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Conjoint Marital Therapy: Proxy Voice Intervention and Softening in the Context of Couple Enactments

Ryan B. Seedall
Brigham Young University - Provo

CONJOINT MARITAL THERAPY: PROXY VOICE INTERVENTION AND SOFTENING IN

THE CONTEXT OF COUPLE ENACTMENTS

by

Ryan B. Seedall

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of a thesis submitted by

Ryan B. Seedall

This thesis has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory

_____   _____
Date   Mark H. Butler, Chair

_____   _____
Date   Robert F. Stahmann

_____   _____
Date   Richard B. Miller

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_____   _____
Date   Mark H. Butler
                                          Chair, Graduate Committee

Accepted for the Department

                                          _____
                                          Robert F. Stahmann
                                          Chair, Marriage and Family Therapy

Accepted for the College

                                          _____
                                          James M. Harper
                                          Dean, School of Family Life

ABSTRACT

CONJOINT MARITAL THERAPY: PROXY VOICE INTERVENTION AND SOFTENING IN

THE CONTEXT OF COUPLE ENACTMENTS

Ryan B. Seedall

Department of Marriage and Family Therapy

Master of Science

This study evaluated the effectiveness of proxy voice intervention, embedded within

couple enactments, on client-perceived softening. During enactments, direct couple interaction is

the focus while the therapist coaches from the periphery. In the context of an enactment, the

therapist may use proxy voice when partners appear to be distressed and expressing themselves

in terms of secondary emotions by modeling appropriate attachment and self-concept expression.

The primary research question was whether therapist use of proxy voice in an enactment would

be more likely to bring about softening effects, or whether use of proxy voice was counter-

intuitive to enactment conceptualization and would bring about effects related to struggle (e.g.

withdrawal or negativity). The review of literature sets forth (1) enactments as common factors;

(2) enactments conceptually and operationally; (3) proxy voice in the context of enactments; and

(4) the effects of proxy voice on softening versus withdrawal or negativity. Proxy voice occurred

42 times in nine research sessions where proxy voice was delivered repeatedly in a 20-30 minute enactment episode. Results indicated that proxy voice was significantly (both statistically and clinically) associated to softening while dissimilarly linked with withdrawal or negativity. Results also suggested that proxy voice may be used to dampen volatility and foster couple softening during enactment in the following ways: (1) proxy voice temporarily increases the structure of the couple interaction, thereby allowing the therapist to dampen reactivity and model healthy expression before returning to direct couple interaction; (2) proxy voice is a *hypothesis* of softer emotions that fits the clients' experiences, helps them to feel validated, and encourages them to consider something in a newer, softer way; and (3) proxy voice taps into foundational relationship dynamics surrounding self-concept and attachment experiences that "propel" interaction processes but remain outside conscious awareness or explicit expression for the couple. These preliminary findings suggest that proxy voice intervention embedded within a fluid, carefully delineated, and discriminating model of enactments effectively facilitates essential elements of couple interaction (expression of primary affect, and self-concept and attachment threats) while promoting self-reliant couple interaction and increased couple softening.

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CHAPTER I

Introduction

Studies investigating the efficacy of various therapeutic models have shown that few differences exist between models in terms of the active ingredients that facilitate change (Elkin et al., 1989; Hanna & Ritchie, 1995; Imber et al., 1990; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). Jacobson and Addis (1993) concur by stating, "in their natural form there is considerable overlap among the major models of couple therapy" (p. 88). Although researchers continue to conduct outcome research, focus has shifted to process research identifying common factors that promote positive relationship change across diverse clinical models (Butler & Gardner, 2003; Davis & Butler, 2004).

Current scholarly work has recommended enactments as a potential common factor change mechanism leading to positive outcomes in relationship therapy and used independent of theory, model, or problem (Butler & Bird, 2000). During enactments, the therapist directs the family to talk directly to each other with the purpose of modifying interaction (Minuchin & Fishman, 1981). The overall goal of enactments is "couple/family self-reliant interaction" with the family being centralized in that interaction and the therapist acting primarily as process coach (Butler & Gardner, 2003).

Recent scholarly work has provided a more explicit conceptual and operational definition of enactments, thereby increasing their applicability for therapists operating from diverse clinical orientations and models (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2001; Butler & Gardner, 2003; Davis & Butler, 2004; Nichols & Fellenberg, 2000). A snapshot of a single enactment with its constituent phases (introduction, facilitate, evaluation) has been set forth (Allen-Eckert et al., 2001; Davis & Butler, 2004; Nichols & Fellenberg, 2000), in addition

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to a five stage developmental model which adapts enactments to varying couple emotionality, volatility, and reactivity (Butler & Gardner, 2003).

Butler and Gardner (2003) also list subsidiary enactment-based interventions that facilitate couple dialogue: therapist structuring according to couple relationship dynamics, therapist positive connotations, reframing, modeling or coaching attachment based self-expression, and *proxy voice*. Consistent with contemporary process-outcome research methodology focusing on discrete outcomes of specific interventions in order to identify the active ingredients of therapy (Elkin et al., 1989; Hanna & Ritchie, 1995; Imber et al., 1990; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975), this study investigated a specific, single subcomponent of enactments, namely *proxy voice* (Butler & Gardner, 2003), linking it to the occurrence of spouse softening in couple therapy.

The initiation phase of proxy voice begins when, in the context of an enactment, the therapist perceives that distress is present, but the speaking partner appears to be having difficulty with expression of primary affect in terms of his/her experience of attachment or self-concept concerns, threats, or longings in the relationship (Butler & Gardner, 2003). After asking permission to proxy speak and sliding her chair alongside the speaking partner, the therapist begins the clarification phase by offering an empathic response to the speaking partner, tentatively speaking in proxy voice, positively reframing the speaking partner's experience, making explicit primary affect, and linking it to attachment and self concept threats. The therapist then allows the speaking partner to evaluate the intervention during the processing phase, thereby making clear his/her experience before continuing the couple dialogue.

Although proxy voice has the potential of facilitating couple interaction and increasing couple softening, it does represent a departure from the conceptualization of enactments because it partially shifts focus from the couple to the therapist and represents a somewhat more directive approach, akin to teaching, which some literature has identified as increasing the likelihood of therapist-client struggle (Butler & Bird, 2000; Miller & Rollnick, 2002). Therefore, this research sought to address whether the use of proxy voice interventions in the context of an enactment would facilitate couple softening, an index of immediate or proximal therapeutic effectiveness, or if it is more likely to increase some form of therapist-client struggle.

While enactments can be conceptually defended as a common factor change mechanism independent of a particular theory, model, or problem, empirical research is needed to validate this assertion. It is anticipated that research that empirically tests important components of enactments (e.g. proxy voice) and validates them as leading to clinically significant process outcomes (e.g. softening) will reinforce the standing of enactments as a viable common factor change mechanism in relationship therapy, thereby leading to increased awareness of enactment-based interventions as promoting positive relationship change and growth in therapy.

CHAPTER II

Literature Review

Although couple enactments have been discussed in family therapy literature and taught as clinical interventions for decades (Minuchin & Fishman, 1981), couple enactments in therapy are a relatively new focus of research. The following review of enactment literature addresses six topics: (1) the common factor approach and its role in marriage and family therapy; (2) the conceptualization of enactments as a common factor change mechanism; (3) the operationalization of enactments, including the phases of a single enactment and the five stage developmental model; (4) the conceptual and operational definitions of proxy voice intervention in the context of enactments; (5) softening as an index of therapeutic effectiveness; and (6) justification of this research and potential value of this study.

The Common Factor Approach

Researchers have hypothesized that "different therapies embody common factors that are curative, though not emphasized by the theory of change central to any one school" (Asay & Lambert, 1999, p. 29). This hypothesis has increased research aimed at discovering common factors that do not supercede, but rather stand meta to theoretical orientation. Knowledge of common factors is thus foundational to the successful practice of marriage and family therapy. A number of scholars have offered varying categorizations of common factors in psychotherapy (Black, 1952; Frank, 1971; Grencavage & Norcross, 1990; Orlinsky & Howard, 1986; Strupp, 1973; Ziskind, 1949). More recent scholarly work by Lambert (1992) has identified four common factor dimensions: client/extratherapeutic variables, relationship variables, technique/model factors, and expectancy/placebo effects (see Appendix A: Common Factors). Common factors are of great potential value because they yield insight into

foundational therapeutic interactions and interventions contributing to positive outcomes.

Although common factor research in psychotherapy has increased in recent years, much less scholarly work has been done in the field of marriage and family therapy. This is evidenced by the existence of but one related literature review (Butler & Bird, 2000), one survey of clinicians in MFT (Blow and Sprenkle, 2000), and several theoretical articles (Sexton, Ridley, & Kleiner, 2004; Sexton & Ridley, 2004; Sprenkle & Blow, 2004a; Sprenkle & Blow, 2004b; Sprenkle, Blow, & Dickey, 1999). This lack of scholarly work can be attributed to the fact that much of the effectiveness research has been linked to specific theoretical orientations, strict treatment protocols, and comparing one modality against another. The results of programmatic research, while yielding some very important data, focus on finding the "best" modality and do not analyze what might be common between two modalities in effectuating change. The previously mentioned articles addressing common factors represent a nascent shift toward identifying those dimensions of therapy interaction and intervention that account for significant variance in outcome across theories and models in marriage and family therapy.

Of importance is the understanding that the purpose of common factor research is not to displace theoretical orientations, but rather to complement the necessary attention given to specific models of MFT and protocols relating to treating specific problems with analysis and understanding of specific change mechanisms that are independent of theoretical orientation (Sprenkle & Blow, 2004a; Sprenkle & Blow, 2004b). The common factor approach is also a viable complement to model-/theory-based and problem-focused training for beginning therapists. By emphasizing those dimensions that have been found to effectively facilitate change in therapy across a variety of clinical models (Castonguay, 2000; Ogles, Anderson, &

Lunnen, 1999; Sprenkle et al., 1999), common factors training represents a reasonable

precursor and prerequisite to more specialized training in specific models or problem areas

(Sprenkle & Blow, 2004a). Finally, an emphasis on common factors is profoundly evident in

the development and articulation of core competencies in the practice of MFT (MFT Educators

Summit, Reno, NV, July 16-18, 2004).

At this time, common factor research has primarily focused on *dimensions* of therapy

that effectuate change rather than specific *change mechanisms* which coincide with the goals

and conceptual framework of the respective models. Research is needed to identify those

therapeutic maneuvers, such as enactments, that can be effective over a wide variety of clinical

situations and across a number of theoretical modalities. The results provided from such

research would allow the common factor approach to be a more practical approach in marriage

and family therapy than it is currently. The purpose of the present study was to empirically test

proxy voice intervention in the context of couple enactments. Research on a specific

component of enactments, specifically proxy voice, will further substantiate enactments as a

candidate common factor change mechanism in relationship therapy.

Conceptualization of Enactments as a Common Factor Change Mechanism

Utilization of Enactments in a Variety of Relational Therapies

In relationship therapies, a conceptual argument can be made for enactments as one

candidate for common factor status because of their potential application independent of a

specific theory, model, or problem. Many prominent theoretical models in marriage and family

therapy include couple interaction processes as important foci in treatment and utilize some

form of enactments to 1) assess couple dynamics (Minuchin & Fishman, 1981); 2) restructure

relationships (Minuchin & Fishman, 1981; Shields, Sprenkle, & Constantine, 1991); 3) increase

communication and listening skills (Gottman, 1999; Gottman & Levenson, 1999); 4) redirect the process and patterns of the relationship (Greenberg & Johnson, 1988); and 5) facilitate attachment-based disclosure and listening (Butler & Gardner, 2003; Davis & Butler, 2004).

The use of enactments in marriage and family therapy is most well-known in structural therapy to assess family interaction and structure (Minuchin & Fishman, 1981). Behavior marital therapy utilizes behavioral rehearsal coupled with feedback to help the couple gain problem-solving skills and improve their influence patterns and foster more positive interaction (Gottman, 1999; Jacobson & Anderson, 1980; Jacobson & Margolin, 1979). In the Relationship Enhancement approach and other skills therapies, the therapist teaches the couple communication and relationship skills, and then supervises the couple interaction through each individual skill using actual couple issues (Guerney, Brock, & Coufal, 1986). Enactments in emotionally focused therapy have an intrapsychic focus and are used interpersonally to "make concrete and explicit certain aspects of their experience" (Greenberg & Johnson, 1988, p. 158). In this way, enactments can be used to facilitate or highlight change. A conceptual argument has also been made for the utilization of enactments in narrative therapy, as each partner's narrative is expressed within the scaffolding of an enactment (Brimhall, Gardner, & Henline, 2003).

Enactments in Fostering the Responsibility and Relationship

Additional theoretical evidence for enactments as common factor change mechanisms may be found by considering the conceptual argument setting forth their role in facilitating the key emotional processes of responsibility and relationship, thus working to decrease emotional reactivity while generating greater emotional receptivity between partners (Kerr & Bowen, 1988).

Responsibility. The therapist-client relationship can most often be characterized as one of struggle or cooperation (Butler & Wampler, 1999), which refers to a potential relationship dynamic that exists between a therapist and each client and has been attributed to treatment outcomes both empirically and clinically (Butler & Bird, 2000; Friedlander, Wildman, Heatherington, & Skowron, 1994). Enactments foster couple responsibility for outcome and allow clients the opportunity to experience their therapist as understanding, empathic, and focused on the couple's relationship (Rogers, 1951; Satir, 1972). Therapist-client cooperation rather than struggle characterizes the interaction because the couple is the focus rather than the therapist's skills, expertise, or knowledge. Hence, the couple will look to themselves for problem resolution and to the therapist for support, facilitation, and encouragement. As therapists and clients acknowledge the potential for change inside the couple relationship itself, couple strengths come to the forefront, therapist-client struggle decreases, and couple responsibility for change increases.

Relationship. "The dynamic utilization of relationships to bring about change is a characteristic unique to MFT, both conceptually and operationally" (Davis & Butler, 2004, p. 320). Enactments prescribe that couples interact directly while the therapist coaches. Rather than using *therapist* reflection, validation, empathy, and interpretation as the primary venue for change work, therapists use enactments to facilitate emotional understanding between spouses using *couple* interaction, thereby fostering the couple's confidence in their own ability to change, grow, and succeed. By coaching, the therapist shifts focus from herself to the marital dyad or family system, allowing them to facilitate their own change, thereby allowing for a greater chance of lasting, self-regulated change.

In essence, "*enactments are the intuitive venue for relationship work*, using the

relationship itself as the vehicle and focal point for change work, thereby locating the work, changes, and successes of therapy in exactly that relational geography—the couple or family system—that makes the most logical sense" (M. Butler, personal communication, December 15, 2004). For the couple, enactments facilitate (1) effective communication skills; (2) expression and attention to affective experience; and (3) awareness of self-concept and/or attachment dimensions of couple interaction and communication, thereby building interactional confidence, hope, expectancy for change, and self-reliance. This helps to ensure that couples have the greatest opportunity to maintain change after therapy because the relationship has been the agent, instrumentality, and focal point of change rather than the therapist, who is instead the facilitator. Enactments' potential for building and strengthening couple self-reliant interaction with 1) effective communication skills; 2) expression and attention to affective experience; and 3) awareness of self-concept and/or attachment dimensions of couple interaction and communication.

In conclusion, a strong argument can be made for enactments to be included as a common factor mechanism in two key conceptual areas: 1) their ability to be used independently of theory, model, or problem; and 2) their ability to facilitate key therapeutic processes, including couple responsibility and relationship orientation (Kerr & Bowen, 1988). The next section sets forth an operational definition of enactments, providing a snapshot of a single enactment and also a five-stage developmental model.

Operationalization of Enactments

A conceptual understanding of enactments in general leads us to consider them operationally in the context of the current study. The discussion that follows will outline the recent scholarly work regarding enactment operationalization, including an outline of phases

that make up a single enactment (Allen-Eckert et al., 2001; Davis & Butler, 2004; Nichols & Fellenberg, 2000) and a five stage developmental model of enactments (Butler & Gardner, 2003). An operational model consisting of three therapist-facilitated phases of a proxy voice intervention will then be enumerated and further justification of this research will be provided.

