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CHANGE PROCESSES IN COUPLE THERAPY: AN INTENSIVE CASE ANALYSIS OF ONE COUPLE USING A COMMON FACTORS LENS

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The article describes a research study that explored the process of how change occurred for one distressed couple and a specific therapist in a naturalistic setting. Quantitative and qualitative data were collected on the couple at multiple points in the therapy. A research team comprised of five members met regularly to analyze the data and collectively they arrived at a theory of change for the couple posttherapy. Conclusions are made related to how change occurred for the couple with an emphasis on the role of extratherapeutic events, client motivational factors, the therapeutic alliance, hope and expectancy factors, therapist factors, specific techniques and interventions, and other surprise factors that contributed to change.

Pinsof and Wynne (2000) challenge the marriage and family therapy (MFT) field to close the gap between practice and research. Their article inspired us to study, in detail, the process of change in couples seeking therapy at a midwestern university campus clinic. Our goal was to understand *how* couples changed without purposefully prescribing a specific type of theory to the clinical work. Using a common factors lens as a guide (Sprenkle & Blow, 2004a, 2004b), we gathered data from couples throughout the course of their therapy, and then, as a research team of five members, analyzed successful cases retrospectively with the intent of arriving at a comprehensive theory of how change occurred for specific couples. In other words, instead of applying a theory of change to a couple and then testing outcomes, we selected couples who achieved positive outcomes as a result of "therapy-as-usual," and then formulated a theory of change for the specific couples posttherapy. This article reports on our theory of change for one distressed couple who changed significantly over a 13-month period that included 15 therapy sessions. We discuss how the research allowed for both an in-depth understanding as well as unexpected discoveries related to clinical change. We make conclusions about the research, about common factors, and about how studying change in an intense way is an ideal means to generate theoretical ideas and enhance our understanding of how change occurs, both in and outside the therapy room.

THE RESEARCH PROBLEM

To date, researchers have accumulated a wealth of data on couples and couple therapy (Bradbury, Fincham, & Beach, 2000; Gottman & Notarius, 2000; Johnson, 2002). We know that therapy helps couples (Shadish & Baldwin, 2002), and that it not only helps with

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generic relational problems but also can effectively treat disorders such as depression. We also know quite a bit about satisfaction in couple relationships, and what factors might predict relationship stability and divorce (Bradbury et al., 2000; Gottman & Notarius, 2000). However, as Johnson (2002) points out, a central problem remains in our study of couple therapy:

> The central issue with regard to research in couple therapy is quite simply that we, as researchers, have not made research clinically accessible and relevant enough, and we, as clinicians, have not seen research as an aid and so we have not used it. (p. 164)

Central to this concern is that much of the current research on couple therapy tells us little about how change occurs in the therapy room, only that it does occur (Sprenkle, 2002; Sprenkle & Blow, 2004a). This limits the ways in which research informs the actual therapy process, given that each therapy encounter is different, requiring different thought processes, moves, and strategies (Pinsof & Wynne, 2000). Beutler, Williams, and Wakefield (1993) report that clinicians desire to read research studies that focus on therapist and/or client behaviors and how these behaviors connect to important moments of change in therapy. This was one of our primary goals in this research.

Efficacy Research

Efficacy research represents the gold standard for outcome research and consists of clinical trials in laboratory conditions using well-defined treatment manuals adhered to by therapists with high levels of fidelity. Fidelity allows successes to be ascribed to the treatment and its active ingredients and not to other factors. Efficacy research has found that credible models of therapy help almost two-thirds of the people treated, although it tells us little about why or how these models help (Pinsof & Wynne, 2000). Further, it has other weaknesses—it does not reflect the true practice of therapy; it does not relate to the experiences of many therapists; it controls for unique client and therapist qualities; and it is difficult to transport from the research lab to the real world (Henggeler & Sheidow, 2003; Pinsof & Wynne, 2000; Sprenkle, 2002).

Effectiveness Research

Effectiveness research studies the success of treatment approaches as they move from the laboratory into real-life community settings. This kind of research has its own set of problems and challenges (Henggeler & Sheidow, 2003; Pinsof & Wynne, 2000), most notably, that it is difficult to conduct any systematic study of treatment in settings that contain client and contextual variables that are difficult to control, but which influence outcomes nonetheless.

Clinically Relevant Research

Pinsof and Wynne (2000) advocate for a different kind of research—one that takes into account the unique qualities of the therapist and clients and the idiosyncratic ways in which therapy plays out. They surmise that in reality therapists approach each case based on its unique merits and then alter their approach based on direct feedback from clients in sessions. Resulting is a continually changing therapy guided by the responses/reactions of the clients to the moves of the therapist and the subsequent responses of the therapist to feedback from the clients.

Pinsof and Wynne (2000) conclude that in studying therapy:

> What actually occurs does not need to be prescribed in advance, but can be studied retrospectively with meaningful process data that can be collected during treatment. In

other words, the therapy is experimentally operationalized posttreatment. Such process data can then be linked to particular outcomes. (p. 4)

This guiding statement led us to study the process of what occurred in clinically meaningful couple therapy. This bottom-up (rather than a top-down) research approach allowed us to ascertain how both clients and therapists viewed change throughout therapy (Johnson, 2002).

PURPOSE OF THE STUDY

The purpose of this study was to understand and describe a theory of change for one distressed couple and a specific therapist in a naturalistic setting, with the goal of illuminating *how* change occurred for the couple. Our aim was to identify the key therapeutic moments from the perspectives of the clients, the therapist, and an outside team, and to explore their points of agreement and divergence. Our story of change provides a picture of what occurred with this one couple, with the understanding that this picture is based on the perspectives of our specific research team at a specific place and time. We collected a wide array of data during the course of treatment and then retroactively analyzed these data to understand how in-session events were connected to outcomes. We view our efforts as exploratory and theory building, related to our understanding of the process of change for couples in general.

To guide our study, we addressed the research questions posed by Pinsof and Wynne (2000) using a common factors lens (Hubble, Duncan, & Miller, 1999; Sprenkle & Blow, 2004a, 2004b; Wampold, 2001) to answer six useful questions: How did this couple change independent of therapy? How did this couple change as a result of therapy? What did the therapist do to facilitate change? What did the clients do to change their own lives? How important were common factors in the process of change? How important were theory-specific change ingredients?

LITERATURE THAT GUIDED THIS STUDY: COMMON FACTORS OF CHANGE

In this study, we were interested in both broad and specific processes of change. We were not only interested in how change occurred in the therapy room but also in events, contingencies, and activities outside of therapy that influenced change. A common factors lens was used both in the data we collected from the couple as well as in our analysis of the change processes. The following are descriptions of the common factors that guided our study.

