Empathy in couple therapy for depression: A discourse analysis of couple
and therapist talk in mutual understanding events

Submitted by Theo Roberts to the University of Exeter in part fulfilment for the
degree of Doctor of Clinical Psychology, May 2015

Word count: Literature Review: 3,979 (excluding table)
Empirical Paper: 7,978

This thesis is available for Library use (after embargo period) on the
understanding that it is copyright material and that no quotation from the thesis
may be published without proper acknowledgement.

I certify that all material in this thesis which is not my own work has been
identified and that no material has previously been submitted and approved for
the award of a degree by this or any other University.
Table of Contents

List of Tables .................................................................................................................. 5

LITERATURE REVIEW

Couple Therapy Process Research: A Systematic Review of the Evidence

Abstract ............................................................................................................................ 7

Introduction ....................................................................................................................... 8

Systematic Review Rationale ....................................................................................... 9

Aim of the Review ......................................................................................................... 10

Method ............................................................................................................................ 10

Data Screening and Sampling .................................................................................... 10

Screening Procedure ................................................................................................... 11

Evaluation Criteria ....................................................................................................... 12

Findings .......................................................................................................................... 21

Aim of the Studies ....................................................................................................... 21

Method and Data Analysis .......................................................................................... 22

Limitations and Bias .................................................................................................... 24

Main Findings and Implications .................................................................................. 25

Discussion ...................................................................................................................... 30

References ....................................................................................................................... 33
Appendix A: CASP checklist .......................................................... 39
Appendix B: Search Strategy .......................................................... 40

EMPIRICAL PAPER

Empathy in couple therapy for depression: A discourse analysis of couple and therapist talk in mutual understanding events ................. 41

Abstract ......................................................................................... 42

Introduction .................................................................................... 43
Couple Therapy ............................................................................... 43
Exeter Model Couple Therapy for Depression ................................. 44
Partner Empathy as Mutual Understanding .................................. 45
Process Research ............................................................................ 47
Discourse Analysis .......................................................................... 48

Aim of the Study ............................................................................. 49

Method ............................................................................................ 49
Design ............................................................................................... 49
Data Collection ............................................................................... 49
Data Screening and MU Event Transcription ................................. 50
Method of Analysis ......................................................................... 51

Analysis ............................................................................................ 53
Location, Frequency, and Initiation of MU Events ......................... 53
Positioning in MU ........................................................................... 54

Extract 1: allowing agency. .............................................................. 54
List of Tables

Literature Review

Table 1. Summary of main findings from the systematic review.................14
Couple Therapy Process Research: A Systematic Review of the Evidence

Trainee Name: Theo Roberts
Primary Research Supervisor: Dr Janet Smithson
Senior Lecturer, University of Exeter
Secondary Research Supervisor: Professor Janet Reibstein
Visiting Professor, University of Exeter
Target Journal: Family Process
Word Count: 3,979 words (excluding abstract, table, and references) and appendices: 4,133 words

Submitted in partial fulfilment of requirements for the
Doctorate Degree in Clinical Psychology, University of Exeter
Abstract

There is considerable evidence that couple therapy is effective, both in improving relationship satisfaction and in treating diagnosed mental health problems. Research in couple therapy has emphasised the need for further process research, examining how change occurs and how positive outcomes are achieved. There is now a growing body of couple therapy process literature available. This qualitative systematic review, based on PRISMA and CASP guidelines, aimed to identify and review existing findings in couple therapy process research. A thorough literature review was conducted in the three main journals publishing couple therapy research, and in relevant online databases. The systematic search strategy yielded an initial sample of 121 studies, of which 19 were retained following specific inclusion criteria: couple therapy session data, empirical orientation, and a focus on the process of change. The review presents and critically evaluates studies’ aims, methodologies, findings, and limitations, in relation to current research and practice in couple therapy. Findings from the review highlight the breadth of processes and models investigated, the value of task-analysis, the need for methodological developments, and a regrettable paucity of cross-reference in the field. Recommendations for future research include the study of processes that inhibit change, the utilisation of multiple measures of change, and the use of micro-analytic sequential methods, such as conversation and discourse analysis, in order to match progress in family therapy process research.

Keywords: Change Mechanisms; Couple Therapy; Evidence-Based Practice; Relationship Satisfaction & Distress; Qualitative Research.
Introduction

There is now extensive evidence that couple therapy works (Sprenkle, 2012). Couple therapy not only positively impacts about 70 per cent of couples who receive treatment, but is also effective for people experiencing a range of mental health problems (Lebow, Chambers, Christensen, & Johnson, 2012). A number of couple therapy models have been developed, some of which have a strong evidence-base regarding their effectiveness.

As in other therapy traditions, the field of couple therapy has experienced a “models war” (Imber-Black, 2011, p.270). This conflict has been critiqued for lacking evidence, as there have been no valid comparisons between couple therapy “schools”, for example through randomised controlled trials (RCTs) (Gurman, 2011). Others have contested that “common factors” can explain the positive impact of couple therapy, rather than therapists’ theoretical school, which leaves the dispute unresolved (Davis & Piercy, 2007; Halford & Snyder, 2012; Sexton, Ridley, & Kleiner, 2004).

In recent years, clinicians have increasingly needed to demonstrate that there is robust outcome evidence for the approach they rely on in their practice (Larner, 2004). As in therapy more generally, this has led to a growth in much-needed outcome research in couple therapy (for a review, see Lebow et al., 2012). However, research into how couple therapy works remains sparse.

Process research, as argued by Sevier, Atkins, Doss, and Christensen (2013), is “vital for understanding how therapy works, improving treatments, and providing intermediate markers for clinicians on client progress during therapy” (p.1). It also bridges the gap between clinicians and researchers
For some years, process studies have been called for in couple therapy to advance our understanding of how change occurs (Johnson & Lebow, 2000; Snyder & Halford, 2012). Fortunately, researchers have started to respond to these calls. The field now boasts a growing body of process research.

However, process studies often “follow their own path” (Garfield, 1990, p.278) by exploring a wide array of therapy models and a range of constructs with conflicting definitions. Garfield (1990) critiqued process researchers for following a particular theoretical interest and reporting overly optimistic conclusions from their findings. Methodological advances have improved this state of affairs in recent years, for example with improved guidance on specific methodologies (Elliott, 2010, 2012), and the development of systematic methods such as task analysis (Greenberg, 2007). Nonetheless, process research findings in couple therapy remain disparate at best and inconsistent at worst (Gurman, 2011). Evaluating these findings in an attempt to integrate them is a first step in identifying what is known, and which areas require further exploration.

**Systematic Review Rationale**

Reviews have been carried out focussing on the efficacy (Sprenkle, 2012) and effectiveness (Lebow et al., 2012) of couple therapy, but process research reviews have been more limited in scope. Some reviews have identified parts of this body of research, such as emotion-focused therapy (EFT) process research (Greenman & Johnson, 2013), common factors (Halford & Snyder, 2012), or process and outcome associations (Lebow et al., 2012).
However, a thorough literature search suggested that to date, no systematic review of process research for couple therapy has been published. The present systematic review was therefore prompted by the following question: What are the empirical research findings for change processes in couple therapy?

**Aim of the Review**

The systematic review aimed to offer a thorough account of findings from couple therapy process research studies. Critically evaluating and compiling these findings was viewed as timely, as process research in the field remains dispersed and lacks cross-reference.

**Method**

This review adhered closely to the preferred reporting items for systematic reviews and meta-analyses guidance (PRISMA, Liberati et al., 2009). The PRISMA checklist is primarily designed for quantitative outcome research reviews. It therefore has limitations when applied to therapy process research, which often utilises complex qualitative analyses from small data samples. Therefore, elements of Tseliou’s (2013) methodology review of qualitative family therapy studies were used to complement PRISMA guidelines. Finally, I utilised the critical appraisal skills programme (Chenail, 2011; CASP, 2013) eight-item checklist to evaluate qualitative studies in the sample (Appendix A). I awarded one point for each fully met criterion.

**Data Screening and Sampling**

I carried out a progressive screening procedure (Figure 1). Search terms used are available in Appendix B. I first searched the three main international
journals that publish couple therapy research: *Family Process*, *Journal of Family Therapy*, and *Journal of Marital and Family Therapy*. EBSCOhost, Medline and Psycharticles databases were also searched.