Much of the earlier literature and teaching videotapes of enactments have led beginning therapists to the errant conclusion that enactments are simple, and that a productive enactment is accomplished merely by telling the family members to talk to one another (Nichols & Fellenberg, 2000). This oversimplification can lead to "permissive" enactments that, without structuring, are vulnerable to destructive escalation of couple/family interaction. Such a result may lead therapists to abandon enactments as a clinical technique, thereby forfeiting the potential power of direct intervention in relationship interaction.

In order to avoid therapist oversimplification, recent scholarly efforts have established a more concrete operational definition of enactments (Allen-Eckert et al., 2001; Butler & Gardner, 2003; Davis & Butler, 2004; Nichols & Fellenberg, 2000). The research has furthered understanding regarding phases and components of a single enactment (Allen-Eckert et al., 2001; Davis & Butler, 2004; Nichols & Fellenberg, 2000), set forth a five-stage developmental model that adapts enactments to couple dynamics (Butler & Gardner, 2003), and outlines specific therapist and client actions/responses in a successful enactment (Butler & Gardner, 2003; Friedlander, Heatherington, Johnson, & Skowron, 1994; Nichols & Fellenberg, 2000).

The three articles that have profiled the phases of a single enactment (Nichols & Fellenberg, 2000; Allen-Eckert et al., 2001; Davis & Butler, 2004) have labeled the phases in a slightly different way, but they each specify a beginning phase where the enactment is introduced, a phase where the couple interacts while the therapist facilitates, and an ending

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phase where the enactment is reviewed and feedback given. For the purposes of this study, the terms initiation, facilitation, and evaluation will represent the phases of a single enactment (see Appendix B).

A fluid, developmental model of enactments developed by Butler and Gardner (2003) allows the therapist to be more aware of couple needs and adapt enactments to a specific constellation of presenting couple dynamics, including varying levels of couple distress, volatility, and reactivity (see Appendix C). This also enables "therapists to use enactments from the earliest to latest stages of therapy" (Butler & Gardner, 2003, p. 313). The five developmental stages outlined by Butler and Gardner (2003) are: 1) shielded enactments; 2) buffered enactments; 3) face-to-face talk-turn enactments; 4) episode enactments; and 5) autonomous relationship enactments. In this model, earlier stages consist of more structured, safe-guarded enactments for use when couple distress and volatility remains quite high. Later stages are therapist-coached, free-form enactments, allowing less reactive couples to interact more directly in real-time interaction.

The goal of this developmental model of enactments is the regulation of interactional proximity, emotional reactivity, and verbal autonomy in couple interaction. This careful structuring safeguards couple interaction, helping promote—through increasingly self-reliant couple interaction focused on self-concept and attachment expression—de-escalation of couple conflict, softening, empathy, and hope. While previously mentioned scholarly work has been valuable in understanding enactments conceptually and operationally, empirical validation of the effectiveness of enactments and subcomponent interventions across a wide range of clinical models and relational therapies is needed. Empirical studies such as this one also need to specify components of enactments (e.g. proxy voice) and verify that they lead to clinically

significant, discrete therapeutic outcomes (e.g. softening). A detailed explanation of proxy voice in the context of enactments follows in addition to a conceptual definition of softening.

Proxy Voice in the Context of Enactments

The proxy voice intervention, also known as proxy expression, speaking in a client's voice, or alter-ego (Bauman, 1972; Butler & Gardner, 2003; Davis & Butler, 2004; Leveton, 1991), has been presented in recent scholarly work as an important component of enactments and particularly effective 1) when couple distress is present but eluding articulation (Butler & Gardner, 2003), and 2) in helping promote attachment based listening and responses (Davis & Butler, 2004). Such a situation fits nicely into the framework and goal of enactments, which is to facilitate self-concept and attachment based expression and help the couple establish new, self-reliant interaction patterns (Butler & Gardner, 2003; Davis & Butler, 2004). Proxy voice, to the extent it enhances emotional expression and understanding, can also be conceptualized as increasing hope and expectancy factors.

Relatively little scholarly work or research has addressed, in detail, the conceptual definition of proxy voice. The majority of scholarly work refers to using the "alter-ego technique" in working with resistant clients/supervisees (Bauman, 1972; Leveton, 1991). The intervention is conceptualized as one similar to role-play, where the therapist acts as the client's "other self." Some similarities exist in that the therapist is facilitating the client's ability to operate at a deeper level, with a greater understanding of his/her inner dynamics (Bauman, 1972). However, the term "proxy voice" is a more appropriate description for the purposes of this research, where the intervention in the context of an enactment is an offering where the therapist to model appropriate expression, offer alternative hypotheses, and coach the clients' interactions rather than act as another part of the client (Butler & Gardner, 2003).

Although a proxy voice intervention is not unique to enactments, it finds a natural place

embedded within the facilitation phase of couple enactments. Proxy voice intervention can be

used throughout couple enactments, but it is particularly effective during the middle enactment

stages after couples have mastered basic communication skills taught in early stages and

understand the importance of framing their emotion in attachment and self-concept terms

(Butler & Gardner, 2003). During this time (stage three and especially stage four enactments),

clients are increasingly able to express themselves in softer, more vulnerable ways but

experience occasional interactional moments when they are unable or unsure how to express

themselves in self-concept or attachment terms, or to specify the affect associated with it. Proxy

voice helps bring self-concept and/or attachment issues, vulnerabilities, anxieties, or threats to

the forefront, past the superficial "scenery" of representative issues that so often obscures them.

Operationalization of Proxy Voice Intervention

Proxy voice intervention can be operationalized in three phases: initiation, clarification,

and processing (see Appendix D for specific examples). In the middle enactment stages, the

therapist does not interrupt healthy interaction—only as couples appear unsure or unable to

express themselves in softer, more relationship focused ways. During *request to proxy speak*

(initiation phase)*,* the therapist perceives confusion or inability of the speaking partner to

express his/her experience (cognition and affect) in terms of core attachment or self-concept

needs. Possible signs of difficulty are client hesitation, frustration, or expression of secondary

affect. At that point, the therapist (1) offers a brief, empathic response to the speaking partner,

(2) asks permission to proxy speak, and (3) slides her chair alongside the speaking partner.

Next, four critical therapist behaviors comprise *proxy voice delivery* (clarification

phase): (1) tentative expression of proxy voice (e.g. "I wonder . . ." or "What I hear you saying

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is . . ."); (2) reframing client expression with a positive connotation; (3) making primary affect explicit; and (4) linking expression to attachment/self concept issues. Each of these behaviors allows the therapist to model client expression in a way that is respectful, non-blaming, relationship affirming and promoting, and conducive to softening. Specifying content is not the primary therapist goal during the clarification phase. Rather, the goal is to model expression in terms of attachment and self-concept threats and allow clients the opportunity to clarify for themselves their feelings and needs and express them to their partner.

During *proxy voice evaluation* (processing phase), the speaking partner and therapist process the intervention. At that time, the client explains what fit and what did not, accepting or rejecting any or all of what the therapist said, and then restates the proxy voice in her/his own way. This allows the speaking partner to conceptualize his/her experience in a way that offers clarification and invites softening of expression. The therapist then invites the client to continue couple dialogue in the context of the enactment by expressing to the listening partner what was processed with the therapist.

In this manner, proxy voice intervention allows the therapist to facilitate positive, potentially softening client interaction during an enactment in three ways: (1) it assists the speaking partner to articulate vulnerable feelings and needs when s/he feels unsure or unable to do so; (2) it models attachment and self-concept expression for both partners; and (3) it helps the clients experience therapist modeling of proxy voice as respectful, non-blaming, and validating interaction and expression, thus promoting speaking partner responsibility for how his/her thoughts and needs are ultimately expressed.

Conceptual Dimensions of Softening

We view self-concept and/or attachment threats as the two primary threats and sources

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of volatility in relationships. Enactments are designed to allow the therapist to bring these into the open while promoting their resolution through couple-softened interaction, and proxy voice is a chief therapist tool for doing this. Proxy voice and its perceived influence on this construct of client softening was the focus of this research.

Gottman (1999) posits that one primary purpose of therapy is to learn to self-soothe as well as soothe each other. Self- and other-soothing limit diffuse physiological arousal (DPA), a term describing the body's general alarm mechanism which activates a number of systems in the body and is associated with lower marital satisfaction. Somewhat akin to that concept is softening, which is associated with lower volatility, greater emotional accessibility, and increased responsiveness and has been set forth as an essential outcome of relationship therapy in the development of new interaction patterns (Greenberg & Johnson, 1988). In the softening process, spouses access "powerful attachment-related [or self-concept-related] fears and/or experiences, which organize their behavior in relation to their spouse" (Johnson, 1996, p. 140) and help them to feel more willing to disclose vulnerable aspects of self (Johnson & Greenberg, 1988). This becomes the wellspring of empathy in both partners.

Successful enactments, of which proxy voice is a part, invite couple softening on five affective dimensions: calming, comprehension, conciliation, relationship orientation, and optimism. Each dimension represents a significant aspect of couple softening and the ability of the couple to move toward emotional receptivity and greater responsibility, neutrality, and relationship focus. The dimensions of softening are evidenced by (1) couple de-escalation, diminished emotional reactivity, and lower contingency in negative exchanges (calming—Butler & Gardner, 2003; Greenberg & Johnson, 1988); (2) increased understanding of the problem, of self, and other (comprehension—Butler, Gardner, & Bird, 1998; Butler & Gardner,

2003); (3) increased receptivity and responsiveness to the needs of the other (conciliation—Butler & Gardner, 2003); (4) viewing the relationship as the focal point of therapy rather than meeting one's own needs (relationship orientation—Butler & Gardner, 2003); and (5) increased hope that the relationship will improve (optimism).

The current study, while seeking to build upon previous conceptualizations of proxy voice and offer a greater operational understanding, measured the perceived effect of proxy voice on client softening, an index of immediate or proximal therapeutic effectiveness. The following sections detail a potential roadblock to softened interaction (therapist-client struggle) and address it in the context of proxy voice intervention. They will also set forth the two components of therapist-client struggle, provide a conceptual justification for the use of proxy voice during an enactment, and explain how this study evaluated the influence of proxy voice.

Proxy Voice and Struggle

One potential concern regarding use of proxy voice relates to therapist-client struggle. Observable struggle, a more systemic term for the psychological construct of resistance, represents covert dynamics that can significantly hinder therapy outcome, including softened interaction (Butler & Bird, 2000). Relevant to this study, therapist behaviors that increase struggle are teaching, advice giving, directiveness, and interpretation (Butler & Bird, 2000; Miller & Rollnick, 2002). Some may argue that proxy voice fits in these categories and is counter-intuitive to enactment conceptualization by interrupting the couple interaction process, thereby reinstituting the therapist-client hierarchy with the therapist in the role of expert. This is a reasonable assertion that needs to be investigated.

Components of Struggle: Withdrawal and Negativity

Therapist-client struggle is often evidenced by noncompliance on the part of the clients.

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Chamberlain, Patterson, Reid, Kavanagh, and Forgatch (1984) categorized resistant responses in five general areas as part of an observational coding system: interrupt/talkover, negative attitude, challenge/confront, own agenda, and not tracking. Other scholarly work has classified arguing, interrupting, negating, and ignoring as four process categories of struggle (Miller & Rollnick, 2002). In this study, reliance on client self-report for our measure of struggle dictated that we simplify these categories to two discrete manifestations of struggle: withdrawal and negativity.

Withdrawal represents more passive or covert noncompliance, evidenced by avoidance of the issue (answering questions other than the one that was asked and bringing up other topics and concerns), inattention (not following or attending what was said), role reluctance (not wanting to participate as speaking or listening partner), misunderstanding/confusion (not understanding the therapist), and emotional unavailability (desire to withdraw) (Chamberlain et al., 1984; Miller & Rollnick, 2002). *Negativity* is characterized by more active and overt noncompliance. This includes interrupting (cutting off or talking over the therapist), irritation (partner-/therapist-directed hostility), defensiveness (feeling blamed and misunderstood), disagreement (minimizing, challenging, or discounting what therapist said), relationship disorientation (decreased desire to focus and work on relationship), and hopelessness (pessimism that things can be resolved) (Chamberlain et al., 1984; Miller & Rollnick, 2002).

Conceptual Justification of Proxy Voice

Miller and Rollnick (2002) offer a useful justification for occasional therapist directives. If the therapist has previously sought to elicit the client's ideas and knowledge on the subject and can provide direction that will increase the client's motivation for change, then the therapist may proceed with the *permission* of the client. Asking for permission honors their

autonomy and communicates respect, choice, and collaboration, thereby increasing the likelihood for intervention effectiveness and decreasing struggle. Confirming to that protocol, proxy voice only occurs when the therapist perceives that the client is unsure or unable to articulate distress in attachment or self-concept terms, and only after the therapist asks permission to proxy speak. The therapist *always* asks for permission before speaking as proxy for the client (see operational definition of proxy voice and Appendix D).

In spite of the conceptual defense provided by Miller and Rollnick (2002) for occasional therapist-directed behaviors, the question remains as to whether proxy voice, considered a critical intervention in the context of enactments, might lead to significant, positive client responses/outcomes (e.g. softening) or increased withdrawal or negativity (struggle). The purpose of this research was to answer that question.

Conclusion

While recent scholarly work has led to the development of a clearer and understandable definition of enactments, the empirical study of enactments as an independent change mechanism and active ingredient in therapy is in its infancy. Analyzing enactments globally and in terms of specific subcomponents is critical to establishing their therapeutic value. Virtually all prior scholarly work has been conceptual and global, substantiating enactments as common factors in relationship therapy and refining their operational definition. Based on the previous model of enactments and the proxy voice subcomponent thereof—with its enigmatic elements of both enactment facilitation and therapist interpretation—we sought to understand the relation of proxy voice to softening versus withdrawal or negativity. Our question was, "Will proxy voice elicit or be related to increased client softening or, rather, to withdrawal or negativity?" We addressed this question in relation to both speaking and listening partners.

Chapter III

Method

Design

Combining observational coding (Chamberlain et al., 1984), interpersonal process recall (Elliott, 1986; Kagan & Kagan, 1990; Kagan, Krathwohl, & Miller, 1963), and client self report, this exploratory process-outcome study analyzed at the episode level the relationship between a proxy voice intervention and client-reported softening. Each discrete occurrence of proxy voice intervention in a 20-30 minute, stage three or four enactment (Butler & Gardner, 2003) episode was coded by the participants using the *Categorical Measure of Struggle* (CMS), thereby generating a nominal metric for data analysis.

Independent and Dependent Variables

The independent variable was each discrete occurrence of a proxy voice intervention as reliably coded using the operational definition of proxy voice (see Appendix D). Proxy voice was experimentally identified and coded by reference to the specific therapist behaviors that initiate, deliver, and process the intervention (see literature review). The frequency of proxy voice interventions during an enactment is technically unlimited; nevertheless, the observed frequency range for this study was between three and seven occurrences. The dependent variable was partner-reported softening, withdrawal, or negativity, measured separately for speaking and listening partners, as indicated by an interpersonal process recall measure developed for this study (Elliott, 1986; Kagan & Kagan, 1990; Kagan et al., 1963).

Participants

Couples

A total of 18 spouses participated in research sessions, generating 84 data points

(average of 4.67 instances of proxy voice per session; two data points per occurrence). Therapist-interns in an accredited marriage and family therapy program at Brigham Young University identified from their pool of clients all clients (1) where a primary focus of treatment was the couple relationship and couple interaction; and (2) who exhibited clinically significant *couple* distress, as evidenced by a couple average of 48 or lower (distressed range) on the *Revised Dyadic Adjustment* (RDAS—Appendix E), or who exhibited clinically significant *individual* distress (63.4 or higher) on the *Outcome Questionnaire 45* (OQ-45). Overall (see Table 1), the mean of couple scores for the RDAS was 43.1 (SD = 8.80) and the mean individual score for the OQ-45 was 58.23 (SD = 13.67).

