (wives: 4.5%, husbands: 6.0%), Latino/a (wives: 5.2%, husbands: 5.2%), or Native American/Alaskan Native (husbands: 0.7%). See Christensen et al. (2004) for detailed participant information on this sample.

In the current study, seven of the 66 IBCT couples from the original study were selected for observational coding. All selected couples were within one standard deviation of the mean pre-treatment marital distress score for couples with similar levels

of growth or decline in acceptance across treatment. Additionally, all seven couples were considered to have completed a full course of treatment (defined by using the full number of sessions allowed in the original study or through a planned termination prior to using all available sessions), had minimal missing video or written data, and consented to the use of audiotape excerpts within scientific articles.

On average, the seven couples selected for observation were 42 years old (mean age of wives: 40.71 years, husbands: 44.14 years), had a college education (mean years of education for wives: 18.14; for husbands: 17.57), had one child, had been in their current relationship for 11 years and married for nine years. Additionally, almost three-quarters of spouses were Caucasian (71.43%, n=10), with the remaining partners being Latino/a (14.29%, n=2), African American (7.14%, n=1) or Asian/Pacific Islander (7.14%, n=1).

Measures

Acceptance promoting and interfering dyadic interactions. The Acceptance Promoting and Interfering Interaction Rating System (APIIRS; Appendix B) assesses in-session interactions in couple therapy that may directly serve to enhance partner acceptance (e.g., partner one vulnerability + partner two validation) or hinder the potential for acceptance (e.g., partner one vulnerability + partner two criticism). APIIRS is a global coding system used to rate both the frequency and intensity of various types of interactions that occur within a couple therapy session. Five categories of interactions are coded: *vulnerability* (expressions of vulnerable emotions, thoughts, or behaviors), *non-blaming intellectual problem discussions* (discussions of relationship issues without blame, in an intellectualized manner), *validation* (affirming statements or behaviors related to the experience of one's partner), *aversive partner behavior* (engaging in a

behavior that is typically distressing for one's spouse), and *pressure to change* (direct and indirect statements suggesting the need for some aspect of a person to change). All initiating behaviors, except pressure to change, are coded along with a positive, negative, absent, or therapist response in order to capture the interaction that occurred; pressure to change is intended to provide an overall assessment of insistence that something be different, regardless of partner's response. After viewing an entire session, the coder rates the extent of each interaction on a 9-point Likert scale ranging from *None* to *A lot*.

Procedures

Original study. The original study recruited couples through media advertisements and clinic referrals, beginning a three-step selection process. The screening procedures included a telephone interview, multiple self-report questionnaires, and an in-person interview that involved the Structured Clinical Interview for DSM-IV and an intake evaluation (Christensen et al., 2004). All couples that met inclusion criteria for participating in the clinical trial, as described previously in the participant section, were randomly assigned to one of two couple therapy treatment conditions. In total, 68 couples were assigned to receive TBCT and 66 to receive IBCT from therapists who were licensed clinical psychologists under supervision by experts in IBCT and TBCT (Christensen, et al., 2004). Analysis of adherence data from over 200 IBCT and TBCT sessions confirmed that the therapists were indeed performing two distinct types of treatment (Christensen et al., 2004). The couples were provided with a maximum of 26 therapy sessions over the course of one year, although on average, couples participated in 22.9 sessions (SD = 5.35) over 36 weeks (Christensen et al., 2004). Couples in both treatment conditions were assessed at pre-treatment, 13 weeks, and 26 weeks in a number

of domains, including relationship satisfaction, individual functioning, communication, and emotional acceptance. For more information about the original study's design and procedures, please see Christensen et al. (2004). For the purposes of the current study, selection of couples and sessions followed very specific criteria (presented below), while the therapist was permitted to vary across couples, such that five therapists were represented in the current study.

Selection of couples. For the current study, after permission from the principal investigator and Pepperdine University's Institutional Review Board were acquired, seven couples were selected for analysis. Only couples that completed a full course of treatment were considered for inclusion in the current study; one additional couple was excluded due to missing data, narrowing the selection pool to 56 potential couples. The study's main inclusion and exclusion criterion were designed to ensure selection of couples with a particular pattern of growth or decline in acceptance, as measured by the *Frequency and Acceptability of Partner Behavior Inventory* (FAPBI; Doss & Christensen, 2006). The FAPBI is a 20-item self-report measure of acceptance and behavior change among couples in which each member of a couple is asked to report the frequency in which specific positive and negative behaviors occurred within the past month, and the acceptability of that frequency. Ratings are made on a 10-point Likert scale ranging from *Totally Unacceptable* to *Totally Acceptable*.

Based on their FAPBI scores, couples were then classified into one of three acceptance categories: growth, no growth, or decline. Since only five out of the 56 couples (8.93%) showed less than two points of differences between pre-treatment and 26 weeks, it was decided that the no growth category would include couples with -1.99 to

1.99 points of difference between FAPBI scores at pre-treatment and 26 weeks. Therefore, the growth category constituted couples with over two points of difference between FAPBI scores at pre-treatment and 26 weeks (n=32 couples), and the decline category included couples with less than negative two points difference (n=19 couples). In addition, mean pre-treatment marital distress scores for husbands and wives within each of the three acceptance growth/decline categories were calculated based on data from the *Dyadic Adjustment Scale* (DAS; Spanier, 1976), which is a commonly used self-report measure of marital satisfaction.

In order to study acceptance promoting interactions in a variety of contexts while also examining couples with a higher likelihood of demonstrating acceptance promoting interactions, four couples were selected that reported growth in acceptance across treatment, two that reported declines, and one that reported only minimal shifts in acceptance. Studying couples that demonstrated these particular patterns of growth and decline in acceptance over the course of therapy allowed for an in-depth within- and between-couple examination of the in-session dyadic interactions that occur during opposing trajectories of changes in emotional acceptance. All selected couples had husbands and wives with pre-treatment DAS scores within one standard deviation of mean pre-treatment DAS scores for their acceptance group, in order to decrease the likelihood of selecting divergent, outlier couples. Pre-treatment FAPBI scores ranged within each acceptance group and were not required to be within one standard deviation, as the amount of acceptance for a particular couple is a subjective, culturally specific preference; thus, emphasis was placed on the amount of growth or decline in FAPBI scores across treatment and not on the specific FAPBI scores themselves.

Selection of sessions. After the seven couples for the current study were identified, six therapy sessions from each couple were selected for observational coding. Since sessions one through four constituted the assessment and case conceptualization phase of IBCT, sessions five through 26 were deemed appropriate for selection within the current study. All sessions selected for observational coding were chosen based on multiple factors. First, to maximize the potential for selecting sessions that contained ample acceptance promoting interactions, data from the Session Ratings by Therapist questionnaire was used. Therapists completed this questionnaire after each couple therapy session in order to describe nine aspects of the therapy session (e.g., did couple arrive late, which interventions were utilized). Particular attention was given to two questions that asked the therapist to rate their own effectiveness and the session's benefit for the couple on a 10-point Likert scale. These ratings were summed to establish an index of how effective and beneficial each therapy session was; sessions rated the highest were generally selected. Other criteria taken into consideration included on-time arrival to therapy sessions, high therapist-report of IBCT adherence, and the utilization of multiple IBCT interventions during the session. High concordance between therapist self-report of which interventions were used and observer ratings (Cruz, 2009) indicated that the therapist reports would likely be a valid representation of what occurred within the therapy session.

In addition to the data obtained from the therapist's self-report, the investigators attempted to select sessions that represented a comprehensive span across treatment. Research on IBCT has shown that couples tend to improve slowly and steadily across treatment, with gains in acceptance following a similar trend (Christensen et al., 2004;

Doss et al., 2005). In order to best understand the dyadic change processes that occur within IBCT, it was important to select sessions, where possible, that would facilitate the observation of acceptance promoting interactions spanning the entire course of treatment.

In certain circumstances, the selected sessions changed after commencing observational coding. Given the exploratory nature of this study, it was most useful to code sessions that contained ample acceptance promoting or hindering interactions. Therefore, sessions with minimal coded interactions (e.g., if the session was spent discussing recent work stressors or more superficial topics) or sessions with poor audio/video quality were excluded so that additional sessions with more useful data could be included. For these reasons, eight of the 42 originally selected therapy sessions were substituted.

In addition to the 42 coded therapy sessions, the feedback session for each couple was also observed (but not coded). In IBCT, the feedback session constitutes the end of the assessment phase of treatment in which the therapist describes his or her formulation of the couple's interactional process and current distress, while also eliciting the couple's input and perspective. This collaborative conceptualization provides critical information for the understanding and global coding of a couple's interactions in therapy, such as the couple's typical interaction pattern and which behaviors are typically considered to be aversive for each spouse. In addition, five couples were also selected for practice coding in order to assist with development of the coding system prior to commencing observational coding with the seven selected couples. Practice couples consisted of four growth couples and one decline couple; sessions were selected according to the same sequenced strategy previously described.

Design

Due to the exploratory nature of this study and the complex dyadic interactions under observation, it was imperative to use a research design that allowed for the integration of multiple data sources (e.g., observational coding, clinical expertise) and the integration of a priori assumptions within the study's development and design. Discovery-oriented process research is a multiphase research strategy that utilizes clinical expertise and theory to guide a rigorous study of psychotherapy change processes (Greenberg, 1992; Mahrer & Boulet, 1999). It relies upon observation of therapy sessions, the utilization of multiple sources, and creative analysis in order to build models of client change (Doss, 2004; Greenberg, 1992, 1999, 2007; Mahrer & Boulet, 1999; Rhodes & Greenberg, 1994). This methodology is commonly used when conducting a task analysis of how specific events in therapy are resolved (Greenberg, 1992). Given the added complexity of studying two individuals (the couple) as well as multiple interactions believed to promote acceptance, this study utilized relevant components of task analysis to help guide the qualitative process.

In the current study, discovery-oriented process research was conducted in the following ways. Consistent with the first step in task analysis (Greenberg, 1992), a general model for how IBCT couples ideally grow in acceptance was obtained through consultation with multiple clinical and research experts (including the principal investigator of the original study, the principal investigator of one of the previous IBCT process studies, as well as the supervisory investigator of the current study), in addition to a review of theoretical texts (e.g., Jacobson & Christensen, 1998). This framework provided a guide for conducting the specific study of change processes, allowing for the

second step of task analysis to occur, in which the multiple types of acceptance promoting interactions within IBCT were identified and described (Greenberg, 1991, 1992, 1999). Next, the significance of the selected interactions was verified in three ways (Greenberg, 1992). First, the theory under investigation suggests that these specific interactions serve to enhance acceptance within IBCT. Second, IBCT research has demonstrated a clinically significant relationship between changes in emotional acceptance and improvements in marital satisfaction (Doss et al., 2005), providing support for the further study of acceptance promoting behaviors. Third, post-therapy client reports and post-session therapist reports were used to identify couples and sessions with high likelihood of acceptance promoting interactions, which is another method suggested for verifying the significance of the task(s) being studied (Greenberg, 1992).

Based on expert consultation, prior research, and theoretical underpinnings, a preliminary coding system was created. This process is similar to the rational model generated in step four of task analysis, in which theoretical and clinical knowledge is used to develop a preliminary performance diagram (Greenberg, 1992). These multiple phases of observation, refinement of the measurement criteria, discussions of important interactions, and reference to theoretical and expert judgment were completed in a cyclical manner by the investigator, as indicated by the data, until saturation of the coding system and observational ratings was apparent. The coding was completed by the primary investigator for the current study; therefore, the data were generated by a single informed rater enrolled in a doctoral program in clinical psychology. After observational coding was completed by the investigator, themes, patterns and quotes were examined within each couple, as well as within and between each acceptance category.

Chapter 3

Results

Detailed characteristics of the couples and sessions selected for observation are provided first, followed by the study results, which are presented in two sections; first, the development and refinement of the coding system is described, followed by qualitative description and comparison of couples that reported growth, no growth or declines in emotional acceptance across therapy.

Characteristics of Sample

Husband and wife self-report of marital satisfaction (measured by the Dyadic Adjustment Scale) and emotional acceptance (measured by the Frequency and Acceptability of Partner Behavior Inventory) at pre-treatment and 26 weeks are displayed in Table 1. All selected couples had improved or recovered levels of marital satisfaction at post-treatment (Christensen et al., 2004).

Table 1

Dyadic Adjustment Scale (DAS) and Frequency and Acceptability of Partner Behavior Inventory (FAPBI) Scores for Wives and Husbands at Pre-Treatment and 26 Weeks

	DAS		FAPBI	
Couple ID	Pre-treatment	26 weeks	Pre-treatment	26 weeks
Acceptance Growth				
Couple 1				
Husband	92.00	109.00	17.06	26.10
Wife	70.00	79.00	11.50	20.35
Couple 2				
Husband	92.00	71.00	20.08	22.71
Wife	90.00	89.00	17.08	20.21
Couple 3				
Husband	102.00	100.00	22.29	27.67
Wife	94.00	104.00	29.40	33.29
Couple 4				
Husband	88.00	110.00	19.25	25.33
Wife	77.00	91.00	16.25	22.33
No Acceptance Growth				
Couple 5				
Husband	91.00	90.00	19.62	19.67
Wife	72.00	85.00	14.88	16.42
Acceptance Decline				
Couple 6				
Husband	94.00	101.00	31.38	20.05
Wife	103.00	102.00	23.67	17.00
Couple 7				
Husband	86.00	91.00	19.75	11.00
Wife	93.00	83.00	17.88	12.33
Mean (SD) for Selected Couples (n=7)				
Husbands	92.14(5.11)	96.00(13.49)	21.35(4.68)	21.79(5.63)
Wives	85.57(12.58)	90.43(9.45)	18.67(5.98)	20.26(6.61)
Mean (SD) for all IBCT Couples (n=65)				
Husbands	86.49(13.17)	92.78(18.82)	21.68(4.85)	23.06(6.02)
Wives	85.47(13.72)	91.14(19.09)	21.42(4.77)	22.80(6.42)

Results for each couple were generated based on the observation of their feedback session and six therapy sessions. Table 2 lists the final selected therapy sessions for each couple.

Table 2

Selected Sessions for Growth, No Growth, and Decline Couples

Couple ID	Selected Sessions
Acceptance Growth	
Couple 1	7, 12, 15, 20, 21, 24
Couple 2	6, 9, 10, 12, 16, 23
Couple 3	10, 13, 15, 19, 20, 22
Couple 4	8, 11, 14, 17, 21, 23
No Acceptance Growth	
Couple 5	10, 13, 16, 19, 21, 22
Acceptance Decline	
Couple 6	4, 8, 11, 15, 17, 24
Couple 7	14, 16, 17, 18, 20, 23

Table 1 and Table 2 demonstrate that the selected couples are fairly representative of the IBCT couples within the original clinical trial, with similar levels of emotional acceptance and marital distress reported prior to receiving treatment and 26 weeks after treatment began. The sessions selected for each couple span the full range of therapy, providing an overview of in-session dyadic interactions that occur across the course of treatment.

Research Objective #1: Creation, Use, and Revision of the Acceptance Promoting and Interfering Interaction Rating System

Creation and use of the dyadic coding system. The development of the Acceptance Promoting and Interfering Interaction Rating System (APIIRS) was influenced by multiple sources. Based on the theoretical description of how couples generate acceptance within IBCT, a behavioral coding system had been previously created to assess in-session acceptance promotion behaviors (Sevier, 2005). This original global coding system was also intended to measure other in-session individual behaviors, including constructive change, positive behaviors, and negative behaviors. For the purpose of this study, the acceptance-promotion behavior subscale was used as a catalyst for creating an expanded coding system of acceptance promoting dyadic interactions.

In this prior coding system, four items comprised the acceptance promotion subscale: *accommodation* (benign reactions to aversive partner behavior), *descriptive discussions* (non-blaming discussions about problematic interactions or differences), *validation* (compassion, validation or support for the partner), and *vulnerability* (expression of soft or vulnerable experiences and emotions). After viewing an entire session, the observer was instructed to rate the extent of each behavior on a nine-point Likert scale ranging from *None* to *A Lot*. However, since inter-rater reliability on the acceptance promotion subscale was low (*Inter-class Correlation Coefficient* = .51), this subscale was referenced as a loose guide while creating APIIRS.

The first step in developing the coding system required consultation with expert IBCT clinicians and researchers in order to obtain knowledge about strengths and weaknesses of prior research, as well as a clinical understanding for how best to

behaviorally assess acceptance within IBCT. This consultation served to enhance both the investigator's general understanding of acceptance within IBCT as well as various methods for operationally defining components of emotional acceptance; accordingly, this initial consultation was consistent with step one (explicating the clinician's cognitive map) and two (selection of description of a task) of task analysis (Greenberg, 1992). These expert consultations resulted in multiple recommendations suggesting that coding more specific behaviors within an interactional framework was paramount to understanding the development of emotional acceptance in couple therapy. It appeared that the acceptance promotion behaviors captured within the original coding system might be best understood within the context of the couple's interaction instead of as individual behaviors; therefore, the response to specific acceptance promotion behaviors was considered to be equally important to the initiating behavior in the effort to understand how emotional acceptance develops in couple therapy. Additionally, it seemed essential to include a study of acceptance hindering interactions within the dyadic coding system to better understand the multiple pathways acceptance can be created *and* prevented within IBCT.

In order to expand the prior, individually oriented methods of coding acceptance into a dyadic, interactional framework, the initiating behaviors that would serve as the main categories of interaction were defined to include vulnerability, non-blaming intellectual problem discussions, validation, aversive partner behavior, and pressure to change. Next, a rational analysis was conducted through creating a preliminary list of possible reactions to these five initiating behaviors (e.g., empathy, defensiveness). The only initiating behavior not assigned response codes was pressure to change, which was

determined based on the notion that explicit pressure for a partner to be different would be harmful to the generation of acceptance regardless of the response. Similarly, the absence of pressure to change was thought to facilitate an environment in which acceptance could be created.

Next, actual couple therapy sessions were viewed in order to incorporate data from clinical observation within the interactional coding system, in addition to the knowledge obtained through theoretical literature, existing research and expert consultation. These sessions were selected from couples not otherwise included within this study, representing a wide range of growth and decline in emotional acceptance across therapy. This preliminary observational data was used to refine how the acceptance promoting and hindering interactions were described and measured within the coding system. For example, it became apparent that when coding multiple sessions of a particular couple's therapy it was useful to re-watch significant segments of observed sessions, as the rater's knowledge of the couple and their behavior strengthened with further observation of a couple's interaction patterns throughout therapy. Second, an additional response category was created in order to capture the occurrence of a therapist's response that prevented a direct partner response. Although APIIRS was not designed to capture the therapist's behavior, it was found that an immediate therapist response after the initiating codes actually prevented a direct partner response, thus eliminating the potential occurrence of an acceptance promoting or hindering interaction between the couple. Therefore, it was deemed important to note this specific form of therapist response so as to better understand the dyadic change processes under study.

After preliminary observational use of the coding system, the investigators determined that APIIRS was sufficiently revised and prepared for use within the current study (see Appendix B for the coding system and Appendix C for the rating sheet used in this study). Thus, the empirical analysis of couples specifically identified for use in this study commenced. Consistent with the process of cycling through observation, refinement of the measurement criteria, discussions of important interactions, and reference to theoretical and expert judgment, minor refinements to the coding system were completed as the preliminary model of acceptance promoting interactions was applied to observation of the seven couples included in this study. When additional minor revisions to the coding system were made, previously coded sessions were revisited to ensure that all sessions were coded with the same criteria. Larger, conceptual insights and descriptions of specific codes and interactions were integrated into a revised version of APIIRS for future use after the coding was completed (see Appendix D for the coding system revised based on study findings for future use).

The experiential use of APIIRS during this investigation led to invaluable insights into the process of completing observational, interactional ratings. As previously mentioned, it quickly became apparent that certain interactions and sessions would require repeated observation to ensure high quality ratings. As the investigator's clinical understanding of a couple was enhanced with increased exposure to the couple's therapy sessions, it was important to review segments of therapy sessions in which multiple acceptance promoting and interfering interactions were noted. In this manner, the quality of the coding was improved with increased knowledge of a couple's in-session dynamics.

Another reason for reviewing segments of therapy sessions was the complexity of the interactions that were observed. Factors such as the seating arrangement (were couples sitting close together or far apart?), vocal tone (loud vs. soft), and distance from the camera (how well could you see a partner's face and eye gaze?) all influenced the behavioral interpretation of an observed interaction. Through repeated observation of important video segments, the investigator was able to consider how these variables influenced the coding and how to capture complex interaction consistently across all couples (despite variations in these in-session situational factors). Reviewing sessions also enabled the investigator to evaluate the multiple codes often selected to describe more complex interactions. For example, consider the following interaction from one of the selected sessions:

> Wife: I do think he is a good dad, and he is a good provider, and the kids love him to death.
>
> Therapist [*therapist speaks after a brief silence*]: And I think that's important that you say that and I think it's important that you hear that, [*Husband*].
>
> Wife [*turns to Husband*]: Have you never heard me say that before?
>
> Husband: First time. [*Husband laughs*]
>
> Wife [*Wife speaks with a louder tone*]: Do you want to take an oath on that?
>
> Therapist [*directed towards Husband*]: But what I'm thinking is that it's important for you to hear that tonight.
>
> Husband: Mm-Hmm.
>
> Therapist [*directed to the Husband*]: I'm sure it's not the first time you have heard that.

Husband [*directed to the therapist*]: No, it's important to hear that tonight, because in the midst of an argument it is nice to hear a diffusing statement like that. [*Husband now directly speaks to his Wife*] But I'm not giving you one! [*Husband laughs*]

Wife: [*Wife looks down, laughs quietly, then raises her eyebrows and begins to fidget with a paper in her hand*]

Husband [*Husband speaks in a softer tone*]: No, [*Wife*] is a great mom, she is a great mom, our kids-

Wife: [W*ife interrupts Husband and proceeds to talk about how Husband instigated a fight at a recent dinner*]

This sequence reveals the complexity of the interaction patterns coded within APIIRS. For this example, four codes were assigned to best reflect what was observed. First, wife validation + husband no response was assigned to represent the wife's initial compliment of her husband's role as husband and father, after which no verbal or behavioral reaction was initially observed. Second, wife validation + husband compassion/appreciation/ reassurance/apology was applied once he expressed appreciation for the wife's "diffusing statement." Third, husband aversive partner behavior + wife withdrawal and/or decrease in positive non-verbal gestures (e.g., eye contact) was noted as the wife looked down and verbally retreated from the conversation in response to the husband's sarcastic comment that he was not going to provide his wife with a return compliment. Last, husband validation + wife criticism/attack was coded after the husband eventually does compliment the wife's parenting ability and the wife reacts by criticizing the husband's recent behavior. This 30 second interactional sequence provides a good example of the

complexity and clinical judgment required in identifying which interactional codes best represent a behavioral sequence between a couple.

A second insight into the process of using APIIRS was the need for a detailed notation system. With the multitude of acceptance promoting and hindering interactions observed within each therapy session, an organized, detailed documentation method was essential. The note taking system developed for this investigation documented the following components of an interaction: the time code at which the interaction occurred, the initiating and responding person, a summary of the interaction (not a verbatim transcript), the interactional code and intensity level, other notes, and follow-up questions (see Appendix E). These notations helped to develop the descriptions of interactions in the coding system and provided a more systematic method for generating the global ratings. While APIIRS is intended to provide a global rating and not a microanalytic depiction of interactions, the use of a thorough notation method for documenting in-session interactions assisted in creating a more systematic, less subjective approach to assigning ratings.

Once the observation of a session was completed, a third insight into the use of APIIRS related to the manner in which numerical global ratings were generated. The following method was generated for transforming the specific interaction codes into global ratings: first, numerical values were assigned to represent the intensity of an interaction (i.e., low intensity = 1/3 point, low/moderate intensity = 1/2 point, moderate intensity = 1-2 points, moderate/high intensity = 2 ½ points, and high intensity = 3 points), and second, the number of times a specific interaction occurred was considered along with the intensities of those interactions. However, these numerical designations

for the interaction's intensity level were not used rigidly; global ratings were consistently reviewed to ensure that they accurately represented the clinical impressions of the quantity and quality of acceptance promoting and interfering interactions observed within the therapy session.

Conducting observation and ratings for a single 50-minute therapy session took approximately three hours. This time estimate includes the initial observation of the therapy session (totaling approximately two hours) and repeated observation of specific interactions throughout the session (totaling approximately one hour).

Revision and refinement of APIIRS. Clinical judgment was used to refine the coding system after observation of therapy sessions commenced in order to incorporate an enhanced description of various initiating and responding codes, as well as methods for categorizing nonverbal codes.

Expansion of initiating and responding codes. Based on both frequent and infrequent observation of specific styles of interaction, components of the coding system were modified accordingly. For instance, increased emphasis was placed on more subtle displays of vulnerability after realizing that direct expressions of vulnerability were less frequently observed. Based on theoretical understandings of how acceptance is ideally generated within IBCT, it was expected that early therapy sessions would include less frequent and less intense expressions of vulnerability as couples learned to shift from more blaming, defensive statements to genuine emotional expressions as part of empathic joining. However, observational coding revealed that direct soft, vulnerable statements were less common than expected; instead, all couples (regardless of how much growth or

decline in acceptance was reported across treatment) appeared to display vulnerability through more indirect means (e.g., anger, self-deprecating statements).

To respond to the more frequent indirect expressions of vulnerability, the coding of vulnerability shifted such that these indirect, seemingly less vulnerable statements were rated with higher intensity than initially assigned. Particularly when a demand-withdraw pattern is apparent (when one partner persistently pursues a topic of discussion and the other partner increasingly withdraws from the conversation, with both components of the interaction serving to exacerbate one another), expressions from the withdrawing partner were considered to have added intensity to account for the rarity and likely difficulty this partner had in voicing concerns or opinions that might have increased the length or intensity of the difficult conversation. For example, in the following interaction one wife deviated from her typically withdrawn stance and expressed herself. Although she expressed her discontent in a mildly accusatory manner, to reveal her inner thoughts and feelings was a vulnerable act:

> Wife [*Wife is looking at therapist, Husband is looking at Wife*]: I've been noticing it more and more again. Every evening, [*Husband*] disappears and watches TV. There is no family activities [W*ife begins shaking her head and looks down*], especially with me working now too, I don't have as much opportunities to do things myself. I don't know, I just have had a general feeling of dissatisfaction the past couple weeks.
>
> [*Six second pause*]
>
> Therapist: Does this come as a surprise to you, [*Husband*]?

Husband [H*usband looks at therapist, Wife shifts her gaze around the room*]: Uh, well I guess not entirely. We had a couple little grouches back and forth.

Based on the expanded understanding of vulnerable disclosures and the specific knowledge of this couple, the interaction was understood as beginning with a vulnerable statement of greater intensity than initially perceived. The interaction was subsequently coded as both wife vulnerability + husband no response (low/moderate intensity) and wife vulnerability + husband validation (low intensity) in order to best represent the acceptance promoting and interfering components of this interaction.

The expectation for what constituted a non-blaming intellectual problem discussion was also expanded after early observational coding. Consistent with IBCT's emphasis on unified detachment as a strategy for increasing emotional acceptance, the investigators expected to observe increased non-blaming interactions as therapy progressed and couples become more aware of their interactional patterns around conflict. Surprisingly, non-blaming intellectual problem discussions were infrequently coded across the course of therapy, as couples appeared to maintain a blaming stance or would only address a small component of an interaction with an intellectualized manner. After reviewing examples of potential non-blaming intellectual problem discussions with the supervisory investigator and discussing how the observed interactions related to theoretical literature, the expectation for what constituted a non-blaming intellectual problem discussion was modified. Instead of solely representing an emotionally disengaged discussion of the couple's interaction pattern, descriptions of only one partner's contribution to the interaction pattern were incorporated into the understanding

of this initiating behavior. For example, this husband described his personal experience during conflict:

> Husband [*with a soft tone, looking at the therapist*]: My anger was almost a response to her anger… many times I realized I really wasn't even that angry, it was just I had such a sense of fairness… It seems when she treated me with anger and frustration I would just play the part and respond to it. Overall I don't think that I'm that angry of a person, cause usually as soon as I know that I do feel angry, usually what I do is, I wouldn't say that I suppress it, but take control of it. I start just logically thinking of things, and immediately it just starts to shut off. I've learned to do that over time, with many emotions I do that.

Although this quote contains a slightly accusatory stance towards the wife (that his anger is a response to her own expressions of anger and frustration), the overall statement entails a description of his internal process during conflict. When explanations of personal contributions to interaction patterns occurred, the non-blaming intellectual problem discussion code was utilized. However, it was assigned with less intensity than if the statement had incorporated a description of the combined interaction around a theme.