Client Factors and Extratherapeutic Events

Client factors consist of both static (e.g., age, gender, race) and nonstatic characteristics of clients (e.g., individual learning styles, family cohesion, expressed emotion; Sprenkle, Blow, & Dickey, 1999; Talman & Bohart, 1999). They include characteristics or qualities of clients (e.g., level of motivation, commitment to change, inner strength) that influence change (Duncan & Miller, 2000). Extratherapeutic events are influential happenings outside of therapy that play a major role in change. Whether clients choose to discuss these events in therapy or not, they inevitably influence the process.

Therapist Variables

According to Wampold (2001), some therapists are better than others, although we do not have clear evidence in MFT of these differentiating features (Blow, Sprenkle, & Davis, 2007). Clinical trials attempt to control for therapist factors in that the therapist is encouraged to follow a manual as closely as possible in order to make change attributable to the ingredients found in the manual as opposed to the skills of the therapist. In clinical trials, it is assumed that all therapists are equally competent in manual delivery and skill level. In contrast,

Wampold (2001) offers strong statistical evidence that the therapist often contributes far more to outcome than the particular therapy he or she happens to be using.

The Therapeutic Alliance

The therapeutic alliance is a key change variable across all theories of MFT (Blow & Sprenkle, 2001), and numerous studies support its importance (Bachelor & Horvath, 1999). The alliance has three primary components delineated by Bordin (1979). These are the bonds (the affective quality of the client–therapist relationship including trust, warmth, and caring); the tasks (the extent to which the client is comfortable with the activities of therapy and finds them credible); and the goals (the agreement between the client and therapist on the goals of therapy).

Hope and Expectancy

These variables include the portion of improvement that results from the fact that the client is in treatment, has hope that change can occur, and believes that treatment is credible. These treatment variables contribute to the motivations of clients to change and to their beliefs that change is actually possible (Snyder, Michael, & Cheavens, 1999; Sprenkle & Blow, 2004a; Sprenkle et al., 1999).

Nonspecific Treatment Variables

Sprenkle and Blow (2004a) also provide a group of variables that are important in the process of change. These include behavioral regulation, cognitive mastery, and emotional experiencing. Behavioral regulation refers to targeted behavior change. Cognitive mastery refers to shifts in the ways clients view their problems. Emotional regulation refers to a focus on emotions and to shifts in the emotional experiencing of clients. These three variables are present in some way in all theories but are punctuated differently and are more or less important theoretically depending on the dominant theoretical approach favored by the therapist and/or the specific needs/preferences of the client(s).

METHODS[1]

Measures Used and Points of Data Collection

In our study, we aimed to gather data on all couples who presented for therapy and who met the inclusion criteria of living together in a committed relationship for at least one year. For each case, we gathered both quantitative and qualitative data that would not only allow us to conclude that change occurred for the couple, but would also provide sufficient evidence of their specific pathways to change. It is important to note that a primary emphasis of the research was to keep the therapy sessions as typical as possible. All participants (therapist and clients) were aware that they were involved in the research project; however, the point was for the therapist not to do anything differently because of the research.

Quantitative data. We collected intake information on a general demographics questionnaire. We videotaped all sessions in order to capture the specifics of each meeting. The couple completed the Dyadic Adjustment Scale (Spanier, 1976) at intake and termination to measure change in the relationship over the course of therapy. A Life Events Questionnaire was given at pre- and posttreatment to gather data on major events in the lives of the clients that would possibly influence outcomes. We modified a session rating form (Johnson, 1995) to meet the unique needs of our site and study. This form consisted of 19 items that asked general questions about client progress in therapy, satisfaction with therapy, hopefulness, and the benefits of therapy. Both clients and therapist filled out this form independently at the end of every session. The therapist would review the scores and, if necessary, process any of the items in the following session. This one component of the research detracted from the natural flow of therapy.

However, ethically we did not feel that we could ignore the feedback provided on these forms, and in this way, the research influenced therapy.

Qualitative data. We collected qualitative data in order to understand deeper meanings in the change processes and to clarify meanings in the quantitative data. Data collection occurred during two follow-up interviews with the clients and one with the therapist, in order to gain an in-depth understanding of client and therapist views of change and key change events. The first couple interview occurred immediately posttreatment, and the second approximately 18 months posttherapy.

Descriptions of Participants and Context

The clinic. The clinic where the data were collected is an on-campus clinic for a family therapy training program. The majority of clients come from inner-city, low-income neighborhoods. The clinic uses a sliding fee scale and fees are generally low, although all clients pay something for each session.

The therapist. The therapist on the case was an advanced doctoral student in MFT who also maintained a successful private practice. At the time of the study, she saw clients in the on-campus clinic as part of practicum, was enrolled in three doctoral courses, worked a 20-hr a week research assistantship, and maintained a private practice. She described herself as an integrative and holistic therapist favoring an Emotionally Focused approach. She stated in her posttherapy interview:

> I always felt that it is really important to not be afraid of their feelings and help them regulate their feelings in order to get through their feelings instead of defend like usual. I think I do work pretty much from an Emotion-Focused perspective.

The research team noticed the therapist assuming a nonexpert stance and maintaining hope for the couple. She was calm, nonjudgmental, approachable, and often used humor as a way to join with clients and get through difficult sessions.

The clients[2] and the therapeutic context. Descriptions of the clients evolved through the process. Our initial impressions were obtained through the review of case charts related to the couple. These impressions shifted as we engaged in discussions with the therapist, interviewed the clients, and observed each session both alone and as a group. The following description includes the consensus of the research team regarding the couple. Our description is influenced by the literature on couples (Gottman, 1999; Johnson, 2002) as well as by structural (Minuchin, 1974), Bowen (Bowen, 1978), and Emotionally Focused therapies (Johnson, 2004).

The couple was markedly distressed in their initial presentation in therapy. Over the course of therapy, they improved and these changes were sustained at an 18-month posttherapy follow-up. John, the husband, was a 48-year-old Caucasian male. In his family of origin, he was the older of two children, although he reported that he was not close with his family. He was twice married, and had two children from his first marriage with whom he had no contact since the marriage ended. During the course of therapy, John presented with differing moods. At times, he was compliant and it seemed easy to convince him of things. At these times, he presented as the more introverted and withdrawn of the couple and conveyed a helpless attitude in therapy, making statements such as "What can I do? You see how she is?" At other times, he was highly volatile and prone to outbursts when triggered by his wife or the therapist.