![Figure 1. Summarised data sampling procedure with number of studies generated for each screening level.](image)

**Screening Procedure**

The initial literature search yielded 121 articles that met the search criteria. I then screened article abstracts for inclusion criteria:

1. Quantitative and qualitative data used came from couple therapy sessions.
2. Evidence of an empirical orientation: Analysis of clinical data and reporting of findings.
3. Focus on process of change and mediators in therapy.
Although novel approaches to exploring therapy process post-hoc have been developed, this review aimed to emphasise the use of empirical data from therapy, which is why I chose therapy session data as an inclusion criteria. Following these criteria, I excluded studies that examined family therapy rather than couple therapy. Articles where the main focus was theoretical or methodological issues with limited empirical data were also excluded. Finally, I excluded empirical studies that focused on therapy outcomes rather than process or change mechanisms. These exclusion criteria yielded an initial sample of 21 studies, from which a further two studies were excluded: One study relied solely on data from post-treatment research interviews with couples (Christensen, Russell, Miller, & Peterson, 1998), and one examined methodological issues in measuring change in couple therapy (M. Olson & Russell, 2004). I examined references from articles that reviewed process research studies (for e.g. Johnson & Wittenborn, 2012) to identify if further studies could be included for the review. Despite this further search, the final literature review sample still contained 19 studies.

**Evaluation Criteria**

To evaluate the studies, articles were organised based on a combination of PRISMA gold-standard recommendations (Liberati et al., 2009) and Tseliou's (2013) critical approach to reviewing qualitative analysis family therapy studies. I reviewed the studies with a focus on the following dimensions:

1. Aim of research (therapy process under study).
2. Method (type, rigour, quality of research standard).
3. Data / sample.
4. Type of analysis.

5. Risk of bias / limitations

6. Content and clinical relevance of findings.

Finally, qualitative studies were scored using the CASP (2013) checklist.

After gathering this information, I identified similarities across studies in their aims, methodologies and analyses. I then examined the studies for risk of bias and limitations, including those stated by the authors. I summarised key research findings and implications for clinical practice. I also searched for themes within the studies’ findings. Finally, I carried out a critical appraisal of the studies, aiming to offer preliminary insight into the strength and limitations of existing evidence in couple therapy process research.
### Table 1
Summary of main findings from the systematic review

<table>
<thead>
<tr>
<th>Reference</th>
<th>CASP score</th>
<th>Aim</th>
<th>Design/ method</th>
<th>Data</th>
<th>Analysis</th>
<th>Risk of bias / limitations</th>
<th>Findings and clinical relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benson, Sevier, and Christensen (2013)</td>
<td>N/A</td>
<td>To “examine whether increases in attachment security predict improvements in marital satisfaction during behavioral couple therapy” (p.407)</td>
<td>Longitudinal observational design using RCT data</td>
<td>134 couples in RCT Client self-report scores at pre, mid, and post treatment, and two and five year follow-up</td>
<td>Multilevel model analyses of self-report scores for marital satisfaction and attachment style</td>
<td>Firm conclusions despite data collection issues</td>
<td>Changes in marital satisfaction through BCT may lead to changes in attachment rather than the reverse</td>
</tr>
<tr>
<td>Blow et al (2009)</td>
<td>5/8</td>
<td>“Explored the process of how change occurred for one distressed couple and a specific therapist in a naturalistic setting” (p.350)</td>
<td>Case study design</td>
<td>Single case Pre and post scores Videotaped sessions</td>
<td>Discovery-oriented approach Iterative team analysis of videotaped sessions</td>
<td>Selected case Team analysis Cross analysis only with couple and therapist</td>
<td>No systematic sequence to change Important impact of extra-therapeutic events Therapist factors were key in maintaining positive therapeutic alliance</td>
</tr>
<tr>
<td>Bradley and Furrow (2004)</td>
<td>6/8</td>
<td>To “identify specific therapist behaviors that facilitate softening events in emotionally focused therapy (EFT) for couples” (p.233)</td>
<td>Task analysis of selected therapy events (resolved blamer softening events)</td>
<td>Four video/audio taped sessions with EFT expert therapist and transcripts Presence of therapist-initiated softening event in session</td>
<td>Discovery-oriented task analysis using EFT and counselling responses coding schemes Thematic analysis</td>
<td>Only one therapist Therapist was main author of approach (EFT) No analysis of unsuccessful softening attempts</td>
<td>Empirically derived map of therapist interventions in successful blamer softening events “Processing fears of reaching” identified as pivotal intervention</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Purpose and Design</td>
<td>Data Collection</td>
<td>Analysis</td>
<td>Results and Conclusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butler and Wampler (1999)</td>
<td>N/A</td>
<td>To conceptualize and investigate treatment process as it relates to the occurrence of struggle versus cooperation</td>
<td>Mixed methods: Repeated measures design (ABBA) Qualitative analysis</td>
<td>Videotapes of one session intervention with 25 couples</td>
<td>Comparison of measures of struggle and cooperation in therapist-responsible vs. couple-responsible process conditions Experimental therapy session embedded into ongoing therapy Student therapists Possible artificial dichotomy between conditions Enactment and inductive process was associated with reduced couple struggle and improved clinical outcomes, compared to therapist directive approach which increased couple struggle and reduced positive outcomes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butler, Harper, and Mitchell (2011)</td>
<td>N/A</td>
<td>“Examined enactments as a therapy process and change mechanism to promote secure attachment in couple therapy” (p.203)</td>
<td>Repeated measures design Enactment first then therapist-centred vs. Therapist-centred then enactment (3+3 sessions)</td>
<td>16 couples six session interventions Pre and post session scores at each session on attachment security and dyadic adjustment</td>
<td>Comparison of within and between session change for enactment first vs therapist-centred first conditions, using ANOVA and t-tests Pilot study Limited sample for quantitative analysis and no control group Inexperienced therapists Use of a not statistically validated measure (SAM) Enactment centred sessions first increased female partners’ attachment security more than therapist centred sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doss, Rowe, Carhart, Madsen, and Georgia (2011)</td>
<td>N/A</td>
<td>To identify the frequency, nature, and predictors of sudden gains (SGs) in couple therapy and their contribution to therapy outcomes</td>
<td>Longitudinal observational design with 18 month follow-up</td>
<td>67 couples in therapy at veterans’ clinic Client reports on symptoms, relationship satisfaction, and behaviour change</td>
<td>Two-level hierarchical linear modelling of data, with a pre-defined definition of SGs Relied on clients’ self-reports of change Specific client-group (veterans) SGs occurred for a significant minority (25%) of couples, and can explain the entire gains for some couples Benefits of these gains were lost at 18 month follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>N/A</td>
<td>Study aim</td>
<td>Methods</td>
<td>Findings/Conclusions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furrow, Edwards, Choi, and Bradley (2012)</td>
<td>6/8</td>
<td>“Examined the effects of a therapist’s emotional presence in predicting heightened levels of client emotional experience in blamer softening events” (p.39)</td>
<td>Task analysis of blamer softening events (unstated)</td>
<td>Therapist emotional experiencing may be necessary for softening events to be successful and promote change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Secondary data</td>
<td>Small sample size for quantitative comparison</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Content analysis of blamer-softening events using measures of emotional experiencing</td>
<td>Biased sample (expert vs. non expert comparison?)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Presence of therapist-initiated softening event in session</td>
<td>No inclusion of broader therapy context</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Therapists need to engage in attachment-related affect (e.g. fear)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glebova et al (2011)</td>
<td>N/A</td>
<td>“To explore relationships between changes in alliance and in progress from clients’ and therapists' perspective … during the initial stage of therapy” (p.42)</td>
<td>Longitudinal observational design</td>
<td>Therapeutic alliance was established from first contact on and remained stable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>195 couples in therapy with seven student therapists</td>
<td>Better baseline relationship satisfaction predicted better therapeutic alliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Client-rated relationship satisfaction and client and therapist rated therapeutic alliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Structural equation modelling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Autoregressive cross-lagged model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helmeke and Sprenkle (2000)</td>
<td>8/8</td>
<td>To Identify clients' perceptions and experiences of pivotal moments in Grounded theory qualitative study</td>
<td>Video/audiotapes of therapy sessions (three couples, one)</td>
<td>Pivotal moments were highly individualised events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grounded theory analysis of session transcripts with</td>
<td>Repetition and presenting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Page</td>
<td>Methodology</td>
<td>Results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jacob, McMonigle, and Metzger (2014)</td>
<td>2/8</td>
<td>To demonstrate the use of existential themes in couple counselling</td>
<td>Case vignette from one couple therapy, researcher/clinician reflections on therapy process. No cross-validation. Problems were related to pivotal moments. Change may occur through specific moments in therapy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson and Greenberg (1988)</td>
<td>3/8</td>
<td>To analyse the process of change in the “best” sessions of EFT</td>
<td>Post-hoc comparison of “best sessions” for high vs. low couples, comparison of response rates on measures. Softening only found in successful couples’ best sessions. Successful couples showed higher levels of emotional experiencing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Olson, Laitila, Rober, and Seikkula (2012)</td>
<td>4/8</td>
<td>To examine the nature of dialogue as it progresses in couple therapy for depression</td>
<td>Four videotaped and transcribed couple therapy sessions, team qualitative analysis using Bakhtinian concepts. Interpretation of clinical material highly tinted by theoretical model. No consideration of limitations. Careful listening on the part of the therapist was critical in developing genuine dialogue in the couple. Dialogical listening may foster sudden changes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Papp, Scheinkman, and Malpas</td>
<td>4/8</td>
<td>To describe how “sculpting brings forward the gestalt</td>
<td>Three case examples, researcher/clinician reflections on use. Findings based on clinician observation with. Sculpting may be a powerful tool for therapists to open up and...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Study</td>
<td>Research Design</td>
<td>Method</td>
<td>Key Findings</td>
<td>Implications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Schade et al.</td>
<td>Longitudinal observational design</td>
<td>Segments of sessions 3, 7 and 11 of 12-session couple therapy with 11 couples</td>
<td>Segments of sessions coded using the Iowa Family Interaction Rating Scale (IFIRS) Multilevel modelling</td>
<td>No triangulation of data (e.g. use of outcome or process data)</td>
<td>Explore process when faced with impasses in couple therapy</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>Schade et al.</td>
<td>Longitudinal observational design</td>
<td>134 couples' dyadic adjustment scores</td>
<td>Multilevel modelling (repeated measures nested within individuals nested within couples)</td>
<td>Construct issues of labelling &quot;positive&quot; and &quot;negative&quot; behaviours</td>
<td>Therapist warmth towards husband associated to husband warmth towards wife</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>Sevier, Atkins, Doss, and Christensen</td>
<td>Longitudinal observational design</td>
<td>Husband and wife behaviour rated on 1224 segments from 956 therapy sessions</td>
<td>Absence of client perspective (external observers)</td>
<td>TBCT and IBCT show different patterns of change in positive and negative behaviours in couples</td>
<td>Therapist warmth may invite emotional experiencing for men</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>Meneses and Greenberg</td>
<td>Task analysis of therapy sessions</td>
<td>Eight couples in therapy Videotaped and transcribed sessions Client-rated forgiveness and</td>
<td>Discovery-oriented task analysis Comparison of resolved vs. unresolved couples Self-referred couples Specific sample (betrayed women) No client</td>
<td>Empirical model of emotional injury resolution</td>
<td>Injurer's expression of shame and empathic distress was central to forgiveness</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Study Code</td>
<td>Summary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wittenborn (2012)</td>
<td>6/8</td>
<td>The study “addressed whether the attachment organizations of novice couple and family therapists were associated with couples’ experiences of their therapists, therapeutic alliance, session impact, and EFT fidelity” (p.50)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woolley, Wampler, and Davis (2012)</td>
<td>N/A</td>
<td>“To identify therapist interventions associated with positive change during… enactments” (p.284)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Wittenborn (2012) 6/8