In addition to expanding APIIRS initiating codes, specific response codes were incorporated into the coding system in order to address significant response styles previously unaccounted for. The main example of an addition is the use of two types of humor: humor that involved appropriate, playful reactions, and belittling, sarcastic, or

otherwise inappropriate humor. The latter type of humor is exemplified in the following interaction:

> Wife [*Wife is looking at the therapist*]: I don't know why sweeping the floors comes up as such a big issue. Sometimes he'll start sweeping it, and in my mind I'm thinking, "I've swept it three times today, should I tell him I've already swept it today, so he doesn't think I just left it?" You know what I mean? So I'll be obsessing, thinking he doesn't think I've swept the floor all day so he's doing it. [*Wife's voice gets quieter*] It's just totally stupid. [*Wife looks down and starts rubbing the back of her neck*]
>
> Therapist: Well, see, both of you-
>
> Husband [*interrupting therapist*]: That is kind of stupid! [*Wife laughs briefly, than gets a serious, almost sad expression on her face and looks down*]

In this example, the husband took his wife's insecure statement that her concerns were "stupid" and used it to make a belittling comment. Had the husband made a joke about how much he loves sweeping, the humor may have lightened the conversation and enhanced the intimacy felt between the couple. Based on the observation of these two forms of humor reactions, the coding system was revised to incorporate both *use of non-belittling humor* and *use of sarcastic / belittling / inappropriate humor* as response codes.

Unfortunately, not all refinements to the coding system were useful. After noticing the infrequency with which validation was observed, the initial definition of validation as an expression of appreciation or understanding for a partner's feelings, thoughts or behaviors was expanded to include spousal agreement with the therapist's own expression of validation. Despite this effort to account for divergent expressions of

validation, it remained an infrequently assigned initiating code; instead, it was more commonly seen as a response to an alternative initiating behavior.

Categorization of nonverbal response codes. Coding nonverbal responding presented a unique set of challenges when attempting to behaviorally describe and categorize acceptance promoting and hindering interactions. As previously mentioned, numerous response categories can potentially be used to describe one partner remaining silent in response to an initiating behavior. If these specific responses were all within one larger category of response, such as various types of negative responding, identifying exactly what type of negative response had occurred would not be as important within a global coding system. However, when the responses could indicate disparate classes of responding, identifying the appropriate response category is critical. When coding solely nonverbal reactions, responses could be labeled as positive (i.e., *neutral response*), negative (i.e., *withdrawal and/or decrease in positive nonverbal gestures*), or *no response*. Differentiating between these three response types was further impacted by video quality; for couples sitting further away from the video camera, observing intricacies in facial expressions that would assist with identifying the appropriate response code was challenging.

Given that labeling an interaction with differing response categories has distinct implications for the qualitative analysis, the following definitions of neutral, no, and withdrawal responding were refined in order to provide improved instructions for differentiating between these three codes. The following definitions were added to APIIRS: a neutral response is where the spouse seems to acknowledge and/or actively listen to what his or her partner is saying, without a significant change in physical or

verbal behavior; no response occurs when there is no change in physical or verbal behavior during or after an initiating behavior by one's spouse, otherwise understood as a lack of behavioral acknowledgment of the initiating component of an interaction; lastly, the withdrawal response occurs when a decrease in positive nonverbal gestures occurs, such as the removal of eye contact.

Differentiating between behaviors and emotions. One of the challenges that emerged in conducting behavioral coding was for the rater to avoid making inferences regarding the unstated emotional experience of a spouse. Although acceptance is inherently an emotional state, APIIRS is designed to assess the behavioral interactions believed to contribute to or interfere with acceptance. This distinction requires raters to use clinical judgment to understand and accurately describe the behaviors observed in-session.

The differentiation between emotions and behavior was particularly challenging in the absence of behavior (i.e., when a partner makes no shift in nonverbal or verbal behavior). Without verbal statements or physical movement, it is impossible to accurately decipher the emotional content of what is observed. However, some of the potentially applicable response codes that could be assigned to represent silence required some level of inference as to a partner's unstated emotions. For example, if a partner was quiet after the occurrence of an aversive partner behavior the *lack of hurt/distress* code may be assigned, particularly if the aversive partner behavior normally elicits a defensive or hurt reaction. Although clinical judgment and intuition can suggest various hypotheses to explain what the partner may be experiencing in his or her silence, the observational coding is intended to describe visible behavior and not internal states. As a

result, the *lack of hurt/distress* code was removed from the coding system. Should a partner directly state that an absence of hurt or distress occurs in response to aversive partner behavior, the *lack of typical response* code can be assigned instead. Lastly, should a partner remain silent in response to a particular aversive behavior, the *lack of hard emotional response* code can be utilized since it describes an observable lack of a particular behavior, as opposed to a lack of an internal emotional state.

Research Objective #2: In-Session Acceptance Promoting and Interfering Dyadic Change Processes Among All Couples and Within Growth, No Growth, and Decline Couples

IBCT couples demonstrated the wide range of in-session acceptance promoting and hindering interactions. In order to summarize these observed dyadic interchanges, the observational data is presented in multiple forms: number and percentages of the total amount of each initiating code and response type, the average session Likert ratings for each interactional code, the average occurrence of specific subcategories of responding, as well as the average ratings of total acceptance promoting and interfering interactions observed across treatment.

Observations across all couples. Table 3 displays the frequency of each initiating code and response category observed within all couples across treatment. Percentages were calculated by dividing the number of times each code occurred compared to the total number of interactions.

Table 3

Percentages of Initiating Codes and Response Categories Observed in All Couples Across Treatment

Interaction Codes	*n*	Percentage
Initiating Codes		
Vulnerability (Vul)	514	42.37
Non-Blaming Intellectual Problem Discussion (NBIPD)	65	5.36
Validation (Val)	84	6.92
Aversive Partner Behavior (APB)	433	35.70
Pressure to Change (PtoC)	117	9.65
Response Categories		
Positive Response (Pos)	421	38.31
Negative Response (Neg)	453	41.22
No Response (No)	121	11.01
Therapist Response (Ther)	104	9.46

The percentages of initiating and responding categories observed among all couples reveals that IBCT couples engaged in interactions beginning with vulnerability and aversive partner behavior more often than non-blaming intellectual problem discussions, validation, or pressure to change. Couples also appeared to react with similar amounts of positive and negative responses; a therapist or no response occurred in less than a quarter of interactions.

To succinctly display the Likert ratings of dyadic interactions, the following is an example of an abbreviation used to summarize the various interaction codes:

H Vul + W Pos

In this abbreviation pattern, the interaction is split into two parts: the first portion (in this case, "H Vul") refers to the initiating component of the interaction, with the first letter representing the initiating partner (H=husband, W=wife) and then the abbreviated

initiating code. Similarly, the second half of the abbreviated interaction portion ("W Pos") displays the responding partner and the abbreviated response category. For this example, the abbreviated interaction is read as a husband vulnerability + wife positive response. With this understanding, Figure 2 shows the average Likert scale ratings for all interaction codes (following the same abbreviation pattern) in IBCT couples across therapy.

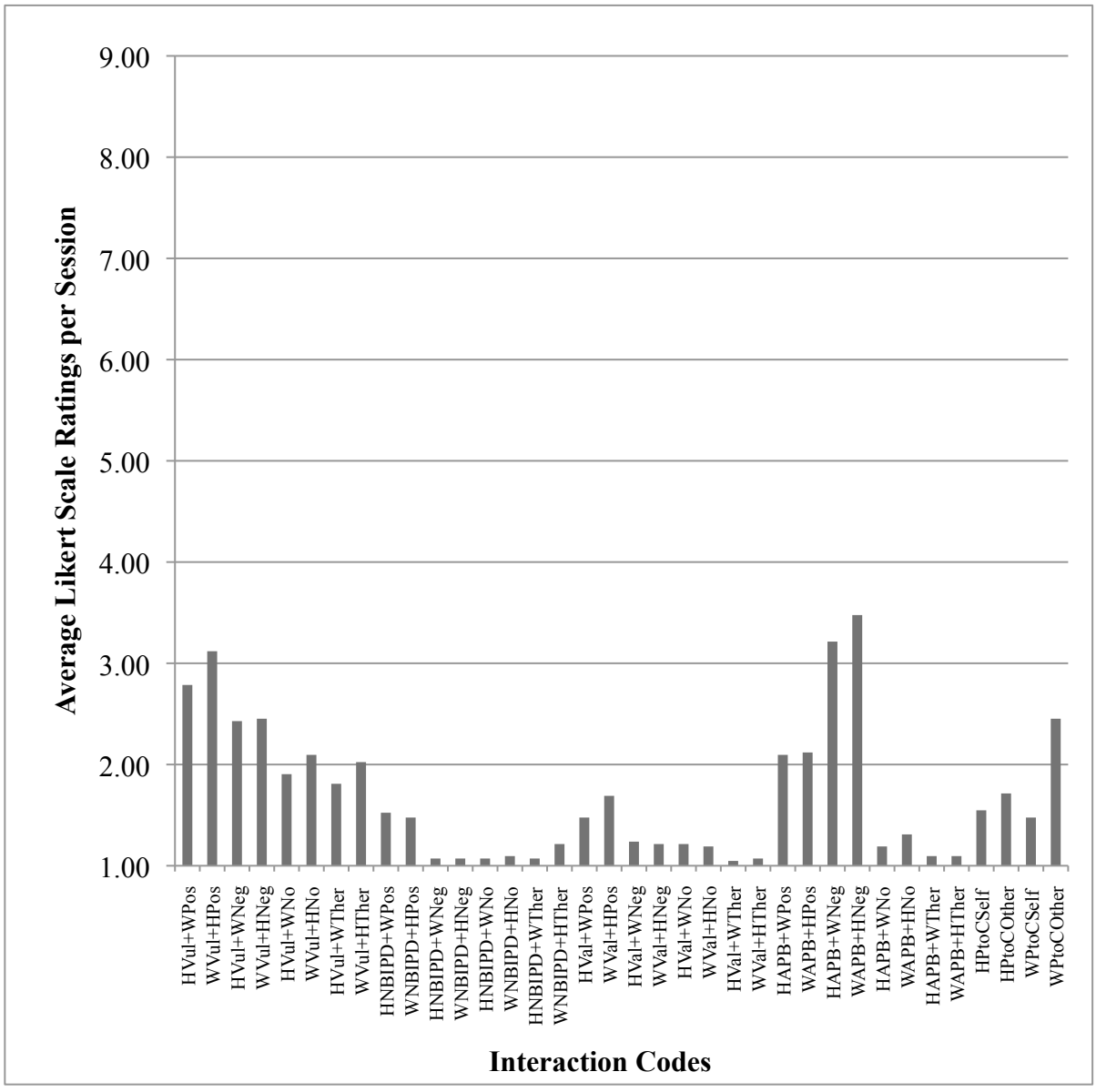

Figure 2. Average session Likert ratings for all couples

This figure provides an overview of how IBCT spouses related to one another in therapy. Although a wide variety of interactions was observed, the assigned ratings appear restricted in range considering that all averages are below a rating of four on a Likert scale of one to nine. Consistent with Table 4, it is evident that the majority of interactions began with vulnerability or aversive partner behavior and ended with either a positive or negative response. A more in-depth analysis of these frequent interactions helps describe the specific types of interactions that occurred.

To begin with the positive reactions to vulnerability, a neutral response of active listening was recurrently observed among responding partners (*n*=87). Other commonly observed positive responses to vulnerability included reciprocal vulnerability (*n*=31), compassion/appreciation/reassurance/apology (n=30), and validation (*n*=24). Negative reactions to vulnerability consisted of equal amounts of blame/defensiveness (*n*=41) and withdrawal (41), followed by criticism/attack (*n*=22) and annoyance/dismissing/invalidation (*n*=10).

When confronted with an aversive partner behavior, positive partner responses most commonly included a lack of a hard emotional reaction (*n*=52). Neutral responses (*n*=17), the use of non-belittling humor (*n*=12) and validation (*n*=9) were also observed. Despite the many instances in which a lack of a hard emotional reaction was observed, partners more frequently responded to aversive partner behavior with a negative reaction characterized by blame/defensiveness (*n*=145) or withdrawal (*n*=75). Responses consisting of criticism/attack (*n*=33), the typical reaction a spouse may have (*n*=20), or annoyance/dismissing/invalidation (*n*=17) were also observed.

Based on theoretical understanding and clinical judgment regarding IBCT acceptance enhancing strategies, interactions that were more clearly acceptance promoting (e.g., partner one vulnerability + partner two positive response) or acceptance hindering (e.g., partner one vulnerability + partner two negative response) are depicted in Figure 3. Ambiguous codes (e.g., interaction codes with no response or therapist response) were not included in either category. In order to obtain the averages, the Likert ratings for each session that comprised acceptance promoting and interfering interactions were first summed, and then divided by the total number of Likert ratings, and this was done separately for acceptance promoting and acceptance hindering ratings. The result is an average of the total acceptance promoting and acceptance interfering ratings for all couples across the course of therapy.

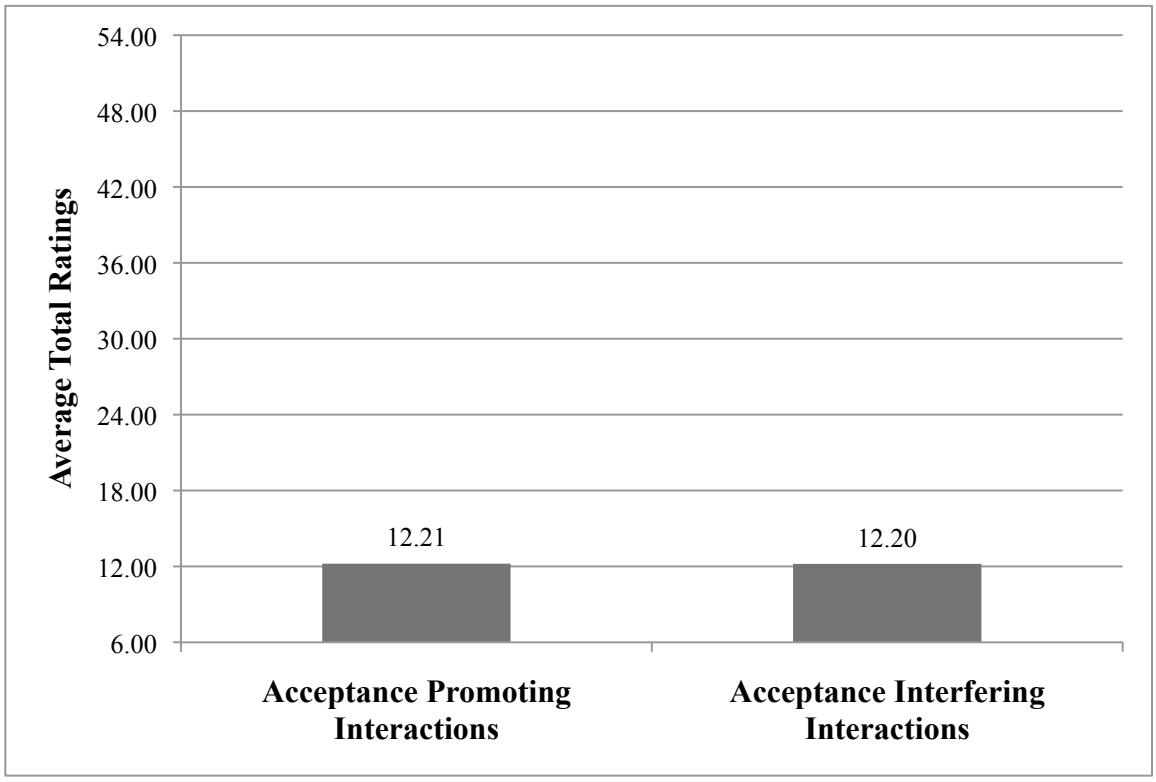

Figure 3. Average of the total acceptance promoting and interfering ratings for all couples across treatment

Figure 3 reveals that the ratings of average acceptance promoting and interfering interaction across treatment were essentially a 1:1 ratio. Analysis of this ratio within acceptance growth, no growth, and decline couples revealed similar findings.

Observations within acceptance categories. The following paragraphs will describe the common interaction codes and patterns for couples within the growth, decline, and no growth categories.

Growth. The types of interactions observed within the four couples that reported growth in emotional acceptance across treatment are presented below. Table 4 depicts the percentages of all initiating codes and response types observed within growth couples across treatment, while the average session Likert ratings are shown in Figure 4.

Table 4

Percentages of Initiating Codes and Response Categories Observed in Growth Couples Across Treatment

Interaction Codes	*n*	Percentage
Initiating Codes		
Vulnerability (Vul)	287	42.90
Non-Blaming Intellectual Problem Discussion (NBIPD)	34	5.08
Validation (Val)	43	6.43
Aversive Partner Behavior (APB)	227	33.93
Pressure to Change (PtoC)	78	11.66
Response Categories		
Positive Response (Pos)	226	38.05
Negative Response (Neg)	217	36.53
No Response (No)	74	12.46
Therapist Response (Ther)	77	12.96

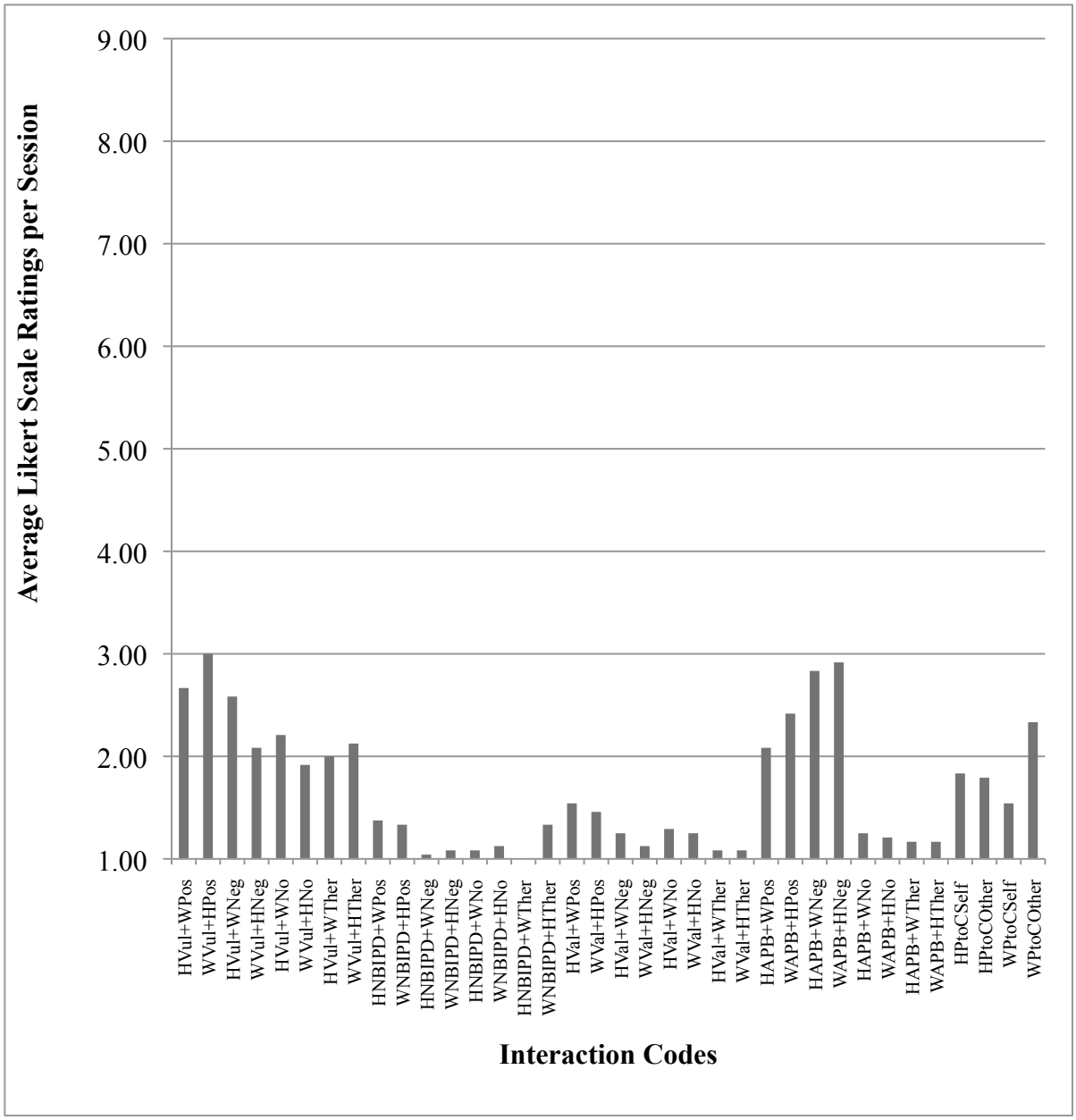

Figure 4. Average session Likert ratings for growth couples

As can be seen in Table 4 and Figure 4, partner one vulnerability + partner two positive response was the most commonly observed interaction code among growth couples, followed by other vulnerability and aversive partner behavior codes with positive and negative responses. The most common positive responses to vulnerability

included neutral (*n*=48), reciprocal vulnerability (*n*=18), compassion/appreciation/ reassurance/apology (*n*=15), and validation (*n*=14). Frequent positive responses to aversive partner behavior consisted of lack of a hard emotional response (*n*=35), use of non-belittling humor (*n*=11), and neutral responding (*n*=11). Analysis of the most commonly occurring negative reactions to vulnerability and aversive partner behavior among growth couples revealed the same top three responses: withdrawal (Vul: *n*=25; APB: *n*=30), blame/defensiveness (Vul: *n*=15; APB: *n*=65), and criticism/attack (Vul: *n*=11; APB, *n*=12).

In both positive and negative interactions, couples that reported growth in acceptance often responded to one another with respect and an openness to hearing one another's perspectives. Even for the one growth couple that appeared more emotionally distant than the other three growth couples, moments occurred in which one partner was effectively able to imagine the experience of the other partner with an open-minded and respectful manner. For example, consider how this husband describes his emerging understanding of his wife's reaction after she became "rigid" in response to his attempt to hug her while she worked from home:

> Husband [*Husband is looking at the therapist, Wife is looking around the room*]: I also thought, gee, it's possible when you're feeling frustrated, uptight, and nervous to want somebody to put their arms around you, as opposed to pushing them away. But then I also thought, because I keep arguing with myself over these things, that for example, when I'm sick I don't want anybody near me. I can understand there are states of mind, I mean some people when they're sick want chicken soup and comfort and care, but I want to be left alone until I'm well.

> [*Wife looks at Husband*] So, I thought, okay, well maybe when [*Wife*] is feeling uptight like that, maybe she doesn't want comforting, maybe she just wants to be in herself until things ease up. [*Wife maintains her hands in her lap, shifting between looking at Husband and at the floor*]

Although the husband's communication that he could appreciate that his wife might have a different experience than he might did not elicit a direct response from his wife, it represents an openness to considering alternative perspectives within the relationship. The husband's consideration of his wife's experience within their interaction furthers his ability to relate to what she might have been feeling; this type of intellectual understanding and perspective taking is encouraged as part of IBCT's unified detachment intervention in which couples learn to discuss their interaction patterns in a more insightful manner. Within this example, the understanding gained though the husband's open-minded reflection represents an acceptance promoting interaction of wife aversive partner behavior (refusing husband's effort at physical affection) + husband intellectual understanding, as the husband was able to appreciate his wife's different experience without necessarily agreeing with or judging whether her perspective was right or wrong.

Particularly notable was the tendency for growth couples to integrate humor into discussions around conflict, which is one component of unified detachment within IBCT. Through laughing at themselves and their interaction patterns, couples were able to effectively deescalate conflictual discussions and increase positive relating. The following excerpt is an example of how a husband aversive partner behavior (husband being critical) + wife use of non-belittling humor interaction enabled a conflictual discussion to transform into a more lighthearted, playful interaction.

[*During a discussion of an ongoing issue related to financial responsibility and control*]

Husband [*with a loud voice, speaking to the therapist*]: Well, I mean, she thinks it's like I have a checkbook and am running around the house the minute I get home.

Wife [*starts gesturing her arms and giggling*]: Well, you make it sound like I'm just running out to stores and writing checks as fast as I can [*Wife uses large arm movements to make a check-writing motion; the couple starts laughing together*].

While their different financial perspectives continued to be an issue discussed throughout therapy, this interaction reveals one way in which the couple maintained their sense of humor (a quality that initially attracted them to one another) in the process.

Another couple found similar ways to laugh in the midst of an emotionally intense discussion. In this couple, the wife expressed feeling rejected and insecure due to her belief that her husband preferred to spend his time with friends instead of her. As the husband began to change his behavior after gaining a deeper understanding of his wife's emotional experience, she expresses doubt about his genuineness. The following quote begins with the husband providing an explanation for his plan to invite his friend to a basketball game if they cannot find a babysitter in order to go together, which triggered his wife's insecurity that he would rather go with his friend in the first place.

Husband: I do want to go with [*friend*], because he hasn't been to any games this year and he's been putting a bug in my ear… but I think more than ever recently, I've been enjoying watching the games with [*Wife*]. She's a great basketball fan, and she's fun, and she's loud!

Wife: [*starts laughing*]

Husband: She gets excited by the plays. I mean really, she understands it well, so it's fun to watch the game with her.

Wife [*with a joking tone*]: Did you just tell [*therapist*] I was loud? [*Wife starts laughing*]

Husband [*laughing*]: Yes! She's a great fan though [*Wife continues laughing*], all the fans should be that way. I'm loud too!

The shared laugher observed within this interaction shifted the focus from feelings of rejection and loneliness to a lighthearted, pleasurable interaction for the couple. As a result, the initially painful, distressing experience was lessened through the husband validation + wife use of non-belittling humor interaction. When humor was observed among growth couples it often corresponded with a shift in the quality of the interaction, as was seen within the preceding examples.

Overall, couples that reported growth in acceptance during therapy demonstrated a general tendency to integrate humor into interactions and were open to appreciating the experience of one's spouse without necessarily agreeing with it.

No growth. The percentages of initiating and responding codes observed in the little to no growth couple are displayed in Table 5, while the average session Likert ratings for this couple with are depicted in Figure 5.

Table 5

Percentages of Initiating Codes and Response Categories Observed in the No Growth Couple Across Treatment

Interaction Codes	*n*	Percentage
Initiating Codes		
Vulnerability (Vul)	60	30.30
Non-Blaming Intellectual Problem Discussion (NBIPD)	11	5.56
Validation (Val)	9	4.55
Aversive Partner Behavior (APB)	107	54.04
Pressure to Change (PtoC)	11	5.56
Response Categories		
Positive Response (Pos)	46	24.60
Negative Response (Neg)	120	64.17
No Response (No)	12	6.42
Therapist Response (Ther)	9	4.81

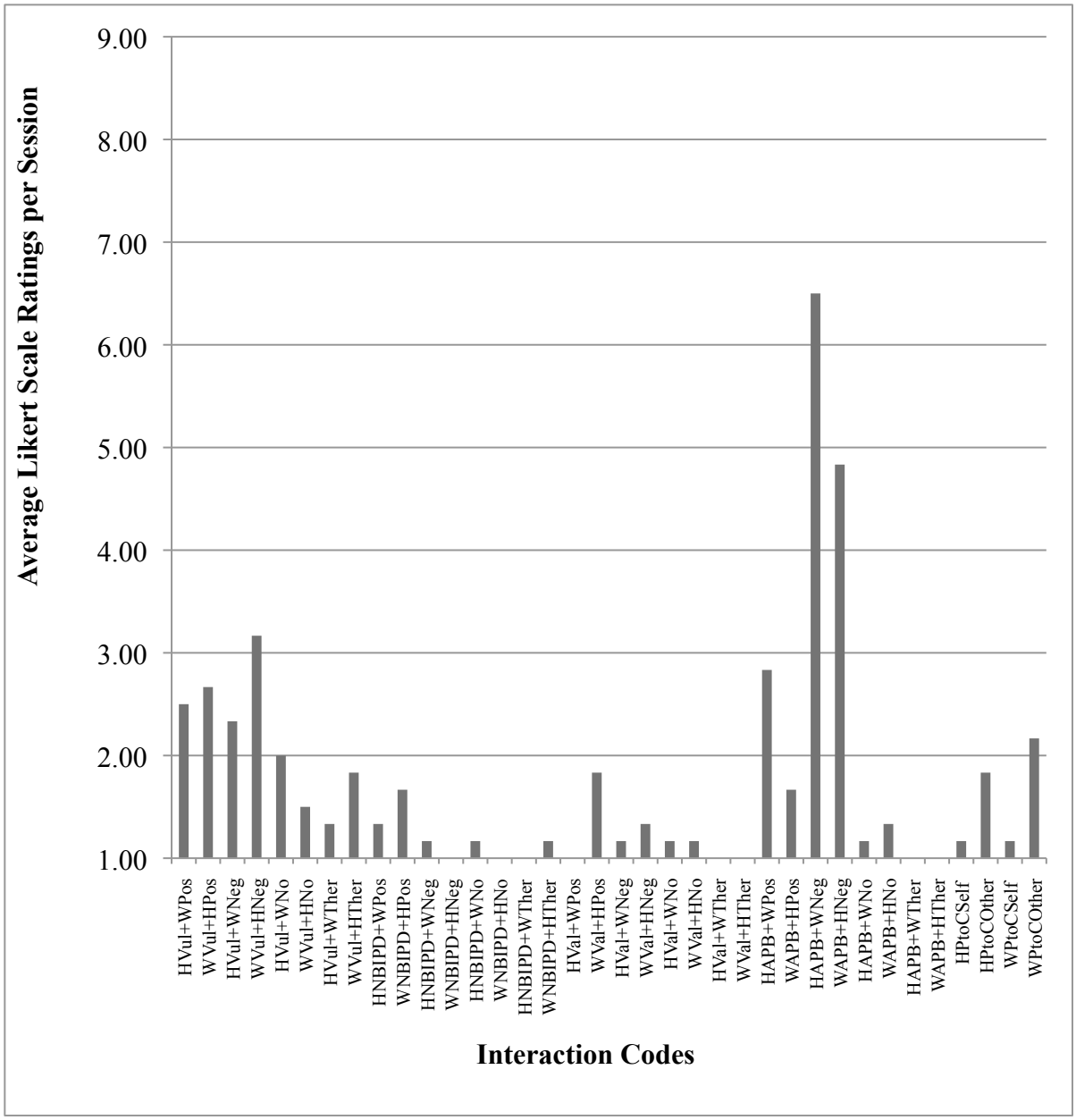

Figure 5. Average session Likert ratings for the no growth couple

The interaction ratings for the no growth couple reveal a unique pattern, as there is a much larger clustering of ratings around partner one aversive partner behavior + partner two negative response interactions than around any other interaction code. In fact, the percentages listed in Table 5 demonstrate that negative responses outweighed positive

responses in an almost 3:1 ratio. The negative responses used most commonly involved blame/defensiveness (Vul: *n*=10; APB, *n*=50), withdrawal (Vul: *n*=4; APB, *n*=22), and criticism/attack (Vul: *n*=6; APB, *n*=12). The most common positive response to vulnerability was a neutral response (*n*=9), followed by similar amounts of reciprocal vulnerability (*n*=3), validation (*n*=3), and compassion/appreciation/reassurance/apology (*n*=3). The only positive response to aversive partner behavior used more than once was a lack of hard emotion (*n*=10).