Rose, the wife, was a 46-year-old Caucasian woman. She was the second youngest of eight children, and referred to herself as the "spoiled princess" who always got her way. She was married once before and in her first marriage, she adopted a biracial son who was 20 at the time of therapy and lived with Rose and John. At the outset of therapy, Rose minimized her contribution to the problems of the couple, and displayed a strong sense of entitlement. She had a difficult time setting boundaries, and seemed unable to say no to children or friends. At the

time of therapy, she was taking Buspar for anxiety along with hormone replacement drugs. Rose was loud during sessions, often talked for the couple, and was far more extroverted than John.

The couple was seen on two occasions at the clinic. The first round of therapy occurred three years prior to this study and lasted eight sessions, during which time the couple worked with an addictions specialist. At that time, Rose called for therapy after she had John arrested for a domestic disturbance when he came home drunk and "tore up" the house. During those sessions, the therapy focused on their financial crises, job losses, drinking, and fighting patterns. The couple described patterns of violence influenced by heavy drinking and frequent arguments—typically culminating in either John or Rose leaving for a few hours, a few days, or even weeks. The first round of therapy ended abruptly following one of the couple's separations.

The second round of therapy lasted for almost 13 months and 15 sessions. The couple had a different therapist for the second round and entered the research study at this point. The time between sessions ranged from 1 to 15 weeks. Rose called seeking therapy after John was court mandated to attend anger management therapy. Rose requested couple therapy because she thought she needed some anger management work herself. The court's involvement was the result of John's arrest for assaulting a man with whom Rose was having an affair. Although Rose telephoned the police after the assault, she later bailed John out of jail. During the course of therapy, the ex-boyfriend remained a source of contention. He continued to pursue Rose and there were ongoing questions as to when or if the relationship had ended. Other content addressed in therapy included violence (on the part of both partners), stepfamily issues, alcohol abuse, financial difficulties, stress management, and parenting difficulties. The couple lived together 14 years, raising their own daughter (8) and Rose's son (20), and they married 6 months prior to returning to therapy. They were of a lower socioeconomic status (ongoing financial difficulties), and both had high school diplomas. At the outset of therapy, John worked the night shift and was overtired much of the time. Rose worked in her own housecleaning business.

The couple displayed a clearly defined interactional pattern of withdraw/pursue, with Rose as the pursuer. Rose was defensive and adversarial with John; John was withdrawn and angry with Rose. He displayed several symptoms of long-term depression, including a lack of interest in many activities. Rose had a low tolerance for criticism. In general, John withdrew, and Rose did things to get his attention. He became angry and withdrew even more. She escalated her pursuit, becoming more destructive within their home, which eventually got his attention, and he would react.

In short, this couple presented with a wide range of difficulties and there were discussions initially about their suitability for this research study. However, this couple displayed remarkable changes during the course of therapy, and we saw many merits to studying this complex couple and believe we arrived at some valuable conclusions.

The Process of Data Analysis

Background to the analysis. Data analysis for this study was intensive and time consuming. The research analysis team consisted of five of the six authors of this study and was made up of three faculty, one doctoral student, and one master's student. The other author (KT) served as the therapist for this couple and did not participate directly in the analysis. As a research team, we were aware of our differences—representing different ages, genders, ethnic backgrounds, theoretical orientations, and levels of experience. No one methodology neatly fit our analysis plan, so we turned to a variety of different methods to guide our process.

We were influenced by consensual qualitative research (CQR; Hill et al., 2005), and we worked to arrive at a consensus among ourselves about our views of the therapy. CQR emphasizes the need to minimize power differences in a team through no one individual in the group claiming expert status and by allowing team members of a lesser power status (e.g., students)

the freedom to express divergent opinions. As a result, we were intentional to create as open a context as possible in which all could freely share their ideas.

We were influenced by the discovery-oriented approach of Mahrer and Boulet (1999), who state:

> The emphasis is on sessions where something happened that was especially valuable, impressive, pleasing, special, distinctive, important, gratifying, unusual, or surprising. . . . The emphasis is on whatever touches you as something impressive happening here rather than relying on your theory, your knowledge, and your being on the lookout for particular kinds of traditional significant in-session changes. (pp. 1482–1484)

As a result, as individual members and as a team, we specifically kept notes concerning "what popped" in regard to our overarching research questions, and we spent a great deal of time discussing these events. We were also influenced by comprehensive process analysis (Elliott, 1989), an interpretive method for analyzing significant change events in therapy. In this regard, we were cognizant of four levels of context: (1) the background (relevant features of clients and therapist separate from the specific therapy); (2) the pre-session context (events that took place in previous sessions or outside of therapy that applied to subsequent sessions); (3) the session context (specific events connected to current sessions we observed); and (4) the episode context, which refers to the conversations around a specific event in the therapy room. These four levels were present as we tried to make sense of the data and tie it all together in a coherent manner.

Finally, we were influenced by the discovery-oriented work of Greenberg (1999). His methodology involves the intensive analysis of concrete change and involves the use of observation, measures, and the subjective input of clients and therapist. He advocates looking at the therapeutic process separate from theoretical assumptions to learn about how change occurred. In his process of analysis, he advocates for, among other things, the development of a tentative map, observing the actual phenomena in session, and then elaborating on and developing the initial map. Looking back, this is exactly what occurred as we developed a tentative map of change at the outset that then evolved throughout our process of analysis.

Steps to the analysis. As a research team, we met regularly to analyze the data as a group. Prior to meeting as a group, we independently viewed the videotapes of the sessions and each team member came to the first group meeting with tentative ideas about how change occurred. We next familiarized ourselves with relevant information about the clients found in the case charts as well as with the therapist and her theoretical orientation. We then reviewed each tape together as a group. We stopped the videotape anytime something touched one of us in the session and we had a group dialogue about the in-session event (all of these conversations were taped and transcribed and were referred to later in the analysis). We also connected these events to larger themes, discussions from previous sessions, our own personal hypotheses, and the common factors lens. We spent enough time talking about these events so that we had a high level of consensus about how these influenced the change process. Over time, a map of change began to emerge that we all were able to resonate with as a depiction of the change process for the couple. As this map emerged, we went back and reviewed tapes and transcripts, looking for key events/therapy moments and understanding these in the larger context of change. Our reading of manuscripts, follow-up interviews, and re-review of tapes allowed us to confirm the keys to change we report below.

As we viewed the tapes, we worked to remain open to new ideas—ideas that challenged our previously held assumptions. We were also cognizant of our own group dynamics and allowed space to stop the tapes and share ideas, no matter how "crazy" they sounded at the

time. Members discussed ideas that resonated in the group with excitement, and many of these became important themes that were sustained over time. Ideas that were perhaps less relevant were not greeted with the same enthusiasm and eventually faded into the background. We acknowledge that some of these ideas might have been important but were washed out in the "group think" that was at times unavoidable. While we had disagreements as a group, these never became contentious or gridlocked. This was due to our commitment to dialoguing about the events and ideas until we worked through our differences.