**Methodology**
- Embedded multi-case design

**Findings**
- Seven novice therapists’ scores on adult attachment and emotion regulation measures, and EFT fidelity
- Couples’ scores on working alliance and session evaluation measures
- Observation of sessions

**Comparison**
- Cross-case analysis using attachment theory framework

**Discussion**
- Comparisons made despite small sample size (N=7)
- No measure of client attachment and relational dimension of attachment
- Simulated sessions

- More securely attached therapists were better at delivering EFT
- Dismissing therapists may avoid expressed emotion in sessions, and feel less effective at affect regulation
- Insecurely attached therapists may elicit more split alliances

### Woolley, Wampler, and Davis (2012) N/A

**Methodology**
- Task-analysis of therapy segments

**Findings**
- 117 enactment segments from 41 couple therapy cases

**Analysis**
- Regression analysis of coded therapist and couple interactions
- Multivariate analysis of variance comparing positive and negative enactments
- Small non-random sample

**Discussion**
- Enactments facilitated healthy relational interactions
- Therapists directing and working with emotions was related to husband positive interaction and therapist structuring related to wife positive interactions
- Structuring, directing, and supporting were used more often with positive
| Zuccarini, Johnson, Dalgleish, and Makinen (2013) | 7/8 | To empirically validate steps in the attachment injury reparation model (AIRM), a forgiveness and reconciliation model from EFT | Task analysis of AIRM events using pre-defined coding scales | Audiotapes of nine resolved and nine unresolved injured couples’ therapy sessions | Comparison of presence and absence of AIRM steps for resolved and unresolved couples using Fisher’s exact test | Frequency of specific EFT interventions | Small sample size: may have overlooked particular types of attachment injury | Resolved couples completed all eight steps of AIRM while unresolved couples only completed initial four steps | Injury softening occurs through forgiveness phase described in AIRM |
Findings

A summary of the studies is presented in Table 1, with details for the six dimensions and CASP scores.

Research into couple therapy process is a relatively recent venture, with only two studies published before 2000. Fifteen of the 19 studies were published from 2011, possibly reflecting a general increase in academic publications in recent years. Studies focused on change processes for specific models. EFT showed thorough deployment of process studies \((n = 7)\), while behavioural couple therapy (BCT), both traditional and integrative, also showed a commitment to the study of change processes \((n = 2)\). Other therapy models were examined, including existential couple therapy (Jacob et al., 2014) and open dialogue (M. E. Olson, Laitila, Rober, & Seikkula, 2012). Most studies did not explicitly state either the therapeutic approach under study or the therapists’ model \((n = 8)\).

Aim of the Studies

The first finding concerned the diversity of processes explored in couple therapy process research. However, three main themes emerged from reviewing the studies’ aims:

- Sequence / mechanisms of change.
- Therapist variables / behaviours.
- Theory validation.

Most of the studies \((n = 10)\) examined either the sequence of change over time in therapy (Blow et al., 2009; Doss et al., 2011; Helmeke & Sprenkle,
2000; M. E. Olson et al., 2012; Sevier et al., 2013), or how specific mechanisms were associated with change (Benson et al., 2013; Butler et al., 2011; Butler & Wampler, 1999; Glebova et al., 2011b; Johnson & Greenberg, 1988). Six studies explored either therapist variables in couple therapy, including therapist emotional presence (Furrow et al., 2012), attachment pattern (Wittenborn, 2012), and existential stance (Jacob et al., 2014), or effective therapist interventions, such as blamer softening (Bradley & Furrow, 2004), sculpting (Schade et al., 2014), and enactments (Woolley et al., 2012). Finally, three EFT studies aimed to validate previously developed change process models, including blamer softening (Bradley & Furrow, 2004) and forgiveness and reconciliation (Meneses & Greenberg, 2011; Zuccarini et al., 2013).

Although these categories discriminated the studies’ aims satisfactorily, there was some overlap. One study focused on both therapist behaviours and theory validation (Bradley & Furrow, 2004), and one examined the sequence of change while aiming to validate hypothesised differences between traditional BCT (TBCT) and integrative BCT (IBCT) (Sevier et al., 2013).

**Method and Data Analysis**

Three main methodologies were identified:

- Case study design.
- Task analysis of therapy events.
- Longitudinal observational design.

Four studies employed a case study design (Blow et al., 2009; Jacob et al., 2014; M. E. Olson et al., 2012; Papp et al., 2013), and four utilised task analysis (Bradley & Furrow, 2004; Furrow et al., 2012; Meneses & Greenberg,
2011; Zuccarini et al., 2013), although Furrow et al. (2012) did not explicitly state this method. Another four studies relied on longitudinal observational design, that is measuring change over time in clinical settings using quantitative and qualitative measures (Doss et al., 2011; Glebova et al., 2011b; Schade et al., 2014; Sevier et al., 2013).

This left seven studies with less common approaches. Two studies by Butler and colleagues (Butler et al., 2011; Butler & Wampler, 1999) utilised experimental repeated measures designs to test a hypothesised change process. Johnson and Greenberg (1988) utilised mixed methods to compared scores obtained from coding qualitative data. Finally, one study relied on self-report process data from a randomised controlled trial (Benson et al., 2013), one employed a grounded theory qualitative design (Helmeke & Sprenkle, 2000), and one applied embedded multi-case design (Wittenborn, 2012).

Sample size varied from one couple in case study designs (e.g. Blow et al., 2009) to 195 couples in therapy a longitudinal observational design study (Glebova et al., 2011b). However, most studies used relatively small samples, particularly when coding session transcripts.

Researchers used from one to three types of data in the same study, including client and therapist scores on outcome measures, session videos and audiotapes, transcripts, coded qualitative data, interviews with clients, and therapist notes and observations.

Task analysis methodology showed greater uniformity of design than other approaches, possibly as this method has clear guidelines (Greenberg, 2007). Task analysis appeared closely wedded to EFT research, which may
explain that protocols were more systematic. While case study design is a methodology both researchers and clinicians are usually familiar with, its application to process research showed significant variability across the four studies, both in underlying theories and in data analysis.

Studies that utilised longitudinal observational designs demonstrated methodological ingenuity in investigating processes that are complex to measure. In some cases, elaborate statistical analyses were required to model change over time. For example, Doss et al. (2011) used hierarchical linear modelling after having operationalised “sudden gains” in therapy in terms of session outcome score changes. Other studies coded therapy segments before using multilevel modelling to analyse the data (Schade et al., 2014; Sevier et al., 2013).

