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Couples' Experience of Attachment-Related Change in Context of Couple-Centered,
Enactment-Based Therapy Process and Therapist-Centered
Therapy Process: A Qualitative Study

James W. Ballard

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Master of Science

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ABSTRACT

Couples' Experience of Attachment-Related Change in Context of Couple-Centered, Enactment-Based Therapy Process and Therapist-Centered Therapy Process: A Qualitative Study

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Master of Science

Enactments consist of episodes of direct couple engagement being carefully monitored and coached by the therapist. Enactments have been identified and studied as a potential common factor in marriage and family therapy. Attachment security is considered to be a foundational marker of marital health. This study explored what role enactments play in promoting attachment-related outcomes in therapy. A qualitative group hermeneutic approach was used to analyze the interviews of twelve participants (six couples) who had participated in six experimental sessions: three sessions with a preponderance of therapist-centered process and three of enactment-based process. The results of this analysis provide a general profile of participants' experiences of these two approaches in therapy and contribute to an emerging framework to inform potential best practice of enactments for helping couples work towards more secure attachment. Major findings include the importance of therapeutic alliance and sequencing of interventions for promoting positive attachment-related outcomes.

Keywords: enactments, attachment, conjoint, marital therapy, clinical process

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Introduction

Much of marriage and family therapy research has been dedicated to identifying and examining factors common to the successful practice of therapy. These common factors are suggested to exist throughout the broad range of approaches to therapy and are believed to contribute to positive clinical outcomes independent of any specific model (Sprenkle, Blow, & Dickey, 1999). Enactments consist of episodes of direct couple engagement being carefully monitored and coached by the therapist (Davis & Butler, 2004). Enactments have been identified and studied as a potential common factor in marriage and family therapy (Butler & Bird, 2000; Butler & Gardner, 2003; Butler & Wampler, 1999). Scholars advocating the study of common factors have suggested that any component of therapy aspiring to common factor status must demonstrate universality (being practiced or have the potential to be practiced across a broad range of models/approaches) and utility (being effective in treating a diverse range of clinical problems; Butler, Davis, & Seedall, 2008). Further, a factor's universality and utility should be grounded on extensive empirical and clinical evidence and strong theoretical justification. Spanning over the last decade, studies on enactments have provided growing evidence and justification for the inclusion, application, and further study of enactments as a common factor. Enactment studies have found substantial links between the use of enactments in therapy and multiple positive outcomes and their ability to be used within different models of therapy and for the treatment of a variety of clinical issues (Andersson, Butler, & Seedall, 2006; Butler, Harper, & Mitchell, 2011; Butler & Wampler, 1999; Seedall & Butler, 2006; Woolley, Wampler, & Davis, 2012; Zitzman & Butler, 2005).

Attachment theory has been suggested to be the most cogent theory of adult love, and secure attachment between partners is considered by many marriage and family therapy scholars

to be a foundational marker of marital health (Cassidy & Shaver, 1999; Hazan & Shaver, 1987). Insecure attachment is associated with adverse effects on relationships and therapy, including reduced relational satisfaction and poorer therapeutic outcomes (Mikulincer & Shaver, 2007). While there is much evidence supporting the use of enactments in couple therapy and their promotion of positive clinical outcomes, research examining enactments in terms of their contribution specifically to attachment outcomes in couple therapy is still in the beginning phases, and further research is greatly needed. The few studies that have examined enactments and attachment outcomes have provided support for the ability of enactments to promote positive clinical outcomes in terms of attachment dimensions (Andersson et al., 2006; Butler et al., 2011; Seedall & Butler, 2006; Zitzman & Butler, 2005).

The current study expands clinical understanding of what role enactments play in promoting attachment outcomes in therapy and how it is different and similar to attachment change in response to therapy without enactments. During the course of therapy, each couple was exposed to six experimental sessions: three consecutive sessions with a preponderance of enactments (where partners spoke directly to each other with the therapist coaching) and three consecutive sessions without enactments (where partners spoke primarily to the therapist with their partner present). Following the six experimental sessions, couples were interviewed about their experiences in response to these two approaches and how it affected change in terms of attachment outcomes. The analysis of these interviews found that all three dimension of therapeutic alliance were important to positive attachment-related outcomes, that the sequencing of approaches contributed to more effective alliance building, and that clinical structure influenced participant experience of attachment-related change.

Review of Literature

Theoretical Justification for Enactments

While some therapists have dismissed enactments as just one of many stylized forms of intervention in couple therapy, the use of enactments in clinical practice is presupposed by some of the most basic tenets of systemic therapy. Even among the “multiplicity of therapy approaches” (Blow & Sprenkle, 2001, p. 385), there are elements that are both common throughout marriage and family therapy and also distinguish it from individual therapy (Sprenkle et al., 1999): a relational conceptualization of difficulties, disruption of dysfunctional relational patterns, an expanded direct treatment system, and an expanded therapeutic alliance (Sprenkle, 2009).

Through enactments therapists are able to observe and intervene directly at the level of interaction process. Enactments are helpful in avoiding harmful triangulation while promoting couple responsibility and dyadic self-reliance (Butler & Wampler, 1999). Balancing alliance and neutrality—both more complex in relational therapy than in individual therapy—is reasonably accomplished within the scaffolding of enactments. Through enactment structure, change is realized in the natural context of the primary relationship of interest while accessing the healing resources inherent to that relationship.

Enactments as natural vehicle for interactional process work. While most contemporary MFT models include/integrate an awareness of or attention to individual experience (Gurman & Fraenkel, 2002; Gurman, 2008; Johnson & Lebow, 2000), a foundational systems concept is that individuals are better understood in the context of their relationships (Nichols, 2008). Being more than simply conceptualizing and conducting therapy with multiple individuals simultaneously, a primary focus in MFT is on the interactions between partners/

family members (Sluzki, 1978). In fact, the relationship is often considered the central unit of treatment or “client” and the therapist an advocate for the couple or family system (Johnson, 1996; Wilcoxon et al., 2007). In therapy where conceptualization and intervention are focused on patterns of interaction between clients, clinical process involving clients actually interacting with each other would be ideal. “In this [conjoint] approach, potentially destructive relationship factors can be viewed directly and “in progress” by the therapist, and intervention can be initiated immediately” (Birchler, Wiess, & Vincent, 1975, p. 359). Enactments provide the means for the therapist to facilitate direct partner-to-partner engagement and intervene directly at the level of interaction process for relationship change (Butler, Brimhall, & Harper, 2011; Davis & Butler, 2004; Gardner & Butler, 2009).

From the earliest stages of therapy, enactments bring the full power of the systemic perspective to case conceptualization, clinical assessment, and treatment planning. The potency of some of systems theory’s foundational concepts (e.g. holism, circular causality, interpersonal context, process vs. content, structure, communication) seems critically diminished in a therapeutic approach where partners/family members are largely discouraged from engaging with each other during much of the course of treatment. When clients are asked to describe the difficulty in their relationship, explanations are often linear and attentive to perceptions of personality (Jacobson & Christensen, 1996; Nichols, 2008). A systemic therapist knows that even two honestly reported sides of the story are not often the whole story (Gottman, 1999) and that clients’ interactions with outsiders are not predictive of interactions with a spouse (Birchler et al., 1975), and accordingly seeks to observe the family/couple in action in the immediate context of the session (Minuchin & Fishman, 1981; Nichols, 2008; Nichols & Fellenberg, 2000). Through enactments therapists are able to observe problematic relationship processes firsthand.

Data gathered about interaction from direct observation informs a more thorough conceptualization and comprehensive treatment planning.

A systemic therapist may be able to see past the couple's linear and attributionally oriented explanation of their relational problems, and a seasoned practitioner may require little time observing the couple interact to attain a systemic conceptualization of what is occurring between them. However, a systemic conceptualization of problems not only aids the therapist but, at least equally important, it empowers the couple, and part of the work of therapy is helping clients to develop a more circular and interactional perspective of their own relationship (Nichols, 2008). Through enactments, therapists can engage the couple in an experiential discovery of the patterns and consequences of their interactions (Gardner & Butler, 2009).

As valuable as enactments are to interactional assessment and systemic conceptualization, they can be a powerful mechanism for relationship/interactional change throughout the course of therapy (Butler & Gardner, 2003). It would be a lost opportunity for a therapist, after formulating a systemic conceptualization and deriving such utility from enactment-enhanced assessment, to forgo enactments during treatment, relying primarily on individually oriented interventions. Marriage and family therapy goes beyond simply doing individual therapy with more than one client in the room (Gurman & Fraenkel, 2002; Haley, 1963; Minuchin, 1998). Describing the history of conjoint therapy, Gurman and Fraenkel (2002) note that inasmuch as a model of couple therapy continues to significantly emphasize traditional patient-therapist transaction and reciprocally fails to evolve interventions that significantly emphasize patient-patient transaction, it places "a solid ceiling on its capacity to help induce change" (p. 210). A primary activity in MFT is and ought to be relational mediation, which consists of therapist-coached couple interaction with the therapist engaging chiefly with process

rather than content (Butler, Brimhall, & Harper 2011; Davis & Butler, 2004; Gardner & Butler, 2009; Nichols & Fellenberg, 2000; Woolley, Wampler, & Davis, 2012). This most basic and essential operation of intervening directly in the interaction between partners is best accomplished via experiential enactments.

Building alliance through enactment structure. Extensive research has established alliance as one of the most potent predictors of positive outcome in both individual and relational therapy (Hubble, Duncan, & Miller, 1999; Sprenkle & Blow, 2004). Alliance building is inherently more complex in multi-client therapy than with an individual (Beck, Friedlander, & Escudero, 2006). Recognizing the many unique challenges in multilateral therapeutic engagement, Butler, Brimhall, and Harper (2011) warn that building multiple alliances requires a more sophisticated clinical process adapted to the complexities of relational therapy. They recommend what they have operationalized as dynamic neutrality through multipartial engagement and enactments. Dynamic neutrality consists of active empathic alliance, avoiding personal alignments, and *process engagement and relational advocacy through enactments*.

As in individual therapy, a relational therapist's alliance with couples and families is a conscious, collaborative relationship which includes a strong emotional bond with mutually agreed upon goals and clearly defined tasks (Bordin, 1979; Knobloch-Fedders, Pinsof, & Mann, 2007; Pinsof & Catherall, 1986). However, family members' perspectives, experiences, goals and values are usually not only different but are often directly conflicting and competing. As a result, building an emotional bond with one partner through simply validating his/her experience or agreeing on goals and tasks for therapy can simultaneously have the perceived effect of invalidating the experience and perceptions of the other partner, possibly leading to feelings of alienation and weakening of that alliance (Brimhall & Butler, 2011). These split alliances (where

family members differ in their perception of their relationship with the therapist) seem to be endemic in relational therapy (Friedlander et al, 2006; Pinosof & Catherall, 1986) with potentially deleterious effects on outcome (Pinsoff, 1995).

Furthermore, it is not just a simple risk of inadvertently siding with one partner based solely on the fact that the partners' perspectives are different. The risk is compounded due to the fact that clients are often *soliciting* the therapist to take sides (Symonds & Horvath, 2004). This solicitation can be recognized as a couple's tendency to triangulate the therapist into their conflict. Enactments have been identified as clinical structure suited to guard against the harmful effects of triangulation (Brimhall & Butler, 2011; Butler, Brimhall, & Harper, 2011; Butler & Harper, 1994; Gardner & Butler 2009). A brief review of what these authors have said is relevant to the current consideration of enactments.

Gardner and Butler (2009) recognized both that Bowen's articulation of clinical process and structure is crucial to understanding relational coaching and mediation *and* that enactments promote a more complete realization of this process. Tracing the evolution of the theory and practice of neutrality in relational therapy, Brimhall and Butler (2011) explore how Bowen's proposed solution for avoiding triangulation—suggesting detached objectivity—had the unfortunate effect of forfeiting a powerful means for creating essential therapeutic alliance. Butler, Brimhall, and Harper (2011) demonstrate how enactments represent a clinical process that is ideally suited to achieving a dynamic neutrality consisting of multipartial engagement and fully realized relational advocacy. A brief review of Bowen's ideas about clinical process and structure in response to triangulation illustrates how important enactments are to achieving relational mediation and alliance through relational engagement and advocacy.

Guarding against harmful triangulation and promoting couple self-reliance. Bowen articulated the concept of triangulation as the tendency of distressed dyads to involve a third party in an attempt to stabilize the relationship between the original pair and relieve dyadic tension (Bowen, 1976). A common manifestation of this in therapy is the solicitation for the therapist to “assume the role of either an adjudicator (judge)—tasked with deciding who’s right and who’s wrong—or arbitrator—tasked with negotiating a sustainable compromise” (Butler, Brimhall, & Harper, 2011). Triangulation may also invite the therapist into the role of substitute—one or both partners seeking the therapist as a substitute provider of what each needs from the other partner—or ally—to form a two-versus-one coalition against the other. While this arrangement might allow the pair to temporarily evade having to resolve conflict between them, the habitual inclusion of a third party ultimately undermines the couple’s relationship (Butler & Harper, 1994; Guerin et al., 1999). As described by Nichols, “triangulation lets off steam but freezes conflict in place” (Nichols, 2008, p.128).

While triangles are often used to describe the problematic relationship structure that forms in a family system (e.g. a husband and wife in conflict drawing in a parent, sibling, child or friend to try to alleviate marital tension), a relationship triangle was also key to Bowen’s conceptualization of positive clinical structure and process (Gardner & Butler, 2009). The therapist’s role is to create a therapeutic triangle with the couple (Nichols, 2008). Creating a therapeutic or healing triangle is different from simply being drawn in to the couple’s attempts to triangulate in a third party (Butler & Harper, 1994; McGoldrick & Carter, 2001). According to Bowen, the therapist’s promotion of couple responsibility helps keep the couple “problem in the relationship from which it is attempting to escape” (Kerr & Bowen, 1988, p. 161). In contrast to harmful triangulation, which can compromise the couple relationship, a therapeutic or healing

triangle is where the third party promotes the primary dyadic relationship, maintains a neutral position and systemic perspective on dyadic process, and encourages dyadic responsibility for problem resolution (Gardner & Butler, 2009). All three of these objectives are best facilitated through enactment structure.

The therapist's role in this healing triangle is to contain and manage emotional reactivity and push the problem back into the dyadic relationship to coach subsequent resolution there (Davis & Butler, 2004). Butler and Gardner (2003) assert that a model of clinical process where the therapist monitors and responds to reactivity while coaching problem resolution within the dyadic relationship seems to clearly presuppose enactments. Bowen's model points toward self-reliant couple interaction, involving systematic de-triangulation, and this objective and clinical operation also seems to presuppose enactments. Even so, Bowen failed to realize this presupposition in theory or practice, nor did he describe the developmental progression of enactments over the course of treatment (Butler & Gardner, 2003).

While Bowen aptly recognized the pitfall of triangulation and the need for the therapist to promote the primary dyadic relationship and encourage dyadic responsibility, in practice, his recommended approach consisted of clinical process that primarily concentrates interaction and dialogue in the therapist throughout the course of therapy (Brimhall & Butler, 2011). Bowen conceptualized de-triangulation as involving the therapist functioning as a "control rod" for volatile/unstable relationship elements. The "therapist-as-control-rod" was intended to dampen and manage emotional reactivity by channeling all couple interaction through himself. This straightforward approach may provide the therapist with a high level of control and be temporarily effective in containing and structuring volatile interaction for distressed couples (Kerr & Bowen, 1988). However, if employed over the entire course of therapy, therapist-

centered process appears to have the eventual effect of disempowering couples in their progress toward self-reliant and successful interaction, “either leaving the system essentially unimproved at termination or permanently establishing the therapeutic system, interposing the therapist as an essential member of a viable couple system” (Butler & Gardner, 2003, p. 311). The more dependent the process is on the therapist’s presence, the greater the potential for the change it yields to be only transitory and narrowly confined to the context of therapy (Brimhall & Butler, 2011).

Even after a systemic perspective has empowered each client to relinquish the appeal for the therapist to fix the partner, there may still remain a tendency to solicit the therapist to fix the relationship. “It is easy for the family to wrap itself around the therapist emotionally, install the therapist in an all-important position, hold the therapist responsible for success or failure, and passively wait for the therapist to change the family” (Bowen, 1976, p. 77). As an individual therapist must resist the pull to solve the client’s problems, a relational therapist must resist the pull to fix the couple’s process problems for them.

Regarding models of marital therapy that see partners conjointly but still maintain a mostly individually focused practice, Gurman and Fraenkel (2002) warn that as long as therapists keep therapy predominantly or exclusively individually formatted, they establish the therapist as the central agent through which change must occur. Therapist-centered clinical process concentrates and converges interaction and dialogue in the therapist. With the therapist as the pivotal agent of change, the dynamic resources of the couple relationship remain largely untapped and they are hindered in developing self-sufficiency, as change is mostly dependent on therapist-client process (Gurman & Fraenkel, 2002). Gottman and Gottman (1999) warn that making the therapist “irreplaceable ... may maximize the couple’s relapse once therapy

terminates” (p. 310). Accordingly, Gottman (1999) asserts that partners need to learn how to intervene with each other; “the goal is to empower them,” but “this cannot be accomplished when the therapist remains central to the couple’s ability to interact in constructive ways. In therapy, then, the spouses must interact with one another more than they talk to the therapist” (p. 178-179).

Containing the conflict within the dyad while supporting and therapeutically facilitating resolution between the partners promotes systematic de-triangulation and self-reliant couple interaction. Through enactment structuring of active couple engagement, responsibility for relational work is situated within the couple relationship, and resolution is supported there as the therapist positions herself to be able to *initially* regulate the couple’s immediate levels of interactional volatility while coaching process and promoting interaction that is *increasingly independent of therapist assistance* (Butler & Gardner, 2003).

As couples or families thereby become increasingly able to soothe and soften and avoid interactional volatility and emotional reactivity, the enactment-informed therapist will incrementally remove his or her clinical scaffolding of the couple or family relationship and interaction – by reducing coaching, decreasing structure, and facilitating increasingly from the periphery of the couple or family relationship. (Butler et al., 2008, p. 332).

Couple-responsible and couple-anchored clinical process and success allows them to access and recognize their own resiliency, abilities, and resources that might have previously been in question and enables appropriately timed termination of therapy without undue client anxiety about their ability to succeed without therapist scaffolding (Butler et al., 2008).

Realizing change in natural context of client relationship. This theoretical justification has described some of the ways in which enactment process is consistent with and even

presupposed by or crucial to the realization of some of the foundational principles and operations of marriage and family therapy. The distinguishing elements of the field or common factors mentioned earlier—relational conceptualization of difficulties, disruption of dysfunctional relational patterns, expanded direct treatment system, and expanded therapeutic alliance (Sprenkle & Douglas, 2009)—have each been addressed. The way enactments facilitate the first, a relational conceptualization of difficulties, has been discussed briefly and mostly relating to its denotation/meaning as a common clinical *operation*—as the process or work of deriving a formulation of what is occurring and what should be done with each independent case, or, as articulated by common factor authors, as the translation of difficulties into relational terms (Sprenkle, Blow, & Dickey, 1999) as well as paying special attention to interaction cycles (Sprenkle et al., 2009). Beyond this definition of being a process or the mental work of formulation or translation or even a habit/practice of attending, it is important to consider this commonality in terms of the perspective, assumptions, or beliefs it also denotes (Nichols, 2008).