Trustworthiness, credibility, and rigor. In research such as this study, it is important that the reader is able to view the results with credibility (Morrow, 2005). This study and its findings certainly can be questioned based on the sample size. We wish to remind the reader of the idiographic and emic nature of our work. In this regard, we were not seeking results that would generalize to all couples, but rather we sought to find meanings from the intense analysis of one therapy case and its processes. We worked to come up with a credible map of change for one couple to show the complex and multifaceted nature of change and to generate helpful ideas useful in future larger sampled studies.

Data were triangulated from multiple perspectives. We collected videotapes, paper and pencil measures, and subjective information from qualitative interviews of both therapist and clients. Our team had diversity including varying levels of experience. We viewed tapes independently and as a group. We established ground rules for analysis that would allow for the open discussion of new ideas. Finally, we transcribed all sessions, interviews, and research group discussions that allowed for cross-checking and referencing of themes as they emerged. We were also able to check with both the therapist and the clients long after therapy was over in order to clarify information and further explore their views on change. In this regard, we were able to clear up points of dispute or confusion and our process of interpretation of the data (Morrow, 2005, p. 256) was a "continuous and interactive process" allowing us to go "back into the field for additional data." We believe the variety of sources of data for this study all added to the richness, breadth, and depth of the information.

FINDINGS

Did Change Occur?

One thing was clear in terms of change with this particular couple: change did occur, and it was sustained at an 18-month follow-up. The clients, the therapist, and all members of the research team were in complete agreement on this point. The confirmations of change were validated in the scores on the Dyadic Adjustment Scale, session rating forms, and in the qualitative interviews of therapist and clients immediately posttherapy, as well as in the follow-up interview with the clients almost 18 months later. Rose, speaking for the couple, stated in her 18-month follow-up interview:

> It is definitely not the same as it was. I mean it seems like we're able to get a grip on things better now than opposed to letting things get completely out of hand, you know, just let things go. We're quicker to . . . to apologize to each other and, and to . . . hold and kiss each other from what we were doing before. You know, before we'd just get angry with each other and then it would stay that way for days and . . . just progressively get worse. And uh . . . we still have our little, our little ups and downs. You know it's not. . . . "Oh no, things are perfect," you know what I'm saying? . . . A situation such as ours doesn't go from what it was to, "Oh, there's no more arguing." . . . But we're able to get a better grip on it now than what we use to do, and I think that's because of the therapy. I don't think we ever would have, and I think I'm speaking for John also . . . but I think without it [therapy] we never would have, our relationship never would have survived. (October 10, 2003)

Members of the research team were all skeptical at first if any change would or could occur; in fact, some of us were downright pessimistic because this couple was dealing with so many problems. Change was gradual at first; they initially had several sessions of intense emotional sparring. At some point in the therapy process, there was a distinct leap to a different state characterized by lowered tension and a higher level of relationship satisfaction. This leap occurred in both their relationship with each other and in the scores related to their satisfaction with therapy.

How Did Change Occur?

The literature on change in therapy does not clearly answer this question, and we struggled as we wrestled to understand change. We knew that our views were unavoidably biased and that someone else could look at the data and arrive at different conclusions. However, we realize that all research is biased, and the goal of researchers should not be to eliminate all biases (an impossibility), but to attend to them. By talking openly about assumptions that we each brought to the research project and bringing together data (both quantitative and qualitative) from multiple sources, involving a large research team, and including input from both the therapist and clients, we believe that we created a credible study. One thing we realized early on: the process of change is not as clean as our theorists suggest, who often describe a tidy road to change—these theories were minimally helpful as our research team worked to describe the "how" of change. We next present our ideas about the how of change under broad headings related to common factors and we include a series of figures containing our conclusions about the change process.

Key Component of Change: Client Factors and Extratherapeutic Events

We were amazed by how client-related factors and extratherapeutic events influenced the outcome of therapy (see Table 1). We discuss these below, looking specifically at motivational factors and at the three most significant random events that occurred.

Client motivational factors. Importantly, the clients were motivated to change in spite of their history of difficulties. This initially appeared to be related to the mandate from the court. In the post-interview, the couple admitted that they would not have sought therapy if they had not had this court order. However, over time, this shifted and the couple reported wanting to change for their own personal well-being. While the court order helped get the couple "in the door," the therapist makes the most of the opportunity to engage them in some important therapeutic work. There were also some other key motivating factors (some positive and some negative). They were motivated by their concern for their daughter, their history of past failed relationships, and their previous experience in therapy. A negative factor that motivated Rose was the guilt of her affair, which, at some level, she believed "caused" John to assault her boyfriend, resulting in his being arrested.

Random event: a cancer scare. Perhaps the most significant extratherapeutic event was related to Rose's health. She discovered a large mass in her abdomen and the couple believed it was cancer. This understandably created grave concern and this anxiety was the central focus of several sessions. Rose underwent major surgery and was found cancer free. However, this event influenced the couple's relationship in significant ways. It appeared that the surgery allowed Rose to witness a new level of care and concern from her husband (he was pursuing her with love and concern); the surgery affected her hormonal levels, which might have affected her moods; and third, the existential crisis of possible long-term illness or even death allowed the couple to turn to each other in ways they had not in the past.

Random event: a job loss. Money issues were a primary concern for this couple, and parts of several sessions focused upon managing money. They both worked low-paying, blue-collar jobs, and at the outset of therapy, John worked the night shift at a local factory. This influenced him negatively in two main ways. First, he was overtired much of the time and not able

Table 1
Team Conclusions Concerning Client Factors and Extratherapeutic Events

Extratherapeutic events occur frequently, often without warning.
Therapists should ideally ask about these events and use them as mechanisms to help change.
Positive extratherapeutic events need to be utilized for a therapeutic advantage, i.e., validation, encouragement, reinforcement.
Negative extratherapeutic events can identify patterns of coping that can help the therapeutic process.
There is always a unique dynamic around these events and they bring the couple process into the present.
They allow the therapist to display empathy and understanding, which can deepen the emotional experience.
They can "stir up" the dynamics of a system, allowing for opportunities for intervention, change, and growth.

to be fully present when the couple spent time together. Second, he worried about what Rose might be doing at night while he worked. He ruminated about who Rose was with, if the affair was ongoing, and if she were being honest. This dynamic changed significantly when he was laid off from his job, leading to beneficial outcomes. John became significantly less tired and anxious. He was calmer knowing where Rose was at night. While this structural management of anxiety might not be ideal in contemplation of long-term change, it served to enhance significantly the positive exchanges in their relationship, and it gave the couple the opportunity to rebuild. John began working with Rose in her house-cleaning business, and while in some relationships working together might be disastrous, they discovered that they worked quite well together.