The following excerpt demonstrates the manner in which the no growth couple would communicate about a stressor they experienced during therapy, relating to medical issues with their adopted son. Previous to this interactional sequence, the wife had revealed her confusion at not being able to determine the cause or solution for their son's physical symptoms, and disagreed with the husband's insistence that she take their son to a specialist since their pediatrician last instructed her to monitor their son and come back when they had more observational data regarding his medical issues.

> Husband [*looking at the therapist*]: I'm frustrated because she's so adamant in her position and I don't see that it's… I mean, given that this really bothers [*our son*], and that he's in pain, I don't see taking, and I don't know how long it would take and I know I'll underestimate whatever it would take in her mind. But say it takes 2-3 hours to go see the doctor on this, I see that as time well spent and a priority.
>
> Wife: Then honey, do it.
>
> Husband [*turns to look at Wife, increases his vocal tone*]: Well [*Wife*], there's a little difficulty there because I work downtown. I'd have to come home, get him, and it would be a five or six hour-

Wife [*Wife's vocal volume raises slightly*]: Oh I could rendezvous with you, it would take you 15 minutes.

Husband [*turns to look at therapist*]: And I'm a little frustrated that she's suggesting that I should do this.

Wife [*with a sarcastic tone*]: Hello! You get sick leave. Sick leave covers for things like this.

Husband: Well yeah, [*Wife*], but I also have a full time job and I'm very busy right now.

Wife: And I do too [*Wife is referring to her full time job as a mother*]. [*Husband*], the thing is-

Husband [*rolls his eyes, interrupts Wife*]: Well yeah, you're busy with all this other shit that doesn't need to be done!

Although both partners are clearly distressed about their son's medical issues, their communication maintains an accusatory, insensitive quality; both blame/defensiveness and criticism/attack were used to capture the responses to the aversive partner behaviors evident within this interaction. Instead of working together to figure out how best to handle this issue, the couple argues over whose responsibility it is and the right way to handle the situation.

When conflictual discussions shifted from hard to soft expressions, a blaming response style continued to be present. A typical response style to a vulnerable expression is revealed in the following interactional sequence:

Wife: For me, it's, I guess the underlying is, it's another thing that I'm not taking care of to his satisfaction. [*Husband looks down*] He wants me to do all these

things to satisfy his requirements. I guess for me that's the underlying, it's what I'm doing is not adequate. [*Wife audibly sighs*, *voice starts shaking as if she's crying*] And I obviously don't know what I'm doing, I guess.

[*Eight second pause*]

Therapist: Okay, so that sounds like a fairly personal thing, and that's kind of consistent with that responsibility theme that comes up between the two of you. What about for you, [*Husband*], when [*Wife*] doesn't agree about taking the kids to a specialist [*Husband leans back and puts his hands behind his head while looking at the therapist*], does that seem, does that somehow affect you personally?

Husband: Um, I mean it's very frustrating because I feel like it's a reasonable thing to do and she's so adamant about not doing it, and so stubborn in my mind. And she's getting angry about the fact that I'm suggesting that it's a good thing to do.

Wife: You don't think you're angry?

Husband: Um, I… [*Husband turns to look at Wife*] You're not supposed to be talking.

This interaction, coded as wife vulnerability + husband no response and husband aversive partner behavior (husband's criticism) + wife blame/defensiveness (wife's response to husband's criticism), demonstrates the couple's continued difficulty appreciating one another's emotional experiences. Instead, the couple maintains a focus on challenging the legitimacy of each other's perspectives and justifying one's own behavior. The

couple's trouble communicating and the lack of softer, positive initiating and responding codes were consistently observed throughout their therapy.

Decline. The observational data for the two couples that reported large declines in acceptance over the course of therapy is first summarized through the percentages of initiating codes and response types observed across treatment in Table 6, while Figure 6 displays the average session Likert ratings for the decline couples.

Table 6

Percentages of Initiating Codes and Response Categories Observed in Decline Couples Across Treatment

Interaction Codes	*n*	Percentage
Initiating Codes		
Vulnerability (Vul)	167	48.13
Non-Blaming Intellectual Problem Discussion (NBIPD)	20	5.76
Validation (Val)	32	9.22
Aversive Partner Behavior (APB)	99	28.53
Pressure to Change (PtoC)	29	8.36
Response Categories		
Positive Response (Pos)	149	46.86
Negative Response (Neg)	116	36.48
No Response (No)	35	11.01
Therapist Response (Ther)	18	5.66

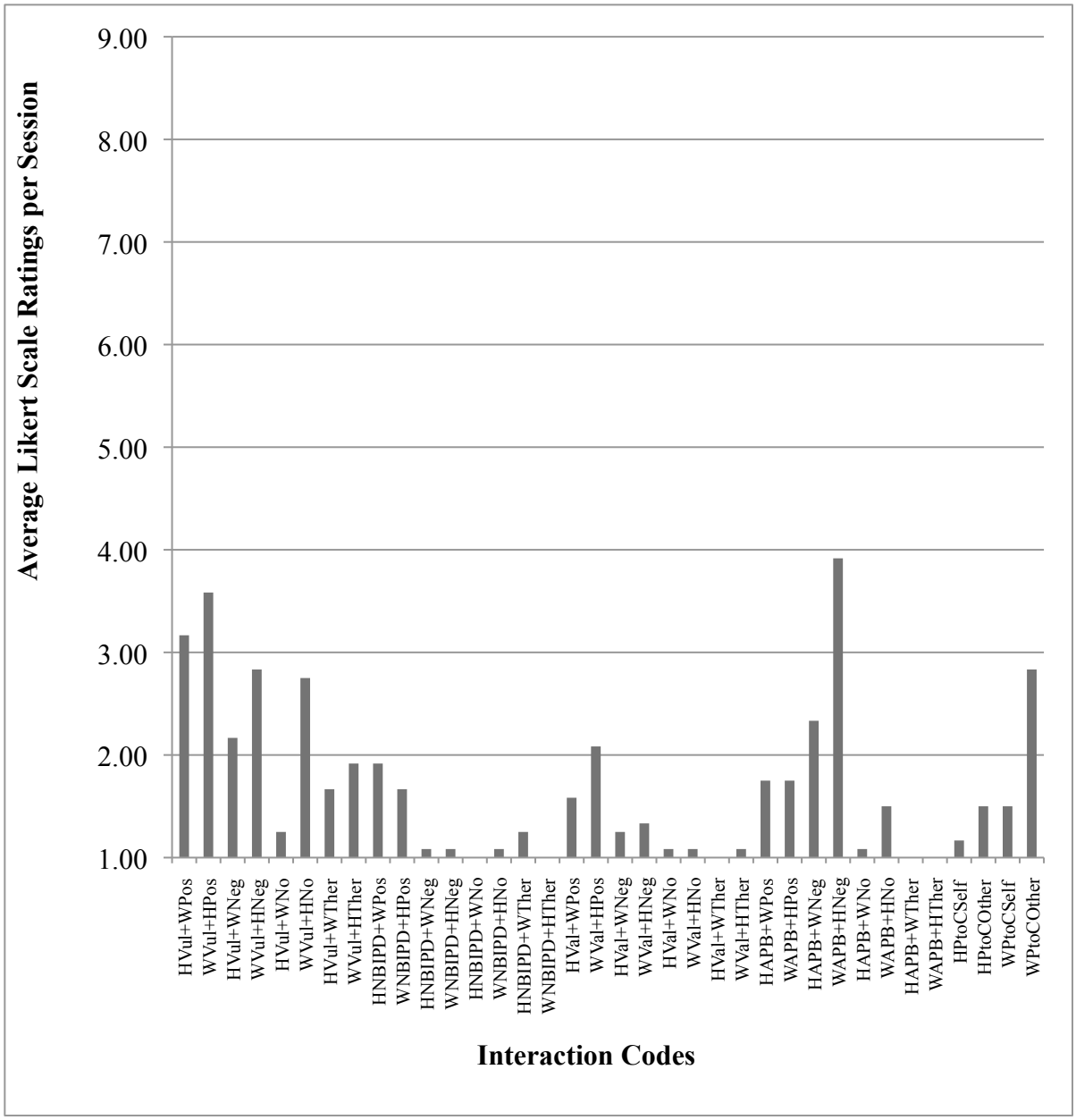

Figure 6. Average session Likert ratings for decline couples

Couples who reported declines in emotional acceptance across treatment had higher occurrences of aversive partner behavior and vulnerability as compared to non-blaming intellectual problem discussions, validation or pressure to change. Decline couples responded to aversive partner behavior through the positive reactions of lack of hard

emotional response (*n*=7), neutral response (*n*=5), and validation (*n*=4); negative reactions to aversive partner behavior and vulnerability included blame/defensiveness (Vul: *n*=16; APB: *n*=30), withdrawal (Vul: *n*=12; APB, *n*=23), and criticism/attack (Vul: *n*=5; APB, *n*=6).

The most common positive responses to vulnerability within decline couples were neutral response (*n*=30) and compassion/appreciation/reassurance/apology (*n*=22), with equal amounts of reciprocal vulnerability (*n*=10) and increased physical and/or positive nonverbal affection (*n*=10). One such example is presented below, during which the husband deviates from his frequent blame/defensiveness responses to the wife's vulnerability and instead provides a compassionate response.

> Wife [*Wife's voice is shaking, as she is crying while speaking*]: I think on some level I'm not going to talk to you without being afraid. And I'm not afraid of you, until you get angry. And I know I can't ask you to not be angry with me. I know that, I got that, it's okay. And I think maybe that's what you were explaining, that, you know, no I'm not really like that, because you've seen me be inappropriately loud to all kinds of people in all kinds of places, you know. But, um…
>
> Therapist: But if to some degree you have a fear of all men, period…
>
> Husband: [*Wife allows Husband to take her hand; Husband speaks in a soft tone*] I don't want you to be afraid, of me especially.

In this wife vulnerability + husband compassion/appreciation/reassurance/apology and wife vulnerability + husband increased physical and/or positive nonverbal affection interaction, the husband is able to respond to the wife's fear and pain without

defensiveness. This interaction is consistent with the softer disclosures and compassionate responding emphasized in IBCT's empathic joining (Jacobson & Christensen, 1998).

While interactions of partner one vulnerability + partner two compassion/appreciation/reassurance/apology are typically categorized as acceptance promoting events, as seen in the previous example, a more detailed examination of one of the two decline couples reveals an alternative finding. For one decline couple, the specific understanding of the partners' background histories and current interactions around conflict contributed to a new understanding of these seemingly positive interactions. For the husband within this couple, his reassuring or apologetic responses to his wife's expressions of distress (whether she expressed herself through soft or hard emotions) were related to an ulterior motivation: to reduce or terminate discussions of conflict and decrease the internal sensation of distress. While this couple had a high percentage of positive responses, many of these responses functioned to end the conversation rather than increase emotional intimacy, as is desired in the expression of soft emotions within empathic joining interventions. To demonstrate this pattern, the following quote provides an example of the husband's attempt to pacify his wife through apologetic means:

> Wife: From my perspective, I feel like I'm the one who has to remind you, "Don't talk to me in that tone of voice."
>
> Husband [*Husband is looking at Wife and nodding; he speaks in a soft, quiet voice*]: Yeah, because I don't hold back.

Wife: I know, but I've told you, you have every right to get angry [*Husband looks down*], but it's how you express it that now is of concern to me. And I have to remind you, "Why are you talking to me in that tone of voice? I am being as calm as possible."

Husband [*Husband is still looking down*]: Yeah.

Wife: And I hate to do that, it makes me angry to do that, because I shouldn't have to remind you. You should be able to think logically and say, "Okay, I will watch my tone of voice." Because that's what I do every time we get into a disagreement.

Husband [*Husband looks up at the therapist*]: Unfortunately, when we do start arguing, I haven't made any significant changes like she has.

Throughout this example, the husband employs various strategies to reduce his wife's anger and distress; these tactics included blaming himself, agreeing with the wife's perspective, and validating her "significant changes." As these strategies proved unsuccessful in appeasing his wife, the husband began to physically withdraw as he shifted his body away from her. While he may genuinely have felt that he was to blame, his physical behavior and the contextual knowledge of his discomfort with expressions of emotional distress provide evidence that his apologetic, reassuring responses were also a form of withdrawal. Despite his intentions to reduce negative confrontation, his reassurance or apologies seemed to enhance his wife's distress as he continued to acknowledge or agree with her perspective, yet did not change his behavior.

Many of the response components of interactions observed within the two decline couples were overtly negative. High amounts of blame, accusation, and defensiveness

were evident as couples argued over one another's perspectives. At times, it seemed as though many contradictory messages were being communicated. With one couple, the wife would tell the husband "Don't talk to me in that tone of voice," and identified his lack of communicating with her to be a significant concern. Yet she also expressed reluctance to communicate about certain issues, as demonstrated in the following quote.

> Husband [*Husband is looking at the floor, speaking in a soft tone*]: I want to help her through her feelings, but there's really not much I can do. First of all, the communication isn't there or I don't know those things are frustrating her.
>
> Wife [*Wife speaks in a direct, escalating manner*]: What would be the purpose of telling you that? Can you tell me, what would be the purpose?
>
> Husband [*Husband turns to look at Wife*]: Isn't communicating always better? What would you expect?
>
> Wife: The same shit over and over again, okay [*Husband looks down*]. That has always been my number one issue – why? Nothing is being done now, so why?
>
> Husband [*Husband looks at Wife*]: What do you want me to tell you?
>
> Wife: No, it's not what I want you to tell me, it's what I want us to do. [*Husband looks down again*] And so, I ain't gonna say anything because I know nothing is going to be done.

As the husband discusses his own concerns about communication, the wife shifts her focus to the need for behavioral change. While both are likely important and valid concerns for this couple, the dialogue around these issues often seems to leave both partners feeling stuck and unhappy, as they cannot figure out the "right" way to behave or

communicate. As they express themselves and claim to understand one another, and yet nothing changes, the wife seems to become exasperated and disengaged.

Another aspect of the in-session interactions observed within the decline couples was the way that stressors impacted treatment. For one couple, the extreme financial distress the husband encountered within his job took up extensive discussion time within the therapy. In fact, the husband would often shift the conversation back to these issues when the discussion had returned to the couple's relational dynamics. This behavior may have been due to the all-consuming nature of his financial crisis, but it may have also represented a form of withdrawal from or avoidance of the intense interactions related to the couple's distress.

The other decline couple became pregnant midway through the couple therapy, which furthered the couple's emotional distance as the wife expressed her feeling that it was her primary responsibility to take care of their baby, with or without the husband. Soon after finding out they were pregnant, she told him, "Just because we're going to have a baby, that's not going to hold me with you, there's just no way." The pregnancy seemed to exacerbate her preexisting sense that she needed to pull away from her husband in order to protect herself emotionally.

The increased emotional distance between these two couples was also evident through the presence of a verbalized threat of separation or divorce. Both couples mentioned the possibility of ending their marriages at some point in the therapy. For one couple this was related to the pregnancy and fear of a second marital separation occurring, whereas the other couple expressed that it may not be worth continuing

marriage with such a high level of unhappiness. This wife explains her sentiment in the following quote.

> Wife [*Wife's tone is loud yet shaky, as she is crying while speaking*]: It would be much better for me to live alone and to annul that no one cares than to live with you and have this happen at all times. I am never feeling good about our relationship.
>
> [*Husband remains silent, without behavioral or verbal acknowledgment of the Wife's statement*]

In this wife vulnerability + husband no response interaction, the wife is responding to her experiences with the husband's lack of supportiveness in her times of need; unfortunately, his lack of response to her distressed statement appeared to exacerbate her sentiment, as this seemed to be yet another experience in which the husband did not respond in a caring, supportive manner. The mention of a potential for separation or divorce seemed to further polarize the couple and reduce the ability for acceptance to be generated.

In summary, the couples who reported declines in emotional acceptance demonstrated diverse forms of withdrawal (reassurance, apologizing, appeasement, subject changes, lack of responding), fewer actively acceptance promoting responses (e.g., less compassionate, empathic responding and more neutral, active listening responding), direct statements of blame or defensiveness, trouble with communication and perspective taking, negatively influential stressors, and the threat of divorce throughout the therapy.

Research Objective #3: Similarities and Differences in Change Processes Among Growth, No Growth, and Decline Couples

IBCT couples that report various levels of growth and declines in emotional acceptance over the course of therapy demonstrated both similar and distinct interactional styles, discussed in the following two sections.

Similarities. Regardless of whether couples reported growth, declines, or no shift in emotional acceptance, in-session acceptance promoting or hindering interactions began with vulnerability or aversive partner behavior and were followed by a positive or negative response. This pattern is evident in both the percentages of initiating codes and response categories displayed in Table 7 and the average session Likert ratings shown in Figure 7.

Table 7

Percentages of Initiating Codes and Response Categories Observed in Growth, No Growth, and Decline Couples Across Treatment

	Growth *n*=4		No Growth *n*=1		Decline *n*=2	
Interaction Codes	*n*	%	*n*	%	*n*	%
Initiating Codes						
Vul	287	42.90	60	30.30	167	48.13
NBIPD	34	5.08	11	5.56	20	5.76
Val	43	6.43	9	4.55	32	9.22
APB	227	33.93	107	54.04	99	28.53
PtoC	78	11.66	11	5.56	29	8.36
Response Categories						
Pos	226	38.05	46	24.60	149	46.86
Neg	217	36.53	120	64.17	116	36.48
No	74	12.46	12	6.42	35	11.01
Ther	77	12.96	9	4.81	18	5.66

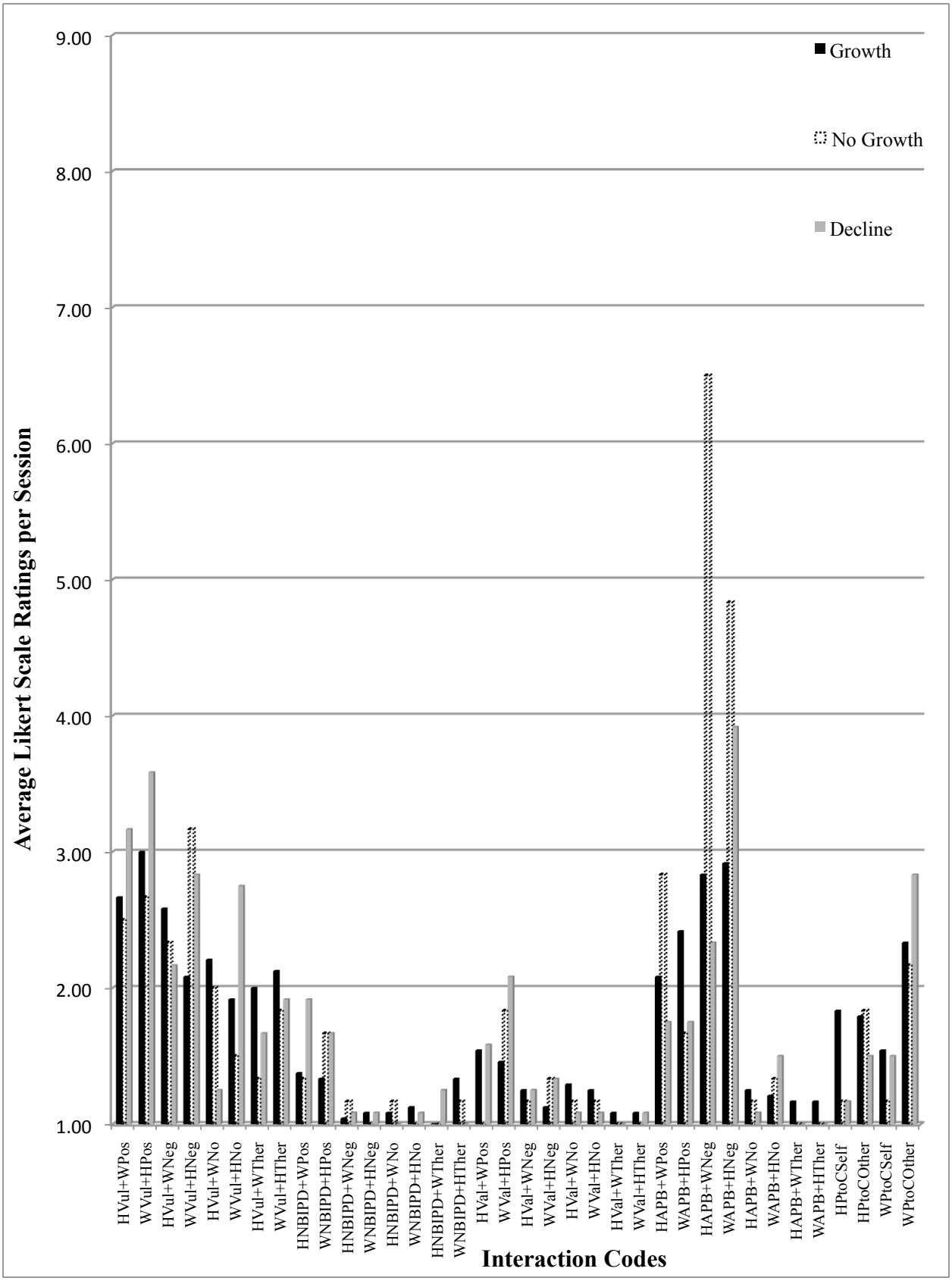

Figure 7. Average session Likert ratings for growth, no growth, and decline couples

In examining the two most frequently observed initiating components of an interaction, Table 8 displays the most common responses to Vulnerability within growth, no growth, and decline couples, whereas Table 9 displays the most common responses to Aversive Partner Behavior among growth, no growth, and decline couples. The average frequency that each response subcategory occurred in therapy is also listed in parentheses next to each subcategory of response. Response subcategories are also listed in order from first to fourth most commonly observed within treatment.

Table 8

Ranking of Average Response Frequencies for Vulnerability in Growth, No Growth, and Decline Couples Across Treatment

	Top four most frequently observed response subcategories			
Interaction Code	1st (*M*)	2nd (*M*)	3rd (*M*)	4th (*M*)
Vulnerability + Positive Response				
Growth	Neutral (12.00)	Reciprocal vulnerability (4.50)	Compassion/ appreciation/ reassurance/ apology (3.75)	Validation (3.50)
No Growth	Neutral (9.00)	Compassion/ appreciation/ reassurance/ apology (3.00); Reciprocal vulnerability (3.00); Validation (3.00)	--	--
Decline	Neutral (15.00)	Compassion/ appreciation/ reassurance/ apology (11.00)	Reciprocal vulnerability (5.00); Increased physical affection (5.00)	Validation (3.50)
Vulnerability + Negative Response				
Growth	Withdrawal (6.25)	Blame/ defensiveness (3.75)	Criticism/ attack (2.75)	Sarcastic/ belittling/ inappropriate humor (1.75)
No Growth	Blame/ defensiveness (10.00)	Criticism/ attack (6.00)	Withdrawal (4.00)	Annoyance/ dismissing/ invalidation (2.00)
Decline	Blame/ defensiveness (8.00)	Withdrawal (6.00)	Annoyance/ dismissing/ invalidation (2.50); Criticism/ attack (2.50)	--

Table 9

Ranking of Average Response Frequencies for Aversive Partner Behavior in Growth, No Growth, and Decline Couples Across Treatment

	Top four most frequently observed response subcategories			
Interaction Code	1st (*M*)	2nd (*M*)	3rd (*M*)	4th (*M*)
Aversive Partner Behavior + Positive Response				
Growth	Lack of hard emotion (8.75)	Use of non-belittling humor (3.75); Neutral (3.75)	Quicker than usual recovery (1.00); Validation (1.00)	Intellectual understanding (0.50); New coping methods (0.05)
No Growth	Lack of hard emotion (10.00)	Neutral (1.00); Validation (1.00); New coping methods (1.00); Intellectual understanding (1.00)	--	--
Decline	Lack of hard emotion (3.50)	Neutral (2.50)	Validation (2.00)	New coping methods (1.00)
Aversive Partner Behavior + Negative Response				
Growth	Blame/ defensiveness (16.25)	Withdrawal (7.50)	Criticism/ attack (3.75)	Annoyance/ dismissing/ invalidation (3.00)
No Growth	Blame/ defensiveness (50.00)	Withdrawal (22.00)	Criticism/ attack (12.00)	Annoyance/ dismissing/ invalidation (5.00)
Decline	Blame/ defensiveness (15.00)	Withdrawal (11.50)	Typical response (4.50)	Criticism/ attack (3.00)

Interestingly, many of the types and average occurrences of responses to vulnerability and aversive partner behavior were coded similarly among all couples. However, specific knowledge of couples is imperative in interpreting the meaning of each interaction type within the emotional and behavioral context of the couple's relationship. For example, the partner one vulnerability + partner two increased physical affection or reassurance could be seen as an acceptance promoting interaction among one couple, and yet could function as a form of withdrawal in another couple. For one of the decline couples, the husband's attempt to apologize or acknowledge problem areas within the relationship was a form of reducing the in-session conflict; however, this withdrawal attempt only served to exacerbate the wife's frustration, thus having the unintentional consequence of escalating the negative interaction. Interactions within this latter example could have included interaction codes such as partner one vulnerability + partner two withdrawal, as well as partner one aversive partner behavior (avoiding conflict discussions) + criticism/ attack (or any number of negative response types) to represent the complexity of this interaction. It follows that whether interactions are experienced as acceptance promoting or acceptance interfering depends on the context in which they are experienced.

Differences. A number of distinctions between growth and decline couples emerged from the observational coding of growth, no growth, and decline couples across therapy. The first difference relates to the willingness to appreciate the perspective of one's partner without necessarily agreeing with it. While all couples displayed variations in perspective taking, couples that grew in acceptance had partners who were generally more open to listening and attempting to understand the emotional experience of one

another without defensive or critical responding. Growth couples tended to express curiosity about one another's experience, making clarifying statements, and/or ask follow-up questions. This next excerpt demonstrates how a wife's non-judgmental curiosity encouraged her husband to explain his perspective, allowing for a new understanding to develop between the couple.

> [*Therapist is explaining the couple's responsibility theme, in which the Husband's responsibility relates to finances and the Wife's responsibility relates to childcare*]
>
> Therapist: These things have a whole different spin because you're crossing into each other's responsibility realm, and you're doing it differently. You don't like that because it creates a lot of fear.
>
> Husband [*In a softer tone than usual*]: And the desire to go out and just take control of it is overwhelming.
>
> Wife [*Wife sits back and looks at Husband*]: What do you mean?
>
> Husband: Well, like if I'm out in the front yard watching the girls, supposedly, and one of them gets too close to the street, your desire is to run out and stop it [*Wife nods*], to correct the behavior you think is wrong. Likewise, when I see $50 run out into the street, [*Wife starts laughing*] my desire is to go jump out and get it back, and I don't want to get hit by the car! [*The couple laughs together*]
>
> Therapist: Or, because usually when the $50 has gone out into the street it's already gone, so what you do is jump on her, I think.
>
> Wife: I think you're right.
>
> Husband: Mm-hmm.