Common factors are considered the “pantheoretical elements” shared by diverse approaches that make therapy effective (Hubble, Duncan, & Miller, 1999, p. 6) and in some ways represent an attempt to move beyond the paradigms of specific approaches (Sexton et al., 2004). This attempt to get past divergent theories and to focus on the commonalities in operations may have been tied to seemingly little discussion of the common theoretical ground. However, in addition to defining “relational conceptualization” in terms of what MFTs *do*, more recent common factor literature includes some description of this element in terms of the way MFTs generally *view* people and therapy (Sprenkle et al., 2009), the conceptual/theoretical commonality. “The essence of the systemic perspective is the belief that people and their problems are best understood and best treated in their interpersonal context” (Johnson, 2003b, p.

369). Nichols (2008) points out that while the difference between individual and relational therapy is ordinarily considered as a technical matter, “the choice also reflects a philosophical understanding of human nature” (p. 7). Indeed, it is the common perspective/belief about *the power and importance of relationships* shared by relational therapists that informs the common operations of relational therapy. Enactment operations represent a clinical realization of this concept/value/belief.

In MFT, the family or couple is seen “as the most commonly salient natural environment for both generating and maintaining change” and “the continuing relationships between and among family/couple members [is seen] as inherently potentially more healing than the relationship between therapists and individual patients” (Gurman, 2001, p. 54). According to McGoldrick and Carter’s (2001) description of Bowen’s theory and approach, Bowen appears to have shared the this perspective.

Because family systems theory does not view change as something brought about through a corrective relationship with a therapist ... the natural system is given clear priority over the therapeutic system. ... Emotional issues and expression of feelings are steered toward the naturally evolving family relationships-where they belong. (p. 283)

As has been mentioned, Bowen did not, however, develop/utilize operations to promote in-session, couple-anchored change, but rather relied on more therapist-centered clinical process (Butler & Gardner, 2003). “The dynamic utilization of relationships to bring about change is a characteristic unique to MFT, both conceptually and operationally” (Davis & Butler, 2004, p. 320). In enactments, the couple relationship/interaction is both a target and mechanism for change (Gardner & Butler, 2003). This represents a crucial recognition of the power and importance of the partners’ relationship with each other. Enactments centralize couple/family

engagement in therapy and privilege their relationship as the primary agent of change, encouraging them to trust in their own abilities and to access their own resources.

Use of Enactments within the Frameworks of Established MFT Models

As the previous section has described some of the ways in which enactments are theoretically presupposed by some of the tenets systemic therapy, it should not be surprising then that enactment process is called for in the treatment protocol of the major therapy approaches/models based on those tenets. Enactments are utilized in some form in a variety of relational therapies and are applied toward diverse objectives associated with those models (Gardner & Butler, 2009). Further, the success of numerous empirically supported approaches is specifically and reasonably connected to the employment of enactments (Davis & Butler, 2004). Some models explicitly call for the use of enactments in therapy and detail their use, such as structural family therapy and emotionally focused therapy. While designated with alternate labels, other models routinely employ enactment process as a fundamental component of their protocol. Additionally, enactments are easily integrated into and uniquely suited to the objectives of therapies where they are not yet routinely utilized (Woolley, Wampler, & Davis, 2012).

Behavioral, problem-solving, solution-focused, and communication skills therapies.

Research on marital interaction recommends that therapists help couples develop a more satisfying relationship through helping them improve their communication and conflict resolution skills, increasing their mutual influence and receptivity to influence, and fostering more positive interaction. This includes helping spouses develop their ability to be spontaneous during marital conflict and assisting spouses to learn to clearly express needs and emotions in positive, less hostile or defensive ways, while helping their partners to listen non-defensively and to more appropriately interpret those expressed needs and emotions. It seems self-evident that

these developments can be best facilitated in the context of the couple's interaction with therapist coaching (enactments) rather than through didactic instruction.

In addition, using enactments in solution-focused and problem-solving therapies provides the means to develop solutions adapted to the specific and unique styles, patterns, values, and circumstances of each individual couple or family. Whether they are labeled as communication skills practice, collaborative problem-solving or solution-searching, role-playing, real-playing, or behavioral rehearsal - enactments are an intuitive and logical approach to the development of relationship skills.

Emotionally-focused therapy. Enactments are a key intervention in EFT and central to its clinical process (Gardner & Butler, 2009; Tilley & Palmer, 2012). EFT aims to reduce couple distress and create a secure bond between partners by reprocessing key emotional responses and restructuring interactions towards accessibility, responsiveness, and engagement (Johnson & Greenberg, 1988). In EFT enactments create manageable amounts of interaction, allowing partners to absorb small moments of successful contact, gradually moving the process toward shaping more secure bonding interactions (Johnson et al., 2005). The creation of secure attachment bonds comes not from the reprocessing of emotional experience, per se, but from moving each partner's emerging emotional experience into new attachment-significant contact and creating new dialogues (Johnson, 2004; Tilley & Palmer, 2012). As described in EFT, enactments are primarily used to 1) enact present positions so they may be directly experienced and expanded; 2) turn new emotional experience into specific responses to the partner that challenges old patterns; and 3) heighten new or rarely occurring responses which have the potential to modify the partner's position (Johnson et al., 2005). Throughout the course of therapy, an EFT therapist will likely create numerous enactments.

Structural, experiential, and Bowenian therapies. Enactments have long been a key part of structural therapy. Within this modality, they are routinely utilized for clinical assessment as well as treatment intervention. Enactments allow the structural therapist to observe and consequently redirect the transactions that constitute the family or couple structure. Similarly, enactments are well suited to the goals and operations of Bowenian and experiential therapies. “Enactments are the natural vehicle for observing or sculpting a tangible, physical representation of structure and experience in couples and families, and subsequently for altering these dynamics, whether the point of focus be boundaries, differentiation, or some other relationship dynamic” (Gardner & Butler, 2009, p. 314).

Narrative and contextual therapies. Coulehan, Friedlander, and Heatherington (1998) identified three themes in the transformation sought with families in narrative therapy. Narrative therapists sought to assist family members in improving their ability to: 1) recognize multiple descriptions of the problem; 2) change and soften their affect; and 3) attribute positive meaning to one another. They recognized that while the general practice and associated interventions of narrative therapy are aimed at helping families achieve change in these three themes, an overarching framework facilitating this process does not exist. Enactments have since been identified as a candidate for such a framework, providing a scaffolding that can be integrated within narrative therapy, promoting narrative therapy principles and processes (Gardner, Brimhall, & Henline, 2003). Enactments can be used to help therapists understand client narratives and couple interaction in context. Gardner, Brimhall, and Henline (2003) hypothesize that through the use of enactments in narrative therapy, clients are assisted in developing a better understanding of their own and their partner’s narratives, adjusting existing narratives,

experiencing each other in a new and different way, and mutually creating new meanings and narratives together within the couple relationship (Gardner, Brimhall, & Henline, 2003).

One of the overall goals of enactments as identified by Butler and Gardner (2003), couple self-reliant interaction, is consistent with narrative therapy's strong emphasis in de-centering the therapist and promoting the couple's ability to take charge in re-storying their own lived experience. Enactments offer a clinical process that favors the clients' experiences and beliefs, while reducing therapist teaching, labeling, and advice giving (which have been shown to be linked to poorer therapy outcomes) (Butler & Bird, 2000; Butler & Wampler, 1999). Similarly, the broader, multigenerational narrative and substantive issues focused on in contextual therapies can be effectively addressed using enactments (Brimhall, Gardner, & Henline, 2003).

Empirical Support for Enactments' Effectiveness in Couple Therapy Outcomes

Substantial empirical evidence independent of any specific clinical model supports the use of enactment process in relational therapies. Extensive review of clinical process research (Butler & Bird, 2000; Butler, Davis, & Seedall, 2008; Gardner & Butler, 2009) and direct empirical investigation of enactments (Andersson et al., 2006; Butler, Harper, & Mitchell, 2011; Butler & Wampler, 1999; Nichols & Fellenberg, 2000; Seedall & Butler, 2006; Woolley, Wampler, & Davis, 2012; Zitzman & Butler, 2005) supports enactments as a natural mechanism for facilitating key MFT processes associated with positive clinical outcomes: namely, 1) decreasing therapist-client struggle, 2) promoting therapist accommodation of couples' world view, 3) promoting couple responsibility and involvement in therapy, 4) increasing couple interactional autonomy and self-reliance, 5) facilitating new experience through direct positive couple engagement, 6) increasing couple soothing and softening, and 7) improving couples' emotional engagement and attachment responsiveness.

Attachment security is a specific area of therapeutic outcome that has received some initial attention in enactment studies. Secure attachment between partners is considered by many marriage and family therapy scholars to be the foundational marker of marital health (Cassidy & Shaver, 1999; Hazan & Shaver, 1987). While there is much evidence supporting the use of enactments in couple therapy and their promotion of positive clinical outcomes, research examining enactments in terms of their contribution specifically to attachment outcomes in couple therapy is still in the beginning phases, and further research is greatly needed. The few studies that have examined enactments and attachment outcomes have provided support for the ability of enactments to promote positive clinical outcomes in terms of attachment dimensions (Andersson et al., 2006; Butler, Mitchell, & Harper, 2011; Seedall & Butler, 2006; Zitzman & Butler, 2005).

Adult Attachment Theory

Attachment theory is considered to be the most cogent theoretical model for understanding adult pair-bond relationships (Hazan & Shaver, 1987). Attachment has been defined as “the stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few specific individuals who provide the subjective potential for physical and/or psychological safety and security” (Sperling & Berman, 1994, p. 8). According to attachment theory, this tendency to seek connection with a few seemingly irreplaceable others extends from “the cradle to the grave” (Bowlby, 1979, p. 123) and is an innate survival mechanism and a primary motivating drive in human beings (Bowlby, 1988).

Secure attachment can provide a secure base and safe haven (Ainsworth et al., 1978; Bowlby, 1988; Johnson, 2002)—serving as a buffer from stress and helping individuals respond to developmental needs, new contexts, and other challenges in a potentially dangerous world

(Bowlby, 1988; Milliken, 2000). Rather than being intrinsically infantile or childish or pathological, this “wired-in” need can be adaptive and form the basis of healthy relationships (Bowlby, 1979; Johnson, 1996). Indeed, secure attachment can actually afford individuals moderate to high levels of both intimacy and autonomy (Bartholomew & Horowitz, 1991).

Association between attachment and therapeutic outcome. Insecure attachment is associated with adverse effects on relationships and therapy, including reduced relational satisfaction and poorer therapeutic outcomes (Mikulincer & Shaver, 2007). Couples who lack soothing and supportive responses, behaviors supporting secure attachment, and who feel that their relationship is not a safe place for emotional engagement, experience severe relational distress and are at higher risk for relational dissolution (Gottman & Gottman, 1999). Insecure attachment is positively associated with depression and anxiety (Beach, 2001; Johnson, 2004; Whiffen, 2003), predicting more severe depressive symptoms (Reis & Grenyer, 2004), increased time to relieve depressive symptoms (Cyranowski et al., 2002), and decreased responsiveness to time-limited therapy (Hardy et al., 2001), and problems in attaining therapy goals (Mosheim et al., 2000). Secure attachment, conversely, is related to positive outcomes in couple therapy (Johnson, 2004; Johnson & Greenberg, 1988). Positive clinical outcomes associated with increasing secure attachment include softening (Andersson et al., 2006; Seedall & Butler, 2006), emotional expressiveness (Feeney, 1995, 1999; Johnson, 2004), and commitment, trust, and relationship satisfaction (Zitzman & Butler, 2005).

Therapy as a means to change in attachment security. Most of the serious issues in intimate relationships are anchored to threats to the security of the attachment bond between partners (Johnson, 2003a). “The business of couple therapy is essentially the business of addressing the security of attachment bonds” (Johnson, 2004, p. 37). The security of the

attachment bond depends on each partner's ability to view the relationship as safe and supportive, where the other partner is available, responsive to their needs, and engaged in the relationship (Bowlby, 1988, Johnson, 2005).

From a systemic perspective, attachment can only be fully understood and addressed within the context of the attachment relationship. Thus, relationship enactments become critical to successful attachment work and attachment therapy (Zitzman & Butler, 2005). The studies that have examined enactments and attachment outcomes have provided initial support for the ability of enactments to promote positive therapeutic change terms of attachment dimensions (Andersson et al., 2006; Butler, Mitchell, & Harper, 2011; Seedall & Butler, 2006, Zitzman & Butler, 2005). However, further research is needed to better understand the specific ways in which direct partner-to-partner engagement as facilitated by enactments helps promote positive change in attachment security.

Summary

Enactments have been identified and studied as a potential common factor in marriage and family therapy, and have demonstrated both universality and utility. Enactment studies have found substantial links between the use of enactments in therapy and multiple positive outcomes and their ability to be used within different models of therapy and for the treatment of a variety of clinical issues. Attachment theory has been suggested to be the most cogent theory of adult love, and secure attachment between partners is considered by many marriage and family therapy scholars to be a foundational marker of marital health. While there is much evidence supporting the use of enactments in couple therapy and their promotion of positive clinical outcomes, research examining enactments in terms of their contribution specifically to attachment outcomes in couple therapy is still in the beginning phases. The few studies that have examined enactments

and attachment outcomes have provided support for the ability of enactments to promote positive clinical outcomes in terms of attachment dimensions, but further research is needed.

The current study expands clinical understanding of what role enactments play in promoting attachment outcomes in therapy. The main questions to be explored were: What perceptions of change do clients describe in response to these approaches? How do clients perceive clinical structure, and how is it significant to their experience of the therapeutic process? What meaning do clients make of their experiences addressing issues with their spouse versus with their therapist? What would clients want clinicians to know about their experience in therapy with these approaches?

Methods

Design

This study employed a qualitative design to access spouses' experience of attachment-related change in relation to participation in enactment-based therapy in comparison to therapist-centered therapy. Data for this analysis was collected through structured interviews at the conclusion of six experimental sessions of therapy—three enactment-based sessions and three therapist-centered sessions—as part of a larger study exploring attachment outcomes in response to enactments (Butler, Harper, & Mitchell, 2011). The transcribed interviews were analyzed using a qualitative approach consisting of a group hermeneutic interpretation of the data (Gale, Chenail, Watson, Wright, & Bell, 1996; Wright, Watson, & Bell, 1996).

Participating Couples

The sample consisted of six married couples that presented for marital therapy at a community mental health clinic in the Western United States. Participants completed demographic questionnaires prior to beginning the study. Table 1 provides pseudonyms used for

participants, self-identified presenting problems, initial RDAS scores, age, and years in their current relationship. The ethnic identity of participants was Caucasian. In couple E, both partners had been previously married; all other participants were in their first marriage.

Initially the first five couples (sequentially) from a larger sample were selected for the analysis. Two couples were not included because they had changed therapists halfway through their participation in the study, which was considered to pose a potential confound to participants' ability to distinguish between the effects of therapist factors versus treatment conditions. After initial analysis of the interviews of these five couples, the analysis team determined that the addition of a sixth couple would be useful to provide redundancy, clarity and confidence in the text (Benner, 1994).

Experimental Condition

Each participating couple experienced six experimental therapy sessions—three sessions of therapist-centered therapy (TC) and three sessions of enactment-based therapy (EB). The sequencing was alternated across participant couples. During therapist-centered sessions, the couples were exposed to therapist-centered clinical process wherein therapists channeled all couple interaction through themselves and refrained from conducting any enactments (see Figure 2 for therapist-centered criteria). During enactment sessions, participant couples were exposed to enactment-based clinical process wherein therapists coached the couple through sustained interaction with each other following Butler and Gardener's model (2003) and Davis and Butler's single-episode conceptualization (2004) of enactments (see Figure 3 for enactment-focused criteria).

Couples and therapists were randomly assigned to begin with either the therapist-centered or enactment-based treatment first. This helped control for possible effects related to sequencing

of experimental conditions. Random alternation of treatment sequence also helped control for the effects of one experimental condition upon the other. Couples were randomly assigned to participating therapists.

Therapist Training and Proficiency

As part of their clinical practicum, participating therapists received 12 hours of specific training from a licensed marriage and family therapist and an AAMFT approved supervisor proficient in both enactments and therapist-centered approaches. The supervisor had also published extensively regarding enactments. Training for both therapy approaches included readings and didactic instruction describing each therapy condition, viewing of videotaped examples, experiential practice through role-play, proficiency tests, and, as needed, reviews of their results. Therapists also received specific training of the descriptive criteria for both therapy conditions used in the study (as listed in Figures 2 and 3). Following training, therapist proficiency in each therapy process protocol was tested by video recording each therapist executing each therapy condition (separately) in an experiential role-play. These proficiency tests were then coded by one of the study's principal investigators according to the criteria for enactment and therapist-centered protocol as listed in Figures 2 and 3. Proficiency for the therapist-centered approach was determined if therapists exhibited at least four of five key therapist-centered indicators (see Figure 2). During the study, therapists were instructed to review the criteria for the appropriate therapy condition that they were to execute before each experimental session. Proficiency for the enactment-based therapy process was attained if therapists executed at least eight of nine key enactment indicators (see Figure 3).

Institutional Review Board and Experimental Compliance

This study was conducted with Institutional Review Board (IRB) approval. Informed consents were obtained from each partner (see Figure 2) prior to participating in the experiment.

Per IRB guidelines, at the conclusion of the sixth session, the study interviewer debriefed each participant through an individual interview and explained the scope, purpose, and procedures of the experiment.

Measures

Data for this analysis was collected through separate semi-structured interviews with each participant spouse after completion of the six experimental sessions. Open-ended questions were presented in the same order with all participants. The interview questions (see Figure 1) were formulated by the primary researchers before any interviews were conducted. Questions were included based on their ability to elicit comments regarding participants' experience of the two approaches and perceived influences of each approach on them, their relationship, and the process of therapy (e.g. "Could you comment on similarities or differences between the two approaches in terms of how hopeful or optimistic you felt?" "...in terms of feeling understood, validated and empathized with?" "...in terms of how safe you felt, during the session, or with your partner afterwards?" in terms of how close you felt with your partner?" "...in terms of how productive or useful the session was?"). Interviews were conducted individually with each partner in close succession to limit opportunities for spouses to discuss with each other the questions or their responses to the interview. Interviewers each had previous coursework in research methods, and received additional instruction on qualitative interviewing for this study.

In the larger study of which the qualitative analysis was a part, participants completed the Revised Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995) before each of the experimental sessions. The RDAS is a measure to assess the level of marital distress and to differentiate between distressed and non-distressed couples. The RDAS was not part of

the qualitative analysis, but participants' initial scores are included in Table 1 for the benefit of the reader.

Analysts

Analysis team members were recruited from the BYU Marriage and Family Therapy graduate program. Diversity in gender of analysts was maintained in the selection of team members. The analysis team included a thirty-two year old male graduate student (the author), a twenty-seven year old male graduate student, a thirty-one year old female graduate of the program with two years as a practicing therapist.

Identification of forestructures. In hermeneutic research, forestructures—preunderstandings of a phenomenon—must be brought into consciousness in order to provide the greatest opportunity for the phenomenon under study to reveal itself (Geanellos, 1998). Gadamer (1990) asserts that forestructures must be provoked to become discernible, and that this is possible through confrontation with the forestructures of others. Accordingly, one method for drawing out forestructures is a conversation with other researchers (Fleming, Gaidys, & Robb, 2003). Preceding the first group analysis meeting, the analysts conducted a conversation to identify significant forestructures by following principles outlined by Geanellos (1998). This conversation lasted approximately sixteen minutes and was recorded and later transcribed.