Table 1: Means and Standard Deviations of RDAS and OQ-45

RDAS (n = 9)	
Mean	43.1
SD	8.80
OQ-45 (n = 18)	
Mean	58.23
SD	13.67

Individual demographics (see Appendix F) are reported in Table 2. Of the 18 spouses who participated, 100% were white, married, and reported a Christian religious affiliation. In addition, 16 spouses (88.9%) were in their first marriage while 2 partners (11.1%) were in their second, and spouses had been together an average of 5.94 years (SD = 4.07). Participants' ages were between the ages of 18 and 45 (18-25 years, 38.9%; 26-35 years, 44.4%; and 36-45 years, 16.7%), and the number of children ranged from zero to four children (0 children, 11.1%; 1-2 children, 33.3%; and 3-4 children, 44.4%). Spouse education was above normal, varying from

those who had attended some college (61.1%) and those who had graduated from college

(38.9%). Annual couple income varied considerably, with 55.6% making less than $15,000;

11.1% making $15,000-$30,000; and 33.3% earning $45,000-$60,000. The average number of

therapy sessions the couples had attended was 5.44 (SD = 3.89).

Table 2: Demographics of participants ($\underline{n}$ = 18)

Gender		
Male	50.0%	($\underline{n}$ = 9)
Female	50.0%	($\underline{n}$ = 9)

Age		
18-25	38.9%	(n = 7)
26-35	44.4%	(n = 8)
36-45	16.7%	(n = 3)

Relationship status		
Married	100%	(n = 18)

Number of times married		
1	88.9%	(n = 16)
2	11.1%	(n = 2)

Years Married		
Mean	5.94	(n = 18)
SD	4.07	

Number of children		
0	11.1%	(n = 4)
1-2	33.6%	(n = 6)
3-4	44.4%	(n = 8)

Religious affiliation		
Christian	100%	(n = 18)

Education level		
Some College	61.1%	(n = 11)
Bachelor's Degree	38.9%	(n = 7)

Annual income		
0-14,999	55.6%	(n = 10)
15,000-29,999	11.1%	(n = 2)

45,000-60,000	33.3%	(n = 6)
Ethnicity		
White/Caucasian	100%	(n = 18)
Number of therapy sessions		
Mean	5.44	(n = 18)
S. D.	3.89	

Couples choosing to participate received a *Participant Letter of Explanation* (Appendix G)*,* containing information about the general purpose of the research, an invitation to participate, and an explanation of confidentiality procedures. Prior to the experimental session, participating couples received, understood, and signed the *Informed Consent to Participate as a Research Subject* (Appendix G). The informed consent explained the general purpose of the research study, what participants would be involved in, their rights as research subjects, confidentiality procedures, and potential benefits and risks of the study. The role of clinical couples in the study, as explained in the informed consent, was to take part in a therapy session in which enactments with proxy voice interventions would be used. In order to reduce attrition and increase the validity of the couples' interpersonal process recall, couples met with an undergraduate coder immediately following the therapy session to view each discrete proxy voice occurrence and complete the *Categorical Measure of Struggle* for each instance of proxy voice. Couples remained blind to the independent and dependent variables throughout the study to avoid any possible demand effects.

<div align="center">

Procedures

</div>

Therapists

Five student therapists (four females and one male) delivered the proxy voice intervention. These therapists were first year students in an accredited, master's level MFT

training program. Because therapist participation represented a convenience sample and was a mandatory part of their regular clinical training, two steps were taken to maintain therapist motivation during the duration of the research: (1) therapists were informed as to the research question and independent and dependent variables, (2) therapists received an incentive in the form of a $5 gift certificate for recruiting their clients to participate in the study.

As part of their clinical practicum, therapist-interns received training in the use of enactments in marital therapy from the primary author of the enactments model. The "manualization" of enactments for the purposes of this study is represented in three texts: Gardner and Butler (2002), Davis and Butler (2004), and Butler and Gardner (2003). These texts explicate enactments conceptually and operationally, providing a component model of a single enactment and a developmental model of enactments over the course of therapy. Training was completed over a four week period. Therapists first read the enactment primers found in the training manual mentioned above. Afterward, didactic instruction highlighting the conceptualization of the components of an enactment, developmental stages of enactments, and proxy voice intervention within enactments was offered. Instruction also included videotape examples of enactments. Finally, training concluded with experiential practice through role-play, emphasizing experimentally correct use of proxy voice intervention.

Coders

Six undergraduate coders were trained to identify each occurrence of proxy voice in the context of enactments. A one hour training session consisted of both didactic and experiential instruction. The coders were taught the conceptual rationale and operationalization of proxy voice in terms of timing, delivery, and feedback. Specifically, coders understood that therapists may choose to use a proxy voice intervention when the clients appear stuck in their interaction,

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unsure of how to express themselves, or unable to express themselves in attachment terms. Coders were instructed that two very overt therapist behaviors signal the beginning of proxy voice for the coder: (1) asking permission to speak as if she was the client, and (2) sliding her chair alongside the speaking partner. After speaking as if she were the client in terms of attachment based expression, the therapist seeks feedback and encourages the client to clarify and change what was said and continue the dialogue. Proxy voice intervention ends when the client expresses in his/her own words what was processed with the therapist. Thus, proxy voice intervention has clear markers allowing highly reliable identification.

As part of the training, coders took part in a role play depicting proxy voice in the context of enactments. Members of the research team met with the primary researcher as needed during data collection to have questions answered, role play, and address any concerns. *After* each therapy session and couple meeting, a second coder reviewed the session and identified all of the occurrences of proxy voice. When compared with the occurrences identified by the in-session coder, inter-rater reliability was 90%.

Therapy Session and Follow-up with Couples

Participating couples and their therapist participated in a therapy session during which a 20-30 minute enactment was carried out and proxy voice was offered numerous times, representing a naturalistic representation of proxy voice within enactments. Video of the session was fed into a private room in the BYU Comprehensive Clinic where one to two of the undergraduate coders viewed and coded the session for proxy voice occurrences in real-time.

When two coders participated in the session, one coder was responsible for identifying each occurrence of proxy voice and the time frame in which it occurred while the other was responsible for compiling the copies of the *Categorical Measure of Struggle* for each partner.

This included checking boxes at the top of each questionnaire, identifying both therapist and client gender and also ensuring that each *CMS* accurately corresponded to each client's role during each segment (speaking or listening partner).

After the session and a 10-minute break, the coder replayed each occurrence of proxy voice for the spouses, inviting them to reflect on their interpersonal process at the time that it happened. Partners filled out one CMS, according to whether they were the speaking or listening partner, for each occurrence of proxy voice. Each partner filled out one CMS for each proxy voice occurrence. Spouses completed the questionnaires independently, and coders were instructed to discourage spouses from collaborating while responding. When both spouses had completed the CMS for the last proxy voice intervention, they were thanked for their time and compensated with a $10 gift certificate to a local restaurant. The results were then recorded, and efforts were taken to ensure couple confidentiality.

Measures

The dependent variable, client perceived softening (measured separately for both speaking and listening partners), was assessed using the *Categorical Measure of Struggle—Part A* (Appendix H). The CMS utilized interpersonal process recall (Elliott, 1986; Kagan & Kagan, 1990; Kagan et al., 1963) in the form of a one item, multiple choice recall measure designed to represent the spectrum of possible immediate client responses to the intervention—softening, withdrawal, or negativity—and highlight each choice's constituent dimensions that were reviewed previously (see literature review).   Each possible client response (softening, withdrawal, or negativity) was represented by a short paragraph with several sentences corresponding to each. There were two forms of the instrument—one for the speaking partner and the other for the listening partner. When possible, the statements representing softening,

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withdrawal, and negativity were the same for both speaking and listening partners. The instructions for the measure were as follows: *After viewing the video segment, circle the letter that* most correctly *represents how you felt immediately after the segment. Clarifications and comments may be made at the bottom of each section.*

The CMS was developed as a part of this study. As a result, no indications of reliability or validity are available. However, careful efforts—explained below—were taken in the measure's development toward non-statistical face, content, and construct validity. Conceptually, the CMS's face validity was evident in the likelihood that others would report that it indeed measured the construct of client perceived softening versus withdrawal or negativity. Both content and construct validity were represented by developing three possible responses to proxy voice (softening, withdrawal, and negativity) that represented the entire theoretical continuum of softening-struggle, thereby ensuring that one of the three responses would fit each client's experience of proxy voice. This was addressed by referring to previous scholarly work regarding softening (Butler, Gardner, & Bird, 1998; Butler & Gardner, 2003**;** Greenberg & Johnson, 1988; Johnson, 1996) and struggle (Butler & Bird, 2000; Chamberlain et al., 1984; Miller & Rollnick, 2002), synthesizing the work into three primary areas (softening, withdrawal, and negativity), developing dimensions for each of those areas based on the scholarly work, and then compiling statements that adequately represent each dimension (convergent validity) while also remaining conceptually distinct from the other dimensions (discriminant validity).

With respect to statistical reliability and validity, the *Categorical Measure of Struggle— Part B* (Appendix H) was developed to provide some information at the conclusion of the study regarding reliability and construct validity. Part B also contains two forms (one each for the

speaking and listening partner), consists of the same constructs (softening, withdrawal, negativity), and represents the same dimensions for the constructs as CMS—Part A, but divides part A into four multiple-choice questions. The primary difference between part A and B is a structural one rather than varying content. Whereas CMS—Part A is in paragraph form, CMS—Part B divides part A into four sentences, thereby providing opportunity to conduct statistical tests of reliability and validity. Question one represents the affect after proxy voice, question two corresponds to the comprehension felt, question three addresses the desires toward conciliation, and question four points toward the relationship motivation and overall optimism.

CHAPTER IV

Results

Data Analyses

The current study explored the effects of a proxy voice intervention on the likelihood of client softening versus withdrawal or negativity in the context of enactments. In order to provide complete and reliable results and to fully understand this study's implications, we asked four data-related questions and conducted the necessary preliminary and primary statistical analyses to answer those questions (intraclass correlation, chi-square analysis, confirmatory factor analysis, and latent class analysis). The following section sets forth questions regarding data analysis, explains the statistical analysis used to answer each question, and reports the findings of this study.

Preliminary Analyses

Question 1. Can we treat client responses for each occurrence of proxy voice as independent of each other with no residual effects on future responses?

The first question tested for the statistical assumption that there would be no residual effects from a prior instance of proxy voice intervention upon couple responses to any subsequent occurrence. In other words, we wanted to know which of the following two conditions existed with respect to the data: (1) later proxy voice occurrences *did not* demonstrate residual effects from previous occurrences, thereby allowing us to treat all 42 instances as independent from one another; or (2) the experiences of couples during previous occurrences of proxy voice contributed to how they responded to later occurrences, thus making it important to analyze the results according to the nine couple clusters and treating them as inter-related and dependent.

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A test of intraclass correlation was used to determine how much of the total variation in softening was an artifact of overall clinical history, including prior experience with proxy voice, versus how much of the total variation was accounted for by the immediate instance of proxy voice alone (Haggard, 1958). The lower the intraclass (within couple) correlation, the more confidence we would have that each occurrence of proxy voice is independent of every other occurrence.

The results of the intraclass correlation ($r = .087$) suggest that only about 8.7% of the total variance stemmed from *within clients*, while 91.3% of the variance was from the *immediate instance of proxy voice* (see Table 3). The corresponding design effect, calculated as 1 + (average cluster size - 1) * intraclass correlation = 1.7, suggests that the cluster nature of the data could be neglected and each occurrence of proxy voice could be treated as independent of one another without distorting any parameter estimates (Muthen & Satorra, 1995). Hence, we felt confident in being able to treat the 42 occurrences of proxy voice as independent of each other without the need to group them into nine interdependent couple clusters, thus allowing a more straightforward analysis of the effectiveness of proxy voice intervention in the context of enactments.

Table 3: Intraclass Correlation Analysis (r)

Part A—CMS
     Overall Question $r = .087$
     Design Effect   1.7
          [DE = 1 + (average cluster size - 1) * intraclass correlation]

Question 2. How effective was the CMS in measuring softening versus withdrawal or

negativity? Specifically, how reliable was CMS—Part A when comparing it with the results generated by the four sub-questions in CMS—Part B? Also, how well do the four sub-constructs of CMS—Part B represent softening versus withdrawal or negativity?

One more preliminary statistical analysis analyzed the reliability and construct validity of the Categorical Measure of Struggle, thereby providing information about the effectiveness of measuring the construct of softening versus withdrawal or negativity. The Categorical Measure of Struggle was developed to meet the needs of this study, as an adequate measure did not exist for measuring the construct of softening versus withdrawal or negativity. Part A consisted of one question with three potential responses in paragraph form representing several dimensions of softening (calming, comprehension, conciliation, relationship orientation, optimism); withdrawal (avoidance, inattention, role reluctance, confusion, emotional unavailability); or negativity (interrupting, defensiveness, disagreement, relationship disorientation, hopelessness). Because the potential for measurement error is substantial in a one item test (CMS—Part A), CMS—Part B was developed by dividing part A into four questions with the same constructs and dimensions for each. As a result, it was important to look first at the likelihood that both parts A and B of the CMS would yield consistently similar results while also analyzing the effectiveness of the sub-constructs in CMS—Part B in representing the overall construct of softening versus withdrawal or negativity.

Confirmatory factor analysis was used to determine if the various sub-items of softening, withdrawal, or negativity, respectively, would in fact statistically cluster together, thus allowing us to simultaneously test the alternate-form reliability of the CMS—Part A and the construct validity of the four questions comprising the CMS—Part B (Long, 1983). Confirmatory factor analysis investigates the "variation and covariation in a set of observed

variables in terms of a set of unobserved factors" (Long, 1983, p. 22) The several items of

CMS—Part A and CMS—Part B were the observed variables, and softening, withdrawal, and

negativity were the anticipated latent variables.

      With respect to reliability (see Table 6) between parts A and B, the path coefficient ($\forall$

= .68) from the overall indicator to the softening construct (CMS) suggests adequate reliability,

although there is some discrepancy between the single item measure and a multiple indictors

latent construct. When analyzing the construct validity as provided by the four questions of the

CMS—Part B, the model fit the data very well (χ^2 = 5.20; df = 3; p = .16; Comparative Fit

Index = .96; Tucker-Lewis Index = .92; Root Mean Square Error of Approximation = .09). The

factor loadings for each question on the CMS—Part B (question 1 = .82; question 2 = .55;

question 3 = .72; question 4 = .66) show that the softening construct was well measured by

each of the four sub-questions.

Table 4: Confirmatory Factor Analysis

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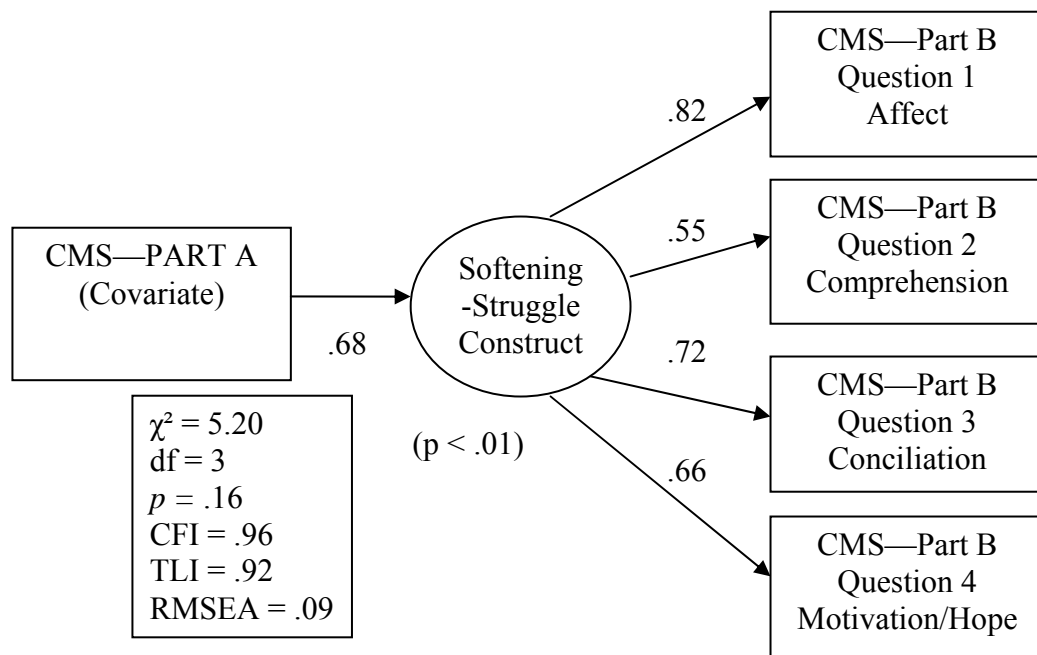
With the concern about the independence of the data resolved and tests indicating the reliability and construct validity of the CMS, we proceeded with the primary statistical tests of our hypotheses.