Random event: a jail sentence. Similar to the loss of a job, serving mandatory jail time is far from positive. However, in this case, John's weekend detentions resulted in one positive outcome: When in jail, John met a fellow inmate who knew John's son from his first marriage. As a result, John reconnected with his son after 12 years and began to spend time with him. This reconciliation between father and son was also the focus of therapy sessions, and Rose was supportive and validating of John's excitement. The couple worked together to build a renewed relationship with John's son.

Key Component of Change: Therapeutic Alliance Factors

We were able to track therapeutic alliance factors and their changes over time using the session rating forms completed by both therapist and clients (see Table 2). The session rating forms indicated strong levels of agreement between both members of the couple as well as the therapist on the goals, tasks, and bonds of the alliance. Overall, the therapist exhibited strong alliance-building skills. She was able to engage the couple early on in spite of their court mandate, and once she established a sufficient level of therapeutic credibility, it seemed to translate to the rest of the therapy. The clients reported that they were comfortable with her as a therapist. Rose confirmed this when she said in the final research interview, "She [therapist] was comfortable to be with, which makes a BIG difference."

The therapist demonstrated excellent relationship-building skills. She accommodated to the clients' language and culture and adjusted herself to fit with their unique relational context. She created space in which the couple could work. She was validating and nonjudgmental, a characteristic that the research team viewed as a strength given that there were many factors that she

could have made value judgments about with this couple. She was able to bring the couple to a place where they could talk together as a team, a way of relating that they were unable to achieve in their home environment. The therapist was not easily rattled and was quietly confident. At one point in the therapy, Rose became enraged and stormed out of the session. The therapist remained calm and clear thinking in light of this tension and this appeared to communicate hope.

The therapist made a calculated decision that aligning with Rose would keep the couple engaged, in spite of the fact that she acknowledged liking John more. She believed that Rose's participation in therapy was more fragile while John was court-ordered to participate. This split alliance (Pinsof, 1995) was indicated on the scores the clients provided on the session rating forms, with Rose providing higher scores initially in the earlier sessions. Later John's scores increased and remained high. In terms of the split alliance, the therapist stated:

> I felt like I wanted to engage him more. . . . I felt like my heart was more with him, but I felt that I had to work harder with her because . . . she was who I had to hook to make the experience work. She was the one feeling frustrated and ready to leave the marriage and that if she was gonna buy into this process . . . I was gonna have to hook into her.

The therapist appeared to be accurate in this assessment because the couple persisted and worked hard in therapy. Despite the alliance with Rose, when the therapist did focus on John, she was warm, empathic, and caring. She was attuned to his needs and noticed his cues related to when he was ready to talk about the affair. At key times, she listened intently to John in a highly focused way and talked to him very quietly. She was relaxed and shared her thoughts in tentative, encouraging, hopeful, genuine, calm, collaborative, and validating ways.

The clients were comfortable with the activities of therapy and gave the therapist high ratings on the tasks questions on the session rating form. The goals aspect of the alliance reflected the least agreement (as compared to the bonds and tasks), although there was still a great deal of agreement. This appeared to be due to the many issues the couple brought to therapy, and in some ways, it was left to the therapist to decide "where to go" on any given day. John seemed least happy concerning the goals component and this may have been the result of his being the most hurt in the relationship. However, his scores improved as therapy progressed and as the relationship improved.

Of particular interest to the research team was what we referred to as "therapeutic mistakes," actions by the therapist that we believed could have been detrimental to the therapeutic alliance. These "mistakes" consisted of therapist statements or behaviors that were off target, mistimed, or out of context with the therapy. Given the therapist's strong therapeutic alliance with this couple, these "mistakes" did not detract from the therapy and even at times enhanced the work and the client/couple alliance. For example, during a particular poignant time in a session, the research team suspected John was feeling frightened about Rose's infidelity. The therapist did not "catch" this, and instead stated, "You seem angry." This inaccurate empathy led to John becoming quieter and then correcting the therapist, "I am not angry, but I am really scared." This had a powerful effect of empowering John to reflect on his feelings and then assert himself by informing the therapist of how he perceived his true feeling.

In this research, the therapist herself evaluated the strength of the therapeutic alliance at the end of each session, and her scores mirrored those of the clients, although her scores tended to be lower than the clients'. At no time did she rate herself higher than the clients did, and the research team viewed this as a strength because the scores indicated that at no time in therapy did the therapist believe that things were going well when the clients thought they were not. In this, the therapist demonstrated attunement.

Table 2
Team Conclusions Concerning Therapeutic Alliance Factors

A sound therapeutic alliance affords the therapist the opportunity to take risks with clients and to get away with the risks if they do not work out.
Mistakes and missed opportunities can be used to therapeutic advantage.
Agreement on goals of the alliance is not always possible in multiproblem couples, and this is made up by other qualities such as assurance and understanding. In this regard, the therapist ideally needs initially to be aligned most strongly with the individuals who are most able to keep the clients engaged in therapy and the process moving forward, without compromising the effectiveness of the therapy.
Therapist ratings of the alliance that are higher than those of the client may indicate a mismatch in the therapeutic alliance involving a lack of awareness, on the part of the therapist, of the strength of the alliance. This may lead to client dropout or dissatisfaction.
Clients appear to be able to be more authentic as treatment progresses and are able to evaluate therapy more realistically.
The relationship clients share with the therapist may, in some cases, mirror the relationship they are experiencing with each other.

On the session rating forms, the clients filled out scores related to their relationship with the therapist as well as with each other. Interestingly, the scores these clients gave to the therapeutic alliance mirrored the scores that they gave to their marital relationship. When they had a conflictual session, they gave the therapist lower scores. This is important to consider in that some distressed couples may have more tentative relationships with their therapist, no matter what the therapist does. This might be indicative of their stress levels or of their overall difficulties in establishing relationships. This supports the findings of Knobloch-Fedders, Pinsof, and Mann (2004), whose study showed that marital distress influences the development of the alliance in couple therapy.

Key Component of Change: Hope and Expectancy Factors

Clients become mired down or stuck when they are unable to formulate goals or mobilize themselves to move toward their goals (Snyder et al., 1999; see Table 3). Hope appears to be particularly important in early sessions, and according to Howard (Howard, Moras, Brill, Martinovich, & Lutz, 1996), moving from demoralization to remoralization is the critical first stage of therapy. In this particular case, early changes such as pre-therapy change helped the clients know that change was possible. For example, John did several things early in treatment he had avoided for a long time. He moved a boat that had been sitting in the couple's front yard for seven years; by doing this he quickly rectified a thorny point of contention between the couple. He also bought Rose flowers, something she loved.