Several relevant forestructures were identified and discussed in terms of what influence they might have on the interpretive process. All three analysts were trained in marriage and family therapy, expressed strong leanings toward attachment theory and inclinations (of varying degrees) towards EFT, had participated as therapists in the study, were relatively novice clinicians (still requiring supervision to practice), and were of a Christian faith. Theoretical forestructures, in particular, can often change during the process of interpretation and further

exposure to the data (Fleming et al., 2003), and notes of these changes were recorded during analysis meetings and individually in memos.

In addition to identifying the forestructures that the team members brought to the process of interpretive analysis, it is important to briefly recognize what influence forestructures might have had even in the initial formulation of the questions asked in the interviews. Perhaps the forestructure most basic in influencing participants' interpretation and reporting of their own experiences was the invitation to compare one approach to another. The majority of the questions asked participants about "similarities or differences between the two approaches." Alternatively, participants could have been asked about their experience in therapy and what they thought happened for them in general. The decision to use semi-structured interviews and the focus of the questions was influenced by the researchers forestructures about therapy and research.

Analytic Approach and Procedure

The word *hermeneutic* refers to the theory and practice of interpretation and understanding (Odman, 1988). Hermeneutic/interpretive phenomenology attempts to uncover meaning by examining the structure of experience through interpretation of the narrative of the participant (Wright et al., 1996). Because participants' knowledge about their personal experience of the process of change is often implicit and embodied, it can sometimes be difficult to articulate and may be described only vaguely; "hermeneutic phenomenology offer[s] a way to uncover this valuable clinical understanding" (Wright et al., 1996, p. 300).

This specific group hermeneutic/interpretive approach to analysis is guided by principles described by Gale et al. (1996) and follows specific procedures outlined by Wright et al. (1996). This approach has been effectively utilized to investigate clients' lived experience of change in relationships, in attachment, during therapy, and specifically in the context of enactments

(Andersson et al., 2006; Bird, Butler, & Fife, 2007; Butler, Gardner, & Bird, 1998; Zitzman & Butler, 2005; Zitzman & Butler, 2009). This group hermeneutic method used in these studies has amply demonstrated its ability to provide rich and valuable understanding to inform clinical practice and future research.

Analytic triangulation. The use of a group approach to analysis is intended to help produce an interpretation that is as grounded to the participants' responses and as faithful to their perspectives as possible. "The inclusion of multiple analysts in the hermeneutic process is for the purpose of triangulation, helping assure stable, reliable results consistent with the data through the consensus and holistic picture arising from the contribution of multiple perspectives" (Butler, Gardner, & Bird, 1998, p. 4). As the conclusions reached will be based on the corroboration and consensus arising out of multiple perspectives, this group approach is intended to safeguard to a certain extent against biases to which one-person grounded theory analyses may be prone.

Analysis phase one. Analysts received written and verbal instruction to familiarize them with the analysis approach including details about each phase and their individual and group objectives. Each analyst was initially given a copy of ten of the transcribed interviews (five couples). The order in which each analyst read the interviews was randomized to avoid favoring some participants' perspectives over others or prematurely foreclosing on the perspectives of other participants due to effects of ordering. Interviews from partners in a couple were kept together in order to help keep a sense of each partner's experience in the context of the other's experience.

Each analyst independently read completely through the transcripts once to gain a general perspective of participants' overall responses to the interview questions. This immersion in the data is to help gain a "sense of the whole" (Giorgi, 1985, p. 10). Each analyst then did a second

reading of the transcripts, identifying significant statements (a word, phrase, sentence, or group of sentences) that provide an understanding of how clients experienced the process of therapeutic change in connection to participating in enactment and therapist-centered approaches.

During this reading, analysts searched for understanding within each participant's interview and in connection to his or her partner's responses to understand themes and concepts in context. By recognizing themes and concepts in context, analysts attempted to identify patterns and relationships in what participants have said and what their partners have said about their experience. The goal was not only to look for patterns and relationships, but to gain a deeper understanding of the meaning of these experiences for participants.

After reading each interview, each analyst recorded his or her own impressions of the participant's experience and patterns observed. This was also done for each couple after reading both interviews, noting interlocking interactional patterns between what husband and wife have reported. The goal was to articulate/answer the questions, "What was this experience like for this participant?" and "How did they experience this *as a couple*?" Following this second reading, each analyst reviewed the identified significant statements and prepared a brief description of each partner's and each couple's experience including ideas and essential themes represented in their interviews.

Analysis phase two. The analysts met together to share their individually produced descriptions and themes, and through the group interpretive process, they sought to reach consensus concerning these. Analysts took turns presenting to the group the descriptions and themes in order to avoid an imbalance of analyst contribution based on ordering. As each description and theme was presented, analysts interjected to ask for clarification or to detract, referencing supporting content from the transcripts as needed. As ideas were challenged, the

group continued to discuss each one further until each member had been able to contribute and discuss his or her perspectives until consensus was eventually reached. Similarities and differences between participant's experiences were discussed and initial patterns and themes were identified and discussed.

In order to allow a closer reading and a more thorough analysis, discussion of these ten interviews was conducted in two meetings over two weeks—the first four participants (two couples) were discussed in the first meeting and the remaining six (three couples) were discussed the following week. After reading and discussing these ten interviews, the team determined to include an additional couple in the analysis to provide a better understanding of the range of participant's experience. Phases one and two were repeated with this additional couple.

A third meeting began with a discussion of this additional couple, followed by a discussion comparing the experiences reported by all twelve participants, including patterns and themes. At the conclusion of phase two, analysts agreed that the richness and redundancy added by the inclusion of the additional two participants (the sixth couple) made meanings and patterns more visible and increased confidence about understanding the participants' experience (Brenner, 1994).

A list of themes was produced and initial formulations about patterns were put forward, which would later be checked against the data as analysts returned to the interviews for a third reading. Following this meeting, the initial list of thirty-three identified themes were added to and organized into twelve larger categories. This organized list of themes was presented by the author to each of the other analysts for review and modification. Additional ideas from these discussions were noted and included in the following stages of analysis.

Analysis phase three. The author and one of the other analysts conducted a third reading of the transcripts, this time searching for additional information and clarification of themes and patterns agreed upon in phase two. In addition to coding the text according to the themes agreed upon in phase two, analysts sought to clarify, refine and elaborate on these consensus themes. Text coded under each category was printed and shared with the third analyst to be able to confirm that the coded text actually represented instances of that specific theme. Notes from this third reading/coding, including impressions and clarification of themes, were recorded to be shared with the team in phase four.

Analysis phase four. All three analysts met to repeat the hermeneutic/interpretive process, refining and articulating the themes and establishing consensus. During this phase, however, the group also discussed how the themes identified in phase two changed as they returned to the text and applied them in context. Analysts took turns sharing and discussing their overall impressions of participants' experiences, refined definitions of themes/concepts, and the patterns and relationships noticed during phase three reading/coding. The team sought consensus through the same group hermeneutic process on the refined themes. In order for a theme/concept to be included, there needed to be strong consensus of at least two of the three analysts without significant dissent/disagreement from the third. Through the same process, they attempted to articulate and agree upon the relationships between themes and patterns observed.

The overall goal of the analysis was to provide a composite and thick description of the central features of participants' experience of enactment-anchored versus therapist-centered therapy process. This includes not only what clients experienced but also how they experienced it and the meanings ascribed to this experience (Dahl & Boss, 2005). Through group discussion, the analysts were able to elaborate, refine, and determine the best articulation of major themes,

sub-themes, and relationships between them. In order to provide a picture of any other experience reported by clients that might provide direction for clinical practice (e.g. important exceptions), inclusion of a theme was not based solely on its prevalence but also on potential value for clinical understanding. Distinctions were made between commonly experienced themes and themes that are still important but less frequently experienced/reported.

The purpose of describing the structure of the experience of change (the relationship between themes/concepts) in a hermeneutic approach is not identical (although similar) to what is attempted in a grounded theory approach. Hermeneutic analysis attempts to keep interpretation true to the participants' narrative (i.e. grounded in the data), and the understanding that evolves from the hermeneutic process is likely inform/contribute to development of theory. However, in hermeneutic phenomenology, the generation of theory is not the principle aim (Wimpenny & Gass, 2000). Understanding the structure of the experience is intended to *help uncover the meaning of the experience*, which is a primary goal of the endeavor (Wright et al., 1996).

Results

All major themes and subthemes presented here represent consensus among team members about the areas participants reported to be impactful or important and the significant patterns and relationships in their experience of the two approaches. Table 2 provides an overview of themes. The ordering of major themes represents an approximation of the sequence in which participants' experiences would potentially have relevance to them during the course of therapy. For example, the major theme of "Sequencing and Combinative Effects of Approaches" is presented first because it represents what aspects of either approach were reported to have the most relevance during the beginning stages of therapy. The themes represented in "Experiences of Structure of Approaches Contributing to Outcome" continue to show how participants were

affected by clinical process and structure but largely describes how their experiences began to diverge. This divergence begins to illustrate what aspects of either approach appeared to work with specific situations and client characteristics. Divergence in experience continues in the themes represented in “Clinical Issues, Goals, and Expectations” and describes how the approaches were found to be relevant for client goals and presenting problems. The themes within “Role of the Therapist” and “Relationship Difference” provide further description of how interaction with the therapist and with spouse appears to have contributed to the goals identified in the preceding “Clinical Issues” section. The themes in “Relationship Difference” also represent participants’ reports of what might be more typical of later and post-therapy experiences, including how the approaches contributed to their longer-term success and their reflections about the value of the approaches in the overall course of therapy. Pseudonyms are used in place of participants’ actual names.

Sequencing and Combinative Effects of Approaches

Respective benefits and recommendation for combination. While many participants reported varying degrees of preference for one approach over the other based on their situations or personalities, one of the most consistent findings was recognition of there being respective benefits to each of the approaches and a recommendation for an inclusion or combination of both approaches during the course of therapy. For instance, Bret reported, “Both had a significant amount to offer.” Amanda agreed and added, “They were both very useful in their own ways. I think it would be good to kind of mesh them together.” Frank explained that having both approaches contributed to a better outcome, “They work well together. ... I think it was a combination ... of them that has really helped.” Edward also reported that “they helped in different ways,” and that he appreciated having a “a mix of the two,” and further recommended

for the “approaches being mixed according to the needs or characteristics of the couple and their relationship.”

Sequencing—General recommendation to begin with TC. In addition to reporting that combining the two approaches would be helpful, most participants also indicated ways to sequence this combination to provide the most benefit. Nine of the twelve participants described experiences that would recommend TC as better suited for the beginning stages of therapy. Participants specifically identified and described ways that earlier TC contributed to more positive experiences in later EB interactions, including TC helping ease participants into to therapy before engaging in more demanding interactions associated with EB and providing a model and skills to be implemented and applied as a couple. Part of TC’s appropriateness for introductory sessions and potential for easing participants into therapy was linked to it being conducive to alliance building with the therapist, seeming comparatively less demanding, and being closer to expectations of what therapy would be like. While the general consensus was that starting therapy with TC was most helpful overall, five participants also described instances where an inclusion of EB interaction earlier in therapy could be beneficial, specifically in providing an awareness to participants and therapist of potential issues needing attention.

TC setting stage for more positive experience in EB. Eight participants reported that beginning therapy with TC was or would have been helpful for preparing for and/or having more success in EB. Of the participants that seemed to have the most positive experiences with EB almost all (five of six) began therapy with TC. Participants reported that having more time in therapy allowed them to get accustomed to the setting and feel comfortable enough to open up to their spouse. Florence described this progression:

It takes me a while to get comfortable and open up. And then it was uncomfortable in the beginning to say these things that I haven't said for a long time to [my husband]. ...

Those emotions were a little bit harder. ... I was maybe not ready ... and then as we moved on it was easier to open up and to feel those emotions.

Amanda said that the time in TC allowed them to get used to the setting and to initially work some issues out before working with each other:

At the beginning I felt uncomfortable and anxious just because I wasn't used to the setting. ... [In EB], I was definitely more comfortable, because we had been in sessions already, and ... felt comfortable with the therapist ... with what the point of being there was and what the set up was going to be. ... It was good to do... more interaction with each other second because ... we had already worked out some things in the beginning.

Not surprisingly then, the participants that appeared to have the most difficulty with EB reported that it felt premature. Even though Carol had three sessions of TC before proceeding to EB, she reported it felt too soon and speculated that more time to get used to the therapist might have made EB more effective for them: "The interactive therapy is good, and ... has its place, but ... it may be better to do it after you've been seeing the therapist for a while ... Because I think we would have been fine if we would have been a little more comfortable with [her]."

TC closer to expectations for therapy. Some participants reported that in certain ways TC seemed more familiar than EB or closer to their pre-counseling expectations of therapy. Bret explained how TC being closer to his expectations made it better for the beginning stages:

It was hard for me ... to feel comfortable with [EB]. ... [The therapist] wanted us to interact with each other, and that was hard, that wasn't something that we had anticipated that we would be doing. ... I remember when she wanted us to face each other, it was like

“Why is she asking us to do this?” ... Start with the therapist approach initially, almost like a decoy, because culturally I really identified very quickly with that method, ... this is how I’ve seen it in the movies or on Oprah or something. ... So I was used to that role, that ... this is how she acts, this is how we act, this is what we do.

TC conducive to alliance building. Part of participants recommending having TC earlier in the course of therapy was that it was helpful in getting acquainted and building trust with the therapist. Bret described how working with the therapist in TC was “good for establishing rapport.” He suggested that, “[TC] was a really great way of warming things up, because we got to know a lot about [the therapist] in the process, ... about what she knew and had learned about what we might be going through in terms of research.” He said this gave him a sense that, “Boy, she really knows what she’s talking about,” and had “a handle on what ... she was doing.”

David further described how having the therapist in a more active role increased his confidence, “When [the therapist] started interjecting and being more in control and trying and to get to the meat, that’s when my confidence grew. Not only in the therapy but in him. And feeling, ‘Oh, like this guy can help us!’” He contrasted this to how he felt less confidence when the therapist turned it back to them to work things out and played “the referee.”

TC establishing model and skills for application in EB. Beyond just providing time to adjust to the therapy setting and getting issues out on the table, TC was also reported to be helpful in providing a model and techniques that could then be implemented as a couple during EB. Amanda said that by having TC lead into EB, “The therapist helped us get started, and then working with each other helped it get farther.” Florence also reported that the therapist was able to help “instigate” the interaction between them:

I think we are not used to that interaction [EB], so it really helped to have [the therapist] be the main focus, ... because I think we needed those [TC sessions] to kind of jumpstart us and get that interaction going between us. ... But ... as she moved toward getting us talking to one another they became more productive ... practicing and getting used to having those conversations between one another.

Adam reported, “They were both important because you need to learn techniques, you need to learn about your problem from the therapist’s perspective, but you also need to talk with your spouse about it.” And his wife, Amanda, also described the importance of discussing as a couple the information provided by the therapist, “That was really helpful to learn ... and then have this information that he had given us to use in the discussions.” Bret explained that TC helped to “set a good tone and a good model,” because “the therapist was “good about modeling really good listening.” He said that because, “that model had already kind of been set up,” later in enactment interactions he had, “a real example, a model there for me to follow.”

Exceptions—Instances when initial EB interaction helpful. While TC seemed to be generally preferred for the beginning stages of therapy, five participants noted exceptions where having EB interactions earlier on in therapy was or could also be helpful. Beth reported that EB helped provide an awareness of where they were and where they wanted to be in their relationship as well as the importance of communication:

I actually think [EB] was more significant probably, I mean it really helped open us up that we really need to be communicating more.... I wasn’t comfortable there yet, but I think at some point I need to be comfortable there, and so it helped us see more of maybe where our goal needs to be for the future.

Her husband, Bret, reported that direct interaction with his wife during EB also provided a similar realization and attributed it, in part, to having to experience more directly the effect that the situation was having on her:

It was a kick in the pants. ... [It] gave me the most realizations about what's really happening, ... from just having to deal with that interaction, instead of dealing with it arbitrarily. ... Really experiencing the emotion of my spouse ... made me do a lot more thinking, ... start to come to grips with the way that I should be seeing things, ... and to realize that my life isn't necessarily living up to my ideals.

Diana and David reported that EB interaction was helpful for their therapist in gaining an understanding of their issues and goals for therapy. Diana suggested how the therapist observing them helped him gain a sense of what to focus on, "Sometimes [the therapist] may not know what to lead without us communicating about what the problem is." And her husband, David, agreed, "Sitting back and listening to us listen and talk to each other, I think it helped [the therapist] realize a little bit more of what was going on in our relationship."

In summary, all participants recognized the two approaches as having respective benefits. Most participants recommended a combination of approaches and suggested TC to be better for earlier on in therapy. Beginning therapy with TC was reported to contribute to more positive EB interactions through helping ease participants into therapy and through setting up a model and skills to be applied as a couple. TC was reported to be helpful in building alliance with the therapist and closer to some participants' expectations of therapy. Early EB interaction was also suggested to be helpful in promoting participant and therapist awareness of potential issues.

Experiences of Structure of Approaches Contributing to Outcome

Eleven of the twelve participants reported that clinical structure affected their experience of therapy. One area of general agreement was in direct engagement between partners being experienced as more demanding. There was a general division in how participants reported experiencing specific aspects of clinical structure: face-to-face interaction with partner (making eye contact), having their conversation observed by the therapist, and level of therapist involvement. Some participants reported face-to-face interaction to be helpful, and some participants reported it to be uncomfortable to the point of being a hindrance. Some described having couple conversations observed by the therapist as awkward and distracting, and others described it as feeling more real and less intrusive. For some, talking directly to their partner was associated with more escalation and blaming, and for others, defensiveness and criticism seemed to increase more when one partner was talking to the therapist. Nine participants described how their comfort with these aspects of clinical structure affected how much they were able to benefit from either approach, including how open they were able to be, how quickly it seemed they were progressing, their level of hopefulness, and/or how close they felt to their partner.

Direct engagement more demanding. Most participants described talking to the therapist as being generally less demanding than talking as a couple. Some participants partially attributed this to the level of effort contributed by the therapist. Carol reported EB involved being, “a more active participant.” Amanda reported appreciating the therapist’s increased involvement during TC, “Because I’m not usually one to talk a lot, so him guiding us was good.” And Beth reported a similar feeling, “a relief that, ‘Oh, I don’t have to say everything!’”

Bret went into further detail about how the structure of TC reduced the perceived demand, “It’s a lot easier to just talk to [the therapist] and be like ‘Okay, cool my turn is done.’”

And of course we're listening to [my wife], but you can always catch what [the therapist] is gonna say [after]. So that was easier." And he contrasted it with the discomfort associated with feeling increased responsibility during EB, saying, "I noticed [EB] was hard particularly. ... much more uncomfortable ... because it's our deal, and we couldn't ignore each other, and we couldn't just talk to [the therapist] and feel like, 'Oh, I'm done I can kick back.' We were to be responsible for talking to each other. And that's uncomfortable."