Limitations and Bias

Three main areas were identified as limitations in the sample of studies. First, studies’ methodology showed potential for bias. Four studies utilised limited samples of three or fewer cases, and most studies (n = 13) relied on self-selected or researcher-selected samples, meaning that the processes under scrutiny may have been strongly influenced by client characteristics. Moreover, the complexity of process research data led some researchers to deploy multiple stepped analyses. While these complex mixed methods may be necessary, in some studies any possibility of replication was compromised (for e.g. Butler & Wampler, 1999). This becomes problematic when researchers make generalisation claims from their findings. Studies also used unpublished (Bradley & Furrow, 2004) or non-validated (Butler et al., 2011) measures at key stages of their analysis process, which confounds research progression. Direct
measures of client perspectives were also absent from many studies \((n = 12)\), which is surprising given that research when couples are asked about change in interviews, they report more positive change than in self-report measures (M. Olson & Russell, 2004).

Second, study findings and conclusions showed risk of bias. The analysis in case studies was often richly intertwined with theoretical reflections (e.g. M. E. Olson et al., 2012). While these types of analyses offered interesting theory-practice links, they further blurred the boundary between observed clinical data and theoretical inferences. In addition, all studies that made predictions found support for at least some of their predictions, at times through an optimistic interpretation of problematic data (e.g. Benson et al., 2013).

Finally, an overall observation of bias was the lack of cross-reference between studies, which is surprising given the specialist nature of the field. However, despite these limitations, findings showed interesting research and clinical implications.

**Main Findings and Implications**

I classified the main findings according to the same categories as study aims: sequence and mechanisms of change, therapist variables and behaviours, and theory validation.

**Sequence of change.** One study found that therapeutic alliance was established from the onset of therapy and remained stable over time, while couples with better baseline relationship satisfaction were more likely to experience better therapeutic alliance (Glebova et al., 2011b). Based on a case study design, Blow et al. (2009) concluded that there was no systematic
sequence to change. However, there was evidence that change occurred at least in part through pivotal moments which were highly individualised for each partner (Helmeke & Sprenkle, 2000). Moreover, in a sample of 67 veteran couples, a quarter experienced sudden gains in the sequence of change over time (Doss et al., 2011), and for some couples these gains explained their total clinical improvement. Doss et al. (2011) also found that sudden gains were related to emotional intimacy and communication in couples, which complemented findings from an early study (Johnson & Greenberg, 1988) in which softening events – events where “both partners are able to respond to the other in an accepting manner in the context of a high level of emotional experiencing” (p.176) – only occurred in couples who experienced significant positive change in therapy. One case study (M. E. Olson et al., 2012) concluded that sudden changes may be elicited through “dialogical listening” on the part of the therapist, which invited new ways of viewing the relationship or problem.

Viewed together, these results suggest that a shift in couples’ emotional intimacy is central to positive change. However, other findings challenged this claim. In a longitudinal study of change in BCT, changes in marital satisfaction in couples preceded changes in attachment (Benson et al., 2013), suggesting that a focus on emotional experiencing may not be as crucial for change as other studies indicate. Moreover, differences in therapy models may alter the trajectory of change, and therefore processes that are identified as central in one theoretical approach may not hold the same value in another. In a comparison of TBCT and IBCT process, Sevier et al. (2013) found inverted trajectories of couple positivity and negativity for these two approaches,
suggesting that therapy focus may impact couples' emotional valence during therapy.

Interestingly, only one study explored impasses in the therapy process (Papp et al., 2013). Based on case illustrations, it demonstrated the effectiveness of sculpting to facilitate change for couples experiencing an impasse, while highlighting the emotional dimension of this technique. Finally, Blow et al. (2009) emphasised the impact of extra-therapeutic events on the process of change, a neglected variable in other studies.

Therapist variables and behaviours. Findings relating to global therapist variables were identified in four studies. Therapists’ attachment style was found to impact the delivery of EFT (Wittenborn, 2012). More securely attached novice therapists were better at delivering EFT, while dismissing therapists appeared to avoid emotional experiencing. Generally, more insecurely attached therapists were found to elicit split alliances, although these findings were based on a poorly counter-balanced sample. In another EFT study, therapist engagement in attachment affect was found to be essential for softening events to unfold successfully (Furrow et al., 2012). M. E. Olson et al.’s (2012) in-depth analysis of one couple’s therapy suggested that therapist attentive listening facilitated genuine dialogue in the couple, although this finding was based on theoretical reflection rather than extensive evidence. Moreover, Schade et al. (2014) demonstrated that therapist warmth was an important variable, as therapist warmth towards the husband was associated with husband warmth towards their wife, suggesting that therapist warmth encourages emotional experiencing for men.
Specific therapist techniques were examined in four studies. Findings emphasised therapists’ contribution to process and identified effective behaviours. Jacob et al. (2014) illustrated how highlighting personal accountability with clients from an existential sense can be an effective technique to increase partners’ mutual empathy and motivation to change. Enactments, “in which therapists invite couples into direct interaction with each other … to successfully enact their relationship in its real-life totality” (Butler et al., 2011, p.205), are a technique which has had comparatively more research focus than other therapeutic manoeuvres. Butler and colleagues (2011) found that starting the therapy process with enactments improved female partners’ attachment security, while beginning with “therapist-centred” sessions negatively impacted male partners’ attachment security, although overall attachment differences were not found between the two conditions when measured over all six sessions. Moreover, the authors overlooked the fact that their results highlighted the ineffectiveness of therapist-centred sessions at the start of therapy, rather than the power of enactment as an intervention. However, a previous study demonstrated that “couple-responsible” process, such as enactment, increased couple responsibility and cooperation between clients and therapist, and decreased struggle (Butler & Wampler, 1999). Finally, in a study that focused on the process of enactments (Woolley et al., 2012), enactments were found to be an effective technique to facilitate healthier relational interactions. Specific interventions were examined, demonstrating that directing and working with emotions were related to husband positive interaction, while structuring was related to wife positive interaction.
Theory validation. Four studies reported findings that related to theory validation, including three EFT studies. Blamer softening has been posited as one of the key events in the process of restructuring interaction in EFT (Johnson, 2007). Bradley and Furrow (2004) developed an empirically derived map of therapist interventions in successful blamer softening events, based on four therapy sessions lead by Susan Johnson. The authors highlighted “processing fears of reaching” as a key part of the blamer softening process, suggesting that EFT’s attachment theory frame of reference was invaluable in supporting clients through an emotionally intense move towards softening. While this study demonstrated strong clinical relevance and important theory validation, it showed methodological limitations, in particular its reliance on data from only one expert therapist, a co-founder of EFT.

Two studies focused more closely on forgiveness and reconciliation in couple therapy. Meneses and Greenberg (2011) used a task analysis methodology to explore how forgiveness unfolds in EFT, building a empirically derived map of resolution of couple’s emotional injuries. Notably, specific components were identified as distinguishing resolved from unresolved couples, for example the expression of shame and heartfelt apology for the injurer, and a shift in the view of the other for the injured. In parallel, Zuccarini et al.’s (2013) study examined therapist focus in the process of forgiveness and reconciliation, based on the attachment injury resolution model. The study validated the importance of the shift from phase one to phase two in the model, as the move to the processing of primary attachment-related emotions for both injurer and injured distinguished resolved from unresolved couples.
Discussion

This systematic review shows that couple therapy process research is a new but a rapidly expanding field. Most of the studies were published in the last few years, so it is not surprising that theoretical and methodological considerations are in their infancy. Considering how this area of research has blossomed only recently, it is worth noting how innovative some of the methodologies were in examining complex interactional processes. This was a clear strength for many of the studies. Task analysis, utilised by EFT studies, emerged as a particularly powerful approach to understanding how specific processes unfold in therapy, as is arguably one of the most robust methods in the sample of studies. However, studies that modelled the sequence of change also provided important information as to when processes occur and which processes call for further micro-analytic research.

Nonetheless, research in the field has a long way to go. An obvious finding from the review was the scarcity of cross-referencing between studies. Only one study (Benson et al., 2013) made references across theoretical orientations, although admittedly with the aim of demonstrating the validity of BCT compared to EFT. While comparing findings in this way is valuable to improving our understanding of process in couple therapy, ultimately the models war is unhelpful to the progress of research. Interestingly, the CASP item concerning consideration for the relationship between researcher and participants was repeatedly unfulfilled by studies. Researchers often did not show reflexivity regarding sample bias or their interests in promoting their approach to couple therapy. As such, the field may show considerable
confirmation bias. Finally, case study designs demonstrated a useful illustrative function, but remained limited compared to more robust methodologies.

Of course, this first systematic review of couple therapy process research holds some limitations. The search strategy may have omitted studies that did not explicitly state a focus on process research or change mechanisms. Yet the approach used appeared to capture a broad initial sample. In fact, researchers should be encouraged to use systematic keywords such as “process research” to encourage cross-reference in this field. Moreover, the review may appear less systematic than reviews examining a more homogenous area of research. The mix of different methods in the sample called for an adaptation of systematic review guidance such as PRISMA (Liberati et al., 2009).