Primary Analyses

Question 3. Is there a greater than chance probability (33%) that each occurrence of proxy voice would lead to client softening as opposed to withdrawal or negativity? Are results different according to role and gender?

This was our primary research question. The CMS represented three exhaustive categorical codes for client responses (softening, withdrawal, and negativity). Due to the exploratory nature of the study, we compared the actual spouse-reported responses for each occurrence of proxy voice (observed frequencies) with random or chance occurrence of softening, withdrawal, or negativity (expected frequencies—1/3 or 33 %) using a non-parametric chi-square test. This test calculates the statistical significance of any observed differences (Greenwood & Nikulin, 1996), and acts as an indicator of how well proxy voice fits the model of client softening versus withdrawal or negativity. With 42 occurrences of proxy voice, each reported on by two partners, the total number of responses is 84. Thus, the expected frequency of each response generated by chance is 28.

For the purposes of this study, we calculated chi-square for the overall results of the CMS—Part A and each of the four sub-questions of the CMS—Part B and compared them against chance occurrence of softening, withdrawal, and negativity (Long, 1983). Extensive testing of part B did not yield additional or more discriminating information. Thus, these analyses are not reported here (see Tables 3, 7, and Appendix I).

Results for All Partners. A nonparametric chi-square test was used to analyze the results

of parts A and B of the CMS for all partners, for only listening partners, and for only speaking

partners and compared them to chance probabilities. Frequencies and chi-square results are

found in Table 5. Both speaking and listening partners on part A indicated a very high

probability of softening after a proxy voice offering (81.0%, n = 68; χ^2 = 86.36, df = 2, p <

.001).

Table 5: Frequencies and Chi-square analysis

Frequencies:
    CMS—Part A (n = 84)

Softening		.810	(n = 68)
Withdrawal		.131	(n = 11)
Negativity		.060	(n = 5)

    CMS—Part A—Speaking Partner (n = 42)

Softening		.810	(n = 34)
Withdrawal		.143	(n = 6)
Negativity		.048	(n = 2)

    CMS—Part A—Listening Partner (n = 42)

Softening		.810	(n = 34)
Withdrawal		.119	(n = 5)
Negativity		.071	(n = 3)

    CMS—Part A—Speaker/Listener Agreement (n = 84)

Agree		.667	(n = 56)
Disagree		.333	(n = 28)

Chi-square analysis:

Speaking & Listening Partners	χ^2	df	p
CMS—Part A (n = 84)	86.36	2	< .001

Speaking Partners	χ^2	df	p
CMS—Part A (n = 84)	43.43	2	< .001

Listening Partners	χ^2	df	p
CMS—Part A (n = 84)	43.00	2	< .001

Separate Results for Speaking and Listening Partners. When testing effects of each

occurrence of proxy voice separately for speaking versus listening partners (CMS—Part A), no

differences were observed. Both speaking and listening partners reported softening effects

81.0% of the time. For both speaking partners ($\chi^2 = 43.43$, df = 2, $p < .001$) for whom the

therapist offered the proxy voice, and for listening partners ($\chi^2 = 43.00$, df = 2, $p < .001$) who

heard the proxy voice, results showed that there was significantly greater than chance

probability of partners experiencing softening following proxy voice intervention.

A slightly different result was found within each instance of proxy voice, as the

frequency of agreement between spouses was slightly lower at 66.7%. Hence, two-thirds of the

time, speaking and listening partners reported similar experiences of proxy voice, while the

remaining one-third of the time they disagreed. A chi-square analysis was also used to compare

the expected and observed frequency of disagreement. The expected frequency of agreement

and disagreement is 50% (softening-softening, withdrawal-withdrawal, and negativity-

negativity represent spouse agreement; softening-withdrawal, softening-negativity, and

withdrawal-negativity represent spouse disagreement). Results indicated a statistically greater

than chance probability that spouses would agree following proxy voice ($\chi^2 = 9.33$, df = 1, $p <$

.002).

Of those fourteen instances of proxy voice where spouses disagreed, 42.9% of spouses

reported feeling softened, 39.3% reported withdrawal, and 17.9% indicated greater feelings of

negativity. In addition, listening-husbands were the ones most likely to indicate a *greater*

response of struggle (42.9%) than their wives. The likelihood of speaking-husbands and

speaking wives indicating a higher form of struggle than their spouses was equal (21.4%).

Listening wives were the least likely to indicate more struggle than their husbands when they

disagreed (14.3%). A chi-square analysis of this data, however, did not yield statistically significant results (χ^2 = 3.07, df = 2, p < .215), thus limiting our ability to fully understand the implications of these findings.

Results for Gender. With respect to gender, frequency distributions and chi-square analysis found few, if any, differences (see Table 6). Due to the structure of the research condition (e.g. couple therapy), females and males were equally often speaking and listening partners (50.0%). Results regarding probabilities of softening, withdrawal, and negativity were similar for males (χ^2 = 38.71, df = 2, p < .001) and females (χ^2 = 48.14, df = 2, p < .001), with a statistically strong likelihood for both men and women that an occurrence of proxy voice would lead to softening rather than withdrawal or negativity.

The results of frequency distributions (see Table 6) and chi-square analyses for speaking and listening partners separately (CMS—Part A), when taking into account gender, indicated that 85.7% of males in the speaking role (χ^2 = 26.00, df = 2, p < .001), 71.4% (n = 15) of males in the listening role (χ^2 = 13.74, df = 2, p < .001), 76.2% (n = 16) of females in the speaking role (χ^2 = 18.00, df = 2, p < .001), and 90.5% (n = 19) of females in listening role (χ^2 = 13.76, df = 1, p < .001) perceived that proxy voice contributed to elements of softening rather than withdrawal or negativity. Thus, softening was reported following proxy voice by both male and female speakers and listeners.

Table 6: Frequencies according to Gender

CMS—Part A (n = 84)

Male—Speaking	.250	(n = 21)
Female—Speaking	.250	(n = 21)
Male—Listening	.250	(n = 21)
Female—Listening	.250	(n = 21)

CMS—Part A—Male Speaking (n = 21)
Softening	.857	(n = 18)
Withdrawal	.095	(n = 2)
Negativity	.048	(n = 1)

CMS—Part A—Female Speaking (n = 21)
Softening	.762	(n = 16)
Withdrawal	.190	(n = 4)
Negativity	.048	(n = 1)

CMS—Part A—Male Listening (n = 21)
Softening	.714	(n = 15)
Withdrawal	.143	(n = 3)
Negativity	.143	(n = 3)

CMS—Part A—Female Listening (n = 21)
Softening	.905	(n = 19)
Withdrawal	.095	(n = 2)

Question 4. Are the results for the sub-constructs found in the questions of the CMS—

Part B similar to the results for the CMS—Part A when using a slightly different statistical

analysis?

Although chi-square analysis is an adequate, informative indicator of the effectiveness

of a model, it also has three major assumptions that could limit application of the results: (1)

normal distribution of observed variables; (2) analysis based on sample covariance rather than

sample correlation; and (3) a sample size large enough to justify the asymptotic properties of

chi-square (Long, 1983). For this reason, it was decided to test the same probabilities as chi-

square using latent class analysis (with slightly different assumptions) of the four sub-questions

found in CMS—part B, thereby increasing the reliability of our findings.

As multiple indicators have been theoretically favored in measuring a latent construct, a

latent class analysis was performed to corroborate the findings based on the single-measure χ^2

tests. Latent class analysis permits analysis into what groups a given sample of cases fall

according to conditional response probabilities. The overall purpose of latent class analysis is to

"find the size of each latent class *and* the estimated probabilities of occurrence for each

category of each variable" (Green, Carmone, & Wachspress, 1976, pp. 170-171).

For the purposes of this study, the aggregate results of the four sub-questions (affect,

comprehension, conciliation, and relationship motivation/hope) found in CMS—Part B were

divided into two classes: softening and non-softening. The results of this comparison are found

in Table 7. Whereas contingency analysis of CMS—Part A yielded probabilities of 80.0% (N =

68) for softening versus 20.0% (N = 16) for non-softening, latent class analysis of CMS—Part

B yielded an adjusted probability value of 75.1% (N = 64; p = .98) for softening and 24.9% (N

= 20; p = .98) for non-softening. While there is a slight difference between the results of the

two analyses, both come to essentially the same conclusion: there is a significantly greater than

chance likelihood that each occurrence of proxy voice will yield responses of softening from

clients, helping to further confirm the results generated by chi-square analysis.

Table 7: Latent Class Analysis

CMS—Part B (Questions 1-4)	%	N	p
Softening Probability	75.1%	64	.98
Non-softening Probability	24.9%	20	.98

CHAPTER V

Discussion

Enactments are therapist-guided couple interaction used for the purpose of maintaining the primary focus of therapy on the couple relationship rather than on the therapist, modifying couple interaction at its source in such a way as to elicit expression of attachment and self-concept needs and threats, and foster couple self-reliant interaction. Although recent scholarly work in enactments has furthered a global conceptual and operational understanding, no empirical research has analyzed enactments in terms of its specific components.

This study utilized observational coding (Chamberlain et al., 1984) and interpersonal process recall (Elliott, 1986; Kagan & Kagan, 1990; Kagan, Krathwohl, & Miller, 1963) to provide a first look at one of the major subcomponents of enactments, namely proxy voice intervention, which allows the therapist to coach when distress is present but spouses are having difficulty expressing themselves in terms of attachment and self-concept threats or longings. Chi-square and latent class analysis tested the overall likelihood of proxy voice to yield clinically significant amounts of softening, withdrawal, or negativity; thus, indicating the perceived effectiveness of the proxy voice intervention in the context of enactments.

This study yielded results that were clinically meaningful as well as statistically significant, as the magnitude of difference between reports of softening versus withdrawal or negativity lead us to the conclusion that proxy voice is associated with softening to a clinically meaningful degree and similarly disassociated with withdrawal or negativity. Findings also indicate that proxy voice was more likely to yield softening effects than withdrawal or negativity for both male and female, speaking and listening partners. Thus, neither differences by gender or role were found. The following section discusses the theoretical and clinical

implications of the results and also sets forth potential directions for future proxy voice and enactment research.

<div align="center">*Theoretical and Clinical Implications*</div>

Proxy Voice and a Developmental Model of Couple Enactments

The results of this study provide significant justification for the use of proxy voice in the context of a developmental model of enactments, as exposited by Butler and Gardner (2003). Their developmental model consists of five enactment stages (shielded; buffered; face-to-face, talk-turn; episode; and autonomous relationship enactments) which can be adapted to varying levels of couple distress, volatility, and expression (see literature review or Appendix C for more information).

This study's results support the idea of proxy voice as an effective therapeutic intervention to foster elements of softening, especially during enactment stages three and four, when couple reactivity is somewhat diminished, partners interact face-to-face in real-time, and the therapist acts primarily as coach of the interaction, but when there are still interactional moments in which attachment and self-concept needs are not adequately expressed, threatening emotional receptivity and closeness. Theoretically, we hypothesize that in terms of facilitating understanding and softening in therapy, proxy voice is the fundamental intervention in the context of enactments.

Proxy Voice versus Withdrawal or Negativity (Struggle)

As stated previously, proxy voice consists of three phases and several key components. During the initiation phase, *request to proxy speak,* partners may exhibit frustration, hesitancy, or expression of secondary affect (e.g. anger). The therapist then offers a brief empathic response, asks permission to proxy speak, and slides his/her chair alongside the speaking

partner. *Proxy voice delivery* occurs during the clarification stage. The therapist tentatively offers proxy voice while reframing client expression, making explicit primary affect, and linking the expression to attachment or self-concept issues. *Proxy voice evaluation* occurs during the processing stage and allows the speaking partner to comment on the aspects of the therapist's offering that fit and those that did not and then offer it in his/her own words to the listening partner.

However, previous scholarly work regarding therapist-client struggle has indicated that therapist teaching, advice giving, directiveness, and interpretation increase the likelihood for therapist-client struggle in therapy (Butler & Bird, 2000; Miller & Rollnick, 2002). Although Miller and Rollnick (2002) posit that occasional therapist directives may be justified if the therapist honors the autonomy of the client by asking the client's *permission*—a technique incorporated into proxy voice—nonetheless, some could argue that proxy voice is counter-intuitive to the conceptual justification of enactments because it reintroduces the therapist-client hierarchy with the therapist as the expert. The primary question of this study was whether clients would view proxy voice as an intrusion by the therapist leading to greater amounts of struggle and forfeiting potential softening effects, or whether occurrences of proxy voice would contribute to significant, positive therapy outcomes.

The data indicate that both types of struggle, withdrawal and negativity, were likely to follow proxy voice significantly *less* often than predicted by chance. Thus, the operational framework of proxy voice appears to limit the likelihood of therapist-client struggle. Keeping with the justification offered by Miller and Rollnick (2002) for occasional therapist directives, the elements of proxy voice that potentially limit withdrawal and negativity are (1) asking permission of the client to proxy speak; (2) tentative expression of proxy voice; and (3)

evaluating with the client what fit, what did not fit, and facilitating their own expression. Each of these implicitly conveys the idea that clients are capable, responsible, and in control of their own expression, with the therapist only offering occasional modeling and coaching.

Proxy Voice and Softening versus Withdrawal or Negativity

Not only does proxy voice *not* lead to greater amounts of withdrawal or negativity, it also appears to be an effective method to facilitate couple softening in relational therapy. The results of this study further illuminate the context in which enactments are utilized and the dynamics of proxy voice in facilitating couple softening. Specifically, the following principles may help clinicians in using proxy voice to dampen volatility and foster couple softening during enactments: (1) proxy voice temporarily increases the structure of the couple interaction, thereby allowing the therapist to dampen reactivity and model healthy expression before returning to direct couple interaction; (2) proxy voice is a *hypothesis* of softer emotions that fits the clients' experiences, helps them to feel validated, and encourages them to consider something in a newer, softer way; and (3) proxy voice taps into foundational relationship dynamics surrounding self-concept and attachment experiences that "propel" interaction processes but remain outside conscious awareness or explicit expression for the couple.

Increasing interactional structure through proxy voice. Earlier stages of the developmental model of enactments are highly structured and safeguarded to shield couple interaction from intense emotional volatility and reactivity. During these stages, the therapist acts primarily as a conduit of the couple interaction and focuses on modeling appropriate, healthy expression to foster nascent softening. As the couple's distress decreases and they gradually become emotionally receptive to one another, enactment stages shift to more free-form, face-to-face couple interaction where the therapist primarily acts as coach.

Proxy voice is an effective intervention during these middle stages of enactments, when couple interaction contains only occasional lapses. Such lapses most often occur during interactional sequences when the following three conditions are met: (1) there are signs of hesitancy or confusion from both speaker and listener regarding the surface interaction (content); (2) there is increased, uncorrected expression of secondary emotions such as frustration or anger; and (3) there are few, if any, expressions in terms of attachment or self-concept needs. All three of these conditions act as warning signs that the couple dialogue is becoming increasingly reactive.

One way the therapist helps to dampen the volatility is by temporarily increasing the structure. The therapist slows down the interaction by again becoming a brief conduit to the couple interaction, during which time, s/he returns to modeling appropriate expression or listening. S/he does this through proxy voice expression. During the evaluation phase of proxy voice, the therapist begins the shift back to direct couple interaction by processing proxy voice and encouraging the speaking partner to express the ideas in his/her own words before continuing the enactment. Because the number of times proxy voice is used in an enactment is functionally unlimited, the therapist may choose to add this small amount of structure to the couple interaction whenever emotional reactivity increases during the enactment.

Proxy voice as a hypothesis and validating experience. In addition to structuring and slowing down the interaction, proxy voice also allows speaking and listening partners to feel validated as the therapist offers a hypothesis that encourages them to look at things in a softer, more relationship enhancing way. With respect to this idea, one caveat is necessary. Proxy voice is more than a summary of client expression, which has the potential to provoke frustration at the unnecessary interruption and threaten the therapeutic relationship.