Discomfort in face-to-face interaction. Three participants reported that the discomfort or difficulty of EB partially had to do with their physical positioning during the session and the requirement of looking at each other. Continuing his description of how TC felt less demanding, Bret explained how this applied also to looking at his wife, "I didn't feel like I necessarily had to make eye contact or really pay attention to my wife's body language [during TC]. We could kind of be shut off. So that was very comfortable." And he compares this with his experience of facing his wife during EB, "It was hard to sometimes feel comfortable looking at my spouse, because she was uncomfortable ... and that made me uncomfortable."

His wife, Beth, reported feeling more "tense and anxious" having to look at each other during EB. She explained that part of was made TC a "much more relaxing atmosphere" for her:

I like to be able to look around, and maybe think about things on my own and play with my fingernails a lot. I'm listening, but I'd like to be able to think about it inside without having to look somebody in the eye, especially when I'm talking about something that's hard to talk about. ... I was still just as focused on what was happening, but it was more comfortable for me to be able to just kind of pull myself back physically just a little bit.

Elaine also reported being adversely affected by the requirement of facing each other during EB:

I could talk to [my husband], [I] just can't look him in the eye when I talk to him. ... It's like putting [you] on the spot. And I don't like to be put on the spot. ... It just makes me really nervous and makes it harder ... to spit things out. ... It's just one person, but that spotlight's on you. ... Kind of nerve-wracking. ... [I] just hate that nervous feeling.

Face-to-face interaction helpful. However, four participants also reported that same aspect of looking at each other during EB as being helpful to them in understanding their partner and feeling understood. Florence stated, "When I said something to [my husband], it helped to have eye contact with him and just speak with him." Both spouses in couple A reported that EB helped them to sense each other's reaction to what he or she had said. Adam, "I could understand her reaction better whether it was positive or negative." And Amanda, "I could feel his response to what I said and vice versa. ... It was good for me to see how he was feeling and then for me to be able to respond so he would know how I was reacting to him."

Included in this group was Bret who was also one of the participants reporting feeling more uncomfortable with face-to-face interaction. He described how the requirement of focusing on his wife while she was talking during EB had a positive impact on him:

The arbitrariness of [TC was that] ... it was easy to not have to deal directly with my spouse's emotions. ... what was behind those words. ... But [EB] really made me feel accountable, I had to pay attention, ... to understand and find meaning in that, when I had to deal with [my wife] in that sense. ... Rather than hearing what was going on, but having to make the effort to directly focus on your wife, that helped me to have sensory evidence of what she was feeling. ... it was concrete.

Escalation and blaming in direct engagement. Three participants reported experiencing more blaming, confrontation, and/or reactivity with direct engagement and that increased therapist involvement helped sessions feel safer and more in control. Beth said direct contact was associated with more blaming and confrontation and preferred talking as a triangle:

I personally felt safer with [TC]. ... We were all just talking together. ... kind of talking as a triangle. ... It just didn't seem as direct, and I felt easier talking that way. Because when we were just having to talk to each other and always looking at each other, it felt like we were blaming more and it was more confrontational.

Both partners in couple D reported that their interactions during EB at times tended towards greater volatility and blaming when there was not sufficient therapist involvement. The husband, David, reported: "More calm or rational responses were when [the therapist] was directing. When he was kind of standing back and letting things happen, it became much easier to get irrational or upset, ... more reactive, ... almost volatile." His wife, Diana, also associated therapist direction with feeling safer and more in control, "I probably felt safer when the therapist was leading it, because I feel like it's not going to get out of control. ... And sometimes if we're just doing it without that guidance, it's maybe like a catfight, or a blame game." She qualified, "If he'll open up and we can have a heart to heart, then I feel comfortable with him," but alternately, she said that if her husband was angry, then having the therapist direct felt more comfortable.

Defensiveness and criticism in TC. Two participants commented on instances where defensiveness or criticism might have increased for the partner listening to his/her spouse speak to the therapist during TC. Florence reported that during TC, "It felt more like a he-said-she-said type of a situation" and described the experience of feeling more defensive during TC: "I would

hear what he was saying [to the therapist], but it was his place to speak and not mine, so I was getting ... upset. ... being defensive. Whereas when we were interacting with each other, I can comment immediately. ... I wasn't quite as defensive."

Bret described a similar experience, not about himself but what he speculated his wife was experiencing. He said that during TC, for him, "it was particularly easy to feel empathized with, validation and understanding," but that this caused problems with his wife: "She kind of had a feeling or like an attitude of, 'Sure, I'm sure you feel that way. You sound like a real hero, Bret.'" He explained, "It was harder for her to believe what I was saying, especially in a situation where she could tell I was feeling very validated by the therapist."

Discomfort being watched. Five participants associated some of their discomfort during EB with having the therapist observe them during intimate conversation. In two couples, C and E, partners reported feeling awkward and/or not as natural being watched in EB. Carter said he felt awkward, "pretending to have this one-on-one conversation with my wife while there was somebody else in the room." His wife, Carol added, "It's hard to interact... with your spouse, who you're very comfortable with ... with someone watching. ... That made me a little uncomfortable, and it seemed a little silly." Couple E similarly reported they are able to talk with each other outside of therapy, but it becomes more difficult to do in therapy. Elaine said that because being watched makes them feel awkward having conversations they might otherwise feel comfortable having alone, she preferred to talk to the therapist during the sessions: "When it's one-on-one with ... my partner outside of therapy, I can talk to him a lot easier and more comfortably. But when we're with the therapist, it's easier to communicate with the therapist."

As mentioned, this discomfort had partly been associated with not having sufficient time to get used to the therapist and therapy. Carol said, "I wasn't very comfortable talking about

those personal feelings with someone watching,” and speculated, “It may have been more comfortable if we had switched to that type of therapy after we had been seeing [the therapist] for an extended period of time.” Bret, reported that “as far as just the initial weirdness of talking to each other with [the therapist] right there, ... [it] got more comfortable as we did it ... because we just kind of knew ... that this is what we’re doing, we sit down, face each other, and we talk.”

Couple interaction under therapist direction more real and intimate. Representing a different reaction to the therapist’s position from that described by couples C and E, who felt awkward having their intimate conversation observed, Amanda reported that the therapist felt more intrusive during TC interactions. She explains that in EB, “It kind of felt like...the therapist wasn’t in the room as in the other approach [TC]. We were working toward the same goal, but there was still this third person involved so it wasn’t as intimate.” She describes the effect of this, “[In TC] we were still connecting, but it wasn’t as strong as [it was in EB], because ... it was more obvious that we had an audience, the therapist.”

Her husband, Adam, agreed that the conversation between them in EB felt more real than going through the therapist in TC, “[EB] definitely helped us get closer together. Because we were communicating with each other, and it wasn’t a therapy setting, it was real conversation.” He explained what helped them to feel like that, “We were trying to have the conversation as if the therapist wasn’t really there. You know, he was just background.”

Diana reported that even with the therapist directing her husband in how to communicate with her, hearing from her husband felt more real, “When [my husband] told me directly, I really felt like, ‘Okay, this [is] for real. ... I really liked that one because, even though the therapist asked my husband to say it, it was when my husband said it that I felt a lot better.”

Link between preference for structure of approach and outcomes. In review, participants as a group were split on which approach they were able to feel more comfortable in based on their experience of the clinical structure associated with that approach. Where face-to-face interaction was experienced as more comfortable and/or more helpful in comparison to their level of discomfort, participants reported preferring and receiving more benefit with EB. Where the discomfort associated with face-to-face interaction was experienced as being more hindering than helpful, participants generally reported preferring TC, and that their discomfort in EB made it comparatively more difficult to receive benefit from that approach. Participants in both groups described their preference for and comfort with the structure of either approach as influencing how much that approach was able to help them feel open, hopeful, close to their partner, or a sense of making progress in therapy.

Hindering discomfort in direct engagement—Better outcomes with TC. Participants that found direct engagement and/or being observed by the therapist uncomfortable to the point of being hindering reported that this discomfort affected their sense of progress and how open, hopeful, or close to their partner they felt. Elaine reported how face-to-face interaction affected her ability to open up and feel close, “It’s easier for me to open up when I’m not directly facing [my husband]. And so I felt closer when I wasn’t. I’m able to open up a little bit more.”

Beth reported that not needing to have her “guard up as much” in TC allowed her to feel more relaxed, and in turn she, “was able to be more emotionally engaged.” She said that it also affected how much or how quickly she was able to open up: “It was easier, or at least quicker with [TC]. ... It wasn’t like pulling teeth.” ... I could open up in 10 or 15 minutes instead of [in EB] we’d get almost to the end of the session and I’d be like, ‘Okay, now I’m ready to talk.’”

Carol also associated her ability to be open and engage emotionally with how comfortable she felt: “Because I was less comfortable interacting with my husband I was less likely to be softened [or] ... open. ... like it was harder to get to the point. ... We were ... more emotionally engaged in [TC], ... because we were just more comfortable.” But she also reported that for her, “[EB] was more real and intimate ... because we had to interact and address pretty serious personal issues that we were having trouble addressing. ... Rather than having ... a third party doing that, it means you have to talk.” She explained that having a more active role in EB helped her to feel more empowered: “Probably [in EB] I felt more empowered—if that’s not contradictory—just because I was interacting, it was less talking by her and more talking by us and interacting. ... because I was a more active participant.”

Beth reported that she felt more confident speaking and that it was easier listening to her husband talk about difficult things when she didn’t have to look at him. She explains:

I had more control over how I emotionally reacted to things with [TC], because I felt more comfortable there, and so I felt like I had more power. I was empowered to share ... and ... work through what I needed to when I felt comfortable. ... Instead of feeling tense and attacked, I felt more relaxed and like we could go somewhere and I had hope again.

Carol explains that discomfort during EB not only made it difficult for her to be open, but her husband’s discomfort also affected her ability to discern his feelings, “I didn’t feel like my husband was totally comfortable [in EB], and so I didn’t know how sincere or how honest or how open he was being.” She also described the effect this had on feeling productive, “I don’t know how productive [EB] was, just because I felt like he was less comfortable, and that probably just created insecurities. ... I probably felt less optimistic.”

Helped by direct engagement—Better outcomes with EB. Conversely, participants who reported receiving specific benefits from eye contact, feeling more comfortable, more natural or less defensive talking directly with their spouse in therapy also reported that EB contributed more to feeling open, hopeful, close to their partners, and/or to a sense of progress in therapy. Florence describes feeling more openness and closeness during direct engagement with her husband, “When [the therapist] was ... trying to get us to talk [to her], ... I didn’t feel as open. Whereas when I was talking more to him, expressing those things, instead of him telling her and me being the third person, ... there was more openness and more closeness.”

Amanda also associated direct engagement with feeling more comfortable, “Interaction with my husband, as opposed to the therapist, made me more comfortable. [EB] was probably better for that,” and more strongly connected, “In [EB] it was easier to connect because we were addressing each other, and I was responding to what he said, and he was responding to what I said. I think there was definitely a stronger connection with [EB].” She also associated direct interaction with productivity and progress, “[In TC] we were discussing issues, and we were making progress, but I think that we were more productive in [EB] because we were working out issues between each other, and we were able to express our feelings more to one another.”

Her husband, Adam, reported feeling closer and more emotionally engaged during EB and associated those feelings with face-to-face interaction. He said, “I think [EB] brought us closer together. ... Because we were engaged in communication with each other during the session, we were definitely more emotionally engaged. We were looking at each other, we were focusing on talking with each other, and listening to each other.”

Florence similarly connects interacting with her husband to the feeling that they were making progress: “It felt like [TC] wasn’t quite working, and it was taking a while. ... like, ‘Oh

boy, this is going to take forever.’ ... But ... when we started spending that more one-on-one time and interacting with each other more, ... it felt like, ‘Hey, we are getting somewhere.’”

In summary, almost all participants reported that the clinical structure of the approaches had an affect on their level of comfort and contributed to therapeutic outcomes. While direct engagement was generally experienced to be more demanding, participants were evenly divided about how specific aspects of clinical structure—face-to-face interaction and the level of therapist involvement—affected their ability to feel comfortable and, in turn, how much they were able to benefit from each approach. Participant preference in clinical structure was related to which approach they reported helping them the most in feeling open, hopeful, close to their partners, and a sense of progress in therapy.

Clinical Issues, Therapeutic Goals, and Expectations

Ten of the twelve participants described how the approaches were relevant to their issues and/or contributed to achieving their goals in therapy. Participants reported that either approach was helpful inasmuch as it contributed to them reaching their goals for therapy. EB was reported to be more relevant and helpful for improving communication and working out issues together as a couple. TC was reported to feel more relevant or helpful where participants reported wanting to work on individual issues or a desire to have more expert guidance.

Directing to relevant issues. Related to perceptions of therapeutic progress was the importance of the therapist directing participants to specific and relevant issues. Diana reported that the therapist helping them have a concrete goal contributed to feeling more hopeful, “My husband and I ... don’t always come to a conclusion, whereas if we’re asked to take on an assignment, there’s more of a hope there ... because you have something concrete you’re working towards, rather than just all these emotions out there floating around.”

Her husband, David, reported that they as a couple needed a high amount of therapist involvement to stay on track: “We needed the absolute, “I’m taking charge this is where we’re going and this is how we’re going to get there.” ... When he was directing it, it really went kind of more laser point to some issues that needed to be addressed and it wasn’t dodgeable.”

Elaine also reported the experience of getting stuck rehashing the same issues when they were directed to talk as a couple. She attributed this to being directed to work on an area they are already proficient in, “Most couples don’t [confide in each other], and so it’d probably work for others, but we usually [do], so it was almost like we were just rehashing the same things over and over again.” She contrasted this to the therapist being better able to direct them to relevant issues during TC, “But, [in TC] where it was more individualized. ... [The therapist] would direct me ... or him to a question and ... talk, one of us to her, at a time. It seemed to help more.”

EB fit with couple issues and communication. EB was reported to be more relevant and preferred in working towards the goal of improving communication and working out issues together as a couple. Carol reported feeling highly uncomfortable with direct engagement but still found it to be relevant to them as a couple because of the issues they were working on, “I think that ... the enactments, [were] really relevant because, I mean obviously we have the issues and so we need to discuss them and address them.” Amanda found EB to fit with their needs, “I think it was probably a little better to work with each other, just because that’s what we were there for.” Florence reported that EB was, “significant in helping us to have those face to face conversations,” which helped reach their goals, “One of the main reasons that we are here is to learn how to communicate with one another again, because we’ve kind of lost that. So to have us actually doing that with the therapist there to guide us is really what’s made the difference.”

TC for therapist expertise and individual issues. TC was reported to feel more relevant or helpful where participants reported wanting to primarily work on individual issues or a desire to have more expert guidance. Edward, reported seeing benefit in EB because he enjoys talking with his wife, “To me, that’s one of the most fulfilling things in there: you just talk about anything and everything.” But he said that it would be more helpful, “for a couple who perhaps do not talk like that much.” For their situation, he said, “That’s something we do on a regular basis anyways. And it was a little awkward.” His wife, Elaine, specified that the therapist’s perspective was more important to her in gaining insight to her own emotions, “It was more meaningful with the therapist ... because my husband and I always talk, but it’s good to get an outsider’s view on things, ... because we’re trying to [find out] what my emotions are doing.”

While Diana reported that the most impactful moment in therapy involved direct communication with her husband, David reported valuing the therapist’s position as an expert above interaction with his wife. He reported that because of his wife having a disorder, the therapist as an expert was better positioned to persuade her than he, as her husband, would be:

I’ve always felt there was some obsessive compulsive aspects with my wife ... I had been saying that for so many years ... and she kept on pushing it away. And [the therapist] started saying it; all of a sudden ears perked up. ...If I would have said that, then it wouldn’t have helped. ...I’m gonna be the bad guy, but if someone else is saying...all of a sudden that becomes validated, and it’s validating for me.

In summary, participants described how the approaches were relevant to their issues and/or contributed to achieving their goals in therapy. EB was reported to be more relevant and helpful for improving communication and working out issues together as a couple. TC was reported to feel more relevant or helpful where participants reported wanting to work on

individual issues or a desire to have more expert guidance. There were exceptions where TC was preferred for working on couple issues because of discomfort in EB, and where EB was preferred for working on individual issues as a couple.

Change in goals. Several participants reported having their goals change after beginning therapy, mostly becoming aware of a need to work on issues as a couple. With these changes, Adam, Beth and Bret reported being helped by EB with what they originally thought were individual issues. Bret reported that EB was unexpected but that as they had more experience with it, he realized more that involvement with each other was what he wanted, “[EB] was very good at getting [my wife] and I involved with each other, which is what we want. And maybe more so I realized as we had gone through the sessions that that’s what we wanted.” Beth reported that EB “was more significant probably, I mean it really helped opened us up that we really need to be communicating more.” She said that even though she was not comfortable there yet, she realized that was where they needed to go.

Adam reported that EB helped with what he had thought was an individual problem. He said, “[My wife and I] had talked about this problem for a long time, but we had never solved [it]. Obviously, that’s why we were here,” and that it was something he needed to work on in individual therapy, “I came in just by myself the first time ... and I didn’t think that my wife needed to come. ... that it was just something I needed to do myself,” until his therapist asked if he would like to invite his wife. Although he reported this individual issue was their reason for being in therapy, his wife said in her interview that working together is “what [they] were there for.” Like his wife, Adam reported receiving the most benefit from working together as a couple, “I’m very, very thankful that my spouse would come ... and I think that the couple-centered approach was the most beneficial ... being able to have conversations with her.”

Carter also reported a similar change in his view about the value of working on issues as a couple. However, he, Carol, and Beth also said that feeling too overwhelmed or uncomfortable in direct engagement made it difficult to benefit completely from EB and preferred to work on their issues through the therapist. Carol, recognized the need for partners to work on issues with each other, “If [EB] was used in the right way, or in the right circumstance with people who are comfortable with that, I think it would probably be more productive, just because you are interacting with the person you have issues with.” But she continued, “For us it wasn’t just because I felt like he was uncomfortable.”

Role of the Therapist

Eleven of the twelve participants commented on the therapist’s role in therapy. Participants described how the therapist’s role as an expert and as an outside third party with no history with the partners contributed to their experience of therapy. This also included the therapist’s ability to provide normalizing validation for participants and to highlight significant parts of their conversation.

Therapist as expert. A consistently identified benefit of TC was the therapist’s professional training and experience. Related to this, participants often described TC as being more informative and instructional. Amanda said the therapist provided information they would not have gotten from just talking as a couple, “I liked the first half [TC] better for ... learning about what we were discussing. He had a lot of information to offer that we wouldn’t have gotten just addressing each other the whole time.” Her husband, Adam, talked about getting this information and learning skills, “The therapist-centered was very helpful, but it was more instructional. You need to learn about your problem from the therapist’s perspective. ... [TC] was more stuff you can use and application ... [and] techniques. Getting the tools I need.”

Bret also said that professional insight was important, including knowing what research has said about their patterns as a couple, “The thing for me that made the most difference with [the therapist] was when I got professional insight, ‘Here’s the bigger trend of what’s happening, here’s what, based on research, seems like is happening with you guys.’” Edward appreciated the therapist’s insight into their patterns, and more specifically into their personal experience, “Talking with the therapist ... we do get some more insights into what we’re feeling ... a better grasp on where our feelings come from and why.”