Based on this review, three recommendations for future research can be made. First, considering that therapy is not effective for about a third of couples (Lebow et al., 2012), future research may want to explore a neglected issue: why and how change does not occur. Only one study examined impasses, while others primarily focused on successes. Another improvement may lie in multiple measures of change, as interviewing couples about therapeutic change has shown to reveal more positive findings than self-reports (M. Olson & Russell, 2004). Finally, micro-analytic methods such as conversation analysis (CA) and discourse analysis (DA) were absent in the sample, whereas they offer important insights into “which client processes are facilitated by which therapist responses under which conditions” (Elliott, 2012, p.71). This contrasts with family therapy research where these approaches have been used extensively (Tseliou, 2013). Elliot (2010) identified these approaches as promising for micro-analytic sequential process research as they offer clinically
relevant qualitatively rich analyses. DA couple therapy studies do exist, but they focus on discursive processes, often without relating these to theorised therapy processes (Edwards, 1995; Kogan & Brown, 1998; Kogan & Gale, 1997; Sinclair & Monk, 2004). CA and DA also fit the systemic underpinnings of couple therapy, and therefore warrant further use in this field.
References


couples therapy: Multiple perspectives. *Journal of Family Therapy, 33*(1), 42–65. doi:10.1111/j.1467-6427.2010.00503.x


## Appendix A: CASP checklist

CASP qualitative research checklist item (CASP, 2013)

<table>
<thead>
<tr>
<th>Item</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Was the research design appropriate to address the aims of the research?</td>
</tr>
<tr>
<td>2</td>
<td>Was the recruitment strategy appropriate to the aims of the research?</td>
</tr>
<tr>
<td>3</td>
<td>Was the data collected in a way that addressed the research issue?</td>
</tr>
<tr>
<td>4</td>
<td>Has the relationship between researcher and participants been adequately considered?</td>
</tr>
<tr>
<td>5</td>
<td>Have ethical issues been taken into consideration?</td>
</tr>
<tr>
<td>6</td>
<td>Was the data analysis sufficiently rigorous?</td>
</tr>
<tr>
<td>7</td>
<td>Is there a clear statement of findings?</td>
</tr>
<tr>
<td>8</td>
<td>How valuable is the research?</td>
</tr>
</tbody>
</table>
### Appendix B: Search Strategy

**Systematic review search strategy**

<table>
<thead>
<tr>
<th>Term sequence</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Couple therapy</td>
</tr>
<tr>
<td>2</td>
<td>Marital therapy</td>
</tr>
<tr>
<td>3</td>
<td>Couple counsel*</td>
</tr>
<tr>
<td>4</td>
<td>Marital counsel*</td>
</tr>
<tr>
<td>5</td>
<td>Marriage therapy</td>
</tr>
<tr>
<td>6</td>
<td>Marriage counsel*</td>
</tr>
<tr>
<td>7</td>
<td>#1 or #2 or #3 or #4</td>
</tr>
<tr>
<td>8</td>
<td>Process research</td>
</tr>
<tr>
<td>9</td>
<td>Change process</td>
</tr>
<tr>
<td>10</td>
<td>#8 or #9</td>
</tr>
<tr>
<td>11</td>
<td>#7 and #10 IN abstract</td>
</tr>
<tr>
<td>12</td>
<td>#7 and #10 IN title</td>
</tr>
<tr>
<td>13</td>
<td>#11 or #12</td>
</tr>
</tbody>
</table>
Empathy in couple therapy for depression: A discourse analysis of couple
and therapist talk in mutual understanding events

Trainee Name: Theo Roberts
Primary Research Supervisor: Dr Janet Smithson
   Senior Lecturer, University of Exeter
Secondary Research Supervisor: Professor Janet Reibstein
   Visiting Professor, University of Exeter
Target Journal: Family Process
Word Count: 7,978 words (excluding abstract, figures, tables, and references), and appendices: 10,441 words

Submitted in partial fulfilment of requirements for the
Doctorate Degree in Clinical Psychology, University of Exeter
Abstract

Couple therapy research identifies partner empathy as a core process for positive outcomes. The Exeter Model of couple therapy (EMCT) for depression builds on both behavioural and empathic approaches in couple therapy to reduce unhelpful couple interactions and promote mutual understanding between partners where one partner is experiencing depression. Based on EMCT, this process research study aimed to investigate mutual understanding (MU), a transtheoretical concept that refers to the moment-by-moment therapy triad talk that constructs partner empathy. Thirty-four therapy sessions from seven couples in EMCT were screened for MU events, based on pre-defined theoretically derived criteria. A discourse analysis (DA) discursive psychology approach was utilised to examine identified MU events. Specifically, participant positioning and the constructive function of discourses were examined in the therapy extracts, as these DA concepts were closely linked to MU criteria. Findings provided insights into the couple and therapist interaction sequences that contribute to MU, suggesting that both systemic-behavioural and systemic-empathic EMCT techniques can facilitate the process. Specifically, circularities, active listening tasks, and eliciting vulnerability were identified as effective techniques for MU. Findings also pointed to clients’ contributions and the impact of discordant discourses. Implications for EMCT practice, and directions for future couple therapy research are discussed.

Keywords: Empathy; Exeter Model Couple Therapy; Mutual Understanding; Positioning; Process Research.
Introduction

Couple Therapy

Couple therapy has evolved over the last 50 years from focusing primarily on reducing couple relationship distress to becoming an evidenced-based treatment of choice for a number of individual mental health problems (Gurman & Fraenkel, 2002; Snyder & Halford, 2012). Research and clinical practice have led to various adaptations of couple therapy: integrative behavioural couple therapy ([IBCT] Jacobson & Christensen, 1996), insight-oriented couple therapy (Snyder, Wills, & Grady-Fletcher, 1991), integrated systemic couple therapy (Goldman & Greenberg, 1992), and emotion-focused couple therapy ([EFT] Johnson, 2004).

Although there has been an “unfortunate gap” between behavioural and systemic approaches to couple therapy, considerable efforts have been made to recognise misconceptions and bridge differences (Gurman, 2013, p. 116). Theoretical integration and core clinical processes that transcend approaches are now emphasised (Lebow, Chambers, Christensen, & Johnson, 2012; Snyder & Balderrama-Durbin, 2012). One notable example of theoretical integration, developed at the Exeter Mood Disorders Centre (MDC), is the Exeter Model of couple therapy for depression ([EMCT] Reibstein & Sherbersky, 2012a, 2012b).

As evidence increasingly supports treatments for couple relationship distress (Snyder & Halford, 2012), some have argued that research should now focus on the universal processes that they share (Benson, McGinn, & Christensen, 2012). Burbach and Reibstein (2012) praised the joining of forces
between behavioural and systemic traditions in couple therapy. Moreover, Baucom, Whisman, and Paprocki (2012) demonstrated how couple-based interventions can be adapted for treating individuals with specific mental health diagnoses. They conceptualised the differences between partner-assisted, disorder-specific, and couple therapy interventions. In doing so, they highlighted a belief that is shared by most approaches to couple therapy, namely that “psychopathology exists in a social context” (Baucom et al., 2012, p.252), in which the partner holds a significant place. EMCT for depression fits both disorder-specific and couple therapy interventions, as it has a dual focus, targeting the identified client’s (IC) depression by improving interaction and empathy in the couple system.

**Exeter Model Couple Therapy for Depression**

EMCT (Reibstein & Sherbersky, 2012b) aims to operationalize the integration of behavioural and systemic dimensions of couple therapy. Its core tenet is that couple therapy for depression can be divided into two modes, the systemic-behavioural and systemic-empathic. It offers clear clinical guidance for using systemic techniques, both behavioural (e.g. circularities, communication skills training, enactments) and empathic (e.g. therapist empathic bridging, circular questioning, attachment narratives). Systemic-behavioural techniques draw on the behavioural tradition in couple therapy, while systemic-empathic techniques are based on systemic and attachment approaches such as EFT. Appendix A provides details of EMCT techniques.

Three distinct bodies of empirical evidence support EMCT for depression. First, there is evidence of an association between marital satisfaction and depression. A meta-analysis of 26 studies examined the
association between relationship satisfaction and depressive symptoms, finding a mean weighted effect size of -0.37 (Proulx, Helms, & Buehler, 2007). Second, empirical research has shown a bidirectional relationship between relationship discord and depression through circular causation (Beach & Whisman, 2012; Sprenkle, 2012). Finally, there is sufficient evidence (Bodenmann et al., 2008; Cohen, O’Leary, & Foran, 2010; Jones & Asen, 2000) for couple therapy to be recommended as a treatment of choice for depression by the National Institute for Health and Care Excellence (NICE, 2010).