Rather, effective utilization of proxy voice in the context of enactments requires that clients experience the therapist as a helpful, caring individual who is seeking to understand their experiences and add to their dialogue an important additional dimension of meaning. As the therapist sets forth a soft hypothesis of the client's experience in terms of attachment and self-concept, the client is able to feel validated, which is a necessary affective precursor to softening. Even if the proxy voice offering is not completely correct, the speaking partner has the opportunity to think about things in a slightly different way, clarify his/her experience in softer terms, and then express that to the listening partner. The cumulative effect of proxy voice, then, is validation through a greater understanding of self and other.

Fostering attachment and self-concept awareness through proxy voice. Perhaps the greatest benefits of proxy voice rest primarily in its bringing into shared consciousness the underlying attachment and/or self-concept threats and/or longings latent but not explicit in the relationship, along with the attendant primary affect. Attachment theory conceptualizes marital difficulties in terms of the couple bond and hypothesizes that partners work toward overcoming anxiety and fear to define their couple relationship as a safe haven and secure base (Bowlby, 1969; Cassidy & Shaver, 1999; Johnson, 2001). Secondary affect is a marker to underlying self-concept and/or attachment issues. Primary affect is a key to accessing them in a relationship-enhancing way. Subsequent resolution of these issues is the gateway to marital healing, growth, and intimacy.

Proxy voice, to the extent that it facilitates expression in terms of attachment or self-concept threats/needs, invites softening and contributes to the establishment of a more secure bond by increasing access to underlying emotions, allowing for open and direct communication and the development of more positive internal working models, and by increasing the

connection between each spouse by helping each experience both themselves and the other as trustworthy, secure, and safe (Johnson, 2001).

Proxy voice helps to facilitate softer expression in a relatively safe way as the therapist sets forth the attachment-based expression as if s/he was the speaking partner. Processing proxy voice with the speaking partners helps them transform the proxy voice expression into their own and gives them a safe venue (through interaction with the therapist) to clarify their attachment and self-concept needs/threats. As the speaking partner continues the enactment by stating the proxy voice expression in their own words, they are more self-aware, confident, and better able to express themselves in terms of attachment and/or self-concept vulnerabilities. Likewise, listening partners are likely to be increasingly open, understanding, and receptive as they continue to see softened, more vulnerable expression from their partners.

Proxy voice is the relational manifestation, in the context of an enactment, of Rogerian dynamics which are typical of Sue Johnson's EFT work, which seeks couple softening through heightening and Rogerian reflective listening (M. Butler, personal communication, August 9, 2004). We acknowledge this method as beneficial but point out that it occurs in the context of a therapist-centralized interaction process and structure. Proxy voice, embedded as it is in enactments, is part of an alternative, couple-centered clinical process and structure, one which we believe exploits the unique opportunities inherent in relationship therapies. Couple interaction and relationship is uniquely and powerfully fostered, assisted, and strengthened through couple self-reliant process in therapy.

Considerations for Speaking and Listening Partners

Because the experience of each spouse during a proxy voice occurrence has the potential to be quite different, this study also tested for differences between speaking and

listening partners. Speaking partners are those for whom the therapist offers proxy voice and they have a more active role in proxy voice than listening partners. Although speaking partners are able to respond to the offering of proxy voice and provide clarification, listening partners do not give direct feedback regarding their experience of proxy voice. Thus, there is great potential for the speaking and listening partners to have vastly different experiences. Separate analyses of the effects of proxy voice for speaking versus listening partners showed that little difference existed between the overall perceptions of both the speaker and listener in each occurrence of proxy voice. Hence, proxy voice may be used with a significantly greater than chance probability that it will be effective in yielding couple softening for both partners.

Nevertheless, a 33% disagreement rate, while less than chance, is clinically meaningful. We recommend further exploration into agreement between speaking and listening partners. It should be noted here that findings were inconclusive regarding the analysis of speaking and listening partners when partners disagreed about the effects of proxy voice. While this data would yield very interesting results regarding the effects of proxy voice on both speaking and listening partners (as well as effects on both genders), we are reluctant to discuss the implications of the findings, as they were not statistically significant due to only 14 occurrences of proxy voice where there was disagreement. Thus, we discuss potential implications based on the general results (both spouse agreement and disagreement) for speaking and listening partners.

Two inherent principles of proxy voice may assist therapists in facilitating softening and agreement in both speaking and listening partners: reciprocity and openness. Although the listening partner for one proxy voice occurrence is in a passive position, it is understood that the same partner who is listening during one proxy voice offering will shift to the speaking role

in future occurrences, thereby allowing both spouses the opportunity to express themselves in a softer, more relationship sponsoring way. In addition, a therapist may choose to include a listening partner after one proxy voice occurrence by rapidly shifting position to assist the listening partner, offering a hypothesis through proxy voice, in terms of attachment and self concept, of how the listening partner might have heard the speaker's expression.

A second potential explanation for the similarity of results between speaking and listening partners is that openness from one partner often begets openness from the other. The goal of proxy voice is not only to foster softening in speaking partners, who gain a greater understanding of themselves; but also for listening partners, who are able to hear softened, more vulnerable expression from their partner, thereby gaining a less threatening "window to their partner's world." Thus, the overall experience of proxy voice apparently can be greater softening for both spouses, resulting perhaps from increasing both partners' self-concept and attachment awareness, relationship orientation, acceptance, and understanding.

The following conceptualizations may assist therapists in facilitating successful navigation of the enactment when two spouses disagree on the overall effects of the proxy voice occurrence. When the speaking partner shows signs of withdrawal or negativity, we recommend placing additional emphasis on the evaluation phase of proxy voice. During that phase, the client processes with the therapist what fits and what does not and is able to make clarifications and changes to the proxy voice. Before continuing the interaction, the speaking partner needs to make the proxy expression "his/her own," thus ensuring that s/he feels softened in the expression towards the listening partner. If the listening partner shows signs of withdrawal or negativity, we suggest that on occasion the therapist may choose to articulate the listener's experience of what the speaking partner said. This may be done effectively by

shifting to proxy voice for the listener by asking permission for the therapist to express how the listener might have heard what was being said. This provides an excellent opportunity to validate the listener's experience as well as model effective and softer ways of listening.

Informal Observations

The following informal observations were not part of the empirical results but are shared, not as a suggestion of fact, but as a possible illumination of future considerations and research possibilities.

Therapist Utilization of Enactments. The therapists who participated in this study as part of the research team received general training in the principles of enactments and then incorporated their understanding of enactments into their own theoretical approaches to therapy. Enactments are fully amenable to incorporation in a variety of therapies and can be adapted not only to each couple's needs but to varying therapeutic styles and approaches. Thus, though not a purpose of this study, the capacity of therapists of various clinical orientations and dealing with a variety of presenting problems to readily incorporate enactments in their clinical retinue provides further support for them as common factor change mechanisms.

Effectively using the proxy voice processing phase. Of the three phases of proxy voice (initiation, clarification, and processing), the most challenging from my observation appears to be processing proxy voice with the clients. During this phase, clients are able to process with the therapist how accurate proxy voice represented their experience, offer clarifications, and then express the idea in their own words. However, clients often react in one of three ways that fails to self-express the idea set forth by proxy voice: (1) the client agrees with everything the therapist says and wants to continue with another thought, or says "Yes, what s/he said."; (2) the client partially agrees and then clarifies directly to the listening partner; or (3) the client

seems to ignore what the therapist says and continues with a separate thought. All three of these situations forfeit the most powerful potential softening moment, when one spouse expresses something to another in softer, more relationship sponsoring terms. The latter two situations also could lead to greater withdrawal or negativity because proxy voice ends with the client not knowing if the therapist really understood or not. Therapists need to structure this phase in such a way that allows clients to evaluate proxy voice and make clarifications with the therapist, and then facilitate the speaking partner's softened, personal expression to his/her spouse.

Limiting enactment and/or proxy voice monologues. One final situation that limits the effectiveness of enactments occurs when one spouse dominates couple dialogue in such a way that severely interrupts and displaces talk-turn interaction, which in enactments is intended to be primary. Such a monologue generally obscures attachment and self-concept needs, and it has an added risk of alienating the other partner. While occasional monologues might be acceptable and possibly even helpful, it is generally best to limit monologues whenever possible. It might also be helpful to ask the following question to a speaking partner that has made a number of continuous comments: "You have said quite a few things that are very important to you. I wonder what the one thing is that you most want your spouse to understand?" In this way, therapists can gain clarification for themselves and the listening spouse, facilitate more softened expression, and, if proxy voice is necessary, be able to facilitate it more effectively.

Conclusion

Limitations and Suggestions for Future Research

Some potential limitations could have resulted in the introduction of one or more confounds to observed effects. We consider here the success of our efforts to minimize any such effects. Although the sample size of 42 was drawn from nine fairly homogenous,

nonrepresentative couples, two factors contribute to our confidence in the results: (1) couples were indeed clinically distressed; (2) intraclass correlation confirmed the independence of the data, thereby leading to clinically significant results for the sample size of 42. A one item measure has a potentially large amount of measurement error. Nonetheless, the four sub-questions of CMS—Part B helped to confirm the construct validity, and reasonable reliability on the CMS—Part A was achieved using confirmatory factor analysis. With respect to comparing the data to chance rather than to a control group, we felt that the exploratory nature of this study justified such an action and led to satisfactory results. However, future inclusion of a control group would generate even richer results and more empirical sophistication.

Observational coding is an empirically optimal way of identifying outcomes associated with proxy voice. The weakness of client self report is its vulnerability to demand effects, as participants might often be evaluating the therapeutic alliance instead. Although efforts were taken to minimize this limitation, including training coders and therapists to reaffirm to participants that they were not evaluating their therapists, we acknowledge this as a potentially significant confound to our results, the magnitude of which is unknown. Although we recommend that future research triangulate on this study's results by employing non-participant observer perspective, we point out that in an exploratory study such as this one, client self report is an efficient method for identifying outcomes and is a valid assessment of an intervention, standing alongside both therapist and observational report in triangulating on any clinical phenomena.

Despite the above potential confounds to the observed effects, the data are sufficiently strong to support the above conclusions and sufficient steps have been taken to minimize the potential concern about the limitations. This study represents an important stepping stone and

provides the framework for further empirical outcome and process research of enactments and their sub-components.

With respect to proxy voice in the context of enactments, two directions of empirical research would yield interesting and rich results and further help both researchers and clinicians understand this potentially useful therapeutic intervention. First, a more in-depth study might continue to analyze the effectiveness of proxy voice in the context of enactments by comparing it to a number of other therapeutic interventions and comparing their results for softening, withdrawal, and negativity. Another option is to develop a detailed coding system that would qualify the effectiveness of therapist delivery of proxy voice and code specific client behaviors as indicative of softening, withdrawal, or negativity.

It is also suggested that research continue to identify and distinguish the experiences of proxy voice for each gender and according to speaking and listening partners. Specifically, it is recommended that the research take an in-depth look at factors that affect spouse agreement or disagreement after each occurrence of proxy voice in whether they felt more softened, negative, or wanted to withdraw. This would include analyzing how agreement or disagreement affect couple-level outcomes of proxy voice and also noting the effect that shifting to proxy voice for the listener has on couple-level outcomes.

Summary

The study of enactments in couple therapy is in its infancy and conclusions from this study are not definitive but rather provide nascent empirical understanding of enactments that complements the extant conceptual defense, thereby inviting future research into this area. Notwithstanding, the results of this study offer evidence that proxy voice intervention embedded within a fluid, carefully delineated, and discriminating model of enactments

effectively facilitates essential elements of couple interaction (expression of primary affect, and self-concept and attachment threats), thereby producing couple softening while simultaneously promoting self-reliant couple interaction, even while navigating varying experiences of distress, reactivity, and volatility.

Most importantly, proxy voice contributes to the overall goal of enactments to foster couple relationship, responsibility, and self-reliance. Although the therapist does briefly interject himself/herself into the couple's interaction, s/he maintains the relationship as the focal point by modeling expression *as if* s/he was the speaking partner, thereby representing only a slight but necessary shift in the couple's interactional trajectory toward a successful enactment and significant, positive therapy outcomes. Such results provide further impetus for enactments and their component stages to be considered as a common factor change mechanism and point toward future empirical research as being imperative in furthering our understanding of the relationship uses and dynamics of enactments.

References

Allen-Eckert, H., Fong, E., Nichols, M. P., Watson, N., & Liddle, H. A. (2001). Developing of the family therapy enactment rating scale. *Family Process, 40*(4), 469-478.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-55). Washington, DC: American Psychological Association.

Bauman, W. F. (1972). Games counselor trainees play: Dealing with trainee resistance. *Counselor Education and Supervision, 11*(4), 251-256.

Black, J. D. (1952). Common factors of the patient-therapist relationship in diverse psychotherapies. *Journal of clinical psychology, 8*, 302-306.

Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy, 27*, 385-401.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books

Brimhall, A. S., Gardner, B. C., & Henline, B. H. (2003). Enhancing narrative couple therapy process with an enactment scaffolding. *Contemporary Family Therapy, 25*(4), 391-414.

Busby, D. M., Crane, D. R., Larson, J. H., & Christensen, C. (1995). A revision of the dyadic adjustment scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy, 21(3),* 289-308.

Butler, M. H., & Bird, M. H. (2000). Narrative and interactional process for preventing harmful struggle in therapy: An integrative empirical model. *Journal of Marital and Family Therapy, 26,* 123-142.

Butler, M. H., & Gardner, B. C. (2003). Adapting enactments to couple reactivity: Five

    developmental stages. *Journal of Marital and Family Therapy, 29*(3), 311-327.

Butler, M. H., Gardner, B. C., & Bird, M. H. (1998). Not just a time-out: Change dynamics of

    prayer for religious couples in conflict situations. *Family Process, 37(4),* 451-475.

Butler, M. H., & Wampler, K. S. (1999). Couple-responsible therapy process: Positive

    proximal outcomes. *Family Process, 38*(1), 27-54.

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research, and*

    clinical applications. NY: The Guilford Press.

Castonguay, L. G. (2000). A common factors approach to psychotherapy training. *Journal of*

    Psychotherapy Integration, 10(3), 263-281.

Chamberlain, P., Patterson, G., Reid, J., Kavanagh, K., & Forgatch, M. (1984). Observation of

    client resistance. *Behavior Therapy, 15,* 144-155.

Crane, D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the

    Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale. *The*

    American Journal of Family Therapy, 28, 53-60.

Davis, S. D. (2002). Common pitfalls of beginning marriage and family therapists utilizing

    enactments. Unpublished master's thesis. Brigham Young University, Provo, UT.

Davis, S. D., & Butler, M. H. (2004). Enacting relationships in marriage and family therapy: A

    conceptual and operational definition of an enactment. *Journal of Marital and Family*

    Therapy, 30(3), 319-333.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Stotsky, S. M., Collins, J. F., Glass, D. R.,

    Pilkonis, P. A., Leber, W. R., Docherty, J. P., Fiester, S. J., & Parloff, M. B. (1989).

    NIMH treatment of depression collaborative research program: General effectiveness of

treatments. *Archives of General Psychiatry, 46,* 971-983.

Elliott, R. (1986). Interpersonal process recall (IPR) as a psychotherapy process research

method. In L. S. Greenberg & W. M. Pinsof, (Eds.), *The psychotherapeutic process: A*

research handbook. New York: The Guilford Press.

Frank, J. D. (1971). Therapeutic factors in psychotherapy. *American journal of psychotherapy,*

25, 350-361.

Friedlander, M. L., Heatherington, L., Johnson, B., & Skowron, E. A. (1994). Sustaining

engagement: A change event in family therapy. *Journal of Counseling Psychology,*

41(4), 438-448.

Friedlander, M. L., Wildman, J., Heatherington, L., & Skowron, E. A. (1994). What we do and

don't know about the process of family therapy. *Journal of Family Psychology, 8*(4),

390-416.

Gardner, B. C., & Butler, M. H. (2002). Enacting relationships in MFT: The empirical,

theoretical, and clinical case for incorporating enactments in the best practice model.

Manuscript under review. Brigham Young University, Provo, UT.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and

empirical considerations. *Psychotherapy, 27,* 143-152.