Beyond the therapist as an expert providing information, two participants reported expecting this capacity as expert to also involve taking a more directive role in discovering and resolving issues. As mentioned, Bret had reported that his culturally-based expectations of therapy had led him to identify more quickly with TC. He added that these expectations included the therapist as being more directive and responsible for therapeutic process, “She’s the therapist, so culturally I’m trained that they’re supposed to tell you what is wrong or tell you what to do and figure things out.” David similarly reported expecting the therapist to take a more directive role, postulating that this expectation came from his own experience, “maybe that’s part of my profession, because I have to go sit down and I explain to [patients] their problem.” He said that as a result, “I was much more responsive to him directing ... I feel like, “That’s why we’re here ... come on get involved here and help us figure out what needs to happen.”

Therapist as third party. In addition to the therapist’s value as an expert was his/her position as a third party or outside perspective. Seven participants commented on how having this outside point of view was helpful when they as a couple were caught up in things or needed additional perspective. Diana explained that the therapist’s position as, “the neutral outside party” helped in “leading and guiding you to say things,” because he could, “look in and see

things ...that neither of you is recognizing about your relationship or about yourselves because you're so caught up in it. ... [and] bring those things out and talk about them.”

Highlighting. The therapist's position outside of the relationship and role as an expert was also reported to be important during enactment interaction between partners. Four participants reported that the therapist highlighting or repeating and drawing attention to what their partner had said was helpful in increasing understanding. Bret reported, “It was useful when [the therapist] would say back to me things that [my wife] had said.” Carol added, “It's nice to have somebody on the sidelines ... bringing up points...that [one of us] feels are important that [the other] may just kind of brush over or not really get, or ... just not really feeling.” She said this would happen when, “[The therapist] would jump in at times and say, ‘Did you hear that? Did you understand that? ... Can you repeat that?’ So I think that probably I felt more understood by my spouse during [EB].” Florence also reported that therapist, “pointing them out to us... helped to [me] recognize, ‘Oh yeah, I did see that. Yeah, I did hear that.’” She said this effect continued after the session, “Even after we left...I'd be thinking about those things.”

No personal history with therapist. Participants also reported that it was sometimes easier to open up to the therapist as a third party because there was no history with her. Frank reported that the therapist's position outside of the relationship made it easier to open up to her in the beginning, “I was less confident to talk to [my wife] during the first three sessions [TC]. We had been through a lot. ... I felt really confident talking to the therapist, because [she] was a third person. ... outside the relationship, so it was very easy and very comfortable.”

Bret referred to how his decisions had affected his wife and the “extent of damage that I had done in our relationship,” and how, “it was difficult for her sometimes to express what she was feeling.” He described the therapist as being someone his wife could talk to when she felt

uncomfortable talking with him, “[My wife] didn’t feel comfortable necessarily telling me when I’m wrong. ... She felt comfortable with [the therapist], ... that she was somebody safe to talk with about those things.” And he added, “I think just the fact that [my wife] was comfortable around her made her stay put, keep coming.” He said that having a supportive third person outside of their relationship made it easier to talk about issues, “because ... it’s almost a three person tennis match with the therapist. ... Almost like [the therapist] was a go between.”

David reported that the emotional involvement between him and his wife and fear of hurting or being hurt made it more difficult to feel safe and be open:

[During EB] it was harder to open up, ... to feel safe, because ... you’re so emotionally attached and so emotionally involved in it. And at times you want to speak the truth, but you don’t want to say it right to their face ... that can be very hurtful and you don’t want to hurt that person. ... Then it becomes easier to put up barriers, “If you’re going to hurt me, I’m not going to hurt you.”

Adding to this, his wife, Diana, said, “The therapist isn’t going to freak out if you say something, but your spouse might. ... I don’t feel like the therapist’s moods really changed.” And, “There are certain things we can both take better from the therapist.” Related to this, she reported that it sometimes is more meaningful to talk to the therapist because he was, “not being judgmental, ... not out to get me, ... just there to listen and try to help. And I don’t always feel that way with my spouse, sometimes ... [he] has these preconceived ideas no matter what I say.”

Diana explained that the therapist was able to be more patient and understanding with her because he did not have the protracted history dealing with her issues that her husband had. Her husband, David, reported having worked repeatedly on the same issues with Diana to no avail, and she described his resulting attitude towards her issues as being one of empathy fatigue: “I

feel like the therapist is more patient than my husband, because my husband is like, ‘I’ve been doing this for years. ... I’m tired of trying to understand ... I don’t care what you have I just want it settled, ... to be done, changed.’” She explained that the therapist was at times able to help her husband be more empathetic, “Probably [he would] tend to be a little more empathetic with the therapist [leading] actually, because the therapist might be able to explain it from a third party stand point, rather than me trying to say [to my husband], ‘Please understand.’”

Normalizing validation. Related to the therapist’s function as an expert and outside third party was his or her ability to provide empathy and normalizing validation to both the couple and individual partners about their experience and difficulties. Beth reported that therapist validation of their experience was helpful and that it was more apparent when talking with the therapist, “I felt more empathized with, especially because the therapist was able to validate that these feelings are okay. ... And we could hear that more with [TC] ... than when we were supposed to be talking to each other.”

Diana reported a similar effect. She said that the therapist, “as the professional,” was able to, “share characteristics of different things to make it more positive. ... So at least I felt like, ‘Okay, I’m not a total dork, you know, other people [also have] anxiety.’”

Her husband, David, also reported feeling validated and relieved having the therapist involved. As mentioned, with this couple there appeared to be a significant difference between partners’ perspectives about what the real issue was for them. David reported that he felt most validated when the therapist started suggesting to his wife that she might have an issue. He said that up until that point, “Sometimes I’m wondering, ‘Am I crazy, what’s wrong?’” He said that the best part of therapy for him was getting at what he considered to be the real issue:

The most positive thing is I felt like we were getting close to understanding the issue at hand. ... That was huge, huge! It was almost like lifting a lead jacket off ... like, "Phew, I'm not crazy!" ... "I finally got somebody to see what it's like." ... Feeling validated in my thought process. ... That was very comforting. Now we still have to deal with it, but...that was immensely positive for me.

It was not made clear in the interviews what effect the therapist validating two discrepant viewpoints might have had for them.

Edward reported a situation where he found a benefit having the therapist as an outside party provide validation and empathy to his wife, "Sometimes, [my wife] likes some validation or some empathy from someone other than me. Because when words come from more than one place, it's more substantial. Because, you know, she knows my bias."

In summary, participants described how the therapist's role as an expert and as an outside third party with no history with the partners contributed to therapy, including highlighting significant parts of their conversation and providing normalizing validation for participants.

Nature of Couple Relationship

As mentioned, the therapist's position outside the couple relationship was reported to be advantageous in certain situations. However, nine of the twelve participants also commented on the difference between the relationship partners have with the therapist and the relationship they have with each other and how the couple relationship affected and was affected by therapy. Participants reported that the relationship between partners often made what they said to each other more impactful than having the same message from or through the therapist. They described how the approaches contributed to couple self-sufficiency, including their ability to

talk to each other after sessions and in the long term. Participants reported that the difficulty they experienced during EB was justified by the overall effect that it had on their relationship.

Ongoing relationship and impact of direct engagement. Seven participants reported that the relationship difference (shared history, shared future, and emotional connection with partner) influenced how impacted they felt by hearing the same message from or through the therapist versus directly from their spouse. Adam recognized the therapist's professional experience as contributing to his or her ability to provide empathy and validation to clients, but also identified an additional contribution connected to the pre-existing, ongoing, and personal nature of the spouses' relationship with each other, saying that he felt more "understood and validated," talking with his wife, "just because of the relationship difference." He explains:

[EB] was stronger, because I agree that the therapist has seen a lot of people with similar problems, and probably can have some empathy, and definitely wants to help with the problem. But he's not as connected as the spouse is, as far as the problem goes, because this is a problem that we've been dealing with, and that we are dealing with, and that we will be dealing with, for as long as it exists.

Florence reported that hearing directly from her husband helped her feel closer, "I think I felt closer having those conversations with him rather than hearing what he had to say and me being the third party type of a thing. ... It was more meaningful to have that interaction between us." Amanda said that the interactions with her husband were more memorable and more meaningful, "[EB] was more meaningful ... because I think I'll remember the moments where we were talking with one another more than I will talking to the therapist. The things that we were able to address between the two of us [were] definitely more meaningful because we were connected, the two of us instead of with a third party."

Bret compared the difference between hearing directly from his wife and having it go through the therapist to “getting the whole thing” versus “the Reader’s Digest version,” and added another comparison, “You just have a different feeling when you read a primary source.” He said that the therapist was the authority in terms of knowing the research and providing professional insight, but contrasting that his wife “was the authority about herself,” and preferred hearing her express herself to him in her own words, even when it was something painful:

Even though it was difficult for her sometimes to express what she was feeling, it was always better. It was always more helpful to hear what she had to say, not because I always liked it, ... but because it was the reality. It was expressed the way she would express it, words, body language, everything, ... just always better.

Diana reported that it felt more real, “when it comes from your spouse,” and explained, “A therapist can say what they think a person’s feeling, but the person who’s really feeling it can express that feeling.” She then described an instance when receiving reassurance directly from her husband had a significant impact on her. Her husband had told the therapist, ““Yeah [therapist], I love her.” And the therapist directed him to, “turn and express that to her.” She said:

And so that coming from my spouse meant more to me. ... [and] went really far with me. I felt much calmer, like, ... “We’re gonna have some rocky times, but the underlying ... love’s there, and the security’s there.” ... More so than if [the therapist] had said, “Yes, your husband loves you.” ... That’s when I went home feeling the most profound effect. ... When it got to my heart the most, [and I felt], “Okay, this is for real, it’s gonna be okay, it’s all gonna work out.”

Promotion of post-session dialog. Two participants described specific ways that the therapist versus the spouses’ roles in EB promoted after-session dialog between partners.

Florence reported that having in-session conversations helped them to have those conversations at home, “It’s getting to where we can take that home more because we have practiced a little bit in session.” Adam said conversations they had in TC were more likely to end when the therapist was gone, while those the partners had between them in session were more likely to continue:

How we were together during the session really carried over after the session ... When we had the therapist talking with us, there wasn’t as much after conversation ... the conversation’s over when the therapist was gone. ... After [EB], on the way home we would ... continue our conversation ... Just because [EB] is extended, I think that’s more influential. ... more productive and useful.

Bret described how feeling more responsible during EB made it more likely for them to continue those conversations:

I felt like it was easier to continue dialog ... [and] to bring up things from [EB]. ... because it was us talking. We were directing it. ... Whereas [in TC], it was [the therapist]’s deal. ... I liked that [in EB] it was us, it was our deal, ... I felt that, “Hey I’m responsible for this. ...I got to make this work ... and start making things better.”... [EB] was forcing us to deal with that reality. ... [The therapist] could step back, “I’m here for you, but this is your marriage, this is between you guys.”

Overly intense EB decreasing post-session dialog. Beth described in-session interaction having a different effect on after-session discussion. She reported that the intensity and duration of their interactions during EB made them less likely to continue talking after those sessions. She subsequently suggested that shortening the period in which partners had to directly interact might make after-session conversation easier:

I think [EB] is good, but it was hard for us to handle ... a full hour of that at one time. ... and then going home and not wanting to [talk to each other], because we just had a lot of it. ... It was a lot of confrontation when we were here, and so when we went home we didn't talk as much face-to-face. ... Whereas [after TC sessions] we could talk more in little amounts of time at home, kind of the same way we did here with [EB], but it was just in smaller, more easy to manage chunks. ... It helped change us in the way that we talked at home. ... Because we were able to work through things together with the therapist in [TC], and then when we went home we could work one-on-one.

Her husband, Bret, made a comment that seems to corroborate her description of this link between in- and post-session discussion contributing to some trepidation, “[In EB] we were to be responsible for talking to each other. And that’s uncomfortable because we go home with each other. ... What we do there could certainly have some effect on when we go home and do it.”

Contribution to couple self-sufficiency. Six participants reported that EB contributed more to the likelihood of being able to continue communicating and connecting after therapy had ended. Participants reported that practicing interactions during therapy was helping them realize their goal of eventually communicating without therapist assistance. Florence reported, “Getting us used to having those conversations together is what’s going to help us, and I think it has helped us, because we’ve taken some of those [conversations] home already.”

Diana also reported that having more successful conversations in therapy was contributing to their increasing ability to have them without the therapist’s assistance: “The more you do it, the more you do recognize those things and that you could do it on your own more easily without the therapist’s intervention.” She explains the effects of learning techniques from the therapist and practicing with each other, “We were able to sit down and have a long calm

conversation without him there. ... That is probably the ultimate goal here, that you don't have to have the therapist your whole life."

Bret also reported having the goal of not needing the therapist and said that he thought EB was, "helping [them] learn to communicate for the long term":

We're setting a standard and ... habits for the future. ... I need to be responsible and able to do this at home, because we won't always have [the therapist]. ... Even though I was being heard with [TC], there was a superficiality to it, and I feel like it was a crutch in terms of giving us long-term success. Ultimately [EB]...is going to get the job done for us, because we are having to learn how we're going to be the rest of our lives.

Adam said EB "focuses on building trust, building [the] relationship" and helped me feel close to my spouse, and confident in our relationship." He explained that building confidence in their relationship helped him have more confidence to be able to continue after therapy had ended: "Just having the help from your spouse gives you a confidence in knowing that person is going to be ... with you. ... You know you're on the same page. I think that really gives you more confidence, [that] when you leave therapy you can ... keep the effects of it alive."

Outcomes justified difficulty. While most participants reported experiencing certain aspects of EB as being more difficult or uncomfortable than TC, five participants also reported that the outcomes justified the greater difficulty and discomfort. Diana says that while talking directly with her husband was more difficult, it also has the potential to get them further, "Even though it's harder, I do like it when [the therapist] tries to have us talk to each other, because I think that if we're sincere it maybe goes further." She continues, "So it's a little more stressful ... [and] a little scarier for me to say things from my heart, because you are taking a risk, but I think it's more beneficial if I do."

Carol was a participant who reported feeling highly uncomfortable during EB, but that the things they were able to talk about made it worth the difficulty. She explains, “It was harder in [EB] because I felt like it was uncomfortable, but the points that were addressed needed to be addressed, and so because of what we were talking about it was worth it for me.” Similarly, Beth reported, “[EB] was probably more significant—more uncomfortable, but probably more significant.” Both she and her husband described EB as being especially difficult for them. Bret reported he thought EB “was a great approach after the fact,” but in the moment “It was really hard, ... and ... often ... discouraging, especially toward the beginning, when we got to deeper stuff.” He continued, “But I think it’s paid off. ... It’s the hardest, ... the most painful, and creates the most anxiety, but I also felt it had the biggest pay offs in the end.”

In summary, participants commented on how the couple relationship affected and was affected by therapy. They reported that the relationship between partners made what they said to each other more impactful than having the same message from or through the therapist. They described how the approaches contributed to couple self-sufficiency, including post-session dialog and their long-term ability to talk and work out issues together. Participants reported that the overall effect EB had on their relationship justified the difficulty and discomfort.

Discussion

The current study proposed to expand clinical understanding of what role enactments play in promoting attachment outcomes in therapy, how it is different and similar to attachment change in response to therapy without enactments, and provide possible indications for therapists to more effectively utilize enactments in helping couples work towards more secure attachment. Accordingly, while there are numerous themes within the current findings that could merit a more extensive treatment, the results of the analysis will primarily be discussed as they relate to

attachment-related experience and change in therapy. However, major points will be addressed briefly concerning general clinical issues and process. A general profile of participant experience, specifically as it relates to best practice of enactments vis-à-vis individual and couple characteristics will be provided. Clinical implications will be integrated throughout the discussion, but an overview of applications of the major findings is provided in Table 3 at the end. Finally, limitations and directions for future research will be discussed.

Overview of Participant and Couple Experience—Emerging Profile and Framework

Participant reports examined individually, within the context of their partner's experience and as a group, provide an emerging framework to inform potential best practice of using enactments in marital therapy. While areas of high participant agreement provided important insight, perhaps the areas with the clearest divergence are more instructive as to best practice, as they clarified in what instances direct engagement through enactments works best and when it is less helpful or even contraindicated.

Participant preference—Enactment-based. Half of the participants (couples A and F and Bret and Diana) reported having more highly positive experiences in EB with generally positive experiences in TC. These participants reported that both approaches were helpful, but that they benefitted more from EB and preferred that approach, and only had minor issues with TC (e.g. that it was not direct enough or didn't seem to help them as much as EB). Most of these participants (except Bret) began therapy with TC and described specific ways this sequencing allowed them to have more success with EB in later sessions (e.g. adjustment time, rapport building, getting issues out, model demonstration, skill instruction, psycho-education). So while they reported appreciating the contribution or value of TC in earlier stages of therapy, the general issue they described having with that approach was that it was not able to help them as much in

later sessions when they reported wanting or needing more interaction and working together as a couple. Amanda's description that, "The therapist helped us get started, and then working with each other helped it get farther," appears to be a general representation of the experience reported by this group of participants.

Although Bret began the experimental sessions with EB, he similarly suggested the value of beginning with TC and that EB did more for him and their relationship. All of the participants who reported preferring EB described experiencing some level of anxiety or discomfort in having to talk as a couple about difficult issues, but what appeared to make Bret unique within this group was the intensity of discomfort he reported experiencing in EB, and that it was mostly in retrospect that he began to appreciate what occurred during that approach. That this couple began engaging in extended face-to-face interactions in EB after only three pre-study sessions might partially explain their discomfort. Issues related to this: a) his wife also reported feeling high levels of discomfort during EB and that EB provided her "significant" realizations about their goals and needing to work on their communication (similar to the "kick in the pants" realization he described having himself), but she reported preferring TC because it was more comfortable, and b) it was his and her intense discomfort that he credits, in part, for the significant impact he said EB had on him personally and on their relationship (e.g. through allowing him to see how his actions had affected her and providing motivation to change).

Participant preference—Therapist-centered. Half of the participants (couples C and E and Beth and David) reported preferring TC, describing more highly positive experiences in that approach and feeling more benefitted by it overall. Most of these participants (with the exception of David) reported appreciating and receiving some benefit from EB, but also having some mixed (i.e. it helped in one area but was a hindrance in another) or marginal (i.e. it was okay but

not as helpful as TC) experiences with it. The primary issues they reported with EB was that it was more uncomfortable and/or did not seem to be as relevant for their issues as TC. The specific experiences contributing to discomfort in EB included feeling overwhelmed by having to make eye contact (Beth and Elaine), increased escalation or confrontation (couples B and D), and having intimate conversation watched by therapist (couples C and E). Related to not having EB feel as relevant to their issues were reports about insufficient direction or instruction in that approach (couple E and David), or being directed to talk as a couple in ways they already do (couples C and E). Commonly reported in this group was that they could see how EB could be very helpful for other couples who need to learn how to talk to each other and/or who are comfortable with that approach, but that it was not as helpful for them because they already talk to each other, wanted more information or direction from the therapist, and/or were not as comfortable with EB interaction in therapy.