Consistent with unified detachment, the wife's expressed desire to hear more of the husband's perspective allowed the husband to state a non-blaming, intellectual description of their interaction pattern. Had the wife responded defensively, this experience of unified detachment would probably not have occurred, making it is less likely that the conversation would have ended with a humorous, new perspective on their interaction pattern.

Growth couples also demonstrated an appreciation for differing perspectives through more frequent utilization of a softer, more explanatory and less defensive response style. For example, one wife struggled with the insecurity that her husband did not preferentially choose to spend time at home with her. As he began to stay home more, she describes her reaction in therapy:

> Wife: I feel bad, that the thought is not just "No, I want you to stay home" and knowing that he is disappointed in that. My next thought is, "I have a… my husband is at home and he is not happy that he is here with me." [*Wife pauses for a few seconds*] That's not a good feeling either.
>
> Husband [*Husband speaks in a soft tone*]: It's not that though, because I don't feel as though I'm not happy just sitting there with nothing to do. And I don't mind that you guys [*referring to Wife and daughter*] go to bed early, I know you guys need the rest. That's fine, but I kind of feel like I'm kind of just left to sit there. It's a good way for me to go out for a little while. It recharges me, it reenergizes me, because then I've gotten to get together with my friends for a little bit. It helps me get through the rest of the week. Then when the time comes when we are there during the day, I look forward to our time together.

Notice how the husband does not try to change the wife's perception by overtly telling her she is wrong or that what she feels is not true; instead, he explains his perspective while compassionately offering reassurance that he genuinely enjoys their time together. In contrast, consider the different reaction to vulnerability that occurs within a decline couple:

> Wife: Two things I mostly feel is that one is threatened, the other is ignored and walked out on [*Wife begins crying*]. We never ever get anything resolved and if I wanted, I just can't do anything about it. I can't do anything about it because it always ends up with threats. It just gets louder and louder. If I say anything, my feeling about it is that if I have anything negative to say to [*Husband*], there's no point in it, there's no point in speaking to him about anything.
>
> Husband [*In a firm tone with rising volume*]: It's my experience that you have very little positive to ever say to me.

In this situation, the husband does not attend to his wife's perspective that she has difficulty communicating with him or to her underlying sense of loneliness, but instead chooses to respond with an accusation. It is possible the husband experienced her statement as threatening and felt a need to respond in defense, or that he too feels lonely. Ultimately, neither partner seemed to feel understood or appreciated by the end of their interaction. This type of sequence and resulting polarization was evident within the no growth and decline couples, as partners often maintained a critical, blaming stance in response to one another.

Another aspect of the softer versus harder, more blaming responses was related to the level of directness infused within negative responses. Couples with no growth or

decline seemed to be more direct and harsh in the delivery of criticism and blame. Statements infused with sarcasm, raised vocal tone, and firm accusations have a different impact than more tentative or indirect forms of defensiveness and criticism. To demonstrate this variation, the following two vulnerability + criticism/attack interactions are provided, with the first example reflecting a more tentative, indirect style.

> Husband [*Husband and Wife are both looking at the floor, Wife has her finger pressed against her upper lip*]: I think to some extent, even though there are these exchanges over [*son*] not finishing his dinner or [*son*] refusing to eat this, I really am very uncomfortable with my own anger. Not so much when it's reflected on a politician on television that I'm arguing with, I mean that's detached enough. But, I think it's, I think there is a really strong discomfort that I have and I suppose that's why I'm aware when I hear [*Wife*] yelling angrily at [*son*] I become very uncomfortable. And so I think [*Husband spending evening by himself*] isn't just escaping from an argumentative situation, but also trying to retreat from what I feel to be my own hostility.
>
> Wife [*Wife looks at Husband*]: But you love to get into arguments (*she looks down*). I'm sorry [*Wife shifts uncomfortably in her seat*].

In this case, the wife's response to the husband's vulnerable explanation of his withdrawal behavior was to critically comment on his tendency to argue; however, she quickly retracts her statement through apologizing, as if she realized the potentially hurtful nature of her comment. In the following example, the husband responds to the wife's vulnerability by challenging her handling of the situation.

Wife [*Wife speaks with a soft tone*]: I've been kind of preoccupied with what's going on with [*son*]. Now, he's got some physical stuff going on and I cannot figure it out for the life of me.

Husband [*Husband speaks in a firm, sarcastic tone*]: Well, what if we take him to the doctor, [*Wife*], that's what doctors are for.

Although just a brief snapshot of the interaction, the direct, belittling quality within the husband's response in the latter example is apparent. Instead of attending to the wife's concern or frustration, his tone and words serve as a direct challenge to her statement, revealing a contrasting style of negative responding as compared to the previous example.

Couples with less growth or decline in emotional acceptance also appeared to utilize sarcastic or demeaning humor more frequently than non-belittling, shared humor. Teasing one another for cherished attributes (e.g., being a loud sporting fan) was better received than using previously shared vulnerability in a sarcastic way (e.g., commenting that a vulnerably expressed insecurity was "stupid"). Generally, growth couples seemed to integrate humor in a manner consistent with aspects of unified detachment, which utilizes humor as a method for promoting distance and relief from typically negative interaction patterns (Jacobson & Christensen, 1998). One growth couple provides an interesting example of how sarcastic, belittling humor was reframed as part of the excitement and debate that initially attracted the spouses to one another. The therapist for this couple helped facilitate a shift from a hurtful, negative use of humor to more engaging, lively humor over the course of treatment. The following quote demonstrates a

component of this transformation, as the therapist works to call attention to the hurtful quality of the husband's humor and facilitates a softer form of communication.

Therapist: So does that mean that since you discovered you had more money this month, does that mean that over the last two weeks this issue [*referring to their theme of responsibility/control around finances*] is still hanging there?

Wife: Mm-hmm. [*Wife turns to look at Husband*] Right?

Husband: I guess, if you think so. You feel the way you feel. (*Wife smiles*)

Wife [*with a softer tone*]: Really?

Therapist: Now let me just check in. Are you saying that to joke with [*Wife*], or are you saying that as a dig from something she said last time she was here? [*Therapist is referring to a previous interaction in therapy*]

Husband: Both.

Wife: Caught you, didn't he! [*Husband laughs*]

Therapist: What is behind that, [*Husband*]? What makes you want to throw in a dig?

Husband: 'Cause I'm just sick of her whining about it. [*Wife's jaw drops, she looks down*]

Wife: God [*pauses*], what mincing words. Geez.

Therapist: So, I'm tempted to say tell us how you really feel, but-

Wife [*laughing*]: But he did.

Therapist: So is that how you're feeling, like [*Wife*] is just whining?

Husband [*with a quieter tone*]: No, I just think that she's… I think the way she feels about it is in her head, a lot of it. I'm not saying it's not real feelings, I'm just saying that it's removed from the truth.

In this example, the therapist worked to facilitate a shift in the husband's use of sarcasm through questioning the underlying meaning of his comments. While the husband retained his playful (and sometimes hurtful) speech even after the therapist addressed his use of humor, the overall frequency of critical, sarcastic humor lessened throughout treatment. This next excerpt occurred towards the end of therapy with the same couple, demonstrating how humor was used differently within their interaction:

[*This excerpt begins after the husband articulated a non-blaming conceptualization of their interaction pattern in an excited tone*]

Husband: So we don't have each other's anxieties because of each other.

Therapist: Right.

Wife [*taking Husband's chin in her hand*]: Good thinking, honey!

Husband [*In an excited tone*]: Ding! [*Both Husband and Wife start laughing*]

Wife: We're cured, now we can go!

For this couple, the IBCT formulation helped explain how the playful debates that initially attracted them to one another had turned into sarcastic, hurtful interactions. This reformulation and intervention around the use of humor assisted the couple in regaining the spirited conversations they enjoyed early in their relationship, so that humor was used in a manner that facilitated a sense of togetherness rather than furthering the polarization between them. Couples with no growth or declines in acceptance did not make a similar shift from hurtful to non-belittling humor.

Although not directly related to the acceptance promoting or hindering interactions coded in this study, two additional notable distinctions were observed between growth and decline couples. First, the two decline couples both mentioned the threat of separation or divorce during the therapy, whereas the growth couples would occasionally express their commitment to their relationship. Second, while all couples experienced some form of stressor during the course of therapy, the stressor's impact on the therapy (and the relationship) varied. One growth couple chose not to talk about their financial and occupational stressors so they could maintain the focus of therapy on the relationship. Another growth couple worked within the therapy to improve communication and understanding around the stressor, effectively helping strengthen their communication and sense of togetherness in managing the strain.

In contrast, the no growth couple was unable to approach their stressor with a sense of togetherness, instead routinely arguing with one another over whose perspective and plan of action were correct. The pregnancy experienced by one of the decline couples served to further polarize the couple as the wife expressed feeling more responsible for putting her needs and the baby's needs before the needs of the relationship. The other decline couple experienced severe financial stressors throughout the therapy; the intensity of the stressors and the husband's reaction to them took up much discussion time within the sessions. While the way that couples managed stressors within the context of the therapy was unique to the couple, a distinction emerged in the way that growth couples seemed better able to use these life changes to generate increased emotional intimacy, whereas the stressors experienced by the no growth and decline couples appeared to exacerbate previous interaction patterns around conflict.

In summary, similarities in the interactions observed among growth, no growth, and decline couples were particularly apparent in the occurrence of partner one vulnerability and aversive partner behavior + partner two positive or negative response. However, differences emerged in the following ways: growth couples were more often able to appreciate one another's differing perspectives (e.g., partner one vulnerability + partner two validation) instead of maintaining a blaming, accusatory stance of right versus wrong (e.g., partner one vulnerability + partner two blame/defensiveness); were more effective in the use of humor to lighten a situation (e.g., partner one aversive partner behavior + partner two use of non-belittling humor) rather than criticize one's partner (e.g., partner one vulnerability + partner two sarcastic/belittling/inappropriate humor); were less direct in critical or defensive responding (e.g., partner one vulnerability + partner two withdrawal versus partner one vulnerability + partner two criticism/attack); were more likely to express signs of commitment rather than threats of separation or divorce; and were more likely to use stressors to increase togetherness rather than generate further distance within the relationship.

Chapter 4

Discussion

The current study utilized a qualitative design to investigate dyadic change processes within Integrative Behavioral Couple Therapy. Consistent with Doss' (2004) research framework for conducting therapy outcome and process research, this study expands upon previous research demonstrating the effectiveness of IBCT (Christensen et al., 2004, 2006, 2010); the significant relationship between IBCT's change mechanism, emotional acceptance, and treatment outcome (Doss et al., 2005); and quantitative change process research (Cordova et al., 1998; Sevier, 2005). Through utilization of a qualitative, discovery-oriented research design, this study involved the creation and implementation of an interactional coding system that resulted in rich and detailed information about the acceptance promoting and hindering interactions of couples across treatment. Through the emphasis on an exploratory investigation of change processes in couple therapy, this study addresses the expressed need by clinicians and researchers for obtaining a greater understanding of how couples change over the course of therapy. This section will begin with a discussion of defining and measuring the construct of emotional acceptance. Second, it will provide a discussion of the various acceptance promoting and interfering interactional change processes observed in couples that reported various amounts of growth or decline in acceptance across therapy. Third, methodological limitations will be discussed. Last, implications for clinicians and for future research will be offered.

Defining and Measuring Emotional Acceptance

Within phase three of Doss' (2004) research framework, in depth investigations are conducted in order to identify, describe, and measure change processes. Past IBCT research studies on acceptance behaviors within therapy utilized an observational coding system that consisted of four constructs rated on a Likert scale. Cordova et al. (1998) assessed soft expressions, hard expressions, detachment, and engagement in the problem, whereas Sevier (2005) implemented an acceptance promotion subscale that consisted of accommodation, descriptive discussions, validation, and vulnerability. In order to generate a more in depth understanding of what couples were doing in-session that helped to create or block emotional acceptance, these coding systems were markedly expanded within the current study to include broader definitions and a dyadic focus. The interactional, detailed focus is consistent with Doss' (2004) recommendation that the study of change processes include an exploratory, qualitative research design in order to describe the client change processes that occur within therapy.

Based on expert consultation and past research, the need to expand upon previous methods for coding acceptance and create a dyadic rating system was evident. In order to move beyond an understanding of the quantity and type of change that occurs and instead focus on how change occurs within couple therapy, research needs to utilize a methodology that incorporates a systemic, interactional perspective of the relationships under study. Previous research focusing on individual behaviors could not adequately address the dyadic, relational context in which changes in emotional acceptance are believed to occur within IBCT. To accomplish this task, acceptance first had to be operationally defined through a dyadic framework. Despite previous examples of how to

measure acceptance related behaviors in therapy, operationally defining a construct such as emotional acceptance through behavioral terms and as a dyadic process proved to be a difficult task. Cordova (2001) defined acceptance as a response to an aversive stimulus. He explained, "Acceptance might be operationally defined as a change in the behavior evoked by a stimulus from that functioning to avoid, escape, or destroy to behavior functioning to maintain or pursue contact" (p. 215). This operational definition of acceptance contains a dyadic focus, as acceptance is seen within a response to an initiating behavior, and was best captured within APIIRS through the partner one aversive partner behavior + partner two positive or negative response interactions. Interestingly, this was one of the most commonly observed interactional styles within this investigation, providing support for both Cordova's behavioral definition of acceptance as well as the value of studying acceptance through a dyadic framework.

Consistent with literature describing the challenges in conducting process research, determining the units and categories of analysis that comprised acceptance promoting and hindering interactions proved to be a complex task (Llewelyn & Hardy, 2001; Woolley et al., 2000). However, the challenge of generating the initial interaction categories was reduced through the use of multiple sources of data, including theoretical text, expert consultation, past research, and clinical judgment. In fact, the allowance for a cyclical process of generating, testing, and refining ideas gathered from a variety of sources was a major strength of the investigatory design. The main challenge occurred when testing the use of APIIRS with a practice sample and subsequently becoming aware of the difference between the investigator's expectations for how each interaction style would occur and the ways in which couples actually interacted in-session. The

interaction definitions were thus expanded in order to account for the initial clinical observations, indicating the importance of using a flexible methodological framework to conducting change process research. The discovery-oriented design was crucial in it's allowance for a flexible approach to creating and refining APIIRS until the coding system seemed saturated in its ability to capture the complex dyadic interactions observed in IBCT. The revised coding system for future use is now a more comprehensive, informed description of how to identify and categorize acceptance promoting and interfering interactions within a couple therapy session.

Another notable discovery was that APIIRS proved to be well suited for studying interactions with an immediate or short-term impact, yet not all interactions occurred in this manner. For example, a partner one vulnerability initiating statement followed directly by a partner two validation comment was a clearly identifiable acceptance promoting interaction. However, many interactions did not seem to occur in this direct pattern. Initiating statements such as vulnerability, which may have involved a softer emotional expression than typically occurred within the couple's interaction, often seemed met with hesitation or neutral responding. The impact of softer expressions may not have been seen directly following the initiating behavior; perhaps as couples began to experience newer, less blaming methods of interacting, the culminating impact of this interaction shift was seen gradually, over time. Each component of an interaction – both the initiating behavior and response style – may have an immediate, short term, and long term impact that is challenging to capture within an in-session behavioral rating system. It is also possible that the acceptance promoting interactions observed among severely

distressed couples, as examined within this study, would take a longer amount of time and consistency for the impact to become apparent to an outside observer.

To further assess interactional change processes over time, it is recommended that future research utilize a dyadic coding system to assess acceptance promoting and interfering interactions across more extensive periods of time. Focusing more specifically on the most frequently observed interactions within this study, future research could use a similar qualitative coding system to APIIRS in order to assess shifts in interactions beginning with vulnerability and aversive partner behavior over the course of multiple sequential therapy sessions. Through narrowing the focus of observation and changing the observational time frame of the coding system from one session to multiple sessions, an index of short-term changes in specific interactions could be obtained. Subsequent analysis could compare shifts in these important interactions across time, allowing for a different perspective on how shifts in the change mechanism occur within couple therapy. Additionally, broadening the study of couple therapy change processes to include assessment of post-treatment follow-up booster sessions or non-session relationship discussions would allow for a greater perspective on the process of change in psychotherapy and the impact of long-term change mechanisms, such as emotional acceptance in IBCT.

Unexpectedly, the higher end of the nine-point Likert scale used within APIIRS was not commonly used within this study. This restricted range may have been due to the difference between the investigator's expectation for how acceptance promoting and hindering interactions would occur and how they actually did occur within the therapy. It is recommended that future investigators consider either revising the Likert scale or the

instructions for how to numerically rate the interactions. Given the preliminary, exploratory nature of this study, the numerical ratings were not assigned liberally and instead were used with caution. As additional studies of dyadic change processes occur, a more developed sense of how to rate couples' interactions within APIIRS may result. Until that time, future raters using APIIRS are encouraged to maintain a conservative approach and rely upon clinical judgment and an investigatory team in order to assign interactional ratings that best reflect what is observed within a therapy session.

Observed Dyadic Change Processes

IBCT couples engaged in a multitude of acceptance promoting and interfering interactions across the course of therapy. It was quite interesting to find that the ratio of acceptance promoting to interfering interaction ratings was essentially 1:1, and surprising to note that this ratio was similar across acceptance growth, no growth, and decline couples. Future research on acceptance promotion and hindrance can further explore this ratio across time and across acceptance growth categories, as one would expect this ratio to shift favorably over time in therapy, particularly in couples who experience growth in emotional acceptance. The 1:1 ratio may in fact reflect that this is an average across therapy, or a simple snapshot of the entire duration of therapy, thus cancelling out differences which might be seen if one were to compare separate indices of early and late phases of treatment. While these couples demonstrated similar interactions, the interaction's meaning and impact on the relationship was unique to the couple. One of the core findings of this investigation is that for all couples, most of their acceptance promoting and interfering interactions began with either vulnerability or aversive partner behavior. Using Cordova's (2001) definition of acceptance, the interactions that reveal

the generation or prevention of emotional acceptance might be more easily identified within the context of a response to an identifiable aversive behavior.

However, Cordova's (2001) definition of acceptance can also assist in the understanding of how partner one vulnerability + partner two response can be indicative of acceptance promoting or hindering interactions. For couples in this study, the expression of distress through soft emotions, anger, humor, and other methods seemed to involve a complex meaning. Many couples appeared to harbor the expectation that expressions of discontentment would lead to escalated, uncomfortable, often angry discussions that further polarized the couple. This impacted both the expression of vulnerability and the response to vulnerable expressions. Perhaps due to the fear of being misunderstood or blamed, partners expressed their discontent through less direct means, thus minimizing the vulnerability inherent in their expressions. Responding partners were likely to react as if the expressed discontent would lead to another replay of the couple's typical interaction around conflict, rather than quickly changing to a more empathic, validating reaction. It is probable that the shift from a more conflictual interaction style to a more understanding, accepting interaction style occurs slowly. Given the lack of frequent high intensity interactions, the observational data from this investigation is consistent with other findings that suggest that change occurs through numerous smaller, incremental interactions that culminate in new ways of relating and reductions in distress over time (Christensen, Russell, Miller, & Peterson, 1998).

Contrary to prior research suggesting the frequent use and significant relationship between unified detachment and treatment outcome (Cordova et al., 1998; McMurray, 2007), non-blaming, intellectual problem discussions were less frequently observed

within this investigation. IBCT theory suggests that as therapists initially reformulate and describe the couple's interaction patterns and as the couple's understanding and awareness of these patterns is enhanced over time, the couple will engage in more frequent non-blaming, descriptive discussions (Jacobson & Christensen, 1998). This pattern was particularly prevalent for one growth couple that described a non-blaming conceptualization of their pattern around conflict just two sessions before termination. However, other couples rarely provided such a comprehensive, non-accusatory summary of their interaction patterns.

There are many potential reasons why non-blaming, intellectual problem discussions were not observed as expected. First, these descriptive discussions may have occurred in sessions not selected for inclusion within this investigation, particularly since late-occurring sessions were not systematically selected for observation in this study. Second, couples may be more likely to describe only partial aspects of their interaction process in a non-blaming manner over the 26-session course of therapy, whereas this ability may have strengthened post-therapy or should therapy have continued for more sessions. Third, the couples may have relied upon the therapists' skill to reframe conflict patterns as understandable interactions around differences, instead of attempting this on their own. Fourth, the therapist's frequent reformulation of the couple's interaction may be sufficient for a cognitive change to occur within the couple, such that they develop a less blaming understanding of their issues without necessarily articulating this within the therapy. Last, couples may engage in these non-blaming discussions in a different manner than a therapist might. Expecting couples to articulate a compassionate,

comprehensive understanding of their complex dynamics may be unrealistic, as they may use different methods or language to express their unique perspectives.

Couples also rarely displayed partner one validation + partner two response interactions. Consistent with the definition of validation offered in the IBCT book for therapists, validation "refers to demonstrating not only that the listener has understood the speaker but that their point of view is valid and their feelings understandable" (Jacobson & Christensen, 1998, p.176). Inherent in this description is that validation occurs as a response that demonstrates understanding and appreciation for the partner's perspective. The use of a dyadic observational framework confirmed that consistent with IBCT's definition of validation, couples within this study were more likely to respond with validation than to initiate an interaction with a validating comment. Although the focus of this investigation was on the couple's in-session interactions, it is important to note that the therapists frequently provided validation of each spouse throughout the therapy, which is an essential component of the IBCT therapist's stance (Jacobson & Christensen, 1998). Perhaps the therapist's validation served as a model of effective non-blaming responding for the couple, similar to how the intellectualized conceptualization of a couple's interaction pattern is often articulated by the therapist and thought to be absorbed by the couple. It would be interesting to examine how validation responses develop over time within IBCT couples and how therapists can enhance the couple's validation of one another.

The infrequency of validation as an initiating code poses a question of whether it is a useful initiating category within APIIRS. Due to the exploratory, discovery-oriented nature of this investigation, removing validation at this point may be premature. Couples

display acceptance promoting behaviors in unique ways, so while the couples in this study primarily responded to other initiating behaviors with validation, different couples might utilize validation as the start of an interaction. Furthermore, assigning which behavior is the initiating and responding component is a delicate balance, as these interactions can occur quickly within a discussion. Validation that occurred directly in response to a previous statement was easier to code as a responding component of an interaction, whereas validation that may occur after a delay is more likely to be seen as an initiating component of an interaction. Given the complexity of dyadic coding, it is recommended that validation remain incorporated into APIIRS both as an initiating category of interaction and a response to other initiating behaviors.

An important discovery within this investigation was the noticeable use of humor as a component of acceptance promoting and hindering interactions. Not initially conceptualized as part of APIIRS, humor was added due to frequent observation of its affiliative and distancing function. Couples that reported growth in acceptance tended to laugh at themselves and retained a playful quality to their interactions, whereas couples that reported declines in acceptance were often seen using more overt sarcasm and belittling forms of humor throughout therapy. The use of humor did not seem dependent on preexisting ways of relating, as seen through one couple's ability to shift their humor style from negative and sarcastic to positive and constructive, with the therapist's guidance. The ability to laugh amidst challenging discussions appeared to help couples create distance from the negative experience of conflict and simultaneously enhance emotional intimacy in the process. Long-term married couples have identified humor as a particularly important component of a successful marriage (Lauer, Lauer, & Kerr,

1990). In fact, couples with higher relationship satisfaction have been found to use more positive humor and less negative or avoidance-related humor in both positive and conflictual situations, whereas couples with less relationship satisfaction tended to use negative humor in both types of interactions (Butzer & Kuiper, 2008). These findings are consistent with both IBCT's theoretical incorporation of humor into the therapy and the observation of dyadic interactions within this study.

To this investigator's knowledge, this is the first IBCT study to explore the role of humor within the therapy. The discovery-oriented and qualitative design of the study allowed the investigator to incorporate specific forms of humor into the coding system when they were observed and considered in the context of acceptance promotion and hindrance, expanding the lens from which to understand and study IBCT. Given these findings, it is possible that humor may be more central to acceptance promoting or interfering behaviors than previously understood. In addition, the role of humor in generating emotional acceptance is consistent with the strength-based approaches to therapy and research as it focuses on positive qualities that improve satisfaction rather than negative interactional styles that are pathologized.

Another key finding was that couples seemed to differ in their approach to understanding and discussing their distress. Growth couples often displayed an openness and curiosity about one another's perspectives, or at least infrequently engaged in accusatory or blaming statements. In contrast, no growth and decline couples generally had at least one partner who insisted on maintaining a perspective that one partner was right and the other was wrong, often making critical or disparaging remarks about the partner perceived as wrong. This distinction can be explained through the idea of a

collaborative set, which is described in behavioral marital therapy as an understanding of difficulties within the relationship as being mutually created and maintained, requiring a combined effort in order to alleviate distress (Jacobson & Margolin, 1979). Couples with a collaborative set generally respond to tasks or problems with a sense of togetherness (Jacobson & Margolin, 1979); this was evident in the united way that some growth couples approached stressful situations in therapy, whereas stressful events experienced by decline couples tended to exacerbate preexisting polarization. Furthermore, the development of a collaborative set is negatively impacted if one or both spouses are unable to identify and acknowledge their own shortcomings and the changes that they could make within the relationship (Jacobson & Christensen, 1998). As IBCT therapists are instructed to help couples develop a collaborative set at the outset of treatment (Jacobson & Christensen, 1998), the therapists' observed efforts to utilize a non-blaming reformulation of couple distress seemed effective in developing or maintaining a collaborative set for some couples in therapy, while other couples were less willing to adopt this approach.

Methodological Limitations

The limitations of this study are important to note when interpreting the findings. The small sample size necessary for this exploratory, qualitative study of change processes reduces the transferability of the data to a larger population (Kazdin, 2003). Consistent with phase three of Doss' (2004) model and discovery-oriented process research, this study was intended to provide an in depth exploration of dyadic change processes within IBCT; therefore, it was not intended to obtain results that were generalizable beyond the scope of this research. The investigators' theoretical

perspectives were made explicit and enabled the rich and detailed descriptions of acceptance promoting and hindering behaviors within this study, consistent with the discovery-oriented process research approach. This study explicitly stated the intention to examine acceptance promoting and interfering constructs within IBCT's theoretical framework and included a description of how the data is and is not consistent with IBCT, enhancing the theoretical validity of the investigation (Kazdin, 2003).

Another limitation of this investigation involved the sole use of behavioral observation. Studying interactions believed to promote or interfere with emotional acceptance through a behavioral lens only allows for one source of information that contributes to emotional acceptance within IBCT. Intrapsychic processes, background histories, and behaviors outside of therapy sessions are also likely to have strong influence on the amount of emotional acceptance created, maintained, or desired within a couple. It is also difficult to infer a person's motivations, attributes, or opinions solely based on observable behavior (Tashakkori & Teddlie, 1998), as was evident in the difficulty involved in differentiating between neutral responses, no response, and withdrawal responses. Using the client's FAPBI self-report of acceptance levels outside of the therapy session helps reduce this potential concern by integrating each couple's perspective into the research design. The therapist's self report of which sessions were most beneficial and effective, as well as which IBCT interventions were incorporated was also intended to strengthen the selection of sessions deemed meaningful by both therapists and couples. Emerging research on this clinical trial has revealed that therapist self-reports of treatment adherence are consistent with naïve observer adherence ratings,

suggesting that therapists were accurately able to identify and rate in-session interventions (Cruz, 2009).

The study also took steps to enhance the credibility of the results in order to increase the believability and validity of the data (Mertens, 2005). First, the use of client self-report, therapist self-report, expert consultation, clinical judgment of the investigators, and observational coding enabled the voice of multiple important participants (e.g., couples, therapists, experts) to be embedded within the investigation. This triangulation of data sources and perspectives serves to strengthen the study design and the merit of the findings (Kazdin, 2003). Second, a negative case analysis strategy was utilized through including couples that did not report growth in acceptance (Mertens, 2005). The inclusion of couples that reported both growth and decline allowed for a broader perspective on interactions believed to promote acceptance through the examination of interactions that blocked emotional acceptance.

A third strategy employed to enhance credibility of the findings involved prolonged and substantial engagement in the coding process (Mertens, 2005). Through repeated observation of entire therapy sessions and important interactions within a session, the coding system and ratings were reassessed until it was determined that saturation had occurred and no additional codes were warranted. A component of these immersive processes included the fourth credibility enhancing strategy, peer and expert review (Mertens, 2005). The primary investigator had regular meetings with the supervisory investigator in order to review complex segments of therapy sessions and discuss the expanding conceptualization of acceptance promoting and hindering interactions. Qualitative investigators are encouraged to consult with experts in order to

verify the extent to which the raw material (e.g., video data) reflects the constructs under study (Creswell, 2007). Given that this study only used one rater, these consultation meetings were essential in ensuring that the ratings were an accurate reflection of acceptance promoting interactions within IBCT. These four primary strategies and in depth descriptions of the use and results of APIIRS are intended to enhance credibility and confirmability, which is the extent to which results are confirmable by others (Kazdin, 2003). The detailed observation notes, coding manual, and description of the research procedures provide a basis for which future research can replicate and add to these findings.