**Partner Empathy as Mutual Understanding**

One core process in EMCT for depression concerns developing empathy and connection between both partners (Reibstein & Sherbersky, 2012a, 2012b). This focus builds on the extensive theoretical and empirical research in EFT on the role of empathy in couple therapy (Greenman & Johnson, 2013; Johnson, 2004; Johnson, 2007). The present study focuses on this transtheoretical core process. To refer to this process, I chose to use the term “mutual understanding” (MU) between partners, a term employed in EMCT. MU is defined as the moment-by-moment therapy talk that constructs empathy between partners, and is based on the contributions of IBCT, EFT, and EMCT. MU also builds on constructionist concepts of co-construction (Jacoby & Ochs, 1995) and relational subjectivity (Drewery, 2005). Specifically, MU involves:

- Nonblaming talk about a shared problem.
- Vulnerability talk.
- Talk about shared hopes and fears.
- Talk of daily rituals of connection.
IBCT, EFT, and EMCT offer different theoretical concepts that contribute to what MU refers to in the therapy room. IBCT talks of enabling “empathic joining” through “acceptance”, which is “designed to promote compassion, understanding, and intimacy” (Cordova, Jacobson, & Christensen, 1998, p.439). Acceptance work has been identified as key for improvements in couple interaction to be maintained over time (Gurman, 2013). EFT refers to “affiliative statements” between partners, defined as “statements that involve self-disclosure, sharing, or understanding” (Greenman & Johnson, 2013, p.51). Finally, EMCT contends that promoting “mutual understanding of [partners’] emotional lives” constitutes a key element in the systemic-empathic frame of the model (Reibstein & Sherbersky, 2012a, p.275). A summary of theoretical and clinical contributions to the concept of MU is presented in Appendix B.

EFT process research has shown how emotional experiencing and empathy facilitate change in couple therapy (Greenman & Johnson, 2013). Johnson and Greenberg (1988) found that couples who showed highly significant improvements in relationship satisfaction after EFT demonstrated a significantly larger number of affiliative statements during therapy, while those who did not improve showed an absence of emotional experiencing. Moreover, successful blamer-softening events (i.e. a critical partner takes a position of vulnerability seeking reassurance and comfort) have been identified as an important process for change (Bradley & Furrow, 2004). Couples who resolve attachment injuries, characterised as abandonment, betrayal or breach of trust, show significantly higher improvements in relationship satisfaction compared to unresolved couples (Makinena & Johnson, 2006). EMCT builds on these findings, since from a systemic perspective, improving relationship satisfaction
is fundamental to enable clinical improvement for clients experiencing depression and relationship discord (Reibstein & Sherbersky, 2012a). However, as noted by Greenman and Johnson (2013), further process research is needed to understand the moment-by-moment interactions between clients and therapist that enable partner affiliation. By investigating MU, this study conceptualises and explores these moment-by-moment talk interactions in the context of EMCT for depression.

**Process Research**

EMCT (Reibstein & Sherbersky, 2012b) provides a broad set of therapist techniques built upon empirical evidence, clinical experience, and theoretical research. It does not aim to offer a prescriptive stage-by-stage protocol for therapists. As such, it lends itself to process research that explores the talk associated with specific therapist interventions or therapy events.

By examining MU in EMCT, this study was grounded in a systemic approach. It explicitly used a social constructionist perspective (Gergen, 2009), which views our understanding of the world, ourselves and others as actively constructed by language, through human interaction (McNamee, 2004).

Process research has been defined as “any research that examines the process of therapy itself, as opposed to either the input variables of therapy … or the outcomes of therapy” (Oka & Whiting, 2013, p.19). Discourse analysis (DA) offers a persuasive methodological framework for this form of research, and presents a good epistemological fit with the assumptions of systemic therapy (Burck, 2005; Strong, Busch, & Couture, 2008). It also fits with the chosen social constructionist perspective (Georgaca & Avdi, 2011). Finally, DA
provides conversational evidence which is highly relevant to systemic therapists (Couture & Strong, 2004).

**Discourse Analysis**

DA is a theoretical and methodological approach to discourse with historical roots in a range of academic disciplines, including linguistics and philosophy (Edwards, 2006, 2012). Gee and Handford (2012) defined DA as “the study of language in use. It is the study of the meanings we give to language and the actions we carry out when we use language in specific contexts” (p.1). Language, rather than reflecting individuals’ thoughts and feelings, performs social actions that gain their particular meaning through context.

The deployment of DA methodology in the study of systemic therapy has remained a marginal, relatively recent venture. While DA is utilised in family therapy research (Tseliou, 2013), a review of the literature suggested that DA use in couple therapy research has been limited, taking a discursive “external position” (Avdi & Georgaca, 2007) rather than an interest in theorised couple therapy processes (Edwards, 1995; Kogan & Brown, 1998; Kogan & Gale, 1997). Many systemic researcher-practitioners feel that DA can help bridge the gap between the evidence-base and clinical practice (Charlés, 2012; Moore & Seu, 2010). DA has also been presented as an under-utilised method for micro-analytic process research (Elliott, 2012), and an opportunity to understand dialogic processes in therapeutic conversations (Burck, Frosh, Strickland-Clark, & Morgan, 1998). Within DA, positioning theory (Davies & Harré, 1990) and the constructive function of talk (Wiggins & Potter, 2008) have been identified as robust concepts for analysing therapy talk (Georgaca & Avdi, 2009). These two
constructs are particularly fitting for studying MU, as MU markers may involve shifts in participant positioning and the emergence of alternative discourses.

**Aim of the Study**

MU is defined as the moment-by-moment therapy talk that constructs empathy between partners. The aim of this study was to explore how MU is co-constructed by therapist and partners in EMCT for depression. The study was guided by the following questions:

- How do EMCT techniques encourage MU?
- How do clients and therapist shift positionings in MU events?
- How do discourses present in therapy enhance or inhibit MU?

**Method**

**Design**

The study utilised a DA methodology. It was guided by a discursive psychology (DP) approach, which provides a robust theoretical background for examining the discursive construction of psychological concepts, and is particularly suited to studying qualitative data from naturalistic settings (e.g. therapy sessions) (Edwards & Potter, 2001; Edwards, 2012; Wiggins & Potter, 2008). Specifically, I followed Wiggins and Potter’s (2008) seven-step methodology (Appendix C).

**Data Collection**

I utilised video recordings of couple therapy sessions at the MDC AccEPT clinic in Exeter as the data pool. Therapy sessions took place between
June 2010 and January 2013, and were conducted by expert EMCT therapists and supervised trainee EMCT therapists. Therapy duration ranged from five to 21 sessions. Sessions lasted one to one and a half hours. A research assistant who had no involvement in the study randomly selected the sample used for screening. The sample consisted only of heterosexual couples. Therapy sessions at the clinic had been video recorded for supervision, training and research purposes. Only sessions with couples that had provided informed consent for video recordings of their therapy to be used for research were utilised. The study obtained ethical approval from the Psychology Department Ethics Committee and from the NHS Research Ethics Committee (Appendix D).

Data Screening and MU Event Transcription

I used five predefined criteria to identify therapy moments that qualified as MU events: nonblaming problem talk, disclosures of vulnerability, therapist empathic bridging, talk about shared hopes and fears, and talk about connection rituals (Appendix B). I did not retain three theoretically-derived interactions in the MU event criteria: soft emotion (such as sadness), strong emotion (such as anger), and descriptions of attachment patterns. The first two lacked specificity, and attachment pattern talk was predicted to span long sequences rather than discrete events. Two of the five interaction criteria were required in a brief therapy event for it to qualify as an MU event.

I examined the initial phase of therapy for this study. EMCT clinical experience (J. Reibstein, personal communication, December 6, 2013) suggests that, particularly with higher conflict couples, work on MU is more present in the initial phase of therapy, when the focus is on de-escalation (Naaman, Pappas, Makinen, Zuccarini, & Johnson-Douglas, 2005). Starting
couple therapy with enactment-based sessions has also been shown to increase couple attachment security (Butler, Harper, & Mitchell, 2011). I therefore screened couple therapy sessions one to four for MU events. I also screened final sessions as I assumed that in successful therapy MU events would occur during the consolidation ending process.

Appendix E provides a summary of the screening process. I screened 34 sessions in-depth from seven couples in EMCT. For two couples, a trainee co-therapist was also present for the therapy, and for one couple, therapy was led by a trainee therapist. Due to missing and damaged DVDs, I was unable to screen some of the sessions as planned. In five cases, I used later sessions instead due to missing data. I identified nine MU events for analysis. I then transcribed therapy sessions with MU events. Detailed DA transcription of MU events included five minutes pre and post marker event, to provide sufficient conversational context for the analysis.