One of the ways David stood out in this group is that he was the only participant to answer yes to the interview question “Was there anything remarkably negative during either experience?” Even the participants in this group who reported high levels of discomfort in EB also reported still receiving some benefit from it, and most of the issues they had with EB were reported to have minor to moderate effects for them (i.e. that it was distracting/difficult, but not causing major problems with therapeutic process). Answering the question about there being anything “remarkably negative,” David said that it was the experience of “spinning our wheels talking about the small things. ... rearguing an argument that we had,” which he had earlier attributed to not having enough authoritative direction from the therapist. He was similar to the other participants in this group in his desire for more therapist involvement and in reporting, “I can see how that could be effective with some couples, ... but for our case that was not an

effective way,” but different in the reason, that it was “because there’s some illogical thought processes that I’m dealing with” (i.e. his wife’s anxiety). So while the other participants who preferred TC said it was because EB was not as relevant because they already talk, he said it was less relevant because talking as a couple wasn’t going to convince his wife she had a problem or help her to fix it.

Couples B and D stood out from the other four couples in that that reactivity appeared to be an issue and the partners reported significant differences in their preferences for the approaches. Couples A and F (who preferred EB) and couples C and E (who preferred TC) were similar in that they reported feeling safe with either approach and with their partner in general. However, in couples B and D all four partners described noticing at times a greater tendency towards escalation and reactivity in EB, including feeling more confrontational, negative emotion, and concerns that the interaction could get out of hand. Accordingly, they said that in these instances they felt safer talking to the therapist. Even with the intensity and discomfort of these interactions both couples had one partner who reported preferring EB. As mentioned, both partners in couple B reported mostly not enjoying EB interaction in the moment; Bret differed from Beth in that, looking back, he preferred EB. In couple D, however, there were significant differences in how the partners experienced the interaction as it was happening. Diana reported appreciating and being positively influenced by having her husband provide reassurance to her in an EB interaction. David, however, reported that sometimes he recognized interactions that she was enjoying which were less than enjoyable for him: “There were times when she felt like, ‘Oh, it’s great,’ and I’m going, ‘This sucks.’” This was an example of the extent to which participants even within the same couple were able to have highly different experiences of the same therapeutic intervention.

Sequencing of Approaches—Importance of Alliance

Comparing the experiences of participants who reported benefitting the most from EB to those who reported having less positive experiences with it, one of the most salient issues to emerge is the importance of therapeutic alliance. In this area, the results of this study were highly consistent with what Johnson and Talitman (1997) found concerning predictors of success in EFT, that the couples most likely to be satisfied after therapy were those “who made a positive alliance with the therapist and, more specifically, who saw the tasks of EFT, which promote emotional engagement, as relevant to their problems” (p. 146). Alliance has been differentiated into three components or dimensions: bond between clients and therapist, agreement on therapeutic goals, and perceived relevance of therapeutic tasks (Bordin, 1979, Pinsoff & Catherall, 1986). Johnson and Talitman reported that overall, therapeutic alliance predicted successful outcome in EFT, but found that the task dimension in particular was an especially strong predictor of couple satisfaction in therapy. The results of the present study confirm their finding, and task alliance will be specifically addressed. However, according to participants’ reports, the other two dimensions of alliance also appeared to play important roles in how participants responded to enactments in therapy. The bond dimension of alliance will be addressed here specifically as it relates to sequencing in therapy and its effect on client comfort in attachment work.

Sequencing for establishment of alliance—Beginning with TC. Initially reactivity was speculated by the analysis team to be the main reason for feeling uncomfortable with direct engagement in sessions and preferring to work through the therapist. Reactivity appeared to be an issue for couples B and D, and they reported that they felt safer going through the therapist (although each had a partner preferring EB). However, for couples C and E (with both preferring

TC) reactivity did not appear to be a major issue, and they reported feeling safe with their partner in both approaches—as did couples A and F (where both preferred EB). What may have made a difference for couples A and F was not only having enough time to get comfortable with the therapy setting but to feel comfortable and safe with the therapist also.

As mentioned, five participants associated some of their discomfort during EB with having the therapist observe them during intimate conversation. One of these participants, Carter, explained, “[EB] was a little more intimate, and maybe that’s part of the reason I was a little more uncomfortable with it. Because it feels like a conversation that you’d normally be having with no one else there.” His wife, Carol, said that this discomfort was partly due to not having sufficient time to get to know the therapist and speculated that, “We would have been fine if we would have been a little more comfortable with [her].” She elaborated, “And not that she was weird, or that we were uncomfortable with her as a person, it’s just weird having a third party involved in an intimate conversation.” This additional time to get comfortable with the therapist might have had the effect of making it feel less like a stranger was listening to their intimate communication.

These participants as well as couple E reported that they felt comfortable talking outside of sessions, but during the session they felt more comfortable addressing their issues with or through the therapist rather than with each other. It appears that therapeutic alliance was sufficient for them to feel comfortable talking to the therapist about difficult issues with their spouse listening, but something more was required to feel comfortable having the therapist listen to them talk to their partner about the same issues in session. Their interviews did not provide enough information to discern exactly what made the therapist involvement as observer of intimate conversation more uncomfortable than therapist as middleman in intimate conversation.

However, their reports seem to confirm that for some clients a stronger working alliance may be required to engage in EB process as compared to the level of alliance required in TC.

According to Bordin (1979), part of the collaborative relationship between clients and therapist that constitutes a successful therapeutic alliance is an emotional bond based on mutual trust and positive regard. Bret and David suggested that TC process might be more helpful for getting acquainted and building trust with the therapist. Both reported that their confidence in their therapist increased as they saw that he was competent in his role—being able to demonstrate understanding of couple issues and pertinent research and capable of directing the work of therapy. In addition to getting comfortable with the therapist as a person, it appears it may be important for clients to also become confident in the therapist as a professional. Bret and David were from the two couples that appeared to have the most issues with reactivity. Their desire to know that the therapist was competent and in control seems appropriate in light of the concerns they expressed about the potential for escalation during direct engagement.

In summary, the bond between therapist and clients appears to be especially important where reactivity is an issue or where clients may feel uncomfortable having intimate conversations observed by a third party. Participants suggested that TC was useful in building this bond with the therapist. Interaction with the therapist during TC helped them to become comfortable with her as a person and confident in her as a professional. Gaining initial trust in the therapist through TC can provide confidence for the partners to risk engaging directly with each other in later EC interaction.

Butler, Brimhall, and Harper (2011) further support this sequencing. Enactments remove the therapist from direct person-to-person interaction, engage the couple relationship centrally at

the level of interaction, and favor facilitation of the couple's emotional engagement with each other rather than with the therapist. They explain that:

This standing to the side of the emotional and empathic interaction in therapy can result in family members experiencing less of a direct working alliance with the therapist. Thus, it may be important for a therapist to begin with therapist-centered process for the purpose of building alliance (p. 211).

The therapeutic alliance provides sufficient safety for partners to venture into interaction as a couple, as the focus increasingly emphasizes emotional engagement with each other. In this way, the bond between the therapist and each partner can, in turn, strengthen the bond between partners (Garfield, 2004).

Sequencing for initial softening and de-escalation. Beyond the benefit of helping establish a stronger working alliance, Butler, Brimhall, and Harper (2011) also suggested that beginning with TC would be additionally helpful for couples where emotional reactivity is a concern. Therapist facilitation of empathy and softening through early TC or calibrated shielded/buffered enactments will increase the likelihood of more positive interaction in more direct engagement later on. Again, as the couple progresses, the therapist will increasingly emphasize *couple* empathy and softening. The risk for triangulation seems greater for couples where reactivity is more of an issue (e.g. couples B and D). Accordingly extra care should be taken in establishing a strong alliance with these couples while guarding against being drawn into a triangle that could undermine both alliance and the couple's relationship. See Brimhall and Butler (2011) and Butler, Brimhall, and Harper (2011) for a more in depth treatment of building alliance and avoiding triangulation in multi-client therapy with enactments.

EB building on TC. Five of the six participants who reported having the most positive experiences with EB began the experimental sessions with TC and described how that sequencing helped them to have more success in EB. Amanda's statement that, "The therapist helped us get started, and then working with each other helped it get farther," appears to indicate more than just TC allowing them to adjust to the therapy setting and therapist before taking on more demanding couple work. According to these participants' reports, it appears to also suggest how combining the approaches in this sequence might yield outcomes greater than the sum of their separate contributions. TC was reported to be helpful in providing a model and techniques that could then be implemented as a couple during EB. These participants described EB as an application or practice of what they were learning and feeling in TC.

Improving interactional competency between partners is a common change mechanism in effective relational therapies (Sexton, Alexander, & Mease, 2004), and successful development of this competency requires facilitating partners to engage directly with each other in the session (Gottman, 1999; Jacobson & Christensen, 1996; Minuchin, 1974). Jacobson and Christensen (1996) explain that it is insufficient for the therapist to provide instruction about a specific skill, "The only way to shape the skills ... is by having the couple practice them in the session" (p.173). Evidence suggests that competency in communicating with the therapist does not necessarily translate into competency communicating with an intimate partner, leading to the recommendation that therapy focus on the *couple's* in-session interactions (Birchler, Wiess, & Vincent, 1975). Generalizability of skills to interactions outside of the session may be inhibited when partners are not encouraged to practice them in session (Pinsof & Wynne, 1995).

Enactments are the pathway through which individual change is translated and crystallized into relational/interactional change. As skills taught to partners must be applied and

shaped in direct interaction with the other partner in order to be fully developed, the same applies to other initially therapist-patient interventions (e.g. solution building, examining attributions, exploring narratives, or processing emotion) (Brimhall, Gardner, & Henline, 2003; Tilley & Palmer, 2012). If these therapist-partner interactions are the starting point, they must be translated and transacted into new partner-partner interactions (Johnson & Greenberg, 1988; Pinsof & Wynne, 1995). Whatever influence individual experience can contribute to improving the couple's ability to interact in more adaptive and satisfying ways, the conversion of this effect into interactional change should not be expected to be automatic but is prudently facilitated within the context of in-vivo couple interaction. Through enactments, individual experience can be turned into a relational event, and individual change (e.g. in skill, insight, attribution, narrative, emotion, etc.) becomes interactional change (Dandeneau & Johnson, 1994; Johnson et al., 2005).

It is possible that couple E's experience might have been different if they had instead begun therapy with TC. One of the reasons they gave for not receiving as much benefit from EB was that during that approach they were largely directed to work on an area they were already proficient in. Elaine explained that being asked to confide in each other was not helpful because they "usually confide all the time." Of their experience in EB, Edward said, "We really did feel good about it, ... and learned some things that the other was feeling [that] we didn't see before. But it did feel a little unguided or a little in the dark." They also reported especially valuing the information and insights about their specific issues the therapist provided during TC—*after* the enactment sessions. Beginning therapy with TC or leading into EB interaction with more TC instruction in each session may have been more beneficial as they would have first been presented with pertinent information, skill instruction, and modeling relevant to them learning to

work as a couple through their specific issue *before* being directed to talk with each other.

In their study of the process of couple healing following infidelity, Butler, Bird, and Fife (2007) confirmed the sequencing recommended by the participants of the current study:

Because clients at the beginning of therapy often lack the necessary self-and other-awareness needed to appropriately communicate to their spouse, ... therapists may need to first help clients explore meaning and find understanding of their experience through therapist-client dialogue. Such dialogue facilitates individual self-awareness and models appropriate listening and communication. As new cognitive and emotional insights are attained by the clients, the therapist should then facilitate the expression of these insights to the partner through enactments. (p.18)

Even if treatment begins with the therapist teaching a skill or even modeling and practicing it with an individual partner as the other observes, therapy must provide the opportunity for partners to develop, practice, and solidify this competency with each other.

Therapeutic Goals and Expectations

Agreement on goals and alliance. Part of therapeutic alliance is mutually endorsing or valuing the goals or objectives to be pursued in therapy (Bordin, 1979). The importance of this area of alliance seemed best illustrated by couple D, where there appeared to be significant disagreement between partners about the source of their distress. In David's report, he largely attributed their marital difficulty to his wife's anxiety, while she reported that her anxiety was related to issues in their marriage. According to what David described, this conflict in perception about perceived issues and the related goals and relevant tasks had the potential to substantially undermine the therapeutic alliance. It is important for therapists to recognize this frequently occurring pitfall and the way it specifically relates to clinical structure. Understanding these

tendencies in distressed couples can help therapists to more effectively utilize enactments through more appropriate sequencing.

In distressed couples, partners' perspectives about their relationship—including their goals for therapy—are usually not only different but can be directly conflicting and competing. Because of this, building an emotional bond with one partner by simply validating his/her perspective or agreeing on goals and tasks for therapy can simultaneously have the perceived effect of invalidating the perceptions of the other partner, possibly leading to feelings of alienation and weakening of that alliance (Brimhall & Butler, 2011). A pointed but seemingly simple definition of alliance from individual therapy illustrates the complexity of forming this working relationship in multi-client therapy: “the construct [of alliance] includes those aspects of the relationship that facilitate the collaborative work of therapist and client against a common foe: the client’s pain and suffering (Bachelor & Horvath, 1999, p. 137).” That can be a problem when one partner attributes his/her pain and suffering to the behavior or person of their spouse.

Jacobson & Christensen (1996) explain how partners in distressed couples attempt to make sense of their interactions and often posit the cause and responsibility for the conflict in the other partner. This fault-finding can lead to vilification—making attributions that their issues arise out of the partner’s deficiency: moral deficiency (i.e. badness, e.g. “You’re mean/selfish/unloving”), deficiency in emotional adjustment (i.e. psychiatric diagnosis, e.g. “You’re depressed/neurotic/imbalanced”), or inadequacy in personal competence (i.e. social ineptitude, e.g. “You don’t know how to communicate/express your feelings/treat a lady”). As justification takes hold, the partners feel increasingly justified in their efforts to reform the wayward other (Dimidjian, Martell, & Christensen, 2008). Supporting this, Andersson et al. (2006) found that in the earlier stages of therapy partners in more volatile couples demonstrated

a self-focus or self-preoccupation, which was characterized by seeking to meet their own needs first and focusing on partner change. Awareness of clients' perceptions of each other and goals at the beginning of therapy can inform more effective sequencing and structuring of interventions.

The language used by David in his interview suggested emotional reactivity, attributions of partner deficiency, a focus on partner change, and frustration with ill-fitted therapeutic intervention. He said that during EB sometimes their interactions were "more reactive ... almost volatile." Concerning how helpful he thought EB was, he said, "I can see how that could be very effective with some couples, but for our case that was not an effective way because there's some illogical thought processes ... that she has." Related to this, he said that one of the most negative experiences was, "When we were just spinning our wheels talking about the small things, going back and forth between each other, that literally felt like a waste of time ... re-arguing an argument ... I just felt like it was going nowhere, this is not going to help." For David, being directed to continue to engage in extended episodes of face-to-face enactments while he was still in this mindset appeared to initially erode trust in the therapeutic process and undermine the working relationship.

Vilification can negatively affect how clients perceive the therapist's instruction to talk directly to their partner. The prospect of having to be vulnerable with a morally deficient spouse (e.g. one who is perceived as uncaring) is likely to induce anxiety ("I'm just going to get hurt!"). And being asked to work on an issue with an emotionally deficient spouse (e.g. perceived as crazy) might seem like a frustrating waste of time ("We're not going to get anywhere! / Why am I involved? He's the one with the issue!"). If the partner is still perceived on some level to be the other's "foe," it should not be surprising that direct engagement with him or her is experienced as adversarial. Unless the therapist is able to help them to develop a more collaborative

framework, enactment interaction is likely to continue to be as David experienced: “more of a tug-of-war than a work-together-to-figure-this-out.”

While perceiving an intervention to not be relevant towards achieving the goals of therapy is an issue of task alliance, “The client's assessment of the therapy tasks are partially predicated on a sense of agreement on what are accepted as reasonable goals of the therapy” (Horvath & Luborsky, 2004, p. 564). By helping reactive couples begin to change their perspectives about each other and the *nature of their problem*, the therapeutic *goals* that accompany these new perspectives are the foundation on which evolving *task* alliance can be built. Reframing their negative cycle of interaction as the “externalized” common foe is a relieving antidote to the punctuated, vilifying attributional stalemate so common in distressed relationships. Integrative couple therapy (Jacobson & Christensen, 1996) emphasizes assisting couples to adopt a helpful, circular “formulation” or perspective about their conflict and negative cycle of interaction. The first phase of EFT is cycle de-escalation, which includes identifying the negative cycle and framing it as the enemy (Johnson et al., 2005).

Experiential awareness of negative cycle of interaction. Unless balanced with therapist engagement *with the system at the level of process*, individually focused therapist-patient interrogatory may be incomplete in helping clients identify their negative cycles of interaction as the problem and not their partner as the problem. Fogarty (1983) warns, “All too often therapeutic systems reinforce fixing the blame, the diagnosis, the therapy on one or more particular members of the family” (p. 46). Without systemic framing of difficulties, spending the majority of the time working with an individual partner in a distressed couple might even confirm the suspicion with which so many clients enter therapy: “We’re having difficulty mostly because there is something wrong with him/her (or alternately, “...because there is something

wrong with me”). Clinical structure and process that maintain the couple as client and their negative cycle of interaction as the enemy can be helpful in overcoming this pitfall.

Through enactments, therapists can engage the couple in an experiential discovery of the patterns and consequences of their interactions (Gardner & Butler, 2009). Andersson et al. (2006) reported that participants in their study identified gaining relationship orientation as an important outcome of enactment intervention. Brief and carefully monitored episodes of direct engagement—couched between more safeguarded shielded and buffered enactments—may assist couples in gaining an awareness of their negative cycle of interaction during the earlier stages of therapy. With appropriate coaching and processing, the experiential insight provided through this interaction can aid the therapist in framing their negative cycle as the mutual enemy and thereby help the couple towards de-escalation and softening prior to engaging in more sustained episodes of direct engagement.

Change in goals. Related to enactments promoting awareness of interactional issues and a relationship orientation, several participants reported having their goals change after beginning therapy, mostly becoming aware of a need to work on issues as a couple. With these changes, Adam, Beth and Bret reported being helped by EB with what they originally thought were individual issues. Bret reported that EB was unexpected but that as they had more experience with it, he realized more that involvement with each other was what he wanted. Beth reported that EB “was more significant probably, I mean it really helped open us up that we really need to be communicating more.” She said that even though she was not comfortable there yet, she realized that was where they needed to go.

Building discrepancy. It appears that direct unshielded enactments can help provide clients an ongoing awareness of areas for improvement and where they would eventually like to

be. This is similar to the concept in Motivational Interviewing (MI) of developing discrepancy “between present status and desired goal, between what is happening and how one would want things to be (one’s goals)” (Miller & Rollnick, 2002, p. 22). Some attention has been given to the potential to involve a significant other in motivational interviewing process: “For example, the significant other may help develop discrepancy for the client by providing him with constructive feedback ... on the costs and benefits of the problem behavior for himself as well as for important others.” (Burke et al., 2002, p. 350) This appears to fit Bret’s description of his experience of change in through enactment interaction.

In Motivational Interviewing, change is motivated by a perceived discrepancy between present behavior and important goals or values. This discrepancy is traditionally developed through a conversation or interview between the therapist and client. However, Bret reported that he perceived his conversations with the therapist as doing more to preserve the status quo by insulating him from experiencing his wife’s emotions more directly. He said that it was the intensity of the direct engagement with his wife that helped him to “realize that my life isn’t necessarily living up to my ideals” and motivated him to feel accountable to “start making things better and changing.”