Additionally, this study is limited due to the lack of diversity among the sample. With the majority of spouses being in their early 40s, college educated, heterosexual, and Caucasian, the coding system for acceptance promoting interactions was created based on a rather homogenous sample. Conducting this study with a more heterogeneous sample may reveal variations of acceptance promoting or interfering behaviors not observed within these seven couples. Given the collaborative conceptualization of the couple's issues that the therapist and couple work to develop, IBCT inherently incorporates the couple's unique cultural perspective into the reformulation of the couple's themes and interactional process (Sevier & Yi, 2008). Through the qualitative, observational exploration of the ways that couples of unique cultural backgrounds display acceptance promoting and hindering behaviors, this study is consistent with American Psychological Association's [APA] description of how research designs can contribute to evidence based practice (APA, 2006). However, future research with more heterogeneous samples

is recommended in order to gain a more comprehensive, diverse understanding of acceptance promoting and hindering interactions among couples.

Clinical and Research Implications

The in depth observational data gained through this investigation has numerous implications for couples therapists and future process research. Phase three of Doss' (2004) outcome and process research framework recommends a vigorous investigation of change processes within a treatment; while many clinicians and researchers have indicated a need to understand the change processes that contribute to effective treatment, many also comment on the challenging nature of conducting these types of investigations. This investigation did not prove otherwise – process research is indeed a labor intensive, challenging methodological approach. However, given the rich detail gained about acceptance promoting and interfering interactions due to the discovery-oriented design, the value of process research for clinicians and researchers is apparent.

Investigators either considering whether to conduct process research or those already engaged in process research may benefit from the following recommendations. First, process research is a time consuming methodology, indicating the need for researchers to have patience and to devote adequate time to thorough investigations rather than rushing for answers. In the current study, this was critical during repeated observations of therapy sessions. Taking frequent breaks from the observation of particular couples or sessions and discussing the observations with the supervisory investigator assisted the primary investigator in managing the labor intensive processes of coding and recoding numerous therapy sessions. Future research would likely benefit from having a team of coders to assist in coding discussions and provide peer support.

Second, as process research is more commonly done, the methodology involved will become more detailed, with increased guidelines and suggestions. Prior process research typically focused on a single task within individual therapy, such as through task analysis. The current study addresses the misconception that this form of research only relates to specific episodes within therapy, providing a model for how process research can not only be applied to change processes across treatment, but to dyadic interactions rather than solely studying individual behavior. Without a clear methodological guide for conducting a study of dyadic change processes, it required that the researchers embrace the ambiguity inherent in research focusing on discovery rather than empirical validation.

While the current investigation relied upon multiple data sources to help reduce ambiguity, both in determining the categories for observational analysis and in conducting the analysis itself, the uncertainty was a constant presence to contend with. Upon reflection, this ambiguity provided an exciting opportunity to generate an understanding of change processes that emanated from the data, contributing a unique perspective on dyadic change processes within IBCT. Maintaining a flexible approach in how this study was conducted was imperative. For example, when certain sessions provided minimal observational data related to acceptance promoting and interfering interactions, allowing for additional therapy sessions to be coded was essential in maximizing the understanding of the specific change processes under investigation. Studying a small sample, another commonly cited limitation of process research, yet allowing sufficient time to study the sample in depth is a worthwhile and rewarding process that will likely influence future larger scale research studies and eventually enhance clinical practice.

The understanding of dyadic change processes gained within the current study can be applied to continuing investigations within phase three of Doss' (2004) research framework, involving expansion of the study of client change processes to include study of the therapy change processes. The need to incorporate a study of the therapist into the interactional process was clear throughout this investigation, shown by the necessary addition of the therapist response category to APIIRS. Through studying how the therapy and client change processes interact to influence one another, future investigations can then examine the relationship between these change processes and the change mechanism, emotional acceptance (Doss, 2004). Initial approaches to engaging in this complex dyadic + therapy change process investigation could entail a comparison of acceptance promoting and hindering interactions that occur with and without the therapist's involvement, or a task analysis of specific IBCT interventions (e.g., unified detachment) that incorporates the therapist and couple's contribution to an interaction.

To address the difficulty in categorizing nonverbal behavior experienced within this investigation, as well as to enhance the overall assessment of in-session interactions in general, future research should supplement behavioral coding with measures of physiological arousal and affect, as well as self-report measures. Not only will this integration of assessment of internal states and external behaviors assist with distinguishing between observed neutral, withdrawal, and no response types, it will likely enhance the overall depiction of what couples experience in therapy and how this contributes to both in-session and overall treatment outcomes. These ratings can also be completed with multiple coders to enhance reliability of the findings.

One example of research that utilizes multiple assessment methods is Baucom et al.'s (in press) study of verbal and vocal expressions within demand-withdraw interaction patterns, in which observational ratings, encoded arousal, language, and power influence tactics were examined. Results showed that both power processes and encoded arousal were significantly related to the occurrence of demand-withdraw interaction patterns (Baucom et al., in press). In fact, the emotional experience of demanding and withdrawing partners was found to vary, such that demanding behaviors were more associated with anger and frustration, whereas withdrawing behaviors were associated with anxiety (Baucom et al., in press). It is likely that the internal, potentially anxious experience of the silent responding partners observed within this study contributed to the difficulty differentiating between neutral, no, and withdrawal responses.

Baucom et al.'s (in press) incorporation of multiple forms of assessment revealed novel information related to behavioral interactions within couples, demonstrating the importance of continuing to incorporate multiple forms of assessment within future investigations, as behavioral interactions are likely to be only one aspect of the variables that serve to enhance or prevent the development of emotional acceptance within IBCT. In addition, recent research indicating that spouses are more likely to withdraw when discussing topics chosen by their spouse than in self-initiated topics (Baucom, McFarland, & Christensen, 2010) suggests that future observational studies of dyadic interactions would benefit from incorporating measurement of how initiating and responding components of an interaction vary in topics chosen by each spouse. Thus, a continued dyadic focus and assessment of multiple variables has great potential for

facilitating a deeper understanding of the interconnected dynamics that occur within couple therapy, which may ultimately help to improve relationship satisfaction.

Given the key finding that vulnerability and aversive partner behavior interactions were the most common interactions observed across therapy, researchers also need to study these particular interactions more closely. Additional qualitative, exploratory investigations would further the understanding of these dyadic change processes and help develop models for how these interactions occur within therapy (Doss, 2004). Research should also incorporate the therapist's influence on the process and in-session outcome of these dyadic interactions. How do therapist responses facilitate or hinder the development of emotional acceptance within these interactions, and how do therapist responses need to differ depending on the response style observed within these interactions? Aspects of this type of research have recently been completed through a task analysis of empathic joining that resulted in an empirical model for how therapists can facilitate this intervention and how empathic joining assists in the development of acceptance (Steenwyk, 2008). As the current investigation revealed that acceptance promoting and interfering interactions can occur through multiple interactional styles (e.g., vulnerability expressed through soft disclosures or indirectly through anger), research that focuses on defining and describing these styles is warranted. Recent research by Caughlin & Scott (2010) provides an example for how this specification has occurred for the demand-withdraw interaction pattern, as they have identified four types of demand-withdraw styles observed in dyadic interactions: discuss/exit, Socratic questioning/ perfunctory response, complain/deny, and criticize/defend. A more specific understanding of the varied ways couples engage in acceptance promoting and interfering

behaviors would facilitate the refinement of IBCT that occurs with phase four of Doss' research framework.

It is also recommended that future research explore the ratio between acceptance promoting and interfering interactions within couple therapy. Given that minimal differences were found between the average rating of acceptance promoting to interfering interactions among growth, no growth, and decline couples, it would be interesting to examine this ratio within a larger sample size. Furthermore, studying this ratio over time, across therapy would likely provide useful data on to the trajectory of change in IBCT.

Although less common within the current study, given the contrast between prior research findings on unified detachment and the low levels of non-blaming, intellectual discussions seen within this investigation, it is recommended that future research further explore unified detachment within IBCT. While therapists in the current investigation routinely offered a non-accusatory reformulation of the couples' distress, couples infrequently articulated their own emerging understanding and recognition of these patterns within their relationships. When non-blaming discussions did occur, they were often focused on only one spouse's contribution to the interaction pattern (typically the speaker described his or her own influence on the interaction). If therapists could encourage couples to more describe their interaction pattern in an intellectualized manner, this may strengthen the couple's understanding of their mutually influential interactions and promote a sense of togetherness, as is intended by unified detachment.

Given the complexity of the acceptance promoting and interfering interactions observed within this study, it is recommended that both clinicians and researchers strive to understand the meaning of the interactions within the context of the couple. This

contextually informed approach to interpreting in-session behavior was necessary for assigning APIIRS global ratings; continued detailed examination of the types and implications of these various interactional styles is warranted. The dyadic focus and ideographic knowledge obtained through qualitative studies of small numbers of couples would likely help elucidate how therapists can facilitate the development or maintenance of a collaborative set within couple therapy. For couples with a collaborative set, a balance between generating acceptance and contingency-based behavioral change appeared useful within the couple therapy, whereas couples without a collaborative set did not achieve a helpful balance between those two treatment components. It follows that attentiveness to the interplay between these dialectic aspects of the therapy for couples with various degrees of a collaborative perspective requires further investigation.

Lastly, it is recommended that clinicians and future researchers devote attention to the role of humor within couple therapy. As humor was commonly seen to be affiliative or critical within growth and decline couples, respectively, a more explicit exploration of humor with acceptance promoting change processes is warranted. Questions remain regarding the influence of pre-treatment use of humor on the role of humor within therapy, as well as how therapists can integrate humor in a useful manner.

Conclusion

The aim of this investigation was to create and utilize an observational method for exploring in-session dyadic change processes within IBCT. The current study provided a critical component within the research effort to understand change processes as part of studying psychotherapy outcome and process (Doss, 2004). In particular, the expansion of previous forms of behavioral coding to include a dyadic, interactional emphasis

resulted in a wealth of information about the way couples relate to one another in therapy, and how these interactions occur within couples reporting various levels of growth or decline in IBCT's change mechanism, emotional acceptance. This study also contributes to the expressed need for change process research, providing useful information to clinicians and future researchers. Through the qualitative, discovery-oriented approach to this investigation, this study provides a more detailed understanding of the acceptance promoting and interfering interactions that spouses engage in across the course of integrative behavioral couple therapy.

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APPENDIX A

Literature Review Table

I. Evidence-Based Couple Therapy

Author, Year, Title	Publication Type	Objectives/ Hypotheses	Sample	Variables/ Instruments	Research Design	Results/ Statistics	Major Findings
Baucom, Epstein, LaTaillade, & Kirby (2008). Cognitive-behavioral couple therapy.	Book chapter	N/A	N/A	N/A	N/A	N/A	• This book chapter describes the background theory and current understanding of cognitive-behavioral couple therapy (CBCT). It provides an overview of the interventions and method for conducting this form of evidence based couple therapy. • CBCT's basic premise involves the understanding that emotional and behavioral responses to relational events are influenced by cognitive processing errors (e.g., distorted appraisals, unrealistic expectations). Therapy aims to help couples reevaluate their interpretation of relational stimuli to improve the cognitions, behaviors, and emotions that contribute to perceived relationship quality.

Baucom, Shoham, Mueser, Daiuto, & Stickle (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems.	Journal article	Purpose: To examine the empirical status of couple and family therapy for treating marital distress and individual adult disorders	N/A	N/A	Literature review	N/A	• Behavioral Martial Therapy and Emotion-Focused Therapy are both empirically supported treatments for couple distress. • Couple therapies that are possibly efficacious treatments for couple distress include Cognitive Marital Therapy and Insight-Oriented Marital Therapy. • A number of couple and family based treatments appear to be helpful for individual adult disorders, such as depression, agoraphobia, female sexual dysfunction, alcoholism, and schizophrenia.
Christensen & Jacobson (2002). Reconcilable differences.	Book	N/A	N/A	N/A	N/A	N/A	• A practical guide for couples, based on IBCT, that aims to help couples build stronger relationships. • Provides detailed descriptions and vignettes of how to build acceptance and promote change.
Christensen (2010). A unified protocol for couple therapy.	Book chapter	N/A	N/A	N/A	N/A	N/A	• This book chapter describes five basic principles found within evidence based couple therapy: (1) a dyadic conceptualization of problems, (2) modification of emotion-driven dysfunctional or destructive behavior, (3) elicit avoided emotional expressions, (4) develop effective communication, and (5) emphasize strengths within the relationship. Research and clinical implications are discussed.

Greenberg & Johnson (1988). Emotionally focused therapy for couples.	Book	N/A	N/A	N/A	N/A	N/A	• This book provides theoretical understanding, research findings, and clinical recommendations for conducting emotionally focused couple therapy (EFT). • EFT is rooted in attachment theory and focuses on the emotional context of relational experiences, helping couples restructure insecure attachment bonds in order to develop secure attachment styles within their primary romantic relationships.
Greenberg, James, & Conry (1988). Perceived change processes in emotionally focused couples therapy.	Journal article	Purpose: To assess couples perceptions of change processes 4-months after therapy concluded	• 21 Canadian couples who had received Emotion Focused Therapy [EFT] in a couples research project • On average, the sample was 35.7 years old, had lived together for 8.24 years, and was middle class	• Dyadic Adjustment Scale (marital satisfaction) • Critical Incident Technique interview (descriptions of change events)	Qual-itative	• Five areas of critical change processes were revealed: expression of underlying feelings leading to changes in perception of the partner, expressing feelings and needs, acquiring understanding, taking responsibility for experience, and receiving validation.	• The expression of underlying feelings might be an important change process in EFT due to its ability to change how partners perceive and respond to one another. • Understanding relationship dynamics on an intellectual and emotional level appears to lead to new responses in the relationship.
Hayes, Luoma, Bond, Masuda, & Lillis (2006). Acceptance and commitment therapy: Model, processes, and outcomes.	Journal article	Purpose: To present and review the theoretical model and research supporting Acceptance and Commitment Therapy (ACT).	N/A	N/A	Review study	N/A	• ACT is part of the third wave of behavior therapies and focuses on acceptance of psychological events instead of changing them. • The combined results from correlational, component, change process, and outcome comparison research suggest that ACT is an effective therapy for a wide range of problems.

Jacobson & Christensen (1998). Integrative couple therapy: Promoting acceptance and change.	Book	N/A	N/A	N/A	N/A	N/A	• IBCT manual for therapists • Book describes the rationale for IBCT and presents a detailed description of the theory, interventions, obstacles, and relevant diversity issues.
Jacobson & Margolin (1979).	Book	N/A	N/A	N/A	N/A	N/A	• This book provides a conceptual framework for couple interactions based on a behavioral, social learning perspective. Guidelines for generating a conceptualization, therapy interventions, adapting treatment for particular problem areas, and relevant research findings are provided.
Johnson (2004). The practice of emotionally focused couple therapy: Creating connection.	Book	N/A	N/A	N/A	N/A	N/A	• This book is a guide for therapists in conducting emotionally focused couple therapy. It provides an overview of the theoretical, attachment-based conceptualization of couple distress, as well as in-depth descriptions of how to conduct in-session interventions that culminate in the reorganization of attachment bonds.
Johnson (2008). Emotionally focused couple therapy.	Book chapter	N/A	N/A	N/A	N/A	N/A	• This book chapter provides an overview of emotionally focused couple therapy. It includes a description of the theoretical, attachment-based conceptualization of couple distress and the interventions utilized to assist couples in the development of secure attachment bonds.

Johnson & Lebow (2000). The "coming of age" of couple therapy: A decade review.	Journal article	Purpose: To provide an overview of significant developments in couple therapy within 1990-2000	N/A	N/A	Review study	N/A	• Recent developments in couple therapy include a scientific understanding of basic elements of relationship distress and satisfaction, evidence that couple therapy is effective at reducing marital distress, and the development of empirically validated couple therapy approaches. • Couple therapy research needs to be made more relevant for clinicians, including the study the process of change.
Linehan (1993). Cognitive behavioral treatment of borderline personality disorder.	Book	N/A	N/A	N/A	N/A	N/A	• This book provides an in-depth description of dialectical behavior therapy for treating individuals with borderline personality disorder. Theoretical explanations and treatment strategies are discussed in detail.

Snyder & Wills (1989). Behavioral versus insight-oriented marital therapy: Effects on individual and interspousal functioning.	Journal article	Purpose: To compare the effects of behavioral marital therapy (BMT) and insight-oriented marital therapy (IOMT)	• 79 couples (29 in BMT, 30 in IOMT). 84.1% of couples were Caucasian and age averaged 40.1 years for husbands and 37.1 years for wives.	• Global distress scale of the Martial Status Inventory (marital satisfaction) • Areas of change questionnaire (behavioral description of marital distress) • MMPI (personality) • Tennessee self-concept scale (individual functioning)	Experi-mental	• Couples in both treatment conditions demonstrated clinically significant improvements in marital satisfaction and maintained these improvements six months post-treatment. • Small decreases in individual psychopathology and increases in self-concept were also found for individual partners at post-treatment. • While both BMT and IOMT couples were found to have significant increases in verbal agreement, only IOMT couples also showed significant increases in nonverbal positiveness.	• BMT and IOMT are both equally effective treatments for marital distress, with gains maintained over six months post-treatment. These findings confirm previous outcome research with similar results.

Wills, Faitler, & Snyder (1987). Distinctiveness of behavioral versus insight-oriented marital therapy: An empirical analysis.	Journal article	Purpose: To determine whether BMT and IOMT couple be learned from treatment manuals and delivered in distinct ways, such that observational coding could distinguish between the two treatments.	• 24 audio-taped sessions from 17 couples, conducted by 3 therapists • Couples were married and living together. On average, husbands were 42.9 and wives were 39.4 years old. Most subjects were White, 24% were Black.	• Therapist Intervention Coding System (therapist compliance)	Correlational	• Therapists did not cross-over treatment specific interventions, demonstrating the distinctiveness of the two treatments. • Therapists conducting BMT mostly used skills-training or education interventions, whereas therapists conducting IOMT used nonspecific interventions (e.g., telling statements) and insight-oriented techniques.	• Therapist's use of BMT and IOMT interventions can be reliably distinguished and coded. • Therapists in treatment studies can reliably use multiple forms of treatment without mixing treatment components together. • BMT is a highly structured treatment approach that uses more interventions within a time period than IOMT.

II. Couple Therapy Outcome Research

Author, Year, Title	Publication Type	Objectives/ Hypotheses	Sample	Variables/ Instruments	Research Design	Results/ Statistics	Major Findings
Christensen, Baucom, Vu, & Stanton (2005). Methodologically sound, cost-effective research on the outcome of couple therapy.	Journal article	Purpose: To provide guidelines for better therapy outcome research and make suggestions for more efficient and less costly therapy outcome research.	N/A	N/A	Review study	N/A	• Case design studies that focus on a small group of couples can provide more detailed information about mechanisms of action and response to treatment; studies that focus on the analysis of treatment components and open clinical trials are also encouraged. • Researchers and practitioners should work together to develop methodologically sound couple therapies and to conduct both efficacy and effectiveness studies in order to maximize the therapeutic benefit for distressed couples in therapy.

Christensen & Heavey (1999). Interventions for couples.	Journal article	Purpose: To provide a review of empirically demonstrated effective interventions for couple distress, prevention programs, and methodological issues related to research in these two areas.	N/A	N/A	Review study	N/A	• Prior research clearly shows that couple therapy is more effective in reducing marital distress than no treatment, with recent meta analyses showing that approximately 36-41% of couples have either both partners demonstrate reliable improvement or shift from distressed to nondistressed over the course of therapy. These improvements have been shown to last anywhere from six months to four years post-treatment. • A review is provided of the specific effects of behavioral marital therapy, cognitive behavioral marital therapy, and emotionally focused couple therapy; and of how these couple therapies impact individual disorders (e.g., depression, anxiety). • Prevention programs have also been shown to be helpful interventions for couples. • Methodological recommendations for future research include studying more diverse samples, focusing on effectiveness in natural settings rather than efficacy in controlled settings, developing more powerful interventions, and gaining a more thorough understanding of intervention effects over time.

Jacobson & Addis (1993). Research on couples and couple therapy: What do we know? Where are we going?	Journal article	Purpose: To provide an overview of what is known about couple therapy, including effective treatments, how these treatments work, and outcome predictors.	N/A	N/A	Review study	N/A	• Behavioral couple therapy (BCT) has been shown to be an effective treatment for relationship distress, as compared to a control group. • Couples who are severely distressed, older, and emotionally disengaged are all harder to treat in couple therapy. • There is not much research on change processes in BCT. • Further research is recommended in the following areas: process research, gender issues, and domestic violence.
Pinsof, Wynne, & Hambright (1996). The outcomes of couple and family therapy: Findings, conclusions, and recommendations.	Journal article	Purpose: To provide an overview of the effectiveness of couple therapy and to explore the major issues for future research evaluating couple therapy outcomes	N/A	N/A	Review study	N/A	• Consistent evidence from literature reviews and meta-analyses suggests that couple therapy is effective. • Future couple therapy research should focus on treatment effectiveness, clearly defined problems, treatment components thought to relate to outcome, cost-effectiveness, and multicultural considerations.

Shadish & Baldwin (2005). Effects of behavioral martial therapy: A meta-analysis of randomized controlled trials.	Journal article	Purpose: To review the results from randomized experiments comparing BMT to a no-treatment control group and determine if there might be publication bias affecting effect estimates.	• 30 BMT studies, including 15 unpublished dissertations.	N/A	Meta-analysis	• BMT is more effective than a no-treatment control group, although there was much variance in the effect sizes reported in different studies. • There was a higher average effect size for published studies (d = .71) than unpublished studies (d = .47), although this was not statistically significant.	• BMT produces greater results than no treatment. • There appears to be some amount of publication bias, with published studies reporting larger effect sizes than unpublished studies.
Snyder, Castellani, & Whisman (2006). Current status and future directions in couple therapy.	Journal article	Purpose: To review the effectiveness of couple therapy, to discuss methods for evaluating the processes of change and predictors of treatment outcome, and to make recommendations regarding future research directions in couple therapy	N/A	N/A	Review study		• Couple therapy is generally found to be effective at reducing both relational distress and co-morbid psychological difficulties. • Methodological suggestions for investigating change processes include regression analysis of mediation, hierarchical linear modeling, and task analysis of change process that focuses on examining "mini" outcomes of interventions within sessions • Directions for future research include smaller-level studies such as an analysis of treatment components; identification of individual, relationship and treatment factors contributing to successful and unsuccessful outcome; research on change processes; research on emotion regulation processes

III. Couple Therapy Process Research

Author, Year, Title	Publication Type	Objectives/ Hypotheses	Sample	Variables/ Instruments	Research Design	Results/ Statistics	Major Findings
Beutler, Williams, & Wakefield (1993). Obstacles to disseminating applied psychological science.	Journal article	Purpose: To review the incompatibilities between research and clinical practice and make suggestions for how to overcome these difficulties.	• 56 total therapists, comprised of 20 psych-ologists, 6 psychiatrists, 26 MFCCs, and 4 social workers.	• A questionnaire assessing from where and how much research clinicians read, and how helpful research was for their clinical practice.	Survey	• 80% of respondents read research articles, however only 35% of the journals they read were primary research journals. • The most strongly endorsed area of helpful research topics (87%) was "research that focuses on therapist and/or client behaviors leading to important moments of change during psychotherapy" (p. 56). • 82% of respondents stated that "research that links the process of therapy to differential outcomes" would be helpful.	• Therapists read, apply and value research findings. • Clinicians are more commonly exposed to research by reading professional newsletters, magazines, and/or workshops, as opposed to primary research articles. • Clinicians feel that research on therapy change process and how this relates to differential outcomes would be very helpful.

Christensen, Russell, Miller, & Peterson (1998). The process of change in couples therapy: A qualitative investigation.	Journal article	Purpose: To develop an explanation of change processes in couples therapy.	• 13 hetero-sexual couples who had attended at least four couple therapy sessions in a university-based family therapy clinic. • Ave-rage age was 30.5 years old for women and 32.0 years old for men.	• Interviews with each partner in the couple	Qual-itative	• Three clusters of change that co-occurred with relationship satisfaction increases were identified: changes in affect, cognition, and communication. • Change was said to occur gradually through small, incremental but significant experiences, as opposed to clearly identifiable breakthrough moments.	• Changes in affect, cognition, or communication impact one another, implying that change in one area is likely to influence change in other areas. • Change was described as occurring slowly, over time during treatment.
Cordova (2001). Acceptance in behavior therapy: Understanding the process of change.	Journal article	Purpose: To try to provide a behavioral understanding of acceptance, to discuss how therapists promote acceptance, and to evaluate when acceptance is a useful clinical goal.	N/A	N/A	Method-ological discussion	N/A	• Changes in acceptance can be measured through observation coding systems, self-report assessment, and/or clinical observation, and depend on the issue for which acceptance is trying to increase. • Acceptance is a useful therapeutic goal when an aversive stimulus is causing significant aversive consequences. Acceptance would involve changing the stimulus value from an aversive outcome to a more attractive outcome. • There is need for researchers to define the targeted aversive stimuli and describe what the shift from aversion to acceptance looks like.

Doss (2004). Changing the way we study change in psychotherapy.	Journal article	Purpose: To discuss previous obstacles to studying change in therapy and present a methodological framework for future studies of therapeutic change.	N/A	N/A	Method-ological discussion	N/A	• Reducing the polarization between outcome and process research is critical for progressing research on psychotherapy change. • An integrated process and outcome approach to studying psychotherapy change would include the following steps: (1) forming a basis to study mechanisms, (2) understanding change mechanisms, (3) understanding change processes, and (4) application of an understanding of change.
Greenberg (1992). Task analysis: Identifying components of intrapersonal conflict resolution.	Book chapter	N/A	N/A	N/A	N/A	N/A	• Task analysis is a method developed for the study of individuals engaged in a specific task, aimed at understanding both how the task occurs and is resolved. • Eight steps for conducting task analysis are reviewed: (1) Explication of the implicit map of experts, (2) Selection and description of a task, (3) Verification of the significance of task resolution, (4) The rational analysis: Constructing performance diagrams, (5) Empirical analysis: Description of the actual performances, (6) Comparison of actual performance with possible performances: Model building, (7) Verification, and (8) Relating process to outcome.

Greenberg (1999). Ideal psychotherapy research: A study of significant change processes.	Journal article	Purpose: To provide instruction for conducting change process research focused on observation and measurement of in-session client and therapist behavior	N/A	N/A	Method-ological discussion	N/A	• A description is provided of an investigative strategy recommended for task analysis of in-session change processes. • Researching change events should begin with isolating and describing the change events, measuring and explaining the process of change, and lastly studying the prediction of outcomes.
Greenberg (2007). A guide to conducting a task analysis of psychotherapeutic change.	Journal article	Purpose: To describe a method for engaging in a task analysis approach to study therapeutic change	N/A	N/A	Method-ological discussion	N/A	• Task analysis involves a discovery-oriented phase, which involves creating, examining, and synthesizing a rational model for the change event, as well as a validation-oriented phase, in which the components of the model are statistically evaluated to validate the model and relate process to outcome. Specific steps within each phase are discussed. • Task analysis has been shown to be a useful way to examining in-session change events and testing their relation to outcome.

Greenberg & Foerster (1996). Task analysis exemplified: The process of resolving unfinished business.	Journal article	Purpose: To present the steps involved in a task analysis designed to identify in-session performances and the relationship to outcome for an empty-chair technique used in resolving unfinished business	• 11 resolved and 11 unresolved events involving unfinished business work using empty-chair technique.	• Experiencing scale (emotional involvement) • Structural Analysis of Social Behavior • Client's Emotional Arousal Scale • Client Vocal Quality measure • Post-session resolution measures	Mixed methods	• Steps involved in the discovery and verification phases: (1) articulation of general assumptions, (2) selecting and describing the task and the task environment, (3) the rational analysis, and (4) empirical analysis • Resolved events had significantly more expressions of intense feelings, needs, understanding of the self and other, and positive views of the other. • No significant differences were found with regard to the presence of blaming or negative views of the other.	• This refined model and scale appears to capture the change process involved in resolving unfinished business. • This task-analytic method is an ideal method for creating empirically grounded models for how clients change in therapy.