Gottman, J. M. (1999). *The marriage clinic.* New York: W.W. Norton.

Gottman, J. M., Declaire, J., & Goleman, D. P. (1998). *Raising an emotionally intelligent child.*

New York: Simon and Schuster.

Gottman, J. M., & Levenson, R. W. (1999). What predicts change in marital interaction over

time? A study of alternative models. *Family Process, 38,* 143-158.

Green, P. E., Carmone, F. J., & Wachspress, D. P. (1976). Consumer segmentation via latent

class analysis. *Journal of Consumer Research, 3*, 170-174.

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

Greenwood, P. E., & Nikulin, M. S. (1996). *A Guide to Chi-square Testing.* New York: John Wiley & Sons.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional psychology: Research and practice, 21* (5), 372-378.

Guerney, B., Jr., Brock, G., & Coufal, J. (1986). Integrating marital therapy and enrichment: The Relationship Enhancement approach. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 151-172). New York: Guilford.

Haggard, E. A. (1958). *Intraclass Correlation and the Analysis of Variance.* New York: Dryden Press.

Hanna, F. J., & Ritchie, M. H. (1995). Seeking the active ingredients of psychotherapeutic change: Within and outside the context of therapy. *Professional Psychology: Research and Practice, 26*(2), 176-183.

Hubble, M. A., Duncan, B. L., & Miller S. D. (1999). Introduction. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 1-19). Washington D. C.: American Psychological Association.

Imber, S. D., Pilkonis, P. A., Stotsky, S. M., Elkin, I., Watkins, J. T., Collins, J. F., Shea, M. T., Lever, W. R., & Glass, D. R. (1990). Mode-specific effects among three treatments for depression. *Journal of Counseling and Clinical Psychology, 58,* 352-359.

Jacobson, N. S., & Addis, M. E. (1993). Research on couple therapy: What do we know?

Where are we going? *Journal of Consulting and Clinical Psychology, 61,* 85-93.

Jacobson, N. S., & Anderson, E. A. (1980). The effects of behavior rehearsal and feedback on the acquisition of problem-solving skills in distressed and nondistressed couples. *Behaviour Research and Therapy, 18*(1), 25-36.

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles.* New York: Brunner/Mazel.

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

Johnson, S. M. (2001). Attachment theory: A guide for couples therapy. Unpublished manuscript. Ottawa University, Canada.

Johnson, S. M., & Greenberg, L. S. (1988). Relating process to outcome in marital therapy. *Journal of Marital and Family Therapy, 14*(2), 175-183.

Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationships: A new perspective on impasses in couples therapy. *Journal of Marital and Family Therapy, 27*(2), 145-155.

Kagan, N. I., & Kagan, H. (1990). IPR—A validated model for the 1990s and beyond. *The Counseling Psychologist, 18*, 436-440.

Kagan, N., Krathwohl, D. R., & Miller, R. (1963). Stimulated recall in therapy using video tape—A case study. *Journal of Counseling Psychology, 10*(3), 237-243.

Kerr, M. E., & Bowen, M. (1988). *Family evaluation.* New York: W. W. Norton.

Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldstein (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.

Leveton, E. (1991). The use of doubling to counter resistance in family and individual

  treatment. *The Arts in Psychotherapy, 18,* 241-249.

Long, J. S. (1983). *Confirmatory Factor Analysis.* Newbury Park: Sage.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.*

  New York: Guilford Press.

Minuchin, S., & Fishman, H. C. (1981). *Family Therapy Techniques.* Cambridge, MA: Harvard

  University Press.

Muthén, B., & Satorra, A. (1995). Complex sample data in structural equation modeling. In

  P.V. Marsden (Ed.), *Sociological Methodology* (pp. 267-316). Washington, DC:

  American Sociological Association.

Najavits, L. M., Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic

  therapists: A process-outcome study. *Psychotherapy, 31,* 114-123.

Nichols, M. P, & Fellenberg, S. (2000). The effective use of enactments in family therapy: A

  discovery-oriented process study. *Journal of Marital and Family Therapy, 26,* 143-152.

Ogles, B. M., Anderson, T., & Lunnen, K. M. (1999). The contribution of models and

  techniques to therapeutic efficacy: Contradictions between professional trends and

  clinical research. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and*

  soul of change: What works in therapy (pp. 201-225)*.* Washington D. C.: American

  Psychological Association.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. Garfield,

  & L. A. Bergin (Eds.) *Handbook of psychotherapy and behavior change* (3rd ed., pp.

  311-381). New York: John Wiley & Sons.

Rogers, C. R. (1951). *Client-centered therapy, its current practice, implications, and theory.*

Boston: Houghton Mifflin.

Satir, V. (1972). *Peoplemaking.* Palo Alto, CA: Science and Behavior Books.

Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multilevel-
    process models of therapeutic change in marriage and family therapy. *Journal of
    Marital and Family Therapy, 30*(2), 131-149.

Sexton, T. L., & Ridley, C. R. (2004). Implications of a moderated common factors approach:
    Does it move the field forward? *Journal of Marital and Family Therapy, 30*(2), 159-
    182.

Shields, C. G., Sprenkle, D. H., & Constantine, J. A. (1991). Anatomy of an initial interview.
    The importance of joining and structuring skills. *American Journal of Family Therapy,
    19*, 3-18.

Sloan, R. B., Staples, F. R., Cristol, A. H., Yorkston, W. J., & Whipple, K. (1975). *Short-term
    analytically oriented psychotherapy vs. behavior therapy.* Cambridge, MA: Harvard
    University Press.

Snyder, C. R., Michael, S. T., & Cheavens, J. S. (1999). Hope as a psychotherapeutic
    foundation of common factors, placebos, and expectancies. In M. A. Hubble, B. L.
    Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy*
    (pp. 179-200)*.* Washington D. C.: American Psychological Association.

Sprenkle, D. H., & Blow, A. J. (2004a). Common factors and our sacred models. *Journal of
    Marital and Family Therapy, 30*(2), 113-129.

Sprenkle, D. H., & Blow, A. J. (2004b). Common factors are not islands—they work through
    models: A response to Sexton, Ridley, and Kleiner. *Journal of Marital and Family
    Therapy, 30*(2), 151-163.

Sprenkle, D. H., Blow, A. J., & Dickey, M. H. (1999). Common factors and other nontechnique

    variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan, & S. D.

    Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 325-359).

    Washington D. C.: American Psychological Association.

Strupp, H. H. (1973). On the basic ingredients of psychotherapy. *Journal of consulting and*

    clinical psychology, 41(1), 1-8.

Tallman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In

    M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What*

    works in therapy (pp. 91-131). Washington D. C.: American Psychological Association.

Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs: The heart of healing in families*

    and illness. New York: Basic Books.

Ziskind, E. (1949). How specific is psychotherapy? *American Journal of Psychiatry, 106*, 285-

    291.

APPENDIX A

Common Factors

Client/Extratherapeutic Factors

Extratherapeutic factors, also known as client factors, are estimated to account for 40%

of outcome variance (Lambert 1992). These include everything associated with the client's

experience and life circumstances, such as strengths, supportive environmental elements, and

life events attributed to chance (Hubble, Duncan, & Miller, 1999). Tallman and Bohart (1999)

hypothesize that the "client's capacity for self-healing is the most potent common factor in

psychotherapy" (p. 91). Whether therapy is ultimately successful or not depends on the

motivation and willingness of the client to use his/her own strengths to bring about desired

change. In this view, the therapist acts more as a support, resource provider, and facilitator of

change rather than the instrumentality of change, providing a healing context and assisting the

client to use prepossessed strengths and resources (internal processes) to bring about healing

(Tallman & Bohart, 1999; Wright, Watson, & Bell, 1996).

Relationship Factors

Relationship factors, also known as the therapeutic alliance, have been found to account

for 30% of the outcome variance (Lambert, 1992). This dimension is perhaps the most

researched of the common factors, as research measuring therapist effectiveness has found that

perceived effectiveness of the therapist was based more upon relationship factors than technical

factors (Najavits & Strupp, 1994). The most common relationship factors mentioned in the

research are caring (Hubble et al., 1999; Tallman & Bohart, 1999), empathic understanding and

involvement (Gaston, 1990; Hubble et al., 1999; Najavits & Strupp, 1994; Tallman & Bohart,

1999), warmth (Hubble et al., 1999; Najavits & Strupp, 1994), encouragement (Hubble et al.,

1999; Tallman & Bohart, 2001), affirmation (Hubble et al., 1999; Najavits & Strupp, 1994); and similarities in ideas about therapy goals and tasks (Gaston, 1990). These are self-evident dimensions of relationship and alliance that can be intuitively operationalized and enacted.

Technique/Model Factors

Technique or model factors account for 15% of outcome variance (Lambert, 1992). A *model* has been defined as "a collection of beliefs or unifying theory about what is needed to bring about change with a particular client in a particular treatment context. Models usually include techniques." (Ogles et al., 1999, p. 202). Focus on models and techniques has allowed for greater specificity of therapy through treatment manuals, empirically supported treatments, and protocol driven interventions (Ogles et al., 1999). Increased research in common factor dimensions has provided a complement to techniques and models in understanding change in therapy.

Placebo, Hope, and Expectancy

The final dimension of common factors identified, *placebo, hope, and expectancy factors*, accounts for 15% of outcome variance (Lambert, 1992). Hope is conceptualized as perceptions about personal ability to find appropriate routes to one's goals and to begin and continue on those pathways (Snyder, Michael, & Cheavens, 1999). Placebo and expectancies refer to those ideas of both the clients and therapists that things are going to improve that lead to increased hope and a significant outcome. Overall, the factors involved here depend primarily on client desires and what both the client and therapist believe are possible results of therapy (Snyder et al., 1999).

APPENDIX B

Snapshot of a Single Enactment

Initiation Phase

In the initiation phase of enactments, the therapist lays the foundation for successful couple interaction and engagement. This consists of assessing couple dynamics and needs, introducing the enactment, didactic instruction, and structuring. While the initiation phase is utilized prior to each enactment throughout therapy, it is expected that the time needed to lay the foundation and make the shift from the initiation phase to the facilitation phase will decrease as the couple becomes more familiar with enactments and begins to gain mastery over attachment and self-concept expression.

Therapist *assessment* reviews areas that are most relevant for the couple at that specific time and the dynamics surrounding the issues, including the amount of time dedicated to an issue and the successes and difficulties experienced (Allen Eckert et al., 2001). Because successful enactments require adaptation to varying amounts of couple reactivity and volatility, it is essential for the therapist to assess couple dynamics and emotionality and adapt the rest of the enactment accordingly (Butler & Gardner, 2003). This is not meant to be a thorough assessment in which the therapist is the focus of the interaction and seeks complete understanding of the couple situation. The main goal is for the therapist to gather enough information for an adequate conceptualization of the issue and couple dynamics and to assist the couple in choosing the enactment content focus.

After assessing the couple dynamics and needs of the situation, the therapist *introduces the enactment* to the couple (Davis & Butler, 2004). Once again, whether this is the first time the couple has ever experienced an enactment in therapy, or whether they have done it

numerous times, this step is an important one. The depth and breadth of the introduction will depend, however, on the amount of couple experience with enactments, relationship dynamics, emotionality, and volatility. There are two primary aspects to introducing enactments: discussion of the purpose of enactments and the role of the therapist (Davis & Butler, 2004). After reviewing couple goals for the session and for therapy in general, the therapist discusses with the couple the purpose of the enactment and the potential of the enactment to aid the pursuit of their goals. In addition, it is important that the role of the therapist be outlined in some detail with respect to therapist involvement, modeling, coaching, and potential interventions (Davis & Butler, 2004; Nichols & Fellenberg, 2000).

The therapist then facilitates the specification of the *content and process focus,* being sure to adapt both to the couple's emotional reactivity, problem focus, and goals of therapy. This is coupled with didactic instruction about the process of the enactment, including appropriate communication skills, client roles, and expectations for successful navigation through the enactment (Davis & Butler, 2004; Nichols & Fellenberg, 2000). The therapist teaches them about those elements of positive communication process that will aid them in structuring their self-expression and assist them in reaching their goals (e.g. I-statements, first person language, soft start-ups, reflective listening, requesting change positively, etc.). Most importantly, clients should understand the primary roles of the speaking and listening partners, which are to focus on relationship oriented, attachment and self-concept based expression and empathic, non-defensive listening (Butler & Gardner, 2003). Some expectations for the attachment based expression and listening are that the goal of the couple interaction is emotional safety (Johnson & Greenberg, 1988), and that it is essential to understand the difference between primary and secondary emotions and to express oneself and listen in terms

of primary emotions (Davis & Butler, 2004). As the couple becomes more familiar with this process, this component of the initiation phase may serve to focus the enactment on specific skills and attachment expressions, highlighting those areas the couple has indicated they would like to improve. Davis and Butler (2004) also suggest that the above processes be modeled if necessary, thereby complementing the didactic instruction.

Physical structuring is the final component of the initiation phase. At this point, the therapist regulates the physical structure as the final preparation for the enactment and to facilitate the appropriate interaction. The therapist first regulates the physical proximity of the couple, according to the current couple dynamics (Allen Eckert et al., 2001; Davis & Butler, 2004; Nichols & Fellenberg, 2000). This could include encouraging the couple to turn their chairs toward one another and move them closer together if volatility is relatively low (Nichols & Fellenberg, 2000), or creating safe separation between them by limiting the visibility of nonverbal expressions if emotionality is extremely high. Next, the therapist removes herself from the couple interaction and invites the couple dialogue (Allen Eckert et al., 2001; Davis & Butler, 2004; Nichols & Fellenberg, 2000). For extremely volatile couples, the therapist may not be removed from the interaction, but her role changes from the director and interviewer to one who models proper self-concept and attachment based self expression and listening (stage one and two enactments, Butler & Gardner, 2003).

<div align="center">*Facilitation Phase*</div>

The facilitation phase is the time between the initiation and closing of the enactment, and is, intuitively speaking, the substance of the enactment (Allen-Eckert et al., 2001). The primary purpose of this phase is to facilitate increasingly independent couple interaction in terms of attachment and self-concept needs. This has also been referred to as *sustained*

engagement, defined as "a sequence of speaking turns in which family members are observably willing to disclose thoughts or feelings on the designated topic, to share or cooperate, to show interest and involvement in the discussion, or to be responsive and attentive" (Friedlander, Heatherington et al., 1994, p. 442). Sustained engagement is one of the primary goals of each enactment episode as the couple moves from disengagement with each other to an atmosphere of trust, validation, and engagement by (1) recognizing personal accountability; (2) facilitating communication leading to a greater understanding of the other's thoughts and feelings; and (3) forming new constructions about the gridlock.

Several key components comprise the facilitation phase in which the therapist and couple co-create a positive relationship enactment: sustaining the interaction, coaching and facilitating the interaction, and facilitating self-concept and attachment based expression (Davis & Butler, 2004). *Sustaining the interaction* keeps the couple engaged once the enactment has begun (Nichols & Fellenberg, 2000). This includes maintaining positive interaction and redirecting negative interaction (Davis & Butler, 2004). The therapist is able to maintain positive interaction primarily through structuring and commendations (Davis & Butler, 2004; Nichols & Fellenberg 2000). During this phase, therapist interruptions are regulated according to the needs of the couple with the overall goal being minimal disruption. As the therapist removes herself from the interaction, it may be necessary to structure by reminding the couple to speak to each other rather than the therapist and to avoid eye contact with each client (Nichols & Fellenberg, 2000).

Commendations and redirecting negative interactions are also valuable techniques in sustaining the interaction. The offering of commendations gives the couple immediate feedback regarding their interaction and helps encourage further positive interaction. The most effective

commendations are "brief, specific, and process (rather than content) oriented" (Davis &

Butler, 2004, p. 12). While it is important to offer commendations, the therapist should take

care to ensure that the commendations are unobtrusive and do not interrupt the couple's

process. The goal of redirecting negative interactions is to limit the extreme emotionality and

volatility that might threaten the interaction with disengagement. It is essential that the therapist

assess the situation and, if necessary, slow down the interaction by interjecting herself in the

dialogue and interaction process, as a defusing and deflecting crucible.