Even in the darkest moments in therapy, this couple remained hopeful. The hope scores for both clients and the therapist on the session rating forms were consistently high no matter how volatile the session. For example, in spite of their difficulties, the issue of separation or divorce never arose. The therapist reported that she did not see the affair as being a relationship ender, but rather as a part of their interactional pattern:

> I think that what I did was . . . giving them, I think, a lot of hope . . . I think I gave them a space for the hope to fill in, and I saw it and it allowed them to see it as well, cause I know other couples come in, and I don't feel as hopeful for them. I felt like she . . . they had told me that they . . . kept coming back to each other, and . . . they

were . . . so demonstrative when they were feeling good and so they helped me feel hopeful for them. The only times that I don't feel hopeful is when I can tell one of the couple is really not working to make the marriage healthier—that it's more about just, and I see this every once-in-awhile—it's more like building your case to leave, and that's hard because it's just like spinning your wheels. It's like they've already checked out. So I see much more success and am more hopeful when, even if they've checked out as far as having an affair or saying that they're thinking about leaving or all that stuff, when they're willing to grow. [If they're saying], "I'm not willing to grow in this marriage," you know, "I'm not willing to make it better," . . . it makes it much harder to be [hopeful].

The couple were committed to working things out and staying together and this is an important component of sustained hope and motivation. However, the therapist also did specific actions to create hope. For example, she provided hope by acknowledging the challenge: "It is not easy . . . but you're working on it." During one session, she said, "I am not giving up on you both." On another occasion, she predicted change by asking, "I'm wondering if you'll see a turnaround with the kids?" In another instance, after seeing positive changes, she predicted more changes for the future. In addressing their conflict over parenting, she stated, "You may have different solutions, but you both want the same thing for your child." All of these statements exemplified the therapist's optimism and they collectively seemed to contribute to the overall optimism in therapy. During the course of therapy, the research team noticed the therapist normalizing many of the couple's experiences. By doing so, she again promoted hope and repeatedly assured them that things could be better. Her view of hope was realistic. She said, "It is not easy but you are working on it." She also used a lot of validation and frequently emphasized strengths and positive changes.

In addition to maintaining hope and normalizing the couple's experiences, the therapist skillfully used reframes as a way of engendering hope. For example, she reframed their parenting difficulties from that of two adversaries to that of two people wanting what was best for their children. She reframed Rose's anger and impulsiveness as "high energy, motivation to improve your relationship." The same reframe (energy) was used to describe the daughter who was acting out. The therapist reframed the affair in the context of a long, enduring relationship:

Table 3
Team Conclusions Concerning Hope and Expectancy

Hopefulness has a recursive effect whereby the therapist's hopefulness can lead to increased hopefulness on the part of the couple, which, in turn, may increase the therapist's hopefulness.
Early changes, such as pre-session changes, help clients believe that change can occur and these need to be highlighted early in the therapy.
Therapist hopefulness needs to be evident at the outset of therapy. It is important that this hopefulness be communicated to clients in a genuine and realistic manner.
Reframing is important in the generation of hopefulness. Changing the frame of the problem allows clients to view their problems in ways that are more positive.
Normalizing is a type of reframing that leads to hope.
Supervision and consultation helps therapists move to a positive frame of how change can occur.
Therapists need to communicate to clients that they can help, are committed to the clients, and will not give up on them.

"You trusted once, so you can come to it again . . . you don't have to develop it anew—it is already there." The ex-boyfriend repeatedly driving by their house was a large irritant to John, and the therapist reframed this as "John being the winner who has Rose." The research team was struck by the genuine and even "artistic" manner in which the therapist offered alternative descriptions to the couple's struggles. Over the course of therapy, the therapist's reframes were genuine and meaningful for the couple, who later picked up on the therapist's interpretations and descriptions and used them as well.

Supervision also allowed the therapist to remain hopeful. There were times when she felt discouraged and talked with her supervisor, and then was able to regain her hopefulness. The therapist talked a hopeful language and demonstrated hope. She communicated to her clients that she was able to help them, that she was committed to them, and that she would not give up on them.

Key Component of Change: Therapist Factors

The therapist seemed to be an excellent fit with this particular couple and remained calm (or at least appeared calm) despite a great deal of conflict, much tension, and frequent angry outbursts by the couple (see Table 4). Implicitly, this sent a message to the couple that "your problems aren't so bad that you're freaking me out." The therapist was a strong leader but she worked collaboratively with the clients. She freely communicated her ideas but did not impose her agenda on the process in an authoritarian way. She provided her input in tentative and curious ways and not as directives. If the clients disagreed with something she said, she openly discussed and explained the disagreement, or tried something different.

The therapist did many things difficult to teach or quantify. For example, she delivered suggestions to the couple with seemingly perfect timing, appropriate voice inflection, and genuine empathy. No matter how mired in heated content the couple were, the therapist maintained a focus on process. Another feature of her therapeutic style was the number of times she repeated things in sessions. Her suggestions, offered again and again, seemed to work in a

Table 4
Team Conclusions Concerning Therapist Factors

A major role of the therapist in couple therapy is simply to help the couple stay embroiled in the change process.
Appropriate self-disclosure can be helpful to the therapeutic process.
Clients may need to hear the same thing from a therapist repeatedly before they will internalize it.
Therapists are clearly different with different clients and the ability to fit to clients is an essential therapist skill.
Therapists may operate more from overarching premises or principles of change than specific theories of change.
Therapy is a human process grounded in authentic relating. This is probably how therapists practice in reality. Manualized treatments may move therapists away from this authentic relating.
Therapy works best when therapists do not push their agendas aggressively but fold them into the process.
Therapists do not have to be perfect as therapists or even pretend to be perfect. A therapist who trusts the process does not have all the answers and uses "mistakes" for therapeutic advantage.

hypnotic-like manner, becoming a "mantra" for the clients, who later utilized her words themselves (Helmeke & Sprenkle, 2000).

A feature of the therapist's therapeutic style that initially troubled several members of the research team was her self-disclosure. Potentially a detractor to the therapy and the therapeutic relationship, her disclosure seemed pertinent to the topic of discussion, was delivered at particularly appropriate times, and was utilized sparingly.

Interesting to note, as a team we worked hard to identify the therapist's core theoretical orientation by watching the videotapes, but this was difficult. Each of us could easily identify specific aspects of particular theories, but we could not pin down a consistent theoretical orientation. Despite the therapist later identifying herself as working primarily from an Emotionally Focused perspective, this was not evident in all of the sessions, although we could see parts of it at certain times in the work.