Greenberg, Ford, Alden, & Johnson (1993). In-session change in emotionally focused therapy.	Journal article	Purpose: *Study 1*: • To determine differences in the way couples deal with conflict at the beginning and end of treatment. *Study 2*: • To examine potential differences in the degree of affiliation and depth of experience in conflict among peak and poor sessions, as identified by clients. *Study 3*: • To examine the role of spousal self-disclosure in determining the quality of a partner's response.	*Study 1*: • Videotaped couple therapy sessions from a previous study that examined EFT effectiveness in 8-10 sessions. • Couples were typically Caucasian, educated, had middle incomes, and were not considering separation. *Study 2*: • 6 couples with an early-in-therapy peak session and 10 couples with a late-in-therapy peak session. *Study 3*: • One session from each couple in EFT was examined.	*Study 1*: Independent variable [IV]: EFT (vs. wait-list control group) Dependent Variable [DV]: couple behavior • Dyadic Adjustment Scale (DAS) (relationship satisfaction) • Structural Analysis of Social Behavior (quality of client responses) *Study 2*: IV: Client-rated peak vs. poor sessions DV: Depth of experience and degree of affiliation • Experiencing Scale (client emotional involvement in therapy) • Structural Analysis of Social Behavior • Post-session questionnaire *Study 3*: IV: Intimate self-disclosure and subsequent talk-turns DV: Couple interaction • Self-disclosure coding system (intimacy and affect congruence) • Structural Analysis of Social Behavior	*Study 1*: Quasi-experimental *Study 2*: Causal comparative (comparing peak vs. poor sessions) *Study 3*: Causal comparative (multivariate)	*Study 1*: • Results indicated that there was a significant increase in affiliative behaviors and a reduction in the amount of in-session negative interactions between sessions 2 and 7 *Study 2*: • Friendly statements and deeper emotional experiencing were characteristic of peak sessions whereas hostile statements were characteristic of poor sessions. *Study 3*: • MANOVA • More affiliative behaviors were coded after the self-disclosure occurred.	• These findings suggest that spousal self-disclosure is likely to result in reciprocal self-disclosure by the other partner, ultimately resulting in a change in the couple's negative interaction pattern. *Study 1*: • Couples increased their levels of affiliative statements and reduced their level of hostile behaviors from session 2 to 7. *Study 2*: • There is a strong association between affiliative statements, depth of experiencing, and peak sessions. Peak sessions were also more likely to have friendly, accepting statements. • Fewer self-focused statements and more blaming, hostile statements characterized poor sessions. *Study 3*: • Therapist facilitation of intimate spousal self-disclosure results in an increased likelihood that the spouse's partner will respond affiliatively.

Heatherington, Friedlander, & Greenberg (2005). Change process research in couple and family therapy: Methodological challenges and opportunities.	Journal article	Purpose: To discuss the methodological challenges and opportunities in couple and family therapy research, while making specific recommendations for enhancing change process research.	N/A	N/A	Method-ological discussion	N/A	• Further change process research should focus on five areas: (1) articulating and testing systematic change processes, (2) client change processes, (3) covert intrapersonal processes, (4) strategies for analyzing data from multiple participants, and (5) similarities and differences among change processes for various cultural groups
Johnson & Greenberg (1988). Relating process to outcome in martial therapy.	Journal article	Purpose: To explore client performance on relevant variables and the occurrence of a key change event, for both couples who had the most and least successful results from Emotion Focused Therapy [EFT].	• Six couples from a larger EFT study who had the least and most amount of change during therapy • On average, couples had been together for eight years, had 1.7 children, and 15 years of education	• Dyadic Adjustment Scale (marital satisfaction) • Experiencing Scale (client emotional involvement in therapy) • Structural Analysis of Social Behavior (quality of client responses)	Mixed methods	• For successful couples, the proportion of affiliative responses was 95.5%, compared to 25.5% in unsuccessful couples. • For successful couples, the proportion of autonomous responses was 78.5%, compared to 48% in unsuccessful couples. Successful couples	• Successful couples displayed more affiliation, acceptance, disclosure, and less dominance. • Implications for therapists include focusing on facilitating deeper levels of experiencing self-disclosure and exploration. • Implications for researchers include the need to describe theoretically hypothesized client change processes and then to empirically test whether these change processes occur and are related to significant outcome.

Laurenceau, Hayes, & Feldman (2007). Some methodological and statistical issues in the study of change processes in psychotherapy.	Journal article	Purpose: To discuss methodological limitations and to make recommendations for studying therapeutic change processes	N/A	N/A	Methodological discussion	N/A	• Process research can address the course of change, which can involve studying individual and group trends, comparing these trends to what would be predicted by the underlying theory, and examining differences between treatment responders and non-responders. • Process research has been limited due to the lack of within-treatment follow-up assessments that measure symptom change and possible mediators of outcome. • Recommendations for study designs and statistical evaluations of change are included.
Llewelyn & Hardy (2001). Process research in understanding and applying psychological therapies.	Journal article	Purpose: To review the types of psychotherapy process research and to justify why process research should be used in order to increase therapeutic effectiveness.	N/A	N/A	Methodological discussion	N/A	• Types of process research include descriptive studies, hypothesis testing, and understanding theoretically hypothesized change. • Process research helps provide a greater understanding of what happens in therapy, and as a result will help therapists become more effective and help elucidate the processes that lead clients to change.
Mahrer & Boulet (1999). How to do discovery-oriented psychotherapy research.	Journal article	Purpose: To describe and subsequently improve how to conduct discovery-oriented process research	N/A	N/A	Methodological discussion	N/A	• Questions about the occurrence, effects and sequencing of significant in-session changes can be analyzed through discovery-oriented process research. • Logistics and methodological steps for conducting discovery-oriented process research are discussed.

Nock (2007). Conceptual and design essentials for evaluating mechanisms of change.	Journal article	Purpose: To outline the conceptual and methodological requirements for evaluating the mechanisms of change, and to discuss the importance of change mechanism research.	N/A	N/A	Method-ological discussion	N/A	• The most important criteria for demonstrating mechanisms of change include strong association, specificity, temporal relation, and experiment. • Mechanisms of change should be studied because it can help clarify the similarities and difference between treatments, it will increase efficiency and effectiveness of treatments, and it will increase the general understanding of behavior change.
Pachankis & Goldfried (2007). On the next generation of process research.	Journal article	Purpose: To highlight limitations of current therapy process research approaches and discuss the need to adopt process research methods that generalize to real-world psychotherapy	N/A	N/A	Review study	N/A	• Pre-post outcome research designs do not adequately capture the in-session client and therapist behaviors involved in mechanisms of change. • Process research is recommended for understanding the mechanisms underlying client change processes and is more relevant for clinicians.

Pascual-Leone & Greenberg (2007). Emotional processing in experiential therapy: Why "the only way out is through".	Journal article	Purpose: To investigate client change by examining whether there are emotional sequences during the in-session resolution of global distress, and to determine whether these processes predict good in-session events.	• 6 sessions from different clients who participated in EFT clinical trials were observed for qualitative analysis. Average session number was 5.2	• Classification of Affective-Meaning States (observational coding) • Client Experiencing Scale (client use of internal experience to resolve problems) • Expert clinical judges for determining good versus poor in-session events	Mixed methods	• Results supported the rational/ empirical model that was created of the steps involved during in-session advanced emotional processing. • Clients with good in-session effects (measured by high experiencing) had significantly longer emotional events than clients with poor in-session effects. • Results indicated a significant positive relationship between in-session effects and good overall treatment outcome. •	• Engaging in affect-meaning experiences within session was predictive of good in-session outcome. • This study demonstrated that a processing sequence of emotions, as predicted by an underlying theory, could positively predict a peak in productive emotional processing which in turn can predict good treatment outcome.
Rhodes & Greenberg (1994). Investigating the process of change: Clinical applications of process research.	Book chapter	Purpose: To describe the clinical applicability and different strategies for conducting process research.	N/A	N/A	N/A	N/A	• Process research designs are created by moving between theoretical (general) and observational (specific) levels. Authors describe a rational-empirical research strategy for theory verification and discovery in process research.
Woolley, Butler, & Wampler (2000). Unraveling change in therapy: Three different process research methodologies.	Journal article	Purpose: To present three different methodologies for conducting process-outcome research	N/A	N/A	Methodological discussion	N/A	• Three different process-outcome research methodologies are described and the relative strengths and limitations of each are evaluated. These methodologies include grounded theory (an inductive, discovery-oriented approach), change event analysis, and experimental manipulation.

IV. Outcome and Process Research Within Integrative Behavioral Couple Therapy

Author, Year, Title	Publication Type	Objectives/ Hypotheses	Sample	Variables/ Instruments	Research Design	Results/ Statistics	Major Findings
Atkins, Berns, George, Doss, Gattis & Christensen (2005). Prediction of response to treatment in a randomized clinical trial of marital therapy.	Journal article	Purpose: To examine pretreatment predictors of change in marital satisfaction within IBCT and TBCT, focusing on demographics, intrapersonal and interpersonal variables	• 134 couples from a study on TBCT and IBCT • On average, married an average of 10 years, had at least one child, and were Caucasian. • Partners did not have certain psychological disorders	Criterion Variable: Dyadic Adjustment Scale Predictor variables: measured through a demo-graphics questionnaire, intrapersonal and interpersonal variable measures	Correl-ational	• Hierarchical linear modeling • Better communication and greater desired closeness are associated with less initial marital distress, whereas greater initial distress is associated with poorer affective communication and more steps taken towards separation or divorce. • Strongest improvement in therapy occurring in couples that had been married 18+ years.	• Demographic variables did not seem to predict outcome. • Intrapersonal variables explain a small to medium amount of variance in change in satisfaction • Interpersonal variables helped to explain some of the variability in initial level of distress. • Overall finding was that relatively little predicts successful or unsuccessful outcome.

Atkins, Eldridge, Baucom, & Christensen (2005). Infidelity and behavioral couple therapy: Optimism in the face of betrayal.	Journal article	Purpose: To examine the treatment outcome for couples in which one partner had an affair.	• 19 couples from a larger randomized clinical trial of TBCT and IBCT, which was 14.2% of the total sample	Predictor Variable: The presence of infidelity Criterion Variable: Marital satisfaction • Dyadic adjustment scale (marital satisfaction) • Infidelity questionnaire	Correl-ational	• Hierarchical linear modeling • Infidelity couples began treatment more distressed than non-infidelity couples. • Similar amounts of change were made for both infidelity and non-infidelity couples during therapy. • Couples where the affairs were not disclosed before or during treatment were almost all considered treatment failures.	• While infidelity couples are more distressed than non-infidelity couples at pretreatment, however they seem to attain equivalent levels of marital satisfaction by the end of treatment as non-infidelity couples. • Both IBCT and TBCT can be effective for couples dealing with infidelity. • Affairs that are not disclosed either before or during treatment appear to be very harmful to the relationship.

Baucom, Atkins, Simpson, & Christensen (2009). Prediction of response to treatment in a randomized clinical trial of couple therapy: A 2-year follow up.	Journal article	Purpose: To examine the predictive relationship between four groups of variables (demo-graphic, intrapersonal, communi-cation, and other inter-personal) and 2-year treatment outcome	• 130 couples that represent a subset of the couples studied in the original clinical trial. • The sample was on average 42-43 years old (ranging from 22 to 72), college educated, married 10 years, and was 77% Caucasian (with 8% African American, 5% Asian or Pacific Islander, 5% Latino/a, 1% Native American, and 4% other).	Criterion Variable: Dyadic Adjustment Scale Predictor variables: Demo-graphic Intrapersonal (neuroticism, mental health and diagnoses, family history of distress) Communi-cation (affective, constructive, demand-withdraw, encoded arousal, power processes) Other Interpersonal (closeness-indepen-dence, commitment, sexual satisfaction, decision making influence, power bases, distress severity, treatment condition, clinical significance)	Correl-ational	• Hierarchical linear modeling • Number of years married was significantly associated with treatment response for all couples. • None of the intrapersonal, other interpersonal, or self-reported communication variables were found to be predictive of treatment response. • For couples who received IBCT, high levels of soft influence tactics were significantly associated with higher treatment response categories. • For all couples, lower wife encoded arousal was significantly associated with higher levels of treatment response. • For moderately distressed couples, lower levels of hard influence tactics were significantly associated with treatment response category.	• The numerous communication variables that were shown to be predictive of treatment response at 2 years post-treatment contrasts previous research findings that years married was the single demographic predictor of treatment outcome, with no intrapersonal variables shown to be significant. • Study findings confirm that couples married for a longer amount of time were more likely to respond favorably to treatment. • For moderately distressed couples, hard influence tactics and wife's encoded arousal were predictive of treatment response at 2 years post-treatment, which is consistent with the notion of collaborative set in that couples may have been more likely to have a shared investment in working on relationship issues and also had an increased willingness to compromise.

Christensen, Atkins, Baucom, & Yi (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy.	Journal article	Purpose: To examine the outcome of couples that engaged in a study comparing TBCT and IBCT, five years after treatment ended.	• 134 chronically and seriously distressed couples • On average, age in the early 40s, married for 10 years, Caucasian and had children.	Independent Variable(s): Couples therapy (TBCT or IBCT) Dependent Variable: Marital satisfaction • Dyadic Adjustment Scale (marital satisfaction) • Marital Status Inventory (steps towards divorce) • Two subscales from the Marital Satisfaction Inventory – Revised (problem-solving communication; affective communication) • Mental Health Index (individual spousal functioning) • Martial Activities Questionn-aire	Experi-mental	• Five years post-treatment, IBCT couples reported an average of 96.2 on the DAS, whereas TBCT couples reported average DAS scores of 96.6. • For both IBCT and TBCT, approximately one third of couples were classified as recovered, one third classified as deteriorated (most of whom were divorced), and one third classified either as unchanged or improved at five years post-treatment. • IBCT and TBCT couples engaged in similar amounts of TBCT behaviors at five years post-treatment, however couples classified as recovered were more likely to report higher levels of IBCT and TBCT behaviors at five years post-treatment.	• The trajectory of change for IBCT and TBCT couples involved marked improvement in satisfaction over the course of therapy, slight decreases immediately after therapy termination, with gradual improvements continuing over the course of five years. • Approximately half of IBCT and TBCT couples demonstrated clinically significant improvement at the five year follow-up, with no significant differences between treatments. • These results compare favorably with other randomized clinical trials of couple therapy, although the divorce rate within this clinical trial was markedly lower than that reported in other clinical trials (26.8% in this study, compared to 38-43.6% in other studies).

Christensen, Atkins, Berns, Wheeler, Baucom, & Simpson (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed couples.	Journal article	Purpose: To examine to overall and comparative efficacy of TBCT versus IBCT in treating seriously and chronically distressed married couples	• 134 seriously and chronically distressed married couples from Los Angeles, CA and Seattle, WA. • On average, couples were in their early 40s, were high school graduates, and had one child. • Most participants were Caucasian (79% of husbands, 76% of wives). Other represented ethnicities included African American, Asian or Pacific Islander, Latino/a, Native American or Alaskan Native.	Independent Variable(s): Couples therapy (TBCT or IBCT) Dependent Variable: Marital satisfaction, relationship stability, communication, spouses' individual functioning, and client reactions to treatment. • Short therapeutic bond measure (therapeutic alliance) • Dyadic adjustment scale (marital satisfaction) • Global Distress Scale of the Marital Satisfaction Inventory – Revised [MSI-R] (marital satisfaction) • Problem solving communication (from the MSI-R) • Affective communication (from the MSI-R) • Marital status inventory (steps towards divorce) • Compass outpatient treatment assessment system (individual functioning) • Client evaluation of services questionnaire	Experi-mental	• Hierarchical linear modeling • "TBCT couples improved more quickly than IBCT couples but then plateaued while IBCT couples showed slow but steady improvement across treatment with no flattening out or deterioration" (p. 183). • Based on the DAS, 71% of IBCT couples (65% based on the GDS) and 59% of TBCT couples (57% based on the GDS) showed reliable improvement or recovery. • 73% of moderately distressed couples and 54% of severely distressed couples were improved or recovered at the end of treatment. • Individual mental health changed only to the extent that marital satisfaction changed. • Clients were generally satisfied with treatment and had a good bond with their therapist.	• TBCT and IBCT are effective treatments for both moderately and seriously distressed couples. • Statistically significant effects indicated that couples ended treatment with improved relationship satisfaction, stability, and communication. • Individual functioning improved only to the extent that marital satisfaction improved. • Despite being demonstrably different treatments, both TBCT and IBCT performed similarly across measures. • TBCT couples tended to improve more quickly but then flatten out over the remainder of therapy, whereas IBCT couples had reliable and steady improvement over the course of therapy.

Christensen, Atkins, Yi, Baucom, & George (2006). Couple and individual adjustment for 2 years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy.	Journal article	Purpose: To examine the outcome of couples that engaged in a study comparing TBCT and IBCT, 2 years after treatment ended.	• 134 chronically and seriously distressed couples • On average, age in the early 40s, married for 10 years, Caucasian and had children.	Independent Variable(s): Couples therapy (TBCT or IBCT) Dependent Variable: Marital satisfaction • Dyadic Adjustment Scale (marital satisfaction) • Marital Status Inventory (steps towards divorce) • Two subscales from the Marital Satisfaction Inventory – Revised (problem-solving communication; affective communication) • Mental Health Index (individual spousal functioning) • Martial Activities Questionn-aire	Experi-mental	• IBCT couples experienced a shorter initial deterioration period (14 weeks) than TBCT couples did (22 weeks) post-treatment. • IBCT moderately distressed couples had more consistent change as a group relative to the greater variability seen in other groups (e.g., TBCT couples and IBCT severely distressed couples). • IBCT couples reported using more IBCT behaviors at follow-up than TBCT couples used TBCT behaviors. • At two years post-therapy, two thirds of IBCT couples and 60% of TBCT couples were classified as improved or recovered. • 74% of IBCT couples and 69.7% of TBCT couples maintained their gains during follow-up. • For couples that did not improve in therapy, 55.6% of IBCT couples and 21.4% of TBCT couples improved	• Almost two thirds of couples were reliably improved or recovered at two years post-treatment. • After therapy, there was a pattern of an initial drop in marital satisfaction followed by a gradual increase in satisfaction over the following two years. • Client satisfaction with services is strongly related to changes in marital satisfaction over the following two years post-treatment. • IBCT couples that stayed together had greater overall improvements in marital satisfaction than TBCT couples.

Cordova, Jacobson, & Christensen (1998). Acceptance versus change interventions in behavioral couple therapy: Impact on couples' in-session communication.	Journal article	Purpose: To examine whether IBCT leads to predictably different types of communication processes than TBCT over the course of treatment	• 12 clinically distressed marital couples • Couples were between 21 and 60 years old, married, living together, Caucasian, and were in the middle SES	Independent Variable(s): Couple therapy (IBCT or TBCT) Dependent Variable: communication processes • Global Distress Scale (GDS) of the Marital Satisfaction Inventory (overall marital distress) • Four 5-point rating scales designed to measure Soft Expressions, Detachment, Hard Expressions, and Engaging in the Problem.	Experi-mental	• While equal amounts of detachment were found in early TBCT and IBCT, only IBCT had a significant overall increase from early to late sessions. • IBCT couples engaged in significantly more soft expressions late in therapy than TBCT couples did • IBCT couples initially engaged in more hard expressions early in therapy but this significantly decreased over the course of therapy. • Large correlation between increases in non-blaming discussions and decreases in martial distress • Trend towards a moderate correlation between both increases in soft expression and increases in problem engagement with decreases in marital distress.	• IBCT and TBCT result in identifiably different types of change over the course of treatment. • IBCT interventions that promote non-blaming discussions of mutual problems appear to be quite effective. • IBCT efforts to encourage empathic joining may increase soft emotional expression beyond what is achieved in TBCT. • Over the course of therapy, IBCT couples significantly decrease their in-session problematic behavior whereas TBCT couples significantly increase in-session problematic behavior. • The less-structured nature of IBCT, as compared to TBCT, may help couples have more expressions of negative affect and problematic behavior in-session.

Cruz (2009).	Dissertation	Purpose: To assess concordance between therapist self-report and naïve observer ratings of adherence to two forms of marital treatment, TBCT and IBCT.	Two early, middle, and late sessions from 35 randomly selected couples from a larger clinical trail compar-ing TBCT to IBCT.	• Behavioral couple therapy rating manual (adherence scale developed for TBCT and IBCT) • Couple therapist rating scale (adherence scale developed for TBCT and IBCT) • Session ratings by therapist (therapist self-report of adherence)	Correla-tional	• A strong, positive correlation was found between therapist self-reports and graduate ratings for TBCT. • Therapist self-report and graduate ratings for IBCT ranged from weak to strong, positive relationships. • Significant correlations between therapist self-reports and observer ratings were found for both change oriented interactions and acceptance oriented interventions. • One weak correlation was found for ratings of tolerance interventions within IBCT.	• Therapist and naïve observer ratings of in-session interventions were found to have high concordance and consistency, suggesting that therapists were able to accurately report interventions utilized in-session.

Doss & Christensen (2006). Acceptance in romantic relationships: The frequency and acceptability of partner behavior inventory.	Journal article	Purpose: *Study 1*: • To examine the factor structure of the FAPBI, reliability of the factors, and correlation with relationship satisfaction. *Study 2*: • To explore mean differences in the FAPBI between men and women in heterosexual relationships *Study 3*: • To compare the results of the FAPBI from a sample of distressed couples to non-distressed couples.	*Study 1*: • 12,752 participants took the FAPBI on the Internet, the majority of which were Caucasian. • Mean age was 36.9 years. *Study 2*: • 304 community couples, the majority of which were Caucasian. • Mean age was 36.7 years. *Study 3*: • 134 martially distressed couples (mean age was 42.5 years) and 152 non-distressed married couples (mean age was 37.4 years), the majority of which were Caucasian.	*Study 1 and 2*: • Frequency and Acceptability of Partner Behavior Inventory [FAPBI] • Dyadic Adjustment Scale [DAS] (marital satisfaction) *Study 2*: Independent Variable: Gender Dependent Variable: Acceptance and frequency of behavior • FAPBI *Study 3*: Independent Variables: Gender, level of marital distress Dependent Variable: Acceptance and frequency of behavior • FAPBI • DAS	*Study 1*: Psychometric scale development *Study 2*: Causal Comparative *Study 3*: Causal Comparative	*Study 1*: • Four factors were identified: affection, closeness, violation, and demand; two higher-order factors: positive and negative behavior. • Cronbach's alphas were all above .60, with the majority being higher than .70, indicating a high level of internal consistency. • The Acceptance subscale remained moderately correlated with the DAS when controlling for Frequency, whereas the Frequency subscales were much less correlated with the DAS when controlling for Acceptance. *Study 2*: • Men in married/co-habitating couples were somewhat more accepting of female partners; however, in dating couples women were more accepting than men. • Men reported that their female partners had more Closeness and Demanding behaviors than vice versa.	• The FAPBI is a reliable and valid measure. • FAPBI subscales were found to be related to marital satisfaction and sensitive to change. *Study 1*: • The four-factor structure was found to be a consistently good fit for participants with variable demographic information. • Three of the four subscales (Affection, Closeness, and Demand) were found to have high internal consistency, whereas the Violation subscale showed slightly lower levels of internal consistency. • Acceptance of behavior contributes more to the prediction of satisfaction than frequency of behavior does. *Study 2*: • Only small gender differences in heterosexual couples were found for acceptance and behavior frequency levels. *Study 3*: • Large differences were found between the acceptability of partner behavior in community and clinically distressed couples.

Doss, Thum, Sevier, Atkins, & Christensen (2005). Improving relationships: Mechanisms of change in couple therapy.	Journal article	Purpose: To examine how improvements in the frequency of relationship behaviors, emotional acceptance, and communication relate to changes in relationship satisfaction, and what the different roles of mechanisms of change have in early versus late therapy	• 134 married couples • Couples met criteria for serious and stable marital distress • Couples had at least a high school education, were between 18-65 years old, and were fluent in English	Predictor Variables: Changes in acceptance, communication, and relationship behaviors Criterion Variables: Marital satisfaction • Dyadic Adjustment Scale (marital satisfaction) • Frequency and Acceptability of Partner Behavior Inventory • Communication Patterns Questionnaire	Correl-ational	• Hierarchical linear modeling • Both husbands and wives demonstrated significant amounts of change in marital satisfaction over the course of therapy • During the first half of therapy, improvements in the frequency of target behaviors were strongly related to increases in marital satisfaction. • Acceptance increased significantly more in IBCT than in TBCT, and was significantly related to increased satisfaction for husbands over the entire course of therapy and for wives during the second half of therapy. • The amount of change in positive communication was significantly higher in TBCT than in IBCT; no therapy differences were found for changes in negative communication • While there were significant increases in the acceptability of positive and negative behaviors early in	• Behavior change and increases in acceptance in early treatment are associated with improvements in satisfaction, whereas emotional acceptance is associated with improvement in the second half of treatment. • The mechanisms of change had a different relationship with changes in marital satisfaction for each type of couple therapy: TBCT generally improved communication and frequency of partner behaviors than IBCT, but IBCT tended to create more change in emotional acceptance than TBCT • Relapse in the frequency of target behaviors in the second half of therapy was more harmful to relationship satisfaction in TBCT than IBCT, indicating that improvements in acceptance may be effective when behavior change is not. • Since there was not evidence of significant relapse in emotional acceptance during therapy, emotional acceptance may be a more durable form of change.

Erbes, Polusny, MacDermid, & Compton (2008). Couple therapy with combat veterans and their partners.	Journal article	Purpose: To present a rationale and framework for using IBCT with veterans, illustrated through both a theoretical discussion and case example.	• 1 couple receiving IBCT	N/A	Qual-itative case study	N/A	• Couple therapy for veterans is necessary due to the role of support or hardship couple relationships can play in recovery from combat-related pathology. • IBCT can be adapted to working with couples in which one partner has PTSD. The modifications of standard IBCT for this population and the mechanisms by which IBCT for PTSD operates are discussed. • A case illustration provides an example for how IBCT can be an effective form of treatment for couple therapy with veterans that have co-morbid PTSD.

Jacobson, Christensen, Prince, Cordova, & Eldridge (2000). Integrative behavioral couple therapy: An acceptance-based, promising new treatment for couple discord.	Journal article	Purpose: To provide preliminary data on IBCT, a new approach to couple therapy that focuses on acceptance of unchangeable aspects of one's partner and creating intimacy around unsolvable problems instead of increases in marital distress	• 21 couples that were legally married, living together, and between 21 and 60 years old. • Couples were identified as having clinically significant marital distress based on initial scores on MSI Global Distress Scale (GDS > 58)	Independent Variable: IBCT or TBCT Dependent Variable: Marital satisfaction • Global Distress Scale (GDS) of the Marital Satisfaction Inventory (marital distress) • Dyadic Adjustment Scale (marital satisfaction) • Adherence scale (therapist adherence to the treatment) • Behavioral Couple Therapy Competence Rating Scale (therapist competence in conducting TBCT)	Experi-mental	• Change-oriented interventions were significantly more likely to be used in TBCT than in IBCT; acceptance interventions were significantly more likely to be used in IBCT than TBCT • Both husbands and wives experienced greater improvements in their satisfaction following IBCT than they did following TBCT. • 60% of TBCT couples and 80% of IBCT couples either improved or recovered by the end of therapy.	• IBCT was demonstrated to be a distinct and effective treatment as compared to TBCT • Therapists were successfully able to adhere to the specific treatment modality each couple was assigned to, using acceptance-focused interventions in IBCT and change-focused interventions in TBCT • Results suggest that acceptance interventions may be more efficient at producing behavior change than the more direct attempts found in TBCT

McMurray (2007). Adherence to treatment and treatment outcome in marital therapy: Are therapist's interventions related to couple's success?	Dissertation	Purpose: To examine the relationship between therapist adherence and treatment outcome for both TBCT and IBCT	• 35 clinically distressed couples, randomly selected from a larger clinical trial on IBCT and TBCT.	Predictor Variables: Therapist behavior (adherence to treatment manual) Criterion Variables: Relationship satisfaction • Behavioral Couple Therapy Rating Manual (therapist competence in conducting TBCT) • Dyadic Adjustment Scale (marital satisfaction)	Correl-ational	• IBCT acceptance interventions were used more frequently than IBCT tolerance interventions. • Results showed a fairly strong positive relationship between IBCT adherence and treatment outcome only in the early and late stages of therapy. • There was almost no relationship between TBCT adherence and TBCT couples' treatment outcome. • Compatible interventions in the last third of IBCT had a significant effect on treatment outcome. • IBCT interventions used in the first and third stage of IBCT had the strongest relationship with outcome; specific interventions that appeared to drive these effects were unified detachment, problems as differences, and empathic joining.	• The relationship between adherence and outcome differs depending on when in the course of treatment the interventions were used. • Given that TBCT adherence was not related to outcome, the interventions or other factors related to outcome are unclear. • Acceptance-oriented interventions were the most responsible for the relationship between greater IBCT adherence and treatment outcome.