In *coaching* the interaction, the therapist's goal is to facilitate successful interaction by

coaching the couple in basic speaking and meta-communication expression while also

facilitating empathic listening skills (Davis, 2002). Helping the couple gain insight into their

"languaging" and their process is another essential part of therapist facilitation (Davis, 2002).

This refers to both the process and content of the speaking partner's self disclosure and the

listening partner's expressed understanding of that disclosure. Interruption may be more

pronounced as the therapist uses reframing and restating when necessary in ways that model

and coach both spouses to alter their typical articulation and interaction patterns in favor of

more effective alternative process and less inciting expression. As each partner gains these

skills, they develop meta-perspective of their interactions and are able to identify, interrupt, and

alter potential negative process.

The final component of the facilitation phase is *facilitating self-concept and*

attachment-based interaction. "Successful intimate interaction requires tracking multiple

channels of interaction, including content, emotion, and attachment messages" (Davis & Butler,

2004, p. 326). Couples are often unaccustomed to expressing themselves in terms of primary,

attachment-based emotions. Attachment bonds, however, strongly influence the quality of

human experience and provide an "active, affectionate, reciprocal relationship in which partners mutually derive and provide closeness, comfort, and security" (Johnson, Makinen, & Millikin, 2001, p. 145).

The therapist seeks to reconfigure the relationship in terms of a secure bond by promoting expression in terms of attachment and self-concept, listening, and responses in addition to encouraging each partner to "use their emotional experience as a guide to their needs and [to] communicate these needs in a way that maximizes the other's responsiveness (Johnson et al., 2001, p. 148). This includes helping each spouse conceptualize their own experience as well as their partner's in terms of its attachment and self-concept significance and to be able to articulate that experience (Butler & Gardner, 2003; Johnson et al., 2001). Partners listen for, identify, and respond to the primary emotion in addition to helping their spouses to express themselves in that manner. The expression of primary emotions in terms of attachment and self-concept and their associated vulnerability fosters greater emotional closeness and allows new patterns of interaction to develop (Gottman, Declaire, & Goleman, 1998; Johnson et al., 2001).

Evaluation Phase

The evaluation phase gives the therapist and partners the opportunity to analyze the process of the now-completed enactment, helping to solidify change, identify areas of improvement, and endow clients with an understanding of the emotional process they just completed (Allen Eckert et al., 2001). Much of this phase is accomplished through the use of inductive questioning, allowing the couple to analyze their process and draw their own conclusions (Davis & Butler, 2004). The therapist *reviews* by inviting the couple to summarize their interaction (Allen Eckert et al., 2001), recall their individual and couple goals for the

enactment and for therapy (Davis & Butler, 2004), and reframe their interaction in terms of their goals (Davis & Butler, 2004). This could include goals for issue resolution, expression in terms of attachment and self-concept, individual speaking or listening roles, or specific changes in couple dynamics.

During *feedback,* the therapist facilitates self and couple evaluation of the process, in which the clients acknowledge individual and couple successes in their process and offer commendations to each other (Davis & Butler, 2004). This is also a valuable opportunity for them to note where change may be necessary in their interaction (Davis & Butler, 2004). The therapist may be tempted to be the primary provider of feedback. It is important, however, to allow the couple to generate their own evaluation of the enactment because this will lead to establishing goals that are more likely to fit the couple and invite change. The therapist offering of commendations and feedback should be secondary and only to highlight successes or note significant areas for change missed by the couple.

After the couple generates feedback and offers each other commendations, the therapist can then *invite commitments* (Davis & Butler, 2004). This consists of inviting commitments about the process and content of the next enactment, including attachment and self-concept based expression (Davis & Butler, 2004). These commitments act as the springboard to more successful couple interaction and allow the clients the opportunity to step back from their interaction and gain a meta-perspective. As the couple becomes more self-reliant in their enactments, they will be able to navigate through this stage with minimal help from the therapist, thereby modeling real-time, post-therapy kinds of interaction.

APPENDIX C

Five Stage Developmental Model of Enactments (Butler & Gardner, 2003)

Stage One: Shielded Enactments

Couples often enter therapy with a high degree of emotionality, volatility, and reactivity. To direct the couple to speak to one another on a difficult couple issue without establishing appropriate structure would be inviting non-regulated, intense conflict escalation. Shielded enactments provide the structure necessary to lay the groundwork for future success in enactments. At this point, self-reliant interaction is not possible. As a result, 100% of the couple interaction is passed through the therapist, allowing the therapist to model expression according to primary emotions. The speaking and listening roles are completely differentiated, to allow for a slower interaction process, greater partner perspective, problem solving responsibility, and a win-win relationship approach. In future stages, the therapist role is primarily to coach, but stage one utilizes didactic training and modeling to introduce alternative interactions to the couple based on expression of attachment and self-concept needs.

The therapist begins by explaining the rationale for enactments, detailing what a successful enactment will require from each of the partners, and providing encouragement. As the roles are defined and the couple begins, it is very likely that the interaction will escalate. Some of the emotionality is dampened by increasing structure through physical positioning. The therapist asks the couple to turn away from each other, so that their nonverbal cues cannot be inciting. Another way the therapist can facilitate a positive enactment and contain and minimize the emotionality is to structure the interaction by keeping the speaking and listening roles completely separate and distinct, with the speaking partner focusing on conciliatory and relationship oriented express and the listening partner focusing on empathy, nondefensive

listening, and receptivity. During the course of the enactment, the therapist may need to remind each partner that the most essential goal is to understand the other and also be able to express attachment and self concept needs appropriately, rather than trying to defend oneself or clarify content. The therapist acts as a filter for intense secondary emotions by reframing emotionally charged messages and modeling the expression and understanding of needs in terms of primary emotions, attachment, and self concept.

<center>*Stage Two: Buffered Enactments*</center>

As couple reactivity and volatility slowly decrease, the therapist then shifts to *buffered enactments*. It is recommended that the therapist shift from stage one to stage three as quickly as possible, so the progress required to navigate through the first two stages is minimal. Once spouses shows some signs of calming, including decreased physiological arousal and softening through greater conciliatory self-expression and receptivity to their partner, they are then prepared to shift to stage two. Although all of the interaction still passes through the therapist in this stage, s/he acts more as a coach rather than a model of attachment and self-concept based expression. There is more visual contact and closer spacing between partners, and the therapist speeds up the interaction by shifting more regularly between speaking and listening partners. Both the speaking and listening partners are increasingly responsible to express themselves and listen in terms of attachment and self concept needs or distress. The therapist may also prepare both partners for stage three enactments and real-time interaction by helping them continue to conceptualize and express themselves using softer emotions by reflecting, clarifying, and validating the other's comments.

<center>*Stage Three: Face-to-Face, Talk-turn Enactments*</center>

Stage three, f*ace-to-face, talk-turn enactments* represent a major structural shift from

<center>70</center>

stage one and two enactments. Some of the indicators that stage three enactments are appropriate is the willingness of each partner to "relate to each other in a conciliatory, receptive, vulnerable, and relationship-focused manner, together with their willingness to listen without interruption, genuinely attend, seek partner perspective, validate, and empathize" (Butler & Gardner, 2003, p. 319). During this stage, the therapist no longer places herself in between the couple interaction. Partners now face each other and respond directly to their spouse. The therapist then coaches from *outside* the interaction.

While in stages one and two the therapist shielded and buffered the emotional affect, the couple's increased ability and willingness to regulate their own expression and their receptivity reflects capacity for more continuous, real-time interaction. The couple is still distressed and may express themselves at times in terms of secondary emotions, but they have enough understanding of basic communication skills that they can be coached by the therapist to express their distress more productively. The therapist coaches the most during this stage (speech-act-by-speech-act intervention), as s/he seeks to bridge the gap from volatile, assisted expression in stages one and two to non-volatile, autonomous expression evidenced in stages four and five (Butler & Gardner, 2003).

Stage Four: Episode Enactments

When the partners each increase in consistent use of positive interaction in both the speaking and listening roles through greater emotional awareness, expression, and receptivity, they shift to stage four, e*pisode enactments.* In this stage, the couple is distressed but nonvolatile and resilient. Couples interact directly 100% of the time and are able to express themselves in terms of their core attachment and self-concept needs the majority of the time, and there is decreasing therapist intrusion, with only occasional coaching rather than speech-

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act-by-speech-act interruptions. This allows the couple to rely less and less upon the therapist and work through their distress themselves. As the couple experiences some intense and difficult challenges and is able to work through them with minimal therapist intervention, couple responsibility, relationship, hope, and confidence are strengthened and greater emotional closeness ensues.

The therapist's primary role shifts from coaching to affirming during couple evaluation after the interaction. While post-enactment evaluation is part of every enactment, couple reactivity and volatility often impede each partner from taking a meta-perspective of the couple interaction and necessitate that the therapist continue coaching and facilitating during the evaluation. In stage four, the couple is more equipped and willing to take that meta-perspective to monitor their own process, address their emotion in more positive ways, evaluate their interaction in terms of their relationship goals, and commit to individual and couple progress.

Stage Five: Autonomous Relationship Enactments

During the final stage, a*utonomous relationship enactments,* couple interaction is nondistressed and nonvolatile and has become a source of relationship strength and enhancement in terms of *process and outcome*. The couple is able to soothe one another, soften, and shows appropriate responsibility, relationship, and neutrality. High level interaction skills are self-directed, self-managed, and self-corrected, and the therapist acts exclusively as an observer/consultant to the couple.

Operational Checklist of Proxy Voice

Indicators for Use	hesitation, confusion, frustration, secondary affect, constrained expression of attachment or self-concept threats/needs			
PROXY VOICE PHASE	**PHASE GOAL**	**THERAPIST BEHAVIORS**	**EXAMPLES**	
Initiation Phase: Request to Proxy Speak	Identify client difficulty and present proxy voice in a way that will increase therapist-client cooperation rather than withdrawal or negativity.	• brief, empathic response to speaking partner • asking permission to proxy speak • sliding chair alongside speaking partner	• "I can imagine how frustrating it is to be unsure how to express yourself." • "I wonder if you would allow me to add to your words some of the things I think I hear you saying?" • "As I offer what I think I hear you saying, please pay close attention to what does and what doesn't fit for your experience, and we will talk about it afterwards."	
Clarification Phase: Delivery of Proxy Voice	Respectful and non-blaming offering of proxy voice, allowing the speaking partner to clarify what s/he is feeling and model attachment and self-concept based expression.	• tentative expression of proxy voice • positive reframe of client expression • make explicit primary affect • linking expression to attachment/self-concept issues	• "I wonder (tentative expression) if you might be trying to tell Jim, 'You are everything to me (positive reframe), and I feel so scared (primary affect) when I feel like I'm not the most important to you' (attachment/self-concept)" • "What I hear you saying (tentative expression) is 'I really want to be close to you (positive reframe), and it hurts (primary affect) when I feel like you can't trust me' (attachment/self-concept)."	
Processing Phase: Proxy Voice Evaluation	Evaluate proxy voice and allow the client to accept or reject certain parts, explain his/her rationale, and then express those ideas to the listening spouse	• allow client to evaluate proxy voice offering • facilitate client expression that fits with him/her • invite client to continue couple dialogue	• "How was that experience for you?" • "I would like to know if anything fit for you." • "How might you say it instead? What do you wish I would/would not have said?" • "Please tell (her/him) what you just told me?" • "That's okay if you want to say the exact thing that I said, but it means more coming from you." • "Go ahead and continue speaking to (your partner) in the same way you were just talking to me."	

Revised Dyadic Adjustment Scale

Name _____   Date_____

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

	Always Agree	Almost Always Agree	Occa-sionally Agree	Fre-quently Disagree	Almost Always Disagree	Always Disagree
1. Religious matters						
2. Demonstrations of affection						
3. Making major decisions						
4. Sex relations						
5. Conventionality (correct or proper behavior)						
6. Career decisions						

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?						
8. How often do you and your partner quarrel?						
9. Do you ever regret that you married (or lived together)?						
10. How often do you and your mate "get on each other's nerves"?						

	Every Day	Almost Every Day	Occa-sionally	Rarely	Never
11. Do you and your mate engage in outside interests together?					

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

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas						
13. Work together on a project						
14. Calmly discuss something						

From: Busby, D.M., Crane, D.R., Larson, J.H., & Christensen, C. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construction hierarchy and multidimensional scales. Journal of Marital and Family Therapy, 21, 289-308.

Revised Dyadic Adjustment Scale

The Revised Dyadic Adjustment Scale is a 14-item instrument with 7 first-order concepts (decision making, leisure, values, affection, stability, conflict, activities, and discussion) and 3 second-order concepts (consensus, satisfaction, and cohesion) used to "evaluate dyadic adjustment in distressed and nondistressed relationships" (Busby, Crane, Larson, & Christensen, 1995, p. 305). All but one of the items in the RDAS has six possible responses with 0- to 5-point rating. The other item has five possible responses with a 0- to 4-point rating. Scoring is calculated by adding the total point value indicated from each question, with the nondistressed mean being 52.3, the distressed mean 41.6, and the overall mean 48.0.

The construct validity, criterion validity, and internal consistency/split-half reliability of the RDAS has been analyzed and found to be clinically significant (Busby et al., 1995). Construct validity was measured using the LISREL program, with each item reporting t-values above 10 and factor loadings above .50. Construct validity was gathered comparing the RDAS to other samples and with the Locke-Wallace Marital Adjustment Test (MAT). The correlation coefficient between the RDAS and MAT was .68 (p < .01). With respect to criterion validity, the RDAS correctly classified 81% of the cases (14% false negatives and 26% false positives). Discriminant analyses regarding the subscales revealed that the *Satisfaction* subscale (.55) had the largest influence with the *Consensus* (.34) and Cohesion (.32) subscales yielding similar results. The internal consistency and split-half reliability proved to be significant using Cronbach's Alpha (.90), Guttman Split-Half (.94), and the Spearman-Brown Split-Half (.95).

APPENDIX F

Demographic Questionnaire

Name _____   Date_____

To begin, we have a few general questions about you:

1. What is your gender?
        a. female
        b. male

2. What is your age?
        a. 18-25
        b. 26-35
        c. 36-45
        d. 46-55
        e. 56 or above

3. What is your relationship status?
        a. Single
        b. Married
        c. Separated
        d. Divorced
        e. Other _____ (please specify)

4. How many times have you been married? _____

5. How many years have you been in your current relationship? _____

6. How many children do you have?
        a. 0
        b. 1-2
        c. 3-4
        d. 5-6
        e. 7 or more

7. What is your religious affiliation?

       a. Buddhist/Hindu

       b. Christian

       c. Islamic

       d. Jewish

       e. Other: _____

8. What is the highest level of education you have completed?

       a. junior high school

       b. high school

       c. some college

       d. college

       e. graduate degree

9. What is your annual income?

       a. 0-14,999

       b. 15,000-29,999

       c. 30,000-44,999

       d. 45,000-59,999

       e. 60,000 or above

10. What is your race/ethnicity?

       a. White/Caucasian

       b. African American

       c. Asian/

       d. Pacific Islander

       e. Hispanic

       f. Other (specify): _____

11. How many therapy sessions have you had? _____

APPENDIX G

Consent Forms

<u>Guidelines for Therapist's Initial Contact to Solicit Participants</u>

When contacting potential participants for the study, please explain the following items:

Purpose of the Study: A study is being conducted by Dr. Mark H. Butler, an Associate Professor in BYU's School of Family Life, together with Ryan B. Seedall, a Master's Student in the Graduate Program of Marriage and Family Therapy. The purpose of the study is to further understand whether couples view certain therapist behaviors as effective or ineffective during therapy. Furthermore, the study is focused on understanding the role of the therapy process in helping couples improve their interactions, as perceived by the couples themselves.

Participation in the Study: Inform the clients that they have been selected based on their purposes for seeking therapy. Participation in the study, however, is completely voluntary. Make clear that accepting or declining to participate in this study will not affect any therapy they are currently receiving. Also explain that they will be compensated for their time with a $10 gift certificate to a local restaurant.

Invitation for Future Contact: Ask the clients if they agree to be contacted by the researcher to further explain the purpose of the study and answer any questions. Explain that the researcher will be given their contact information in order to send a Participant Letter of Explanation and to then contact them by phone. Further explain that permission to give their contact information does not require them to participate in the study. If the individuals agree to be contacted regarding further information and participation in this study, obtain their name, address, and phone number for future contact by the research team.