Key Components of Change: Specific Techniques Used by the Therapist

The research team identified many specific techniques used by the therapist; ones not already mentioned include humor, education, planting seeds of change, reflective listening, immediacy, clarification, redirection, and many others. However, these were not interventions separate from the therapy, but were connected to, and woven throughout, the entire process. We were unable to identify *one* specific technique that was responsible for a substantial change on its own, or even for a small part of the change. The clients themselves, in talking about change, were much more interested in the person of the therapist and her relating style than anything specific that she did.

Other Ideas That Arose Out of the Data Analysis

Process dynamics are similar around many differing issues in couple relationships. Marriage and family therapy theorists have long believed that changing the process in therapy is a key to healing. This couple's process in the therapy room helped to illustrate this point for us and exemplified that regardless of content issues, relational dynamics follow a similar pattern. For example, Rose and John discussed parenting issues with the therapist more often than Rose's infidelity. Clearly, parenting was easier to talk about—especially early on—and yet, this talk provided an avenue to talk indirectly about the infidelity. When they did talk about the infidelity, their interactional process was almost the same but with a greater intensity of emotions. Resolutions in the parenting arena appeared to set the stage for resolutions surrounding the infidelity, and as relational process dynamics began to shift, it became easier to address the more emotionally charged content of the affair.

If one of the overall goals of couple therapy is to change the process in the relationship, accessing many different content areas can lead to change. This is particularly important when working with difficult issues such as infidelity or with multiproblem couples. Possibly, therapists can initially focus upon less volatile or "serious" issues in an attempt to assess or work on patterns of behavior. Perhaps this is similar to what Schnarch (1995) refers to as an elicitation window in relation to the dynamics around the sexual relating of a couple in which the interactions around the sexual relationship mirror the dynamics of the relationship as a whole.

Realigning boundaries around the relationship. In this case, it was essential to create a strong couple bond that put the couple on the same team and the children and Rose's boyfriend outside of the marital interactions. As their relationship strengthened, they were able to face challenging issues together as a team. The parenting improved and Rose's boyfriend became less of an issue.

Couple therapy that focuses on emotions is a good approach to treat anger issues. For the research team, this case redefined and provided a model for anger management therapy. This therapy helped the couple identify and address their anger in far stronger ways than an

educational program, for example, could have done. It helped John look at his anger in a relational context. His extreme anger, although inexcusable, "made sense" in the context of the relationship and intervening at the relationship level seemed like an ideal focus of intervention in this case.

DISCUSSION

The process of change and a deep understanding of how this occurs has been the pursuit of therapists, theoreticians, and researchers for decades. We too were trying to understand in a more detailed way how the process of change occurs. In general, the research efforts of our field have primarily focused on understanding the efficacy of models and unique ingredients of change (outcome focus); too few studies explore the process of *how* change occurs.

Several things stood out as we worked with this one case. First, the process of change is complex and multifaceted; as such, it is not easy to manualize in a regimented step-by-step fashion exactly what takes place. In all likelihood, no one specific event in therapy or outside of therapy was the key to change; we were not even able to identify a systematic sequence of closely related events. Rather, it seems as if the combination of several events, many unrelated, had the additive effects of bringing about change. Further, in this case, the process of change was an interactional dynamic between the therapist and clients. Some change events were contributed by the clients, some by the therapist, and some were random chance occurrences. Collectively, they led to changes in a relationship. It seems that during the therapy process, enough things moved in the right direction to allow for a sustained change. It is important to note that change is not a discrete variable but it is rather a concept that is more useful to think about in continuous terms. Yes, this couple did change. Was it significant? The couple reports it was to them. They seemed pleased with their investment in therapy.

Could the clients have changed on their own, separate from therapy? We asked this question repeatedly. While it is impossible to know the answer for sure, it seems that, by their report, their participation in therapy was very important and significant. Their engagement in therapy was a key variable in this regard. Ironically, their court order helped to get them in the door, and the therapist helped by making therapy comfortable and safe. The clients came to work, and the therapist worked with them. John and Rose have different timing relative to their engagement in treatment, as occurs with many couples. From the quantitative session rating scores, it appears that the clients gave the therapist a period of grace. Early on, their scores of the alliance were only average and reflected ambivalence about treatment. However, after the couple bought in to treatment, their scores on the alliance were consistently high and they never wavered. It appears that if therapists earn the trust of their clients in the early sessions, it is likely that clients will join the therapeutic process and sign on for a period of sessions.

The extratherapeutic events seemed to help this couple change. Even though these events, at times, created a crisis and deep anxiety, they allowed the couple's key emotional processes to emerge. We wondered if therapists should do more to create crises in the lives of clients by inviting them to face their deepest fears or creating challenges that stir up their emotional issues. For example, in some cases, inviting a key family member such as an estranged parent to a session can stir up deep anxieties that help change occur. In the case of the couple in this study, naturally occurring extratherapeutic events provided rich content that highlighted the central part of the couple's relational dynamics. We wondered if therapists ask enough about events outside of therapy on a routine basis in that they are not written into treatment manuals or theories. As a result, we have few instructions as to how to deal with them, yet these events can have a significant influence on change processes.

Every couple and family come to therapy with many ongoing life events, all presenting windows into the couple process as well as key opportunities for change. While many of these are normative occurrences, some are random and unexpected. These events create stressors and strains and can change the way people see themselves and their lives. Although failure to notice these events may not matter in the long run, in some cases these events may represent the key doorway or perhaps the only chance to address the couple's underlying issues. Positive events need to be used to therapeutic advantage (e.g., validation, cheerleading, punctuation, support). Negative extratherapeutic events tend to bring the couple process into the present and provide key opportunities to strengthen the therapeutic relationship through empathy, concern, and deep understanding.

In this regard, then, we realized that it is important to process extratherapeutic events in sessions, as much as seems relevant, but it is also important not to attach a value to these events. Even the worst events present an opportunity for change that might be missed if they are only viewed as negative events. In the above example, a cancer scare and a job loss were both positive in helping the couple's relationship to heal. Additionally, even though therapists do not always profess to love court orders or mandated clients, the court order in this case "forced" the couple into therapy and the therapist did a good job of turning this into positive motivation. Even though Rose was not court ordered, she saw herself as having anger issues as well, saw her involvement in the relational dynamics, and wanted to be part of the process. In this regard, the court order for her husband was leverage for her involvement in the therapeutic work. The key with these events seems to be related to *how* the therapist utilized them (i.e., as process vs. content) and what frames were placed on them.