Sevier (2005). Client change processes in traditional behavioral couple therapy and integrative behavioral couple therapy: An observational study of in-session spousal behavior.	Dissertation	Purpose: To examine in-session spousal behaviors that are expected to relate to change in TBCT and IBCT for both treatment responders and non-responders.	• 134 clinically distressed couples • On average, the couples were in their early 40s, had been married for 10 years, had children and were Caucasian.	Predictor Variables: Gender, initial satisfaction levels, in-session behavior Criterion Variables: Client change • Dyadic Adjustment Scale (marital satisfaction) • Marital Status Inventory (steps taken towards separation or divorce) • Couple Therapy In-Session Behavior Rating System	Correl-ational	• Hierarchical linear modeling • TBCT couples showed significantly higher constructive change behaviors than IBCT couples. • IBCT couples demonstrated significantly more acceptance promoting behaviors than TBCT couples from the first session until late into treatment. • TBCT couples show significantly more positive behaviors than IBCT couples in the middle third of therapy, however IBCT couples show significantly more positive behaviors than TBCT couples during the last third of therapy. • Negative behaviors in TBCT lessened initially but then increased by the end of treatment; negative behaviors in IBCT increased initially but decreased by the end of treatment.	• Couples did generally change over time but the course of change depended on whether couples responded to treatment, initial distress severity, and the type of treatment was received. • Both IBCT and TBCT improved communication in both personal and relationship problem discussions. • TBCT made larger reductions in negativity and husbands made more gains in positivity than in IBCT. • Couples in IBCT generally showed more acceptance promoting behaviors whereas couples in TBCT generally showed more constructive change behaviors.

Sevier, Eldridge, Jones, Doss, & Christensen (2008). Observed communication and associations with satisfaction during traditional and integrative behavioral couple therapy.	Journal article	Purpose: To examine actual observations of couple communication behaviors while couples discuss both relationship and personal problems without a therapist present, at a pre-treatment assessment and a 26-week assessment. A major goal was to "highlight potential mechanisms of change in therapy by looking at the links between communication shifts over time and shifts in marital satisfaction in each therapy" (p. 147).	• 865 discussions that occurred within moderate to chronically distressed couples that focused on personal or relationship problems. Discussions occurred both at pre-treatment and 26 weeks later. • Couples were from a dataset of 134 couples receiving either TBCT or IBCT • On average, couples were in their early 40s (husbands = 43.5; wives = 41.6), college educated, married for 10 years, and were Caucasian (over 75%).	Predictor Variables: couple therapy (TBCT vs. IBCT) Criterion Variables: changes in communication and marital satisfaction • Dyadic Adjustment Scale (marital satisfaction) • Marital Status Inventory (steps taken towards separation or divorce) • Couple Interaction Rating System (couple behaviors) • Social Support Interaction Rating System (emotional displays and supportive behaviors)	Correl-ational	• Hierarchical linear modeling • Severely distressed couples showed significantly less positivity and problem-solving behavior, while demonstrating more negativity than moderately distressed couples. • Pretreatment satisfaction and communication behaviors were not related to subsequent behavior change in therapy. • TBCT couples demonstrated greater behavior change than IBCT couples. • Increases in problem solving and positivity were related to increases in marital satisfaction, whereas increases in negativity was inversely related to improved relationship satisfaction.	• Couple therapy improves communication. • TBCT couples made larger reduction in negativity and greater gains in positivity than IBCT couples. • No evidence of differences between TBCT and IBCT in changes in communication and marital satisfaction over time. This finding is perhaps due to using coding systems that were more relevant to TBCT behaviors rather than IBCT behaviors. • Pretreatment distress and communications were not related to communication behavior changes over time.

Sevier & Yi (2008). Cultural considerations in evidence based traditional and integrative behavioral couple therapy.	Book chapter	Purpose: To integrate empirical work with cultural competency by exploring issues of cultural sensitivity among TBCT and IBCT.	N/A	N/A	N/A	N/A	• Three domains of therapeutic processes are discussed in relation to TBCT and IBCT: engagement, theory, and treatment models. • TBCT is found to be a more etic model, with potentially less adaptability to diverse cultures due to the rule-based, structured nature of the approach. • IBCT is considered to be more emic than TBCT, largely because IBCT tailors the interventions to each couple through a collaborative process in which cultural beliefs and differences are included. • Implications for training and supervision are discussed.

Steenwyk (2008). Understanding the process of integrative behavioral couple therapy: A task analysis of empathic joining	Dissertation	Purpose: To examine the specific steps involved in successful an unsuccessful experiences of empathic joining within IBCT.	• 6 couples from larger clinical trial • Mean age was 43.8 years for wives and 45.2 for husband; couples married for an average of 11.92 years and had an average of 1 child. • Participants were 58% Caucasian, 33% Latino, and 8.3% Native American or Alaskan Native.	• Therapist post-session questionnaire • Couple Therapy In-Session Behavior Rating System • Structural analysis of social behavior	Task analysis (qual-itative)	• Empirical model of successful empathic joining consists of 5 steps: 1. Problem discussion or argument 2. Vulnerable expression 3. Partner 2 responds to Partner 1 4. Resolution 5. Review and affirmation • Obstacles to empathic joining include blaming reactions or hard emotional expression from either one or both partners.	• The steps of empathic joining are consistent with theoretical assumptions of acceptance within IBCT. • Empathic joining was found to lead to increased acceptance, empathy, intimacy, and affiliation between spouses. • Implications for clinicians are discussed.

V. Miscellaneous

Author, Year, Title	Publication Type	Objectives	Sample	Variables/ Instruments	Research Design	Results/ Statistics	Major Findings
APA (2006). Evidence-based practice in psychology.	Journal article	Purpose: To describe the components of evidence based practice and implications for clinicians and researchers are provided.	N/A	N/A	Summary from APA presiden-tial task force	N/A	• Evidence based practice is the integration of the best research evidence, clinical expertise, and patient values/ expectations. • Examples of "best research evidence" includes clinical observation, qualitative research, and process-outcome studies. • Implications for future research and clinical practice are discussed.

Butzer & Kuiper (2008). Humor use in romantic relationships: The effects of relationship satisfaction and pleasant versus conflict situations.	Journal article	Purpose: To study positive, negative, and avoidant types of humor used within pleasant and conflict situations.	• 154 undergraduate students in a romantic relationship of at least three months duration. • Mean length of relationship was 15.6 months. • Participants included 108 women and 46 men, with a mean age of 19.10 years.	Predictor Variable(s) Situation (conflict, pleasant); Relationship satisfaction Criterion Variable(s) Positive, negative, and avoidant humor use	Correlational	Hierarchical regression analysis • Positive humor was reported as being used the most often, followed by avoidant humor, with negative humor reportedly used the least often. • Higher levels of relationship satisfaction predicted higher levels of positive humor use, and lower levels of relationship satisfaction predicted higher levels of negative humor use. • Individuals with higher relationship satisfaction reported using positive humor more often in pleasant situations than in conflict situations, whereas individuals with less relationship satisfaction reported using more negative humor in pleasant situations than in conflict situations. • Couples with greater relationship satisfaction	• Individuals reported that positive humor is most frequently used within their romantic relationships, followed by moderate amounts of avoiding humor and less amounts of negative humor. • A relationship exists between romantic relationship satisfaction and the use of humor, with more satisfied individuals reportedly using more positive humor in both conflict and pleasurable situations than less satisfied individuals. • Individuals who reported less relationship satisfaction did not distinguish between the amount of negative humor use in conflict versus pleasant situations, whereas individuals with higher relationship satisfaction reported using less negative humor in conflict situations than in pleasant situations. This suggests that individuals with higher levels of relationship satisfaction may use positive humor in conflict situations to deescalate conflict with romantic partners.

Caughlin & Scott (2010).	Book chapter	N/A	N/A	N/A	N/A	N/A	• This book chapter provides an overview of the theory, research, and understandings of demand-withdraw interactions. • Differing perspectives on demand-withdraw interactions reviewed: gender difference, social structure, conflict structure, individual differences, and multiple goals. • Based on research analyzing demand-withdraw patterns in romantic relationships and in parent-adolescent dyads, four distinct styles of demand-withdraw sequences were found: (1) Discuss/ Exit, in which one individual pursues discussion of an issue and the other persons engages in either verbal or physical exit of the discussion; (2) Socratic questioning/ Perfunctory response, in which the demander asks numerous questions and the withdrawer offers simple, typically one-word answers; (3) Complain/ Deny, where the demanding partner makes a complaint about the other partner's behavior and the other partner challenges the legitimacy of the complaint; and (4) Criticize/ Defend, involving a criticism by the demanding partner and a defensive response justifying the criticized behavior by the other partner.

Creswell (2007).	Book	N/A	N/A	N/A	N/A	N/A	• This book provides a detailed discussion of five qualitative research strategies, including narrative, phenomenological, grounded theory, ethnographic, and case study designs. Guidelines for data collection, analysis, and addressing common validity and reliability concerns are provided.
Kazdin (2003).	Book	N/A	N/A	N/A	N/A	N/A	• This book provides a broad yet detailed overview of quantitative, qualitative, and mixed-methods research methodologies. Reliability and validity issues are also discussed.

Lauer, Lauer, & Kerr (1990).	Journal article	Purpose: To contribute to the literature on variables that couples say contribute to stability and satisfaction in marriage.	• 100 couples from multiple US states. Couples were married for 45-64 years, 97% identified as religious, mainly upper middle class, and with 74% having some college education.	• Dyadic adjustment scale (marital satisfaction) • Added items relating to attitudes towards one's spouse (e.g., viewing spouse as best friend) • Open ended questions about the most important to the stability of their marriage	Survey research	• 85% of respondents reported being satisfied in their marriages • The vast majority of spouses (over 75%) said they almost always confide in their partners, they kiss near daily, & they laugh together at least once per day. • The top six reasons husband list as contributing to successful long-term marriages include: mate is best friend, like mate as a person, marriage is a long-term commitment, marriage is a sacred institution, agree on aims and goals, and laugh together frequently. Wives listed marriage is a long-term commitment, like mate as person, mate is best friend, laugh together frequently, agree on aims and goals, and marriage is a sacred institution.	• Husbands and wives reported reasons for successful long-term marriages were in agreement, indicating that men and women tend to value the same things in marriage. • Husbands and wives both ranked the role of laughter and humor within the top six factors that positively contribute to long-term marriages.

Mertens (2005).	Book	N/A	N/A	N/A	N/A	N/A	• This book provides a broad yet detailed overview of quantitative, qualitative, and mixed-methods research methodologies. Reliability and validity issues are also discussed.

Spanier (1976).	Journal article	Purpose: To describe findings related to the development of a marital satisfaction assessment measure.	• 218 Caucasian married persons and 90 divorced persons in Penn-sylvania. • Mean age of married sample was 35.1 and of divorced sample was 30.4.	Dyadic adjustment scale [DAS] (marital satisfaction)	Psycho-metric	• Factor analysis resulted in four factors thought to be indicators of marital satisfaction, including dyadic satisfaction, dyadic cohesion, dyadic consensus, and dyadic differences, resulting in a 32-item scale. • Items were evaluated by experts in order to establish content validity. • Criterion-related validity was established through significant correlations found between total score and marital status. • Construct validity was established through a high correlation between the DAS and the Locke-Wallace Marital Adjustment Scale • Reliability was established through Cronbach's Coefficient Alpha's for the DAS and each subscale, all of which were over .70.	• The DAS appears to be a valid and reliable measure for assessing marital satisfaction.

Tashakkori & Teddlie (1998).	Book	N/A	N/A	N/A	N/A	N/A	• This book provides an in-depth discussion of mixed-methods research, focusing on the strengths and limitations of quantitative and qualitative research conducted in a unified fashion. Specific models for mixed-methods research are described.

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APPENDIX B

Acceptance Promoting and Interfering Interaction Rating System, Used Within the Current Study

Laura D. Wiedeman & Kathleen A. Eldridge

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General Instructions

The Acceptance Promoting and Interfering Interaction Rating System (APIIRS) consists of five categories of acceptance promoting behavior that are used to rate dyadic couple behavior during therapy sessions. These categories are based on the types of couple interactions that may directly serve to enhance partner acceptance (e.g., validating the perspective of one's spouse) and those behaviors that are believed to harm the potential for acceptance (e.g., criticism). Through rating the presence and absence of these interaction styles, a comprehensive depiction of the complex dynamics that occur during couple therapy becomes possible.

Each category of acceptance promoting interactions is rated on a scale of one to nine after the rater has observed the entire selected segment of therapy. The nine-point scale is anchored at one end by "None" (or not at all) and at the other end by "A lot." The rating is based on two main judgments regarding the quantity and quality of interactions that were observed. The *quantity* of the interactions refers to the frequency with which the couple displays the behaviors or attributes in question, relative to other spouses in therapy. The *quality* of the interactions relates to the intensity or depth of the couple's involvement in the interaction, relative to other spouses in therapy. This combined appreciation of both quantity and quality is intended to address the variability

with which couples may engage in these acceptance promoting interactions. For example, acceptance promoting behaviors or attributes may be displayed frequently but with minimal depth, or infrequently but in substantial depth when they do occur.

In order to make accurate judgments about the quantity and quality of acceptance promoting interactions, raters will need to develop a "nomothetic" sense of what is typical for spouses in these kinds of situations. This sense will be developed during a training period when raters practice using the coding system with a series of tapes from couples in therapy. Second, the rater will need to develop "idiographic" knowledge of the particular couple's differences and pattern of interaction surrounding conflict. This will be gained through watching an initial therapy session in which the therapist and couple collaboratively discuss the couple's main difference(s), interaction pattern(s), and emotions.

The rating categories are defined in the subsequent section. It is critical to note that they are not mutually exclusive; any behavior or reaction by a spouse might be an exemplar of more than one item. Due to the complex nature of dyadic interactions, the best way to comprehensively depict what is observed often requires the use of multiple codes. Within each rating category, specific types of dyadic interactions are described in order to help raters recognize these interactions and complete an overall rating for each category after watching the entire therapy session. While the subcategories of each code are intended to provide examples of what interactions constitute each code, the final rating is made based on the overall category and *not* the specific subcategories. It is important to note that in addition to coding the in-session interaction that spouses engage

in, in-session spousal reports of acceptance promoting interactions that occur *outside* of the therapy session should also be coded.

Raters should focus primarily on the interaction between both spouses. Particular attention should be paid to which partner is engaging in a particular behavior and which partner is responding to the particular behavior. Raters will provide a score for each type of acceptance promoting interaction that the husband initiates and that the wife initiates; therefore, the initiating and responding partner are noted in the coding. In many situations, determining which partner is initiating and which is responding can be a difficult task. Since each part of the interactional sequence could be considered a reaction to the previous behavior, there are likely to be many shifts in who is initiating and who is responding. Since the coding is focused on rating the occurrence and intensity of specific interactions throughout the entire session, not the moment-by-moment sequences of interaction, raters will need to develop an overall sense of the various types of interactional sequences that occur in order to capture the complexity of what is observed.

While the focus of this coding system is not on the therapist's statements or behaviors, it should be noted when a spouse engages in a significant initiating behavior (as described in the categories listed in the next section) and the therapist, not the other partner, is the one who responds. When the partner does not have an opportunity to respond because the therapist begins speaking, perhaps focusing on a different part of the spouse's statement or behavior than what is considered to be acceptance promoting, it may hinder the partner's opportunity to provide a response. Details about how to code this type of therapist involvement will be explained in the following sections.

If, while viewing the tape, raters miss or do not understand what occurs, they should immediately stop the tape and replay that portion of the tape. Raters should take notes while viewing the tape, particularly related to the initiating and responding partner, and the type of initiation that occurs. After viewing the entire session, raters should evaluate whether they have enough information to make ratings on all of the categories. It is recommended that raters make note of significant sections in the session and review those sections once more.

Description of Items

Vulnerability

The code *Vulnerability* involves the expression of vulnerable or soft emotions, thoughts or behaviors by the initiating partner and a positive, neutral or negative reaction from the responding partner. Expressions of hurt, insecurity, sadness, tenderness, loneliness, shame, guilt, fear, needs, love or desire are soft expressions when they are shared in a vulnerable way. Behaviors such as self-disclosure, confiding, nervous humor, putting one's self down, expressing hurt, pain, disappointment or grief may also be soft expressions. Initial expressions of vulnerability are likely to be related to one's own experience, as opposed to talking about what one's partner has said or done. Examples might include one partner saying, "I'm just continually bummed about not being able to find a job," "I feel very unattractive to you," or " I wish you wouldn't go on your trip and you were home with us."

This code requires that the rater make a judgment about the genuineness of both the initiator and responder. When one spouse expresses his hurt in an angry, hostile, or accusatory way, he is generally much less vulnerable than a spouse who expresses his

hurt in a soft and heartfelt way. When vulnerable expressions are couched in an angry tone, less vulnerability is apparent because anger serves to hide the vulnerable expression and often relates to a defensive stance in which the partner is already "armed" in case of attack. In fact, some people may feel more vulnerable when expressing anger if their normal stance is to withdraw and not express themselves, as this reveals feelings or beliefs not normally expressed. For example, a spouse may use a loud tone to say, "You made time to accompany this other woman to a stupid baseball game, but you can't seem to make any time for me!" This statement is more likely to make the responding partner defensive or feel attacked, however may still be a vulnerable expression in that the spouse is revealing underlying feelings of rejection. If she were to express the same underlying sentiment in a softer way, such as by saying, "I just don't feel important to you," the responding partner might be more apt to provide a positive response instead. Thus, vulnerable statements can be both soft and hard expressions. The rater's idiographic knowledge of each partner and their relationship will help the rater determine what behaviors and expressions put each individual in a vulnerable state within the relationship. In general, initiating behaviors that include eye contact and are directed to the spouse are considered to be more vulnerable than those vulnerable statements that are made without eye contact and/or to the therapist.

After the initial display of vulnerability, the responding partner's reaction is critical to understand. Positive responses may include reciprocal vulnerability, conveying an emotional or intellectual understanding of the vulnerable partner's experience, validation, non-blaming clarification questions that demonstrate interest and/or compassion. These responses support the initiating partner's vulnerability, whereas

negative responses are thought to create conflict and/or obstruct further vulnerable expressions. Negative partner responses include criticism, defensiveness and blame, among others.

In the situation where a partner engages in a vulnerable behavior and the therapist responds (whether or not the response is directly related to the vulnerable behavior), thus hindering the opportunity for the spouse to respond, this should be coded as vulnerability + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the partner's vulnerability removes an immediate opportunity for the spouse to directly respond. If the initiating partner's vulnerable behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in non-verbal behavior), then the vulnerability + no response code should be used.

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of vulnerability followed by positive or negative partner responses, or the therapist responses, that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Vulnerability + positive response:

- Vulnerability + reciprocal vulnerability (both partners sharing emotions or personal history/issues in a vulnerable way)
- Vulnerability + emotional understanding/empathy (having an emotional understanding of the perspective and experience of one's partner)
- Vulnerability + intellectual understanding (having a logical, conceptual understanding of the perspective and experience of one's partner)
- Vulnerability + validation
- Vulnerability + compassion/appreciation/reassuring/apologizing
- Vulnerability + use of non-belittling humor
- Vulnerability + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Vulnerability + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Vulnerability + negative response:

- Vulnerability + criticism/attack
- Vulnerability + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Vulnerability + contempt
- Vulnerability + blame/defensiveness
- Vulnerability + pressure to change
- Vulnerability + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)

- Vulnerability + sarcastic/belittling/inappropriate humor

Vulnerability + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Vulnerability + therapist response

Non-Blaming, Intellectual Problem Discussion

The code *Non-Blaming, Intellectual Problem Discussion* involves talking about a relationship issue, such as a general pattern or theme, in a non-blaming and intellectualized manner. This type of discussion frequently involves relating a specific incident to the overall conceptualization of the couple's main differences, interaction patterns, and/or emotions. The key is that the discussion of the conflict, or the couple's interaction around the conflict, occurs without simultaneously experiencing the emotional reactions that are typically involved. It is essential that the discussion be non-blaming and somewhat intellectualized in that spouses may be discussing negative emotional reactions, but they are not acting upon them. For example, if the initiating spouse says, "If he would just leave me alone when I'm upset, this would all be fine!" it indicates a blaming or accusatory tone. A non-blaming and somewhat intellectualized version of this statement might be, "If I admitted when I was upset instead of denying it, he probably would respond better and I wouldn't get so annoyed with him constantly asking me "What's wrong?" "

Another example of a non-blaming discussion could include pointing out similarities in each spouse's experience during an interaction by saying, "We were both misinterpreting each other - you were processing the information silently while I wanted to discuss it aloud." In describing the difference or pattern of interaction, partners may

refer to a label (e.g. pursue-withdraw) or a humorous name. This can also take a form similar to "We were doing our thing again."

It follows that non-blaming, intellectual discussions often involve discussing relationship dynamics using words such as "we," "our" and/or "us" (e.g., "Our pattern" or "When we do this…"), suggesting a sense of togetherness and mutual responsibility for their interactional pattern. While the use of these words does not always occur during a non-blaming problem discussion, nor do they signify that a non-blaming problem discussion is definitively occurring when they are used, they are often a good indication that a non-blaming discussion might be occurring.

When the responding partner resorts to reactions such as criticism, blame, defensiveness, or withdrawal, the couple often becomes emotionally engaged in the problem. Partners are no longer gaining an intellectual understanding of their interaction patterns, but instead may experience a rise in emotional reactivity or become fixated on a particular incident rather then discussing patterns in a more general way.

In the situation where a partner attempts to start or continue in a non-blaming, intellectual discussion and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as non-blaming, intellectual problem discussion + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the partner's non-blaming discussion removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses*

not to (e.g., stays silent, no change in nonverbal behavior), then the non-blaming, intellectual problem discussion + no response code should be used.

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of non-blaming, intellectual problem discussions followed by positive or negative responses that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Non-blaming, intellectual problem discussion + positive response:

- Non-blaming, intellectual problem discussion + non-blaming, intellectual response
- Non-blaming, intellectual problem discussion + sharing of personal information (personal history and/or issues)
- Non-blaming, intellectual problem discussion + increase in soft emotions/vulnerability
- Non-blaming, intellectual problem discussion + validation
- Non-blaming, intellectual problem discussion + use of non-belittling humor
- Non-blaming, intellectual problem discussion + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Non-blaming, intellectual problem discussion + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Non-blaming, intellectual problem discussion + negative response*:*

- Non-blaming, intellectual problem discussion + criticism/attack
- Non-blaming, intellectual problem discussion + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Non-blaming, intellectual problem discussion + contempt
- Non-blaming, intellectual problem discussion + blame/defensiveness
- Non-blaming, intellectual problem discussion + pressure to change
- Non-blaming, intellectual problem discussion + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Non-blaming, intellectual problem discussion + sarcastic/belittling/inappropriate humor

Non-blaming, intellectual problem discussion + no response: (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Non-blaming, intellectual problem discussion + therapist response

Validation

A spouse demonstrates validation through stating something positive about his or her partner's behavior or emotional experience, whether through a direct positive statement, compassion, empathy, encouragement, appreciation, and/or support (e.g., "It's okay to feel that way"). Validation occurs when one spouse demonstrates understanding for his or her partner's feelings, for example, a partner may show understanding and empathy through commenting, "I never realized how hurt you feel when I forget to call

and come home late." Validation may also involve a spouse offering an apology, sympathy, empathy, to help, or normalization (e.g., "I do that too sometimes"). Other behaviors included as validation are: offers of reassurance, admitting fault, showing caring and understanding, showing trust or acceptance of the partner, and mentioning something positive about partner's behavior.

Another way that validation might occur is through a spouse agreeing with the therapist's positive or non-blaming conceptualization of the partner's feelings, thoughts, and/or behaviors. For example, the therapist could explain, "Even though being 30 minutes late doesn't seem important to you, she experiences it as a threat of being left alone and gets scared." If the husband responds by saying, "I didn't realize she was scared, I didn't see it that way before," it indicates that he is validating the wife's perspective. Interactions that demonstrate a willingness to appreciate one's partner's feelings, thoughts, or behaviors as differences, rather than as negative qualities, are considered to be validation.

While the first aspect of validation involves a positive comment about some aspect of a partner's behavior or emotional experience, the second component of validation entails how the partner responds. Ideally, the responding partner will react with appreciation, vulnerability or reciprocal positive comments about the initiating partner's behavior or emotions. Negative partner responses include becoming defensive, showing indifference, decreasing physical contact (e.g., moving to sit further away from partner), or blaming. For example, if the initiating partner says, "I didn't know how unappreciated you felt, I'm sorry," and the responding partner reacts by saying, "*Now*

you act like you understand, but it's just because you're trying to look good in front of the therapist!" it demonstrates a defensive response.

In the situation where a partner provides validation towards his or her spouse and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as validation + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the initiating partner's validating statement removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in nonverbal behavior), then the validation + no response code should be used.

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of validation followed by positive or negative responses that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Validation + positive response:

- Validation + validation
- Validation + compassion/appreciation
- Validation + increase in soft emotions/vulnerability
- Validation + use of non-belittling humor

- Validation + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Validation + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Validation + negative response:

- Validation + criticism/attack
- Validation + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Validation + contempt
- Validation + blame/defensiveness
- Validation + pressure to change
- Validation + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Validation + sarcastic/belittling/inappropriate humor

Validation + no response (no change in physical or non-verbal behavior, no acknowledgement of initiating component of the interaction)

Validation + therapist response

Aversive partner behavior

Aversive partner behavior occurs when one partner engages in a behavior or emotion that the other partner is likely to perceive as being aversive, but the other partner's reaction is more benign than in past experiences. The significance of this interaction is that it provides evidence that formerly aversive and seemingly intolerable experiences are becoming more tolerated and/or accepted. For example, a spouse may

report or demonstrate feeling less upset by partner behavior that was difficult to deal with in the past.

Aversive partner behavior does not necessarily mean that the responding partner has to fully accept the aversive behavior. The idea is that the spouse learns to increasingly tolerate the negative behavior instead of responding unconstructively or trying to change it. A spouse may discuss new ways of coping with aversive partner behavior, such as better self-care or engagement in hobbies or interests, instead of responding in destructive ways. For example, in a couple where one spouse wants to talk about his or her day and the other wants to quietly unwind after getting home, the spouse may say, "When he watches TV it doesn't bother me as much anymore because I know that he'll listen more attentively and be more interested in talking with me after he unwinds, than if I start trying to have a long conversation the moment he comes home." In this case, the wife experienced the husband's watching TV behavior as aversive, however she was growing to tolerate this behavior because she was aware that it would lead to a more positive interaction in the near future. Given this same couple, the husband could have said, "I make an extra effort to sit down and debrief about our days since I know it is important to her, just like having a little downtime when I get home is important to me." In this latter example, the husband is accommodating his wife's immediate need for connection, which was formerly experienced as aversive and now is better understood.

In the situation where a partner engages in an aversive behavior directed towards his or her spouse and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as aversive partner behavior + therapist response. This

code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the initiating partner's aversive behavior removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in nonverbal behavior), then the rater may choose to use the codes aversive partner behavior + lack of hurt/distress/typical response or aversive partner behavior + withdrawal, depending on the rater's understanding of the interaction.

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of aversive partner behavior or maintaining/increasing a change emphasis that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Aversive partner behavior + positive response:

- Aversive partner behavior + lack of typical response
- Aversive partner behavior + lack of hard emotional response (e.g., lack of anger/blame)
- Aversive partner behavior + lack of hurt/distress
- Aversive partner behavior + quicker than usual recovery from negative interaction
- Aversive partner behavior + new coping methods/increased self-care

- Aversive partner behavior + intellectual understanding
- Aversive partner behavior + emotional understanding/empathy
- Aversive partner behavior + validation
- Aversive partner behavior + use of non-belittling humor
- Aversive partner behavior + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Aversive partner behavior + negative response:

- Aversive partner behavior + typical response
- Aversive partner behavior + criticism/attack
- Aversive partner behavior + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Aversive partner behavior + contempt
- Aversive partner behavior + blame/defensiveness
- Aversive partner behavior + pressure to change
- Aversive partner behavior + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Aversive partner behavior + sarcastic/belittling/inappropriate humor

Aversive partner behavior + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Aversive partner behavior + therapist response

Pressure to change

Pressure to change occurs when a partner engages in anger, coercion, blame, or other interactions that create, or at least maintain, distress. Pressure to change can be directed at one's partner (e.g., "If you would only initiate sex once per week, then things would be so much better") or at oneself ("I will work on expressing my anger more constructively"). It is important to note that both self-directed and other-directed pressure to change are coded within this category. Pressure to change will likely be evident as a part of the previously discussed codes; any negative reaction to vulnerability, non-blaming problem discussions, and/or validation might entail pressures to change. The pressure for change category is intended to provide a global assessment of the amount of overall pressure to change exerted within relationship interactions. Since this category focuses on the expression of pressure to change and is not concerned with the spouse's response to pressure to change, no interactional codes are needed.

Pressure to change might be seen in overt attempts to change oneself or one's partner, such as a partner saying "Why can't you just make time for me," "Don't play games with me," or "If you just told me that, I would have understood." However, some initiating or responding behaviors might involve subtler pressure for change. For example, a vulnerable expression such as "I wish you would make more time for me" reveals a concern about whether a spouse is important or loved, but also is a request for the spouse to behave differently. In examining these two examples, the first involves much greater pressure to change than the second. Other subtle examples of pressure to change include "I just need to deal with this on my own more instead of talking with you," "I hope you retire soon so you have more time for us," "I wish you would talk to

me about what you're feeling." Even though these statements might make logical sense and could represent ideas that may contribute to a reduction in distress for a couple, they still entails a pressure for one spouse to change his or her way of being, and thus is considered to be pressure to change.