Contact Information for Participant Questions: For questions regarding the research project, the couples may contact Dr. Mark H. Butler (801-422-8786; 262 TLRB, Brigham Young University, P.O. Box 28601, Provo, UT 84602), or Ryan Seedall (801-422-7759). For questions regarding their rights as participants in a research project, they may contact Dr. Shane Schulties, Chair of the Human Subjects Institutional Review Board (801-422-5490; 120 B RB, Brigham Young University, Provo, UT 84602) for any questions regarding this study or their rights as a research participant.

<u>Participant Letter of Explanation</u>

Dear Prospective Participant,

Dr. Mark H. Butler, Associate Professor in Brigham Young University's School of Family Life, together with Ryan B. Seedall, Master's Student in the Graduate Program of Marriage and Family Therapy, is conducting research focused on understanding the role of the therapy process in helping couples improve their interactions and overall experience in therapy.

You have been recommended as a couple who may be willing and qualified to participate in this important research. Your participation would include a typical therapy session with your therapist followed by a one hour meeting with an undergraduate member of the research team who will show you video of several segments of the session. After viewing each segment, you would then complete a one-item feedback questionnaire to indicate your feelings immediately after each segment.

Because your privacy is of great importance, reasonable actions will be taken to keep your information confidential. The feedback questionnaires will be coded numerically, allowing for the removal of all names and identifying information of all participants prior to any analysis (assuring that only Dr. Butler and Ryan B. Seedall, and the member of the research team in the feedback session will be aware of the names of those participating). Any identifying information of individuals participating in this study will be kept locked for confidentiality and no names will be used in the publication of the results.

Participants will receive a $10 gift certificate to a local restaurant at the completion of the meeting with the member of the research team. Your participation in the study will assist in understanding clients' perceptions of certain therapist behaviors and allow us to discover ways to improve couples' experiences in therapy.

As this study is completed, the conclusions will be released to the public in hopes of providing assistance for all therapists who work with couples. Again, the information released to the public will in no way identify any participants or in any way compromise the confidentiality of the participants.

Your participation will be greatly appreciated, and will help further an important effort in the field of marriage and family therapy.

Sincerely,

Mark H. Butler, Ph.D.
Associate Professor, School of Family Life
Marriage and Family Therapy Graduate Programs, Brigham Young University
262 TLRB, PO Box 28601
Provo, UT 84602-8601
(801) 422-8786

<u>Informed Consent to Participate as a Research Subject</u>

Introduction
Dr. Mark Butler, Associate Professor in Brigham Young University's School of Family Life, together with Ryan Seedall, Master's student in the Graduate Program of Marriage and Family Therapy, is conducting research focused on understanding the role of the therapy process in helping couples improve their interactions and overall experience in therapy.

You have been recommended as a couple who may be willing and qualified to participate in this important research. You were selected for participation in part because your therapist identified you as seeking therapy for couple related issues. Your participation is completely voluntary. Declining to participate in the research will not affect any therapy you are currently receiving or might receive in the future.

Procedures and Participation
Participation involves completing a typical therapy session with your therapist at the BYU Comprehensive Clinic followed by a one hour meeting with an undergraduate member of the research team who will show you video of several segments of the session. After viewing each segment, you would then complete a one-item feedback questionnaire to indicate your feelings immediately after each segment.

Risks/Benefits
There are minimal risks for participation in this study. There is the potential for discomfort associated with providing information about your experience in therapy. While there are no known benefits to you for participating in this study, society and people in general will likely benefit from the knowledge gained regarding what couples perceive as helpful therapist behaviors.

Your participation in the study will assist in understanding clients' perceptions of certain therapist behaviors and allow us to discover ways to improve couples' experiences in therapy. The results of this research may specifically help other couples who come to therapy with couple related issues. As this study is completed, the conclusions and benefits will be released to the public in hopes of providing assistance for all therapists who work with couples.

YOU MAY REFUSE TO CONTINUE YOUR PARTICIPATION IN THE STUDY AT ANY TIME

Confidentiality
Although the video tape used to record the therapy session becomes property of Brigham Young University's School of Family Life, reasonable and appropriate actions will be taken to keep your information confidential. No identifying information will accompany any materials, and only research project staff will have access. We will not use your names when analyzing the information. The video and all other materials will be marked by identification number only and will be maintained in a locked file cabinet. The video of your session will only be used during the video review session and will be destroyed at the conclusion of the study, unless you

provide written consent (after your participation in the study is finished) that the video may be used for instructional, educational, and training purposes.

Compensation
Participants will receive a $10 gift certificate to a local restaurant at the completion of the one hour meeting with the coder.

Questions about the Research
For questions about this research study, please contact the Dr. Mark Butler, who is the primary researcher in this study.

Mark H. Butler, Ph.D
Associate Professor, School of Family Life
Marriage and Family Therapy Graduate Programs
Brigham Young University
262 TLRB, P.O. Box 28601
Provo, UT 84602-8601
(801) 422-8786

Questions about your Rights as Research Participants
If you have questions regarding your rights as a participant in a research project, you may contact Dr. Shane S. Schulthies, Chair of the Institutional Review Board, 120B RB, Brigham Young University, Provo, UT, 84602; phone, (801) 422-5490.

By signing this form, you acknowledge that your participation in this research study is voluntary.

I have read, understood, and received a copy of the above consent, and desire of my own free will and volition to participate in this study.

_____
Research Participant   Date

_____
Witness   Date

Instructions from Coders to Clients

As you were told before, this is an opportunity for us to learn more about what works for clients in therapy. No identifying information will accompany any materials. We will not use your names when analyzing the information. The video and all other materials will be marked by identification number only and will be maintained in a locked file cabinet. The videos of your session will only be used during the video review session, and only research project staff will have access to this material without your prior written consent.

To let you know a little bit about the format of this meeting, you will watch several segments from the therapy session you just concluded. As you watch, please remember how you were feeling at the time. After each segment, you will fill out a one-item, multiple choice feedback questionnaire regarding your thoughts and feelings during the segment. The total time this meeting will take is about an hour.

Please feel free to ask questions, and I will do my best to answer them for you. Please be as honest and accurate as possible in answering the questions, and please do not collaborate about your answers.

Once again, thank you for agreeing to participate in this study. It is hoped that it will lead to better therapy and help couples in marital conflict.

Please keep in mind that you may choose not to continue at any time during this meeting.

Do you have any questions for me at this time?

Categorical Measure of Struggle Form A—Speaking Partner

Therapist: ☐ M ☐ F   Client: ☐ M ☐ F   Tape Time: _____

File Number: _____   Date: _____

After viewing the video segment, **circle the letter** that *most correctly* represents how you felt *during the therapy session* **immediately** after the episode. Clarifications and comments may be made at the bottom of each section.

After this part of the session with the therapist and my partner…

A

I felt somewhat **calm** and more understood. My partner, myself, and the therapist **understood each other**. I wanted to **reach out** more to my partner, and I felt **motivated** to improve our relationship. I was **hopeful** that we would overcome the problem.

B

I felt somewhat **troubled**, and I began to feel **restless** or **impatient**. The therapist seemed to **get in the way** of our conversation. I found myself not wanting to talk as much. In some ways, I wanted to **withdraw** and be done at this point.

C

I felt somewhat **frustrated**, perhaps even **upset** and **aggravated**. I felt more **misunderstood** by the therapist and my partner, and I wanted to **correct the therapist** and explain myself. I felt **less hopeful**, and it made it difficult to want to work on our relationship.

Comments:

Categorical Measure of Struggle Form B—Speaking Partner

After viewing the video segment, **circle the letter** that *most correctly* represents how you felt *during the therapy session* immediately after the episode. Clarifications and comments may be made at the bottom of each section.

After this part of the session with the therapist and my partner…

1.   a. I felt somewhat **calm**

        b. I felt somewhat **troubled**

        c. I felt somewhat **frustrated**

2.   a. My partner, myself, and the therapist **understood** each other

        b. The therapist seemed to **get in the way** of our conversation

        c. I felt more **misunderstood** by the therapist and my partner

3.   a. I wanted to **reach out** more to my partner

        b. I found myself **not wanting to talk** as much

        c. I wanted to **correct the therapist** and explain myself

4.   a. I felt more **motivated** and **hopeful**

        b. I wanted to **withdraw** and be done at this point

        c. I felt **less hopeful** and **less motivated**

Categorical Measure of Struggle Form A—Listening Partner

Therapist: ☐ M ☐ F   Client: ☐ M ☐ F   Tape Time: _____

File Number: _____   Date: _____

After viewing the video segment, **circle the letter** that *most correctly* represents how you felt **immediately** after the segment. Clarifications and comments may be made at the bottom of each section.

After this part of the session with the therapist and my partner…

A
I felt somewhat **calm** and **less blamed**. My partner, myself, and the therapist **understood each other**. I was **more interested** in what my spouse had to say and wanted to reach out. I felt **motivated** to improve our relationship and **hopeful** that we would overcome the problem.

B
I felt somewhat **troubled**, and I began to feel **restless** or **impatient**. The therapist seemed to **get in the way** of our conversation. I found myself not wanting to listen as much. In some ways, I wanted to **withdraw** and be done at this point.

C
I felt somewhat **frustrated** and **upset**, and more **blamed** and **misunderstood**. I **doubt** that my partner really wanted to say what the therapist said, and I wanted to **correct the therapist**. I felt **less hopeful**, and it made it difficult to want to work on our relationship.

Comments:

Categorical Measure of Struggle Form B—Listening Partner

After viewing the video segment, **circle the letter** that *most correctly* represents how you felt *during the therapy session* immediately after the episode. Clarifications and comments may be made at the bottom of each section.

After this part of the session with the therapist and my partner…

1.   a. I felt somewhat **calm**

          b. I felt somewhat **troubled**

          c. I felt somewhat **frustrated**

2.   a. My partner, myself, and the therapist **understood** each other

          b. The therapist seemed to **get in the way** of our conversation

          c. I felt more **blamed** and **misunderstood** by the therapist and my partner

3.   a. I wanted to **reach out** more to my partner

          b. I found myself **not wanting to listen** as much

          c. I wanted to **correct the therapist**

4.   a. I felt more **motivated** and **hopeful**

          b. I wanted to **withdraw** and be done at this point

          c. I felt **less hopeful** and **less motivated**

APPENDIX I

Results for CMS—Part B

Results for All Partners. Part B yielded similar overall results to part A (see Table 8).

Question one (Q1--affect) yielded the lowest overall frequency for softening at 61.9% but still

led to a greater than chance likelihood for softening ($\chi^2 = 30.93$, df = 2, $p < .001$). The

remaining questions produced even higher frequencies, with softening effects at 88.0% for

question two (Q2—comprehension), 82.1% for question three (Q3—conciliation), and 83.3%

for question four (Q4—relationship motivation and hope) and each of them yielding

statistically significant, greater-than-chance probability that partners would indicate softening

as opposed to withdrawal or negativity (Q2: $\chi^2 = 111.49$, df = 2, $p < .001$; Q3: $\chi^2 = 90.07$, df =

2, $p < .001$; Q4: $\chi^2 = 96.29$, df = 2, $p < .001$). In addition, with the percentages for withdrawal

and negativity ranging from 4.8% to 20.2%, the results also lead us to conclude that it is

statistically *unlikely* that proxy voice will be followed by either kind of struggle behavior—

withdrawal or negativity.

Results for Speaking and Listening Partners. Question one (Q1--affect) produced the

lowest frequencies of softening (speaking, 57.1%; listening, 66.7%), while the results for

question two (Q2—comprehension) were most similar (speaking, 88.1%; listening, 87.8%).

Despite the varying frequencies of softening for both questions, results for speaking and

listening partners produced statistically significant, greater-than-chance probabilities of

softening following proxy voice (Q1 speaking: $\chi^2 = 10.86$, df = 2, $p < .004$; Q1 listening: $\chi^2 =$

21.57, df = 2; $p < .001$; Q2 speaking: $\chi^2 = 24.38$, df = 2, $p < .001$; Q2 listening: $\chi^2 = 55.07$, df =

2, $p < .001$).

Question three (Q3—conciliation) results yielded the largest range in percentages of softening occurrences, with 71.4% of speaking and 92.9% of listening partners designating their experiences of proxy voice as inviting softening. Again, chi-square results confirmed the frequencies as being statistically greater-than-chance probabilities for softening after proxy voice (Q3 speaking: $\chi^2 = 27.43$, df = 2, $p < .001$; Q3 listening: $\chi^2 = 67.00$, df = 2, $p < .001$).Lastly, question four (Q4—relationship motivation and hope) results for speaking (81.0%) and listening (85.7%) partners were very similar and indicated that much greater probabilities for softening than for withdrawal or negativity (Q4 speaking: $\chi^2 = 16.10$, df = 2, $p < .001$; Q4 listening: $\chi^2 = 52.00$, df = 2, $p < .001$).

Overall, the differences between speaking and listening partners were minimal when analyzing both parts A and B of the chi-square analysis, indicating little variation in perceived effectiveness of proxy voice between speaking or listening partners. For part B, the percentages for withdrawal and negativity ranged from 2.4% to 23.8%, contributing again to the idea that probabilities not only point to proxy voice occurrences leading to significant softening elements but also that the probabilities are much lower than chance that proxy voice will lead to withdrawal or negativity.

Table 8: Frequencies and Chi-square Analysis

Frequencies:
    CMS—Part B—Question 1, Affect (n = 84)

	Softening	.619	(n = 52)
	Withdrawal	.179	(n = 15)
	Negativity	.202	(n = 17)

      CMS—Part B—Speaking Partner (n = 42)

	Softening	.571	(n = 24)
	Withdrawal	.238	(n = 10)

Negativity	.190	(n = 8)

CMS—Part B—Listening Partner (n = 42)

Softening	.667	(n = 28)
Withdrawal	.119	(n = 5)
Negativity	.214	(n = 9)

CMS—Part B—Question 2, Comprehension (n = 83)

Softening	.880	(n = 73)
Withdrawal	.048	(n = 4)
Negativity	.072	(n = 6)

CMS—Part B—Speaking Partner (n = 42)

Softening	.881	(n = 37)
Negativity	.119	(n = 5)

CMS—Part B—Listening Partner (n = 41)

Softening	.878	(n = 36)
Withdrawal	.098	(n = 4)
Negativity	.024	(n = 1)

CMS—Part B—Question 3, Conciliation (n = 84)

Softening	.821	(n = 69)
Withdrawal	.095	(n = 8)
Negativity	.083	(n = 7)

CMS—Part B—Speaking Partner (n = 42)

Softening	.714	(n = 30)
Withdrawal	.143	(n = 6)
Negativity	.143	(n = 6)

CMS—Part B—Listening Partner (n = 42)

Softening	.929	(n = 39)
Withdrawal	.048	(n = 2)
Negativity	.024	(n = 1)

CMS—Part B—Question 4, Relationship Motivation and Hope (n = 84)

Softening	.833	(n = 70)
Withdrawal	.143	(n = 12)
Negativity	.024	(n = 2)

CMS—Part B—Speaking Partner (n = 42)

Softening	.810	(n = 34)

Withdrawal	.190	(n = 8)

CMS—Part B—Listening Partner (n = 42)

Softening	.857	(n = 36)
Withdrawal	.095	(n = 4)
Negativity	.048	(n = 2)

Chi-square Analysis:

Speaking & Listening Partners	χ^2	df	p

CMS—Part B

Question	χ^2	df	p
Question 1 (n = 84)	30.93	2	< .001
Question 2 (n = 84)	111.49	2	< .001
Question 3 (n = 84)	90.07	2	< .001
Question 4 (n = 84)	96.29	2	< .001

Speaking Partners	χ^2	df	p

CMS—Part B

Question	χ^2	df	p
Question 1 (n = 84)	10.86	2	< .004
Question 2 (n = 84)	24.38	2	< .001
Question 3 (n = 84)	27.43	2	< .001
Question 4 (n = 84)	16.10	2	< .001

Listening Partners	χ^2	df	p

CMS—Part B

Question	χ^2	df	p
Question 1 (n = 84)	21.57	2	< .001
Question 2 (n = 84)	55.07	2	< .001
Question 3 (n = 84)	67.00	2	< .001
Question 4 (n = 84)	52.00	2	< .001