We were also struck by examples of the therapeutic relationship in this case. It was truly a human endeavor. The therapist was not perfect, made mistakes, and offered awkwardly worded statements at times. However, these did not get things off track and, in instances, seemed to help the process. As a research team, we concluded that "missed opportunities" look different in the big picture of the process, i.e., once the therapy was complete. The direction the therapist took in these instances and/or the reaction and meaning given to these instances by the clients moved therapy in a direction that we never could have anticipated. Some "mistakes" we witnessed were subtle strategies on the part of the therapist that could not be understood outside of their context. For example, the therapist chose to align more with Rose to keep the couple in therapy. Although in some cases this might have been a judgment error, this therapist used her intuition and experience to take this path and it worked out very well.

Team members were struck at how much we learned from each other and about the process of change as we did this work. This kind of research presents a valuable endeavor for all therapists, both novices and experts, and doing this kind of research with our clients will enhance our therapeutic work. Further, the idea of focusing on outcomes in treatment on a case-by case basis also has a great deal of merit. For example, in this case, the therapist was able to obtain a session-by-session reminder of how things were going by reading the feedback forms. She would read the session feedback forms and this informed her thinking for the next session and at times provided content to be introduced to the clients. She stated that she "would read the sheet and see that he [John] did not feel very connected to me in the session. The next session I would make a conscious effort to make sure he felt attended to." We believe that this kind of research endeavor, along with feedback from clients on a session-by-session basis, can be a valuable component of therapist training and development (Duncan, Miller, & Sparks, 2004).

LIMITATIONS

While this research has value, it also has limitations. As a single-case study, it is certainly not generalizable to all therapy. Further, we are aware that as a research team, we brought

biases related to our own individual beliefs, group dynamics, and university context. A more quantitative data analysis such as observational coding might have afforded different results. However, such an approach would not have allowed for the richness of our discussions and might have precluded noticing important events that were not easy to quantify in the process.

CONCLUSION

This research study, an in-depth analysis of one couple, presents an alternative way to understand the process of change and gives us a window into how change occurs. While we do not offer this approach as a replacement for efficacy and effectiveness research, we believe it has merit in terms of theory development, and in terms of connecting research to relevant and meaningful clinical change events. As the recent APA Presidential Task Force on Evidence-Based Practice (2006) emphasizes, multiple research designs contribute to evidence and different research designs are better suited to address different kinds of research questions. This design fit our research questions well. We also believe that the process of obtaining client feedback from therapy in sessions provides invaluable data, and this is currently a standard part of some therapies (see, for example, the work of Duncan et al., 2004). Further, the process of analyzing data with a group of therapists has promise in terms of therapist training and development.

REFERENCES

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271–285.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In S. D. Miller (Ed.), *The heart and soul of change: What works in therapy* (pp. 133–178). Washington, DC: APA.

Beutler, L. E., Williams, R. E., & Wakefield, P. J. (1993). Obstacles to disseminating applied psychological science. *Applied and Preventative Psychology, 2*, 53–58.

Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy, 27*, 385–402.

Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy, 33*, 298–317.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252–260.

Bowen, M. (1978). *Family therapy in clinical practice*. New York: Jason Aronson.

Bradbury, T. N., Fincham, F. D., & Beach, S. R. (2000). Research on the nature and determinants of marital satisfaction: A decade in review. *Journal of Marriage and Family, 62*, 964–980.

Duncan, B. L., Miller, S. D., & Sparks, J. (2004). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. San Francisco: Jossey-Bass.

Elliott, R. (1989). Comprehensive process analysis: Understanding the change process in significant therapy events. In M. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 165–184). Albany, NY: SUNY Press.

Gottman, J. M. (1999). *The marriage clinic: A scientifically-based marital therapy*. New York: Norton.

Gottman, J. M., & Notarius, C. I. (2000). Decade review: Observing marital interaction. *Journal of Marriage and Family, 62*, 927–947.

Greenberg, L. (1999). Ideal psychotherapy research: A study of significant change processes. *Journal of Clinical Psychology, 55*, 1467–1480.

Helmeke, K. B., & Sprenkle, D. H. (2000). Clients' perceptions of pivotal moments in couple's therapy: A qualitative study of change in therapy. *Journal of Marital and Family Therapy, 26*, 469–484.

Henggeler, S. W., & Sheidow, A. J. (2003). Conduct disorder and delinquency. *Journal of Marital and Family Therapy, 29*, 505–522.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*, 196–205.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). The evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*, 1059–1064.

Hubble, M. A., Duncan, B. L., & Miller, S. (1999). *The heart and soul of change: What works in therapy*. Washington, DC: APA.

Johnson, L. D. (1995). *Psychotherapy in the age of accountability*. New York: Norton.

Johnson, S. M. (2002). Marital problems. In D. H. Sprenkle (Ed.), *Effectiveness research in marriage and family therapy* (pp. 163–190). Alexandria, VA: AAMFT.

Johnson, S. M. (2004). *The practice of emotionally focused couple therapy: Creating connection* (2nd ed.). New York: Brunner-Routledge.

Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process, 43*, 425–442.

Mahrer, A R., & Boulet, D. B. (1999). How to do discovery-oriented psychotherapy research. *Journal of Clinical Psychology, 55*, 1481–1493.

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*, 250–260.

Pinsof, W. M. (1995). *Integrative problem-centered therapy*. New York: Basic.

Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy, 26*, 1–8.

Schnarch, D. (1995). *Passionate marriage*. New York: Guilford.

Shadish, W. R., & Baldwin, S. A. (2002). Meta-analysis of MFT interventions. In D. H. Sprenkle (Ed.), *Effectiveness research in marriage and family therapy* (pp. 339–370). Alexandria, VA: AAMFT.

Snyder, C. R., Michael, S. T., & Cheavens, J. S. (1999). Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies. In M. A. Hubble, B. L. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 329–360). Washington, DC: APA.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15–28.

Sprenkle, D. H. (Ed.). (2002). *Effectiveness research in marriage and family therapy*. Alexandria, VA: American Association for Marriage and Family Therapy.

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

Sprenkle, D., & Blow, A. J. (2004b). Common factors are not islands—they work through models: A response to Sexton, Ridley, & Kleiner. *Journal of Marital and Family Therapy, 30*, 151–158.

Sprenkle, D. H., Blow, A. J., & Dickey, M. H. (1999). Common factors and other nontechnique variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 329–360). Washington, DC: APA.

Talman, K., & Bohart, A. C. (1999). The client as a common factor: Clients as self-healers. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 91–131). Washington, DC: APA.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum.

NOTES

[1]This study was fully approved by the Saint Louis University Institutional Review Board, IRB# 11455.

[2]Key information is changed on these clients to protect their identity. The clients both agreed to participate in the research and gave permission to publish the findings from the study.