It should be noted that although the rater will code the global amount of pressure to change, there are not separate codes for the *absence* of pressure to change. Instead, this is accounted for through using the Likert scale such that if no negative pressure to change occurs in the selected segment for observation, than this category would receive a code of "None."

Subcategories. Although there are no interactional codes for the pressure to change category, the rating system does take into account whether the pressure to change was directed at the self or at one's partner.

Pressure to change – husband initiated:

- Self-directed (pressure for husband to change)
- Other-directed (pressure for wife to change)

Pressure to change – wife initiated:

- Self-directed (pressure for wife to change)
- Other-directed (pressure for husband to change)

APPENDIX C

Acceptance Promoting and Interfering Interaction Rating Sheet

Rating Sheet for Acceptance Promoting and Interfering Interaction Rating System

Kathleen Eldridge & Laura Wiedeman
Pepperdine University

Rater name: _____ Couple code: _____ Session #: _____

Date of coding: _____ **None** **Moderate** **A Lot**

1 2 3 4 5 6 7 8 9

Vulnerability + Positive Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Vulnerability + Negative Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Vulnerability + No Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Vulnerability + Therapist Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Non-Blaming, Intellectual Problem Discussion + Positive Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Non-Blaming, Intellectual Problem Discussion + Negative Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Non-Blaming, Intellectual Problem Discussion + No Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Non-Blaming, Intellectual Problem Discussion + Therapist Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Validation + Positive Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Validation + Negative Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Validation + No Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Validation + Therapist Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Aversive Partner Behavior + Positive Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Aversive Partner Behavior + Negative Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Aversive Partner Behavior + No Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Aversive Partner Behavior + Therapist Response:

Husband-initiated **O O O O O O O O O**

Wife-initiated **O O O O O O O O O**

Pressure to Change:

Husband-initiated

Self-directed **O O O O O O O O O**

Other-directed **O O O O O O O O O**

Wife-initiated

Self-directed **O O O O O O O O O**

Other-directed **O O O O O O O O O**

Notes on the quality of the tape (was there anything about the tape that made it difficult to make ratings, i.e., sound quality, video quality, etc.):

APPENDIX D

Acceptance Promoting and Interfering Interaction Rating System

Revised for Future Use

Laura D. Wiedeman & Kathleen A. Eldridge

Pepperdine University

General Instructions

The Acceptance Promotion and Interference Interaction Rating System (APIIRS) consists of five categories of acceptance promoting interactions that are used to rate dyadic couple behavior during therapy sessions. These categories are based on the types of couple interactions that may directly serve to enhance partner acceptance (e.g., validating the perspective of one's spouse) and those behaviors that are believed to harm the potential for acceptance (e.g., criticism). Through rating the presence and absence of these interaction styles, a comprehensive depiction of the complex dynamics that occur during couple therapy becomes possible.

Each category of acceptance promoting interactions is rated on a scale of one to nine after the rater has observed the entire selected segment of therapy. The nine-point scale is anchored at one end by "None" (or not at all) and at the other end by "A lot." The rating is based on two main judgments regarding the quantity and quality of interactions that were observed. The *quantity* of the interactions refers to the frequency with which the couple displays the behaviors or attributes in question, relative to other spouses in therapy. The *quality* of the interactions relates to the intensity or depth of the couple's involvement in the interaction, relative to other spouses in therapy. This combined appreciation of both quantity and quality is intended to address the variability

with which couples may engage in these acceptance promoting interactions. For example, acceptance promoting behaviors or attributes may be displayed frequently but with minimal depth, or infrequently but in substantial depth when they do occur.

In order to make accurate judgments about the quantity and quality of acceptance promoting interactions, raters will need to develop a "nomothetic" sense of what is typical for spouses in these kinds of situations. This sense will be developed during a training period when raters practice using the coding system with a series of tapes from couples in therapy. Second, the rater will need to develop "idiographic" knowledge of the particular couple's differences and pattern of interaction surrounding conflict. This will be gained through watching an initial therapy session in which the therapist and couple collaboratively discuss the couple's main difference(s), interaction pattern(s), and emotional experiences.

As a rater's clinical understanding of a couples' interaction patterns may develop over time, it may be important to re-watch significant aspects of prior sessions observed for each couple to ensure accurate coding of the type of interaction and of the intensity of an interaction. For example, in a couple for whom expressing distress is a vulnerable act (which is often the case for partner(s) with a tendency to withdraw in the face of conflict), the expression of anger can be a vulnerable act; a novice rater may initially misconstrue the voicing of anger as something other than vulnerability, but when re-watching the interaction may see a lower intensity of vulnerability present in the interaction. Raters are also instructed that if, while viewing the tape, raters miss or do not understand what occurs, they should immediately stop the tape and replay that portion of the tape. Raters should take notes while viewing the tape, particularly related to the

initiating and responding partner, and the type of initiation that occurs. After viewing the entire session, raters should evaluate whether they have enough information to make ratings on all of the categories. It is recommended that raters make note of segments in which multiple acceptance promoting and/or interfering interactions were coded and review those selections once more.

The rating categories used during the coding are defined in the subsequent section. It is critical to note that they are not mutually exclusive; any behavior or reaction by a spouse might be an exemplar of more than one item. Due to the complex nature of dyadic interactions, the best way to comprehensively depict what is observed often requires the use of multiple codes. Within each rating category, specific types of dyadic interactions are described in order to help raters recognize these interactions and complete an overall rating for each category after watching the entire therapy session. While the subcategories of each code are intended to provide examples of what interactions constitute each code, the final rating is made based on the overall category and *not* the specific subcategories. It is important to note that in addition to coding the in-session interaction that spouses engage in, in-session spousal reports of acceptance promoting interactions that occur *outside* of the therapy session should also be coded (however are often coded with a lower intensity level).

Raters should focus primarily on the interaction between both spouses. Particular attention should be paid to which partner is engaging in a particular behavior and which partner is responding to the particular behavior. Raters will provide a score for each type of acceptance promoting interaction that the husband initiates and that the wife initiates; therefore, the initiating and responding partner are noted in the coding. In many

situations, determining which partner is initiating and which is responding can be a difficult task. Since each part of the interactional sequence could be considered a reaction to the previous behavior, there are likely to be many shifts in who is initiating and who is responding. However, as the coding is focused on rating the occurrence and intensity of specific interactions throughout the entire session, not the moment-by-moment sequences of interaction, raters will need to develop an overall sense of the various types of interactional sequences that occur in order to capture the complexity of what is observed. For example, consider the following interaction:

> Wife [*looking at therapist*]: I do think he is a good dad and he is a good provider and the kids love him to death. [*Husband is looking down without any apparent physical or verbal reaction to Wife's statement*]
>
> Therapist: And I think that's important that you say that and I think it's important that you hear that, [*Husband*].
>
> Wife [*turns to Husband*]: Have you never heard me say that before?
>
> Husband: First time [*laughs, looks at Wife and then looks down*].
>
> Wife [*looking at Husband*]: Do you want to take an oath on that?
>
> Therapist: But what I'm thinking is that it's important for you to hear that tonight.
>
> Husband: Mm-hmm.
>
> Therapist: I'm sure it's not the first time you have heard that.
>
> Husband: No, it is important to hear that tonight, because in the midst of an argument, it is nice to hear a diffusing statement like that. [*Husband turns to look at Wife*] But I'm not giving you one! [*laughs*].

Wife: [*looks down, laughs, raises her eyebrows and fidgets with paper in her hand*]

Husband: No, [*Wife*] is a great mom, she is a great mom, our kids-

Wife: [*interrupts Husband and proceeds to talk about how Husband was instigating a fight at dinner*]

This sequence demonstrates the complexity of the interaction patterns coded with APIIRS. Four codes can be applied to represent this interactional sequence.

(1) Wife Validation + Husband No Response [*Occurs when Wife compliments Husband's parenting, and Husband does not make any apparent verbal or behavioral shift in reaction*]

(2) Wife Validation + Husband Compassion / Appreciation / Reassurance / Apology [*Occurs after Wife compliments Husband's parenting, when Husband (after therapist's prompting) says that it is nice to hear a diffusing statement like that*]

(3) Husband Aversive Partner Behavior (being sarcastic) + Wife Withdrawal and/or Decrease in Positive Nonverbal Gestures [*Occurs when Husband jokes that he is not giving Wife a compliment in return, and Wife looks down and raises her eyebrows in response*]

(4) Husband Validation + Wife Criticism / Attack [*Occurs when Husband starts to compliment Wife's parenting and Wife interrupts to bring up something negative Husband did recently*]

This example highlights the complexity of interactional coding. Given that this type of interactional sequence may occur multiple times throughout the session, detailed notes

and observations are necessary. Through keen observation and notes, it is possible to complete the global ratings to best represent the various initiating and responding interactions occurring throughout the observed material.

While the focus of this coding system is not on the therapist's statements or behaviors, it should be noted when a spouse engages in a significant initiating behavior (as described in the categories listed in the next section) and the therapist, not the other partner, is the one who responds. When the partner does not have an opportunity to respond because the therapist begins speaking, perhaps focusing on a different part of the spouse's statement or behavior than what is considered to be acceptance promoting, it may hinder the partner's opportunity to provide a response. Details about how to code this type of therapist involvement will be explained in the following sections.

Although the focus of the coding is on the entire session instead of a microanalytic analysis of interactions, it is essential that raters distinguish between various types of initiating and responding behaviors. Raters will need to be able to determine whether responses are positive, negative, absent, or prevented by the therapist's response. Some responses result in a difficult distinction, particularly a neutral response (within the positive response category), withdrawal and/or decrease in physical non-verbal behaviors (within the negative response category), and no response. It is imperative to remember that it is the *behavior* that is being rated, <u>not</u> the rater's interpretation of the individual's underlying emotional state or intent. While behavioral distinctions between neutral, no and withdrawal responses may be minimal, raters can rely on the following definitions: a *neutral* response is where the spouse seems to acknowledge and/or actively listen to what his or her partner is saying without a

significant change in physical or verbal behavior; *no* response occurs when there is no change in physical or verbal behavior during or after an initiating behavior by one's spouse, otherwise understood as a lack of behavioral acknowledgment of the initiating component of an interaction; lastly, the *withdrawal* response occurs when a decrease in positive nonverbal gestures occurs, such as the removal of eye contact. As these three responses represent three different categories of responding (positive responding, no responding, and negative responding), raters should take particular care in appropriately identifying the most representative response for the observed behaviors. In order to make these challenging distinctions, raters should be guided by consultation with research supervisors, clinical judgment, this coding manual, and the specific knowledge of the couple being studied.

To manage the multitude of data present in an entire therapy session raters are encouraged to utilize a notational system to make note of interactional sequences while coding sessions. Upon completion of viewing a session, raters should review their notes in order to select the most appropriate ranking on the global rating Likert scale of one to nine. This notation framework instructs raters to document the initiating and responding partners, the details of the interaction, any other notes or observations, the intensity level of the interaction, and any questions that result. It should be noted in particular that the assignment of an intensity level (low, low/moderate, moderate, moderate/high, and high) is determined based on the entirety of the interaction, including both the intensity of the initiating behavior as well as the responding behavior. For example, an interaction that involved a fairly intense vulnerable statement followed by reciprocal vulnerability would

generally be rated as higher in intensity than if the initiating statement were followed by a neutral response (to be defined in subsequent sections of this manual).

When determining the global Likert scale ratings, raters can rely on the intensity level ratings such that an interaction with a low intensity is considered to be about 1/3 of a point, an interaction with low/moderate intensity is considered to be about 1/2 of a point, an interaction of moderate intensity is considered to be about 1-2 points, an interaction of moderate/high intensity is considered to be about 2½ points, and an interaction of high intensity is considered to be 3 points. A total rating for a particular interaction pattern can be created through the sum of these ratings, rounding down if necessary. However, please note that these quantitative designations are not to be used rigidly; raters should review the global Likert scale ratings to ensure that they provide an adequate representation of what was observed in-session.

Description of Items

Vulnerability

The code "Vulnerability" involves the expression of vulnerable emotions, thoughts or behaviors by the initiating partner and a positive, neutral or negative reaction from the responding partner. Expressions of hurt, insecurity, sadness, tenderness, loneliness, shame, guilt, fear, needs, love or desire are soft expressions when they are shared in a vulnerable way. Behaviors such as self-disclosure, confiding, nervous humor, putting one's self down, expressing hurt, pain, disappointment or grief may also be soft expressions. Expressions of vulnerability might include anger, self-deprecating humor, and other more indirect, tentative displays of underlying insecurity. Examples might include one partner saying, "I don't know, I just have had a general feeling of

dissatisfaction the past couple weeks" or "I know this sounds pathetic…" Both of these statements include a vulnerable component related to expressing a concern out loud to one's partner.

This code requires that the rater make a judgment about the genuineness of both the initiator and responder. When one spouse expresses his hurt in an angry, hostile, or accusatory way, he is generally much less vulnerable than a spouse who expresses his hurt in a soft and heartfelt way. When vulnerable expressions are couched in an angry tone, less vulnerability is apparent because anger serves to hide the vulnerable expression and often relates to a defensive stance in which the partner is already "armed" in case of attack. In fact, some people may feel more vulnerable when expressing anger if their normal stance is to withdraw and not express themselves, as this reveals feelings or beliefs not normally expressed. For example, a spouse may use a loud tone to say, "You made time to accompany this other woman to a stupid baseball game, but you can't seem to make any time for me!" This statement is more likely to make the responding partner defensive or feel attacked, however may still be a vulnerable expression in that the spouse is revealing underlying feelings of rejection. If she were to express the same underlying sentiment in a softer way, such as by saying, "I just don't feel important to you," the responding partner might be more apt to provide a positive response instead. Thus, vulnerable statements can be both soft and hard expressions. The rater's idiographic knowledge of each partner and their relationship will help the rater determine what behaviors and expressions put each individual in a vulnerable state within the relationship. In general, initiating behaviors that include eye contact and are directed to

the spouse are considered to be more vulnerable than those vulnerable statements that are made without eye contact and/or to the therapist.

After the initial display of vulnerability, the responding partner's reaction is critical to understand. Positive responses may include reciprocal vulnerability, conveying an emotional or intellectual understanding of the vulnerable partner's experience, validation, non-blaming clarification questions that demonstrate interest and/or compassion. These responses support the initiating partner's vulnerability, whereas negative responses are thought to create conflict and/or obstruct further vulnerable expressions. Negative partner responses include criticism, defensiveness and blame, among others.

In the situation where a partner engages in a vulnerable behavior and the therapist responds (whether or not the response is directly related to the vulnerable behavior), thus hindering the opportunity for the spouse to respond, this should be coded as vulnerability + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the partner's vulnerability removes an immediate opportunity for the spouse to directly respond. If the initiating partner's vulnerable behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in non-verbal behavior), then the vulnerability + no response code should be used. If the spouse appears to display a nonverbal behavioral response *during* the initiating component of the interaction (e.g., nods his or her head), a code should be used in conjunction with the therapist response code to best represent

what was observed (e.g., vulnerability + therapist response and vulnerability + neutral response).

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of vulnerability followed by positive or negative partner responses, or the therapist responses, that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Vulnerability + positive response:

- Vulnerability + reciprocal vulnerability (both partners sharing emotions or personal history/issues in a vulnerable way)
- Vulnerability + emotional understanding/empathy (having an emotional understanding of the perspective and experience of one's partner)
- Vulnerability + intellectual understanding (having a logical, conceptual understanding of the perspective and experience of one's partner)
- Vulnerability + validation
- Vulnerability + compassion/appreciation/reassurance/apology
- Vulnerability + use of non-belittling humor
- Vulnerability + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Vulnerability + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Vulnerability + negative response:

- Vulnerability + criticism/attack
- Vulnerability + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Vulnerability + contempt
- Vulnerability + blame/defensiveness
- Vulnerability + pressure to change
- Vulnerability + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Vulnerability + sarcastic/belittling/inappropriate humor

Vulnerability + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Vulnerability + therapist response

Non-blaming, intellectual problem discussion

The code *Non-Blaming, Intellectual Problem Discussion* involves talking about a relationship issue, such as a general pattern or theme, in a non-blaming and intellectualized manner. A partner's description of his or her own component of the interaction, his or her spouse's contribution to the interaction, and/or the combined interaction dynamics would constitute a non-blaming intellectual problem discussion. This type of discussion frequently involves relating a specific incident to the overall conceptualization of the couple's main differences, interaction patterns, and/or emotions. The key is that the discussion of the conflict, or the couple's interaction around the conflict, occurs without simultaneously experiencing the emotional reactions that are

typically involved. It is essential that the discussion be non-blaming and somewhat intellectualized in that spouses may be discussing negative emotional reactions, but they are not acting upon them. For example, if the initiating spouse says, "If he would just leave me alone when I'm upset, this would all be fine!" it indicates a blaming or accusatory tone. A non-blaming and somewhat intellectualized version of this statement might be, "If I admitted when I was upset instead of denying it, he probably would respond better and I wouldn't get so annoyed with him constantly asking me "What's wrong?" "

Another example of a non-blaming discussion could include pointing out similarities in each spouse's experience during an interaction by saying, "We were both misinterpreting each other - you were processing the information silently while I wanted to discuss it aloud." In describing the difference or pattern of interaction, partners may refer to a label (e.g. pursue-withdraw) or a humorous name. This can also take a form similar to "We were doing our thing again."

It follows that non-blaming, intellectual discussions often involve discussing relationship dynamics using words such as "we," "our" and/or "us" (e.g., "Our pattern" or "When we do this…"), suggesting a sense of togetherness and mutual responsibility for their interactional pattern. While the use of these words does not always occur during a non-blaming problem discussion, nor do they signify that a non-blaming problem discussion is definitively occurring when they are used, they are often a good indication that a non-blaming discussion might be occurring.

When the responding partner resorts to reactions such as criticism, blame, defensiveness, or withdrawal, the couple often becomes emotionally engaged in the

problem. Partners are no longer gaining an intellectual understanding of their interaction patterns, but instead may experience a rise in emotional reactivity or become fixated on a particular incident rather then discussing patterns in a more general way.

In the situation where a partner attempts to start or continue in a non-blaming, intellectual discussion and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as non-blaming, intellectual problem discussion + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the partner's non-blaming discussion removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in nonverbal behavior), then the non-blaming, intellectual problem discussion + no response code should be used. If the spouse appears to display a nonverbal behavioral response *during* the initiating component of the interaction (e.g., nods his or her head), a code should be used in conjunction with the therapist response code to best represent what was observed (e.g., non-blaming, intellectual problem discussion + therapist response and non-blaming, intellectual problem discussion + neutral response).

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of non-blaming, intellectual problem discussions followed by positive or negative responses that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Non-blaming, intellectual problem discussion + positive response:

- Non-blaming, intellectual problem discussion + non-blaming, intellectual response
- Non-blaming, intellectual problem discussion + sharing of personal information (personal history and/or issues)
- Non-blaming, intellectual problem discussion + increase in soft emotions/vulnerability
- Non-blaming, intellectual problem discussion + validation
- Non-blaming, intellectual problem discussion + use of non-belittling humor
- Non-blaming, intellectual problem discussion + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Non-blaming, intellectual problem discussion + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Non-blaming, intellectual problem discussion + negative response:

- Non-blaming, intellectual problem discussion + criticism/attack

- Non-blaming, intellectual problem discussion + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Non-blaming, intellectual problem discussion + contempt
- Non-blaming, intellectual problem discussion + blame/defensiveness
- Non-blaming, intellectual problem discussion + pressure to change
- Non-blaming, intellectual problem discussion + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Non-blaming, intellectual problem discussion + sarcastic/belittling/inappropriate humor

Non-blaming, intellectual problem discussion + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Non-blaming, intellectual problem discussion + therapist response

Validation

A spouse demonstrates validation through stating something positive about his or her partner's behavior or emotional experience, whether through a direct positive statement, compassion, empathy, encouragement, appreciation, and/or support (e.g., "It's okay to feel that way"). Validation occurs when one spouse displays understanding for his or her partner's feelings, such as expressing understanding and empathy through commenting, "I never realized how hurt you feel when I forget to call and come home late." Validation may also involve a spouse offering an apology, sympathy, empathy, to help, or normalization (e.g., "I do that too sometimes"). Other behaviors included as

validation are: offers of reassurance, admitting fault, showing caring and understanding, showing trust or acceptance of the partner, and mentioning something positive about partner's behavior (e.g., "You're a good mom").

Another way that validation might occur is through a spouse agreeing with the therapist's positive or non-blaming conceptualization of the partner's feelings, thoughts, and/or behaviors. For example, the therapist could explain, "Even though being 30 minutes late doesn't seem important to you, she experiences it as a threat of being left alone and gets scared." If the husband responds by saying, "I didn't realize she was scared, I didn't see it that way before," it indicates that he is validating the wife's perspective. Interactions that demonstrate a willingness to appreciate one's partner's feelings, thoughts, or behaviors as differences, rather than as negative qualities, are considered to be validation.

While the first aspect of validation involves a positive comment about some aspect of a partner's behavior or emotional experience, the second component of validation entails how the partner responds. Positive responses include appreciation, vulnerability or reciprocally validating comments about the initiating partner's behavior or emotions. Negative partner responses include becoming defensive, showing indifference, decreasing physical contact (e.g., moving to sit further away from partner), or blaming. For example, if the initiating partner says, "I didn't know how unappreciated you felt, I'm sorry," and the responding partner reacts by saying, "*Now* you act like you understand, but it's just because you're trying to look good in front of the therapist!" it demonstrates a defensive response.

In the situation where a partner provides validation towards his or her spouse and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as validation + therapist response. This code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the initiating partner's validating statement removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in nonverbal behavior), then the validation + no response code should be used. If the spouse appears to display a nonverbal behavioral response *during* the initiating component of the interaction (e.g., nods his or her head), a code should be used in conjunction with the therapist response code to best represent what was observed (e.g., validation + therapist response and validation + neutral response).

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of validation followed by positive or negative responses that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Validation + positive response:

- Validation + validation
- Validation + compassion/appreciation/reassurance/apology

- Validation + increase in soft emotions/vulnerability
- Validation + use of non-belittling humor
- Validation + increased physical contact and/or nonverbal affection (e.g., hand holding, eye contact, smiling)
- Validation + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Validation + negative response:

- Validation + criticism/attack
- Validation + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Validation + contempt
- Validation + blame/defensiveness
- Validation + pressure to change
- Validation + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Validation + sarcastic/belittling/inappropriate humor

Validation + no response (no change in physical or non-verbal behavior, no acknowledgement of initiating component of the interaction)

Validation + therapist response

Aversive partner behavior

Aversive partner behavior occurs when one partner engages in a behavior or emotion that the other partner is likely to perceive as being aversive. Which behaviors someone may find aversive can be identified by the case formulation, partner statements

in-session, self-report questionnaires, as well as commonly considered negative behaviors (e.g., criticism). Responses to aversive partner behavior could include both positive and negative reactions. Negative reactions might consist of blame, defensiveness, withdrawal, and/or annoyance. Positive reactions might entail the *lack* of a hard emotional response, intellectual understanding, or the use of non-belittling, context-appropriate humor. A spouse may discuss new ways of coping with aversive partner behavior, such as better self-care or engagement in hobbies or interests, instead of responding in destructive ways. For example, in a couple where one spouse wants to talk about his or her day and the other wants to quietly unwind after getting home, the spouse may say, "When he watches TV it doesn't bother me as much anymore because I know that he'll listen more attentively and be more interested in talking with me after he unwinds, than if I start trying to have a long conversation the moment he comes home." In this case, the wife experienced the husband's watching TV behavior as aversive, however she was growing to tolerate this behavior because she was aware that it would lead to a more positive interaction in the near future. Given this same couple, the husband could have said, "I make an extra effort to sit down and debrief about our days since I know it is important to her, just like having a little downtime when I get home is important to me." In this latter example, the husband is accommodating his wife's immediate need for connection, which was formerly experienced as aversive and now is better understood.

In the situation where a partner engages in an aversive behavior directed towards his or her spouse and the therapist responds, thus hindering the opportunity for the spouse to respond, this should be coded as aversive partner behavior + therapist response. This

code indicates that the partner engaged in a significant behavior, but the spouse did not have a direct opportunity to respond due to the therapist speaking. It is extremely important that this code is only used when the therapist's response to the initiating partner's aversive behavior removes an immediate opportunity for the spouse to directly respond. If the initiating partner's behavior is not directly followed by a therapist comment and the spouse *does* have an opportunity to respond, but *chooses* not to (e.g., stays silent, no change in nonverbal behavior), then the rater may choose to use the codes aversive partner behavior + no response code should be used. If the spouse appears to display a nonverbal behavioral response *during* the initiating component of the interaction (e.g., nods his or her head), a code should be used in conjunction with the therapist response code to best represent what was observed (e.g., aversive partner behavior + therapist response and aversive partner behavior + neutral response).

Raters should note that as with every code, these examples are guidelines and should not be applied rigidly.

Subcategories. These are the examples of letting go of a change emphasis or maintaining/increasing a change emphasis that comprise this overall category. This is not an exhaustive list – others may be present and should be coded even if they do not fit clearly into one of these specific subcategories.

Aversive partner behavior + positive response:

- Aversive partner behavior + lack of typical response
- Aversive partner behavior + lack of hard emotional response (e.g., lack of anger/blame)

- Aversive partner behavior + quicker than usual recovery from negative interaction
- Aversive partner behavior + new coping methods/increased self-care
- Aversive partner behavior + intellectual understanding
- Aversive partner behavior + emotional understanding/empathy
- Aversive partner behavior + validation
- Aversive partner behavior + use of non-belittling humor
- Aversive partner behavior + neutral response (e.g., acknowledgment without significant change in physical/verbal behavior, active listening)

Aversive partner behavior + negative response:

- Aversive partner behavior + typical response
- Aversive partner behavior + criticism/attack
- Aversive partner behavior + annoyance/dismissing/invalidation (not attending to partner's feelings with empathy)
- Aversive partner behavior + contempt
- Aversive partner behavior + blame/defensiveness
- Aversive partner behavior + pressure to change
- Aversive partner behavior + withdrawal and/or decrease in positive nonverbal gestures (e.g., removal of eye contact)
- Aversive partner behavior + sarcastic/belittling/inappropriate humor

Aversive partner behavior + no response (no change in physical or verbal behavior, no acknowledgement of initiating component of the interaction)

Aversive partner behavior + therapist response

Pressure to change

Pressure to change occurs when a partner expresses a desire for or insists upon change in oneself or one's partner, igniting a pressure for something to be different. This can occur through anger, coercion, blame, and/or overt statements (e.g., "You need to take responsibility for your actions"), as well as through softer, gentler expressions (e.g., "I want you to spend more time with me"). These softer statements often suggest a desire for the couple to work hard and improve their relationship, such as when a partner says, "We just have to keep trying to communicate better, I know things will turn around." While the intensity and impact of this softer form of pressure to change is likely different than the initially described, harder forms of pressure to change, both should be coded as pressure to change. Although communicated differently, both examples reflect a desire for some aspect of the partner or relationship to be different.

In addition to softer and harder forms of pressure to change, these statements can be further described as either being directed at one's partner (e.g., "You need to make more time for your family") or at oneself ("I know I should behave differently"). It is important to note that both self-directed and other-directed pressure to change are coded within this category. In the occasion that pressure to change occurs as a statement directed at the couple and not a specific individual (e.g., "We just have to spend more time together"), raters can capture this as both self- and other-directed pressure to change.

Pressure to change will likely be evident as a part of the previously discussed codes; any initiating or responding component of an interaction might include an element of pressure to change. The pressure for change category is intended to provide a global assessment of the amount of overall pressure to change exerted within relationship

interactions. Since this category focuses on the expression of pressure to change and is not concerned with the spouse's response to pressure to change, no interactional codes are needed.

It should be noted that although the rater will code the global amount of pressure to change, there are not separate codes for the *absence* of pressure to change. Instead, this is accounted for through using the Likert scale such that if no negative pressure to change occurs in the selected segment for observation, than this category would receive a code of "None."

Subcategories. Although there are no interactional codes for the pressure to change category, the rating system does take into account whether the pressure to change was directed at the self or at one's partner.

Pressure to change – husband initiated:

- Self-directed (pressure for husband to change)
- Other-directed (pressure for wife to change)

Pressure to change – wife initiated:

- Self-directed (pressure for wife to change)
- Other-directed (pressure for husband to change)

APPENDIX E

Sample Observational Notation Document

Couple ID#	Session #	Time Code	Initiating Partner (husband or wife)	Responding Person (husband, wife, or therapist)	Description of Interaction	Additional Observations	Initiating + Responding Code	Intensity Level (low, low/mod, moderate, mod/high, high)	Other Notes	Questions