**Method of Analysis**

Within DA, analysis findings are viewed as necessarily influenced by the researcher’s assumptions (Jørgensen & Phillips, 2002). The validity of findings is instead measured by two criteria (Potter & Wetherell, 1987): (a) coherence, that is, analytic claims “should let us see how the discourse fits together and how discursive structure produces effects” (p.170), and (b) fruitfulness, which refers to the ability of findings “to make sense of new kinds of discourse and to generate novel explanations” (p.171). To increase adherence to these validity criteria, I reviewed analyses to confirm that they demonstrated coherence with the data. Moreover, longer extracts were used to ensure readers could verify
the coherence of my analysis with the text. Finally, to ensure adherence to DA methodology, both research supervisors reviewed the analyses.

DA methodology utilises different levels of analysis (Georgaca & Avdi, 2011). For this study, two DA approaches were prioritised. I examined extracts with a focus on (a) positioning, that is, “the way in which the discursive practices constitute the speakers and hearers in certain ways” (Davies & Harré, 1990, p.62), and (b) the presence of discourses, that is, how versions of objects are framed through the constructive nature of talk. It was felt that further levels of analysis would be of interest in examining MU, but these were beyond the scope of this study.

I used Kogan and Brown's (1998) concepts of normativity, incitement to discourse, and cultural grid of intelligibility for the analysis. I also utilised the concept of participants’ discursive agenda (Georgaca & Avdi, 2011).

I identified positioning theory as a pertinent approach for examining MU. Key elements of MU, such as nonblaming talk, vulnerability talk, talk about hopes and fears, and talk of connection rituals, involve shifts in positioning (Davies & Harré, 1990; Drewery, 2005; Harré & Van Langenhove, 1999). For example, one may shift from positioning oneself as blamed and the other as critical, to positioning each other as mutually supportive. These changes may concern the IC, the partner, or the therapist’s positionings. Positioning theory asks questions such as: “Who speaks? In whose name do they speak? Who do they address? Who do they speak for?” (Georgaca & Avdi, 2011, p.155).

Moreover, I focused on therapists’ and clients’ discourses as they participate in defining the problems brought to therapy, for example by
formulating who is or is not to blame for them (Patrika & Tseliou, 2015; Wolpert, 2000). In fact, DP “is focused on discourse because it is the primary arena for action, understanding and intersubjectivity” (Wiggins & Potter, 2008, p.73). This emphasis matches my conceptualisation of MU. By analysing discourses in MU events, I aimed to identify the wider discursive practices that contribute to or inhibit MU.

**Analysis**

**Location, Frequency, and Initiation of MU Events**

I identified nine MU events from the sample of 34 therapy sessions. For three couples, no MU event was identified. In one case this was partly due to DVD errors that compromised adequate viewing. In both other cases, the absence of MU events was related to high observed relationship estrangement and significant therapist efforts to engage the identified client (IC), the partner, or both. I did not detect MU events in final therapy sessions, where couples and therapists reviewed therapy gains and highlights and made plans for ongoing issues. Although MU events were jointly constructed through interaction, it is worth noting whose utterances appeared to initiate them: four were initiated by the therapist, two by the IC partner, two by the therapist and the partner, and one by the therapist and the IC.

Some therapy events did not meet MU criteria, but held MU elements. In two extended genogram sessions, whole sessions had a MU flavour, but with no discrete MU event. These sessions were not included in the analysis, as they did not fit MU conceptualisation as a brief sequence.
In the following section I present the analyses of five extracts from the nine MU events. I obtained the extracts by selecting representative (Jørgensen & Phillips, 2002) meaningful sequences that included a MU marker event. Extract 5 is the only extract that does not include the marker event, but instead illustrates a sequence that just preceded it. The first three extract analyses focus on positioning in MU, providing clinical examples of how clients’ and therapist’s positionings participate in the co-construction of MU. The last two analyses focus on the discourses present in MU, and how these influence the process.

**Positioning in MU**

The first extract comes from the end part of John (IC) and Louisa’s fifth therapy session, after a long utterance by the therapist about the circular and nonblaming nature of couple therapy. The couple are in their forties. The triad have been charting family interactions around John’s communication with their adolescent daughter Ella, using a circularity diagram. This MU event is characterised by an unexpected and appreciative reconciliation statement by Louisa, which opens an MU event and simultaneously allows John to gain agency. Details of notations used are provided in Appendix F.

**Extract 1: allowing agency.**

77 Th:  (…) Yeah so I - I just wanted
78 to say that as just an example to really reiterate and I'm not saying
79 it to Louisa but I'm saying it to – this is a circularity this isn't about
80 blame
81 L:  He has broken this (…)
82 Th:  Yeah
The extract begins with the therapist's attempt to restate the therapy agenda: to develop a nonblaming and systemic understanding of John’s depression within the couple and family context. Hesitant markers suggest an uneasy position for the therapist, who is challenging the dominant discourse of linear causality. The therapist’s use of negatives here imply she is navigating a difficult terrain, as she clarifies her neutral position, affirming her non-engagement in a split alliance against Louisa. The therapist also appears explicitly to forestall being viewed as blaming (78-79), a theme which is familiar to couple and family therapists (Patrika & Tseliou, 2015). The reformulation of the systemic therapeutic approach may allow Louisa’s unexpected utterance about change (80). By referring to John in the third person, Louisa’s utterance performs several functions. John is distanced and positioned as lacking agency, as he becomes the object of talk while he is initially absent from the conversation. Louisa also powerfully takes authorship by holding both John and the therapist in expectation about this positive change, through pause,
demonstrating the key role she holds as an IC partner in noticing change during therapy.

However, Louisa then shifts her positioning as she addresses John directly (“you have stopped”). While her use of the word “although” appears to qualify and limit this reconciliation statement, her utterance marks John’s change in behaviour by addressing him directly. Louisa’s use of active voicing references her supportive statements to John (“ignore it ignore it don’t do it don’t do it”). Louisa’s expression of trust and support characterise this MU event, during which John shifts from being positioned in a passive role to tentatively gaining agency (“ºhave Iº”), and asserting authorship for his attempts to change (91; 93-94). The therapist’s expression of dramatic enthusiasm positively reframes the reported change as “amazing news” that deserves time and attention, which provides validation and may consolidate the emerging MU process, further allowing John to voice his perspective.

The extract demonstrates how partners’ references to one another position them in ways that can allow or limit MU between them, for example through the attribution of agency. The therapist’s intervention appears to validate the constructive positioning.

**Extract 2: inviting MU by eliciting partner vulnerability.** This extract is set during the mapping of a circularity. It is Luke and Gemma’s (IC) third therapy session. They are in their early thirties and are planning to have a baby. The MU event is marked by Luke’s unexpected expression of vulnerability, the sharing of fears, and the couple’s ability to engage in nonblaming problem talk.

87 Th: Luke feels (...) what? (...)(…) how does that make you feel –
The therapist’s performance is noteworthy in this event. She first insists on Luke’s feelings by repeating “feel” three times, and by explicitly evoking...
Luke’s passive position “lying in bed on Saturday night”. Her talk suggests a determined EMCT therapeutic agenda (Georgaca & Avdi, 2009), whereby she consistently reframes and completes Luke’s utterances by upping the stakes of vulnerability and secondary feelings (90-101). This process culminates in an extreme case formulation (“it confirms all your worse fears”) (Pomerantz, 1986), which often occur following expression of doubt or disagreement (Edwards, 1995). As such, it appears that the therapist is resolutely positioning Luke as vulnerable (“numb”). Her talk performs both an empathic function, as she names emotions that hesitant markers suggest Luke is uncertain or uneasy about, and a directive function, through assertive hypothesising (108-109).

Luke’s response (102-103) to the extreme formulation seems to convey self-doubt, yet his rhetorical question equally casts him in a heroic role (“putting myself through this”). Note also his provocative disclosure of indifference: “I just couldn’t care less if she just gone for good”. However, possibly encouraged by the therapist’s acknowledgment (“uhuh”), Luke’s following utterance (106-107) both adheres to the vulnerable positioning and positions Gemma as solely responsible for their mutual “love” or loss thereof. This indifferent self-positioning is hypothetically reframed by the therapist as an assertive subjective statement (“are you thinking right that’s it the relationship’s finished?”), which may aim to enhance agency, but it also moves the talk further towards the expression of fears. The therapist also invites Gemma into the conversation by speaking for her and articulating her hypothesised fears (111-113).

The final part of the extract (114-117) further demonstrates the powerful MU potential of charting a circularity, as the therapist’s further hypothesising promotes understanding in the triad’s talk, which may contribute to empathic
bridging (Reibstein & Sherbersky, 2012a). However, note that in this extract where the therapist is standing and writing on a flipchart, neither partner significantly challenges the therapist, which may be interpreted as a result of a positive therapeutic alliance, her persuasiveness, client compliance, or a combination of these processes.

**Extract 3: learning to show empathy.** This event occurs halfway through session four of Katy and Ethan’s (IC) therapy. Katy and Ethan are in their thirties and have two daughters under 3. Ethan has been referred for depression, but Katy also experienced a depressive episode following the birth of their first daughter, who had health problems.