Carter also reported a similar change in his view about the value of working on issues as a couple, but he was unsure how much improvement it provided beyond the insight, “It helped me realize ... that communication is ... a key thing ... we need to have better and more meaningful communication and not be afraid to talk things out. ... I don’t know if it made me any better at it.” He and Beth also said that feeling too overwhelmed or uncomfortable in direct engagement made it difficult to benefit completely from EB and preferred to work on their issues through the therapist. For these participants, enactments may have been effective in developing

discrepancy—helping them gain an awareness of needed change. It is possible that more could have been done to facilitate actual action (e.g. beginning to make the change to communicate as a couple). Incremental movement from precontemplation to contemplation to preparation (Prochaska, 1999) may have required enactments more carefully adapted to their abilities. Here it is important to stress the importance of the developmental progression of enactment scaffolding. The intervention protocol for the current study may have limited the dynamic adaptation of enactments to clients' needs. These participants may have benefitted from more focused instruction with more gradual and incremental progression of enactment structure according to their evolving abilities to engage as a couple.

Beyond building discrepancy in couple therapy, Burke et al. (2002), suggest that, “With appropriate guidance, significant others can become better than professionals at guiding the client” (p. 250) through the other processes of MI, including expressing empathy and supporting self-efficacy. This proposition to facilitate couples in becoming able to sponsor and maintain change for themselves is in line with the primary goals of enactments of promoting the couple relationship as the engine of change and long-term couple self-sufficiency. However, they did not provide specific operationalization of the proposed process, other than to say that it would entail teaching partners to do motivational interviewing with each other. This may be an area where the five-stage developmental model may provide a useful scaffolding for conjoint change work.

Task alliance. Enactment advocates caution against unsophisticated, monolithically applied enactments—oversimplified instructions for partners to just talk to each other—resulting in reenactment of their usual at-home interaction (Davis & Butler, 2004; Nichols & Fellenberg, 2000), which is predictive of poorer clinical outcomes (Butler & Bird, 2000; Shields et al.,

1991). The most immediate clinical concern prompting this warning against inviting them to “argue among themselves as they may do at home” (Shields et al., 1991, p. 13) seems to be the risk of the interaction deteriorating into reactivity and escalation (Davis & Butler, 2004). However, directing a less volatile couple to simply do more of what they have already been doing may also result in poorer outcomes.

Examining early therapy and late therapy spouses’ experiences in safeguarded versus free-form enactments, Andersson, Butler, and Seedall (2006) found that while less volatile couples recognized benefits from the safeguarded enactments, they “reported experiencing the greatest benefit from working at the ‘cutting edge’ of their interaction potential” (p. 312). While the primary reason couple E gave for coming to therapy was Elaine’s post-partum depression, they also wrote that they wanted to be closer and to figure out some issues together as a couple. It seems that having more specific instruction about how to use their own relationship and dialog as a vehicle for addressing issues may have helped their work as a couple remain on the front end of their interactional potential.

The risks of enactments either being too much too soon or not enough of what is needed both seem to be remediable through better assessment and proper calibration. It seems that in many of the cases where these two issues are present, it is likely that there needs to be greater therapist involvement: the therapist that tells the couple to just talk to each other without offering enough direction or intervention is going to terrify the reactive couple that thinks it’s too soon and annoy the couple that doesn’t see the point and thinks it’s a waste of time. Towards this objective of appropriate calibration, Davis and Butler (2004) explain:

The content focus of an enactment is neither random nor haphazard, but rather it should be calibrated to the clients' current level of emotional reactivity and consistent with the

overall process and problem focus in therapy. Carefully and collaboratively determining the content focus before the enactment begins may help to ensure that the couple will be able to sustain the enactment of their relationship to the successful conclusion of their current task. (p. 322)

Enactments need to be calibrated and adapted not only to level of reactivity but also to specific clinical issues to assure they are relevant to the clients' overall goals.

Given the importance of adapting clinical structure and content to be relevant to clients' goals, assessment in this area should be thorough, ongoing and collaborative. Horvath and Luborsky (2004) suggest that the therapist must (a) communicate to the client the key links between therapeutic tasks and the overall goals of treatment and (b) maintain an awareness of the client's commitment to these activities, intervening as needed. Johnson (2002) further recommends that the relevance of the tasks set by the therapist should be transparent: the therapist should be explicit and willing at any time to discuss what he or she is doing and why and should invite regular feedback from both clients about their experience of the therapy process.

It is possible that the study protocol had some effect on therapist transparency concerning the purpose of enactment interventions. To limit the potential for participant awareness of the purpose of the study to influence their behavior during the experimental sessions, they were not informed about the specific purpose and design of the study. The informed consents only indicated that it was "research focused on understanding the role of the therapy process in helping couples improve their marital relationship and overall experience in therapy." Protocol for enactment proficiency included the direction to explain the purpose of enactments, but participating therapists were also cognizant of the methodological objective of limiting participant awareness of the experimental conditions. Task alliance, specifically, may have been

improved with a more explicit and ongoing communication and dialog about the purpose of enactment interventions overall.

Clinical Structure and Attachment Outcomes

Overall, participants' reports of their experiences of clinical structure and process were consistent with recent research in attachment-related change in therapy. Specifically, the findings appeared to fit well with the research of Bradley and Furrow (2004, 2007) on blamer softening events in EFT, Greenberg, Ford, Alden, and Johnson (1993) on in-session change in EFT, Andersson, Butler, and Seedall (2006) on couples' experience of softening in enactments, and Seedall and Butler (2006) on the effect of proxy voice on softening. Managing reactivity, eliciting primary emotion, addressing and processing attachment issues all appeared to contribute to positive change in attachment security. In these areas there is substantial overlap between the models of enactments represented in the aforementioned studies (EFT and the five-stage developmental model). There are also potentially significant differences in the theorized process or prescribed route through which attachment change occurs, specifically, in the moment to moment sequencing of softening events and the degree to which intra-psychoic versus interpersonal experience and processing are valued or emphasized. A comprehensive comparison between enactments in these models is not possible or needed in the present discussion, but some aspects will be reviewed here to help clarify participant reports and to provide direction in clinically applying these findings within these models. But first, a brief review of attachment theory and research concerning how attachment security changes in therapy is helpful.

Attachment working models—Therapy changing view of self and other. Attachment behavior is “regulated by internal working models of attachment, which are cognitive- affective- motivational schemata built from the individual's experience in his or her interpersonal world”

(Sperling & Berman, 1994, p. 8). These working models contain information about one's lovability and the accessibility of others and, accordingly, inform an individual's strategy for connecting with others. (Johnson et al., 1999). According to these working models, information is subjectively filtered to answer the questions "Am I worthy of love and care?" and "Can I count on others in times of need?" (Naaman et al., 2005). It is obvious how doubts about the answers to these questions could be a major hindrance in seeking closeness or support from a partner or being vulnerable and engaging in the relationship.

Attachment research indicates that working models are mainly attributable to experiences in close relationships. Children's developing attachment patterns are linked to patterns of parenting behavior, and adults' pairbond attachment styles are related to their descriptions of childhood relationships with parents (Levy, Blatt, & Shaver, 1998), yet they can change systematically over time *as a function of new relationship experience* (Kirkpatrick & Hazan, 1994). Given that change can occur as a function of new relationship experience, it follows that therapists would seek to foster new experience within the context of current relationships.

Cobb and Bradbury (2003) propose that attachment models of self and other are reciprocally and recursively related to attachment behaviors and suggest that the starting point for change be within the marital dyad, rather than within the individual. They expect that assisting couples to have different experiences in the context of the relationship will subsequently modify the way partners think about each other and their relationship. *Enacting* behaviors such as giving and receiving support will facilitate change in the security of their attachment. Butler and Gardner (2003) assert that engaging the couple relationship for change through enactments is able to affect deeper shifts in attitude, attribution, emotion, and attachment. EFT and the five stage model both hypothesize change in attachment to be best

facilitated experientially between partners and that promoting the expression of primary affect is crucial to softening and forming more positive and secure patterns of interaction (Gardner & Butler, 2009; Johnson, 2004).

EFT and developmental model of enactments. Protocol for the execution of effective enactments in the current study (see Figure 3 for Criteria Indicating an Enactment-Centered Approach) followed Butler and Gardner's (2003) five-stage, developmental model and Davis and Butler's (2004) three-component conceptualization of enactments. It is possible that the study protocol may have diminished the full range and dynamic adaptation that characterizes the five-stage model. To maximize treatment effects, the study protocol may have set things up for therapists to feel like they had to be doing enactments most of session ("a preponderance of enactments"). This is one of the ways that the protocol might have caused some deviation from what might be considered more effectively executed practice and adaptation of intervention to presenting needs.

In describing specific enactment process in EFT, Tilley and Palmer (2012) differentiate how EFT enactments differ from those used in other approaches or models of therapy. They specifically reference how the broader, inclusive definition of enactments suggested in the five-stage model recognizes enactments as an essential feature and common factor in best practice. Proponents of the five-stage developmental model suggest that, "Enactments represent a couple interaction-based approach to facilitating attachment work, one that is independent of any particular therapy model, and as such, enactments may represent a common process element for attachment work in therapy" (Gardner & Butler, 2009, p. 204). So while this is "a generalist model for enactment operations," (Davis & Butler, 2004, p. 321) it is also significantly informed by attachment theory and part of its function is to promote interactions where "primary emotions

are shared in ways that address and facilitate secure attachment (Butler & Gardner, 2003, p. 318). It appears that Tilly and Palmer's assessment may be based more on the inclusive *definition* given by Gardner and Butler than on the full *operationalization* of enactments they provide. In the same article referenced, Gardner and Butler (2004) explain, "although we believe that our model of enactments can be fitted to general couple/family practice, we note its particular harmony with the emotional and attachment focus and goals of EFT" (p. 315).

While there appear to be more similarities than differences in how these models facilitate interaction for increased attachment security, there are some differences in the moment-to-moment sequencing and the balance between intra- and inter- personal processing. The EFT operationalization of enactments may differ from the protocol for enactments used in this study in terms of the moment-to-moment adaptation and sequencing within each session (e.g. therapist prompting of softening reach by the blaming partner initiating enactments). This difference may be more of an issue in terms of the treatment protocol for this study than a discrepancy with the five-stage model.

The five-stage model was explicitly developed to allow fluid adaptation of enactments to changing couple dynamics. Butler and Gardner (2003) explain, "The model is not rigidly linear" but "Each stage is only used as indicated by concordant levels of distress, volatility, and reactivity" (p. 321). The five-stage model allows the therapist to dynamically shift between stages, thereby varying the intervention interval (from individual speech-act/talk-turns to brief or extended episodes of direct couple interaction). Tilly and Palmer (2012) specify that EFT enactments "are initiated in bite-size amounts to create small moments of successful contact, allowing the therapist to help couples digest each of these moments" (p. 4). This is also related to the EFT concept of "slicing risks thin" (MacIntosh & Johnson, 2008, p. 311; or to "slice the risk

finer,” Johnson & Greenman, 2006, p. 608). More dynamically adapting enactments in this way may have been helpful for partners like Brenda, who reported that extended episodes of intense interaction during EB were more difficult to sustain and absorb and preferred when they were able to have their interaction cut down into more manageable bits.

Sequencing of intra-/inter- personal engagement and processing. In EFT, additional emphasis and focus is placed on the intra-psychoic experience of partners, “Enactments bring partners into contact, bridge the inner world of experience and the outer world of interaction, and help give expression to newly processed inner emotional experience” (Tilley & Palmer, 2012, p. 1). Exploring in-session change in EFT, Greenberg et al. (1993) found that increasing emotional exploration and expressiveness that result in new levels of self-disclosure lead to a changed perception of self by the other and to more affiliative behavior by the partner, and accordingly, “intrapyschic experience is deepened in good sessions” (p. 78). However, in the five stage model, while the therapist facilitates evaluation and processing of interactions, it is primarily directed to the couple. However, the difference in intrapsychic focus may be less of a categorical distinction than a matter of degree. As mentioned, Butler, Bird, and Fife (2007) suggested that it might be necessary at the beginning of therapy to help promote self-awareness and explore meaning for clients through therapist-client dialogue. In addition to focusing on attachment issues, the therapist also attends to and promotes awareness of self-concept issues. Having more time for individual processing may have been beneficial to clients like Beth. She explained why she preferred the structure of TC when it came to exploring individual feelings: “I’d like to be able to think about it inside without having to look somebody in the eye, especially when I’m talking about something that’s hard to talk about.” Elaine reported a similar desire to have space

to express herself without having the face-to-face structure encroaching: “I could talk to [my husband], [I] just can’t look him in the eye when I talk to him.”

In EFT, focus on the individual fears and longings of each partner in a more therapist-centered format is key to the blamer softening event. Seedall and Butler (2006) examined how the use of proxy voice within the framework of the five stage model helped facilitate softening. It is similar to interventions in EFT used to heighten and intensify individual partner experience and to empathic conjecture. However, they make a key distinction:

Proxy voice is a relational manifestation, in the context of an enactment, of Rogerian dynamics, which are typical of Susan Johnson’s emotionally focused therapy work, which seeks couple softening through heightening and Rogerian reflective listening. We acknowledge this method as beneficial, but we 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 that we believe exploits the unique opportunities inherent in relationship therapies. Couple interaction and relationship are fostered, assisted, and strengthened through couple self-reliant process in therapy. (p. 426)

While therapists were trained specifically in the use of proxy voice, the specific steps to blamer softening as outlined by Bradley and Furrow (2004, 2007) were not a part of their training or protocol. Again, it seems that adapting enactments to the moment-by-moment process as prescribed in the mini-theory may be reasonably accomplished within the scaffolding of the five-stage model. It is unclear how application of this specific in-session, moment-to-moment sequencing would have affected participants experiences in therapy, but an integration of the mini-theory of blamer softening may have been helpful for some participants.

Enactments in the developmental model can be understood to “constitute a framework of clinical process” (Brimhall, Gardner, & Henline, 2003) or to “represents a valuable scaffolding” (Seedall, 2009, p. 106). Gardner and Butler (2009) explain:

Enactments are not simply a limited intervention or narrow technique, per se, but are better described as the “scaffolding”—or process of clinical interaction—placed over the therapist’s own clinical and theoretical model, across the entire course of therapy, and within which any number of specific interventions or techniques can be used. (p.322)

Gardner and Butler (2004) point out that while there are some ways in which the developmental model may need to be adapted to the specific objectives of EFT, overall, it is already well suited to the general and more global goals of that approach.

Clinical structure effect on emotion—Changing music of attachment dance. The ability of therapeutic structure to promote clients’ experience of the emotion of their partner is crucial to successful attachment work (Johnson, 2004). As much as emotional reactivity was reported by participants to feed into escalation, there are specific instances they described where the directness of emotional communication had an enormously positive impact on them, healing their relationship. Diane said that the most positive part of therapy was when her husband was able to be emotional as facilitated by EB. Bret said he wasn’t able to really understand how hurt his wife was until EB. Carol said that her ability to read her husband’s sincerity, which she would have been indicated by his emotions, was confounded by his discomfort during EB. It appears that whichever clinical structure is going to facilitate manageable expression of primary emotion is more likely to be beneficial.

Concerning when she most desires to be reassured directly by her husband, Diane said, “If it’s ... something that I have a fear about, ... I like to hear it from my husband.” She

explained how, in a session she described as the “most helpful of all,” this direct reassurance helped calm her fear:

The therapist ... asked my husband to share something with me that he felt. And it was that I would feel insecure whether or not he loved me. ... And [the therapist] asked him to tell me specifically. So [the therapist] was the one directing it, but it was when my husband said it that I felt a lot more secure. ... And that for me really has been like a life changing thing that it's really kind of calmed that fear that I had.

This appears to be a good example of how clinical structure facilitating direct engagement was most effective in calming attachment anxiety and promoting more secure attachment.

Clinical structure can help elicit as well as muffle the music of emotion. Explaining how TC insulated him from the emotions of his spouse, Brett said, “It was much more arbitrary when we were doing [TC].” Brett reported that experiencing his wife’s feeling more directly had a significant impact on him. Shielding and buffering can be helpful for secondary affect that leads to reactivity, but primary emotion that has power to move partners into new interactions and towards greater responsiveness. In Brett’s case, the intense discomfort he felt experiencing his wife’s emotions directly in EB had the effect of moving him to attend and respond to his wife. However, it appears that discomfort of direct engagement can also distort clients’ ability to express their emotions. For his wife, Brenda, the requirement of, “Having to look someone in the eye and repeat what they were saying, [was] out of the ordinary for me, so it made me feel tense to be talking about uncomfortable things but also to be doing something uncomfortable that I’m not used to.” She said that this negatively affected her ability to process and express her feelings as she normally would.

For couple C, discomfort during EB was reported to not only make expression of emotions difficult for Carter, but it also made it difficult for Carol to perceive and be moved by the emotion he was expressing. She said that she could tell that he was uncomfortable during EB, which made it difficult for her to discern sincerity because he did not seem like he was responding as he normally would. However, in TC she could tell from his expression and emotion that he was being honest/sincere, which she said made her feel more optimistic. Carol reported that Carter showing emotion during TC was best part of therapy for her. EB may seem like the intuitive route for helping partners to disclose to each other and engage emotionally. In this instance, promoting direct engagement might have initially seemed like a win for a pursuing partner who was longing for increased emotional connection with her husband. However, it seems that if the withdrawing partner is too uncomfortable, the otherwise reassuring direct expression can be confounded by the effect of his discomfort on emotional expression. At this point in therapy for them, another option might have been trying to encourage the expression through buffered or shielded conduiting, wherein the therapist would encourage partners to express their feelings *for each other* without having to face each other and say it directly. It appears from participant reports, that this shielded conduiting was what they described taking place in some of the TC sessions where they were able to hear their partner express their feelings. The difficulty in distinguishing actual therapist-centered process from relationship-focused conduiting appears to have been an issue for both participants and therapists.

Experience of therapist involvement. As mentioned, couples C and E seemed to have a sufficient alliance to feel comfortable with each partner talking to the therapist about difficult issues with their spouse listening, but something else was necessary to feel comfortable having the therapist listen to them talk as a couple about the same issues. It is interesting that for these

couples, therapist as observer of intimate conversation felt more intrusive than therapist as middleman in intimate conversation. And for couples A and F, it appeared to be the complete opposite—the therapist as middleman was reported to seem more intrusive. When working on attachment issues, the difficulty of the process or structure of therapy (e.g. facing each other) for some clients is considered to be as significant as the difficulty of the specific content (e.g. disowned attachment fears, longings, and needs).

Caution about promoting direct partner-to-partner interaction has most often concerned the potential for it to lead to emotional volatility. However, there may be other aspects of how clinical structure affects attachment-related dynamics where the risk is less immediately apparent but that still need to be addressed. For couples C and E, it seemed there was a risk of one partner becoming overwhelmed in direct engagement that might not have been as obvious as a fight breaking out. This flooding seemed less prompted by *couple* reactivity than by the *structure of therapy* (e.g. being put on the spot or being observed by the therapist). Partners' response to clinical structure may be considered an emotional reaction while not constituting reactivity—in the sense that it may or may not lead to escalation or be part of their negative cycle of interaction. As already discussed, it can, however, have an impact on their ability to connect to and be moved by their own and their partners' emotions and attachment needs.

For Beth and Elaine, having to make eye contact seemed to contribute to feeling overwhelmed. In providing direction for work with trauma survivors, Johnson (2002) says that accessing attachment models (information about self and other) may be too demanding initially to allow doing much else at the same time. She explains that their “attention is split between being engaged in the present and, as one client put it ‘always having one eye on the dragon’” (p. 51). If the fear triggered by trying to access attachment trauma is too intense, this can both

restrict the processing of information and emotion as well as the ability to connect to even an overtly caring and supportive partner offering reassurance. In this case, eye contact may intensify the fear or be precluded by it.

This provides additional understanding of how attachment work can be more demanding, how it may require therapists to be attentive to clients' experience of direct engagement and to adapt enactment structure to fit with their ability and preference, and to ensure the creation of a stronger therapeutic alliance (Whiffen, 2003). Johnson and Whiffen (1999) explored how EFT may be adapted to partner's attachment styles, and the current study provides additional understanding about the specific ways that clinical structure affects in-session attachment dynamics and how to adapt interventions to client variables. However, additional research is needed.

Relationship Difference—Couple Self-Sufficiency

Seven participants reported that the relationship between partners made what they said to each other more impactful than having the same message from or through the therapist. Whiffen (2003) affirms that attachment insecurity changes when individuals have conversations about attachment with the attachment figures to whom they are insecurely attached. She recognizes that this formulation changes the role of the therapist to be more a facilitator than a substitute attachment figure. She continues that “the real world attachment figure is in the room,” (p. 395) and the therapist's role is to create security in the sessions so that these pair-bond partners can articulate and be responsive to each other's attachment needs.

Half of the participants commented on how EB contributed more to the likelihood of being able to continue communicating and connecting after therapy had ended. This seems especially notable considering that the interview did not include any questions about long-term

self-sufficiency. Change is most viable and enduring when solutions—for both content and process—are couple created and when healing—individual and relational—is couple anchored (Gardner & Butler, 2009). Marriage and family therapy “is not about solving the problem; it’s about repairing the problem solving mechanism” (Nichols, 2008, p. 76). Additionally, wherever possible, it should be more about helping empower the problem solving mechanism to repair itself.

Limitations and Future Directions

The current study was part of a larger research project (Butler, Harper, & Mitchell (2011). As the current study built on the same design and protocol for experimental sessions, it is consequently subject to similar limitations. One of the most prominent confounds discovered in participant reports might be the effect of the strictness of treatment protocols. Butler and Gardner’s (2003) model recommends that enactments not be one-size-fits-all but must be calibrated to couple reactivity. The protocol of this study allowed less flexibility for adaptation of enactments than would be practiced in the normal course of therapy.

There was also a potential drop-out effect associated with this narrowing of the adaptive range of intervention. A few participating therapists reported that they and/or their clients made the decision to end their participation in the study because the issues they were addressing seemed to be best handled within the approach (i.e. TC or EB) that was other than the one they were committed to for those immediate three sessions (e.g. “The clients were so reactive at that point in therapy that it didn’t seem like they were going to be okay doing extended episodes of face-to-face interaction for two more sessions.” Or “It seemed like they felt that the individual focus in TC was leaving them feeling so alienated that we made the decision to leave the study so that they could spend the majority of sessions doing more conducting of early stage

enactments and more face-to-face interaction.”). While this attrition may have introduced some bias of what participants remained in the study, it can also be instructive as to the importance of the dynamic adaptation of enactments within each session.

Homogeneity of the sample of participants in ethnicity and religion may limit generalizability to other populations. Participating therapists were unlicensed MFT graduate students in their first year and had limited clinical experience, which may limit generalizability to more experienced practitioners. Therapist inexperience may also have influenced the results through the effects of relative unfamiliarity and uncertainty of interns in executing therapeutic interventions with competence and confidence. Perhaps serendipitously, two of the study’s limitations—strictness of study protocol and participation of less experienced therapists—may have best highlighted the importance of the need for therapeutic attunement and fluid adaptation of intervention to changing conditions.

It is important to note the difficulty beginning therapists had distinguishing between TC and early stage shielded enactments. It may be helpful to put forth a clearer distinction in future studies. Part of the instruction for the TC protocol was to address attachment needs and emotions. The intention was to have outcome effects be a result of differences in process and not content, which meant that therapists were asked to focus on attachment content during both approaches. The work done in EFT with one partner at a time could technically be considered conduiting because the message is translated for the listening partner and attachment-focused content is inherently relationally oriented. According to the current operationalization of shielded conduiting, it might be impossible for an attachment discussion with one partner with the other present to actually be exclusively individually oriented, as there is always some degree of a relational framework.

The results of the analysis have mostly been discussed as they relate to attachment-related process in therapy, and certain research and therapeutic models have been more extensively integrated into this discussion than others. The focus of this discussion is also influenced by the forestructures of the author. Other researchers might have chosen to privilege other perspectives and yielded alternate conclusions. While clarifying that this was not a study about EFT, that model has been included in the discussion because of the intersect it represents of the major areas of interest in this study, namely attachment-based, couple therapy that utilizes enactments. It further represents a significant advantage in extensiveness of research and detailing of clinical processes.

Conclusion

Enactments as operationalized in EFT and the five-stage developmental model both represent an increasingly sophisticated clinical maturity because of their integration of theory and research in ways that significantly improve practice (Alexander, Sexton, & Robbins, 2002). Accordingly, the current findings are better understood and may have greater utility in the framework of these already developed clinical models. Within this context, the current study contributes toward a small but incremental fulfillment of the need for research to provide to “an adequate explanation of the process and mechanisms of the bigger and more complex change *process*, rather than mere description and identification of factors” (Sexton, Ridley, & Kleiner, 2004 p. 138).

Extensive research has established alliance as one of the most potent predictors of positive outcome in both individual and relational therapy (Hubble, Duncan, & Miller, 1999; Sprenkle & Blow, 2004). While it is imperative that therapist engagement promote alliance, developing alliance in relational therapy is far more complex than in one-to-one treatment

(Friedlander et al., 1994; Knerr et al., 2011; Symonds & Horvath, 2004). The therapist's alliance with the couple can positively affect the bond between the couple (Garfield, 2004), but unless the therapist is able to navigate building multiple working alliances, the advantages of treating family members conjointly could instead become a liability (Sprenkle et al., 2009). The current study provides initial directions of how to adapt and sequence enactment interventions to optimize the creation of a strong working alliance and to promote positive attachment outcomes in couple therapy.

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Appendix A

Table 1

Participant Demographics, RDAS, and Presenting Problem

Couple	Initial RDAS	Reason for therapy	Age	Years in relationship	
A	Amanda	59	Addiction to pornography (husband's)	26-35	6
	Adam	56	Addiction to pornography		
	Beth	47	Pornography issues and related struggles		
B	Bret	53	Improve communication and strengthen marriage	26-35	3
	Carol	46	Pornography		
C	Carter	45	Pornography	26-35	5
	Diana	44	Anxiety - some relating to marriage		
D	David	41	Wife's anxiety; told it was due to marriage	36-45	18
	Elaine	46	Depression - work together on it. Be closer again.		
E	Edward	56	Post-partum depr. & baggage from prev. marriages	26-35	2
	Florence	36	Build better relationship. Better communication.		
F	Frank	38	—	36-45	20

Note: RDAS = Revised Dyadic Adjustment Scale; $M = 47.25$, $SD = 7.35$; possible scores range from 0 to 60; lower scores indicate greater distress; scores of 48 or below indicate couple is reporting relationship distress (Crane et al., 2000).

Table 2

Major Themes and Sub-themes

Major Themes	Sub-themes
Sequencing and Combinative Effects of Approaches	Respective benefits and recommendation for combination Sequencing—general recommendation to begin with TC TC setting stage for more positive experience in EB TC closer to expectations for therapy TC conducive to alliance building TC establishing model and skills for application in EB Exceptions—instances when initial EB interaction helpful
Experiences of Structure of Approaches Contributing to Outcome	Direct engagement more demanding Eye-contact/face-to-face interaction helpful/hindering Effect of structure on escalation and defensiveness Intimate conversation under therapist observation Link between preference for structure of approach and outcomes
Clinical Issues, Goals, and Expectations	Directing to relevant issues EB fit with couple issues and communication TC for therapist expertise and individual issues Exceptions—TC for couple and EB for individual issues
Role of the Therapist	Therapist as expert Therapist as third party Highlighting No personal history with therapist Normalizing validation
Nature of Couple Relationship	Ongoing relationship and impact of direct engagement Promotion of post-session dialog Contribution to couple self-sufficiency Outcomes justified difficulty

Note: EB = Enactment-based, TC = Therapist-centered

Table 3

Overview of Clinical Implications

Major Themes	Findings	Clinical Application
Sequencing and Combinative Effects of Approaches	Alliance required where client discomfort in EB is high TC can help build alliance, establish model and skills for application in EB Brief initial EB can build awareness and motivation	Adapt sequencing of interventions to client needs and preferences Build alliance early and monitor and maintain throughout therapy
Experience of Clinical Structure Contributing to Outcome	Clinical structure can facilitate or confound clinical process Variability in client preference Effect of discomfort on emotional expression and perception	Attunement to client readiness, preference, and comfort with direct engagement Fluid/dynamic accommodation Working space for intrapersonal processing Structure for openness and connection
Clinical Issues, Goals, and Expectations	Task alliance is essential Both approaches can be appropriate for both individual and relational issues	Transparency about objectives Clearly link therapeutic tasks and goals Regularly invite feedback Direct to relevant issues Ongoing assessment and calibration
Role of the Therapist	Therapist can create security to enable client risking	Build strong alliance and structure for safety before directing clients to interact in challenging direct engagement
Nature of Couple Relationship	EB contribution to couple self- sufficiency Significance of direct engagement Outcomes justified difficulty for clients	Plan for and work towards self-sufficiency Stay at cutting edge of client readiness for direct engagement Be attuned to client comfort, but don't be afraid of stretching

Appendix B

Figure 1

Structured Interview Questions

Interview for E x A Study

The research participant should have completed the study prior to conducting the structured interview. Husband and wife should be interviewed separately, but preferably one right after the other, so as to prevent the first interviewed spouse from prepping their partner.

Remind the participant that the interview will be tape-recorded, and so it is important to speak audibly and clearly. Also, remind the participant that their involvement is voluntary and, if at any time they wish to pause, postpone, or discontinue participation, they are free to do so.

Read the following script:

The purpose of the study and this interview is to better understand couples' experience of different approaches to therapy. During the 6 sessions of the study, your therapist conducted 3 sessions using a "therapist-centered" approach—where much of your interaction was with the therapist—and 3 sessions using a "couple-centered" approach—where much of your interaction was directly with your spouse, with the therapist indirectly involved.

The profession of marriage therapy can benefit from better understanding of couples' experience of these two approaches. We would like to understand similarities and differences in how you felt about each approach, its influence in your relationship, and how it helped or hindered you in achieving the goals for which you came to therapy.

There are just 12 questions, relating to what you noticed, what you felt, and what you experienced. Before we begin, the interview, do you have any questions?

First, I'd like to ask you about what you noticed about the two approaches.

1. Without being told that the therapist used two different approaches to conduct therapy, did you yourself notice any differences or similarities in the way the therapist conducted therapy between the first 3 and last 3 sessions?
 - What were some of those differences?
 - What were some of the similarities?
-

Now I'd like to ask you about what you felt during the two approaches.

2. Were there any notable differences or similarities in the way either approach influenced or helped change your feelings while in the session or after?
 - Could you comment on similarities or differences between the two approaches in terms of how softened, open, or receptive you felt toward your partner?
 - Could you comment on similarities or differences between the two approaches in terms of how safe you felt, during the session, or with your partner afterwards?
 - Could you comment on similarities or differences between the two approaches in terms of how emotionally close you felt with your partner?
 - Could you comment on similarities or differences between the two approaches in terms of how hopeful or optimistic you felt at the end of the session or later?

- Could you comment on similarities or differences between the two approaches in terms of how comfortable or anxious you felt?

Now, I'd like to ask you about what you experienced during the two approaches.

3. Were there any notable differences or similarities between the two approaches in terms of feeling understood, validated, and empathized with?
4. Was therapy any more or less meaningful, whether it was your spouse or the therapist with whom you were primarily talking? How?
5. Could you comment on similarities or differences between the two approaches in terms of how confident or empowered you felt in session?
6. Could you comment on similarities or differences between the two approaches in terms of how productive or useful the session was?
 - *Probe:* Were there any notable differences in the way either approach influenced or helped change you, your partner, or your relationship? What were they?
 - *Probe:* Were there any notable differences in the effectiveness of either approach? What were they?
7. Could you comment on similarities or differences—between the two approaches—in terms of how relevant the experience was?
 - *Probe:* Was either experience any more or less “real” or “intimate”? How?
 - *Probe:* Was either experience any more or less “significant” or “influential”? How?
8. Could you comment on similarities or differences between the two approaches in terms of how emotionally engaged you and your spouse were?
9. Could you comment on similarities or differences between the two approaches in terms of how responsive you and your spouse were?
10. Was there anything remarkably positive during either experience?
11. Was there anything remarkably negative during either experience?

Last of all, I'd like to invite you to offer any other information you think is important.

12. Do you have any other comments or suggestions or recommendations about either of the two approaches about how to make them better?

Figure 2

*Consent Form***Informed Consent to Participate as a Research Subject****Introduction**

Dr. Mark Butler, Professor in Brigham Young University's School of Family Life, and Graduate Programs in Marriage and Family Therapy, is conducting research focused on understanding the role of the therapy process in helping couples improve their marital relationship 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 four normal therapy sessions with your therapist at the BYU Comprehensive Clinic. Before and after each session, you will be asked to complete a questionnaire assessing your perceptions of your relationship with your spouse.

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. There are known benefits anticipated in consequence of your experience of couple interaction based therapy. Additionally, society and people in general will likely benefit from the knowledge gained regarding what couples perceive as helpful therapist behaviors. Therapists and other distressed couples will especially benefit from the knowledge gained concerning what improves couples' relationship quality.

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.

Questions about the Research

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

Mark H. Butler, Ph.D.
 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 BYU IRB Administrator, (801) 422-1461, irb@byu.edu, A-285 ASB Provo, UT 84602.

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

 Research Participant

Date

 Witness

Date

Figure 3

Criteria Indicating a Therapist-Centered Approach

Observational Assessment of Therapist-Centered Proficiency (OATCP)

Maero	Miolo	Frequency Count
Narrative Behaviors =>	<input type="checkbox"/> Encourages and invites partners to share their "story" or perspective with him/her	<input type="checkbox"/>
	<input type="checkbox"/> Empathically listens as one or both partners share their story, feelings, or thoughts	<input type="checkbox"/>
	<input type="checkbox"/> Reflects the partners' feelings	<input type="checkbox"/>
	<input type="checkbox"/> Validates the partners' feelings	<input type="checkbox"/>
	<input type="checkbox"/> Reframes negative comments	<input type="checkbox"/>
	<input type="checkbox"/> Third-person voice	<input type="checkbox"/>
Physical Gestures Channeling Interaction through the Therapist =>	<input type="checkbox"/> Sets partners' chairs to face the therapist rather than each other	<input type="checkbox"/>
	<input type="checkbox"/> Hand gestures that invite/encourage couple interaction with the therapist	<input type="checkbox"/>
	<input type="checkbox"/> Verbal instructions for the couple to interact with or directly talk to the therapist	<input type="checkbox"/>
Creating Insight/Understanding =>	<input type="checkbox"/> Offers appropriate advice, suggestions, or potential solutions	<input type="checkbox"/>
	<input type="checkbox"/> Encourages clients to think of suggestions or solutions	<input type="checkbox"/>
	<input type="checkbox"/> Socratic Dialogue	<input type="checkbox"/>
	<input type="checkbox"/> Suggests new ways of looking at things	<input type="checkbox"/>
	<input type="checkbox"/> Helps partners discover new ways of looking at things	<input type="checkbox"/>
	<input type="checkbox"/> Offers interpretations or insights into couple behavior	<input type="checkbox"/>
	<input type="checkbox"/> Points out negative consequences of dysfunctional interaction patterns, ideas about relationships, etc.	<input type="checkbox"/>
	<input type="checkbox"/> Offers feedback, interpretations, thoughts or feelings regarding clients' comments	<input type="checkbox"/>
	<input type="checkbox"/> Gives communication skill suggestions (e.g., "speak in I terms instead of criticizing or blaming your partner")	<input type="checkbox"/>
	<input type="checkbox"/> Engages in a separate dialogue with one or both partners	<input type="checkbox"/>
Active Involvement =>	<input type="checkbox"/> Actively participates in therapy conversation (either verbally or through attentive listening)	<input type="checkbox"/>
	<input type="checkbox"/> Requests a partner to reframe a statement in terms of how it made him/her feel	<input type="checkbox"/>
Encouragement of Attachment/Emotion Expression =>	<input type="checkbox"/> Offers alternative, more softened statement for partners to repeat	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Figure 4
Criteria Indicating an Enactment-Centered Approach

Observational Assessment of Enactment Proficiency (OAEP)

Adapted from Davis & Butler (2004). Used with permission.

Macro	Mid	Micro	Frequency Count
<input type="checkbox"/> Initiation =>	<input type="checkbox"/> Introduce Roles/Goals =>	<input type="checkbox"/> Explain Purpose of Enactment	
		<input type="checkbox"/> Explain Spouses' Roles	
		<input type="checkbox"/> Explain Therapist's Role	
	<input type="checkbox"/> Specify Topic =>	<input type="checkbox"/> Specify Content Focus	
		<input type="checkbox"/> Set Expectations for Positive Comm/Interx	
		<input type="checkbox"/> Set Expectations for Positive E/A Process	
	<input type="checkbox"/> Establish Structure =>	<input type="checkbox"/> Arrange Spouses for Couple Interaction	
		<input type="checkbox"/> Request First-Person Language	
		<input type="checkbox"/> Remove Self from Couple Interaction	
<input type="checkbox"/> Intervention =>	<input type="checkbox"/> Sustain Interaction =>	<input type="checkbox"/> Maintain Positive Interaction	
		<input type="checkbox"/> Commend positive interaction	
		<input type="checkbox"/> Interrupt negative interaction	
	<input type="checkbox"/> Coach Interaction =>	<input type="checkbox"/> Promote positive expression	
		<input type="checkbox"/> Promote positive attending	
		<input type="checkbox"/> Assist positive attending and/or expression	
	<input type="checkbox"/> Facilitate E/A Interaction =>	<input type="checkbox"/> Promote E/A expression	
		<input type="checkbox"/> Promote E/A listening	
		<input type="checkbox"/> Promote E/A responses	
<input type="checkbox"/> Evaluation =>	<input type="checkbox"/> Recall Goals =>	<input type="checkbox"/> Invites review of enactment goals	
		<input type="checkbox"/> Invites review of enactment roles	
		<input type="checkbox"/> Invites recall of therapy goals	
	<input type="checkbox"/> Assess/Evaluate =>	<input type="checkbox"/> Invites clients to notice what went well	
		<input type="checkbox"/> Invites clients to commend each other for successes	
		<input type="checkbox"/> Invites clients to notice where change is needed	
	<input type="checkbox"/> Commit to Change =>	<input type="checkbox"/> Invite <i>process</i> commitments	
		<input type="checkbox"/> Invite <i>content</i> commitments	
		<input type="checkbox"/> Invite <i>E/A</i> commitments	