A trainee therapist is present (Th2) as well as the lead therapist (Th1). The lead therapist has structured the session around an active listening enactment: the couple have been discussing what happens during their day. Katy looks after the children at home and Ethan works in industry. Katy has just been telling Ethan about her typical weekday. The extract shows a fragile MU event marked by therapist empathic bridging, discussion of a shared problem, and an apology attempt.

72 Th1: So what do you think she’s saying then can you say back to her
73 what (...) what that (...) what you’ve understood from that?
74 E: That it’s (...) it’s either tiring because you’re out all day (...) and
75 doing stuff or it’s tiring because in the same way as my work is
76 tiring when there’s not a lot coz actually looking after children
77 can be very very boring
78 K: [Mmh mmh]
79 E: (...) Coz it is and you know if you go out and I’m on my own it is
80 (...) can be rather (...) tedious
This extract begins with the lead therapist directing an active listening enactment (Reibstein & Sherbersky, 2012b), clearly asking Ethan to address Katy (72-73). With this request, she positions both partners as novice
EMPATHY IN COUPLE THERAPY

communicators who require coaching to learn effective couple communication. Through this systemic-behavioural intervention, she conveys the therapists’ empathic bridging agenda (Reibstein & Sherbersky, 2012a).

Ethan responds to the therapist invitation by demonstrating that he empathises with Katy’s experience at home (74-82). Katy’s overlapping utterances (78; 81) suggest acknowledgment and the initiation of MU. The lead therapist’s response validates and reinforces the empathic bridging (83), possibly in reaction to the fragility of the process. Interestingly, she refers to Ethan as “he”, appearing to address her co-therapist and positioning the therapists as observers of the fragile MU process, possibly in an improvised reflective team role (Sells, Smith, Coe, Yoshioka, & Robbins, 1994).

The poor affiliation between partners is highlighted when Katy dismissively jokes “Do you think just I sit around and drink coffee?” referring back to Ethan’s mention of drinking coffee at work before this extract. This trivialising utterance appears to question the credibility of Ethan’s talk, inciting him to prove his empathy through adamant denial (86-87) and an apologetic statement (90-92). Hesitant markers and a quiet statement (“ºI don’t want to sayº”) invite interest and emphasise his empathy attempt. Ethan’s utterance (89-91) is problematic as it conveys vulnerability and an apology, but reasoned justification (“because I don’t spend so much time with the children”) and hesitant markers (“I don’t think”; “possibly”) suggest that his acknowledgment for Katy’s “hard work” is conditional. The second therapist directly addresses this possible lack of authenticity (92-93), in response to which Ethan tries harder to show empathy (94-98). She then combines a circular question (“did you realise that Ethan finds it hard?”) with a previously identified positive (“he does it
really well"). The conversational confusion (103-106) that follows Katy’s acknowledgment and acceptance (102) possibly confirms the conditionality of Ethan’s empathic vulnerability statement. The lead therapist’s clarification (107) appears to both end the conversational trouble and shifts the focus back to the MU process.

**Discourses in MU**

The analysis of the two final extracts has a broader focus on the construction of discourses in therapy, to show how these influence MU events.

**Extract 4: autonomy vs. couple mutuality.** This extract illustrates a MU event characterised by therapist empathic bridging attempts and an exploration of shared hopes and goals. It occurs in the context of the first therapy session with Pete (IC) and Trisha, a couple in their late fifties. They have shown significant relational discord is the early part of the session, with Trisha dominating the conversation and Pete showing limited engagement.

The extract is from a sequence that was opened by the trainee co-therapist as she asked “What’s our business here and how do we know when things are better between you?” The extract begins with the lead therapist (Th1) summarising Trisha’s response.

91 Th1: So one objective would be if Pete’s mood gets better and he has a lighter mood and was less dependent on you
92 T: No that don’t happen the only time I’ve seen Pete really in his element (...) and it’s been proven like if he’s had a week off work and he’s been home if I do everything he wants (...) I take him up his coffee in the morning I look after him completely (...) everywhere he wants to go I go with him (...) everything he
Okay so Trisha just to be clear about this (...) an objective is that Pete be happy but also that he’s not be as dependent on you yes okay (...) Pete what would be your [Yes]

What would be your objective and how would you know if you worked in this clinic that it was doing something for you? What would be your goal? (…) 

But (...) if I don’t sort my life out (...) I don’t think that I’m going to have one really (...) so (...) I need (...) I just want to be content and happy with my – life and with my wife

But your wife has just said that for her (...) she would think it’s possible your being happy means that she has to do nothing but look after you is that what you think?

No

So how would you know that you’re happy?(...) she said that’s not enough she’s not enough she she doesn’t she does not want her objective would not be that she’s totally at your service (...) at that length so what else what could how would you know what would would we know to look for (...) to help you achieve (...) to make you feel happier?

It’s a difficult question isn’t it

So it’s a very difficult question and probably I should we should ask it slightly better but I’m only asking coz Trisha knew how to answer it (...) Trisha says (...) she needs to be there all the time for you to be happy you say no? (...) 

No not at all no

Ok what does make you what has in the past made you happier?

When she smiles

And what makes her smile more?

When she’s happy ((Trisha laughs))
The therapists’ agenda here is clear in that they seek a workable shared goal for the couple, possibly to de-escalate the ongoing enactment of unhelpful interaction (Naaman et al., 2005). The lead therapist’s summary of Trisha’s perspective (91-92) does not appear satisfactory to Trisha, who reiterates her blaming complaint (93-98), framing the problem as Pete being dependent on her. Note Trisha’s appeal to objectivity (“it’s been proven”) and several extreme case formulations (“everything”; “everywhere”; “completely”) to demonstrate factuality in her account. The therapist both validates Trisha’s view by summarising, and regains authority over the conversation by addressing her directly (“Okay so Trisha to be clear about this”).

As the lead therapist attempts to include Pete’s account by returning to her circular question (101-105), it appears that she aims to differentiate the partners’ views while identifying shared hopes. Note the personalisation (“you”; “your”) to insist on obtaining an individual perspective from Pete. Hesitant and quiet talk markers suggest caution and disempowerment in his response (106-108), which contrast with Trisha’s loquaciousness and the therapist’s directivity. Interestingly, the first part of his utterance suggests subdued disagreement with the shared goal agenda, as it frames the problem as one of individual responsibility through self-blame (“but (…) if I don’t sort my life out (…) I don’t think that I’m going to have one really”). It may also formulate a need for more autonomy.

The unanswerability of the lead therapist’s “difficult question” about what would make Pete happier (113-118) is marked by an extended pause. Note the second therapist’s comment (120) which highlights the conversational trouble. The therapist’s reformulation enables an account of shared hopes to be
achieved (128-130), in response to which Trisha’s laughter (130) appears to ambivalently communicate appreciation and contempt.

This extract illustrates the complex discursive turns that occur in the context of challenging couple communication. Trisha’s talk constructs Pete’s behaviour within a disability discourse, which pathologises dependency (Johnson & Lebow, 2000) and frames Pete’s need to be cared for as a weakness. This disabling discourse is potentially reinforced by cultural gender expectations, further inhibiting MU. It contrasts with the more implicit couple therapy discourse, which frames interdependence and mutuality as key factors in reducing depression. Therapist attempts at encouraging MU are only partly fruitful, as they are received by a powerful disability discourse (93-98) and its desubjectivising correlates, as demonstrated by Pete’s subdued talk.

**Extract 5: hearing the partner’s complaint in MU.** This final extract is from Pete (IC) and Trisha’s second session. It precedes the actual MU marker event, and illustrates the therapist’s initial attempts at validating Trisha’s account and eliciting partner vulnerability. Trisha has just recounted her own experience of depression.

77  T:  I could not stop crying and I’ve since found now if I miss my
citalopram for like three four days I’m crying (…) again
78  Th1:  Uhuh yeah
79  T:  For some reason I just end up crying (…) so
80  Th1:  Well it sounds also like Trisha you’ve had lots of things in your
life that have
81  T:  Oh I’ve had I’ve been through a lot but (…) I’ve coped with
82  everything but (…) the way we are at times I find day after day
83  week after week is grinding and (…) it grinds me down and I'm
Conflicting discourses are again present in this sequence. A care-giver discourse is apparent in Trisha’s talk (Henderson, 2001; O’Connor, 2007), focusing on emotional burden. This is presented in the form of a client complaint (O’Reilly, 2005), highlighted by temporal markers (“day after day week after week”) and evocative imagery (“it grinds me down”). Note also the reference to the protective function of antidepressant medication, which invites a medical discourse into the therapy talk. The therapist validates Trisha’s perspective while attempting to restate a systemic understanding of depression (81-82; 87-89), possibly aiming to make links between Trisha and Pete’s vulnerabilities, an EMCT technique (Reibstein & Sherbersky, 2012b). Trisha’s responses (“I’ve coped with everything”; “I had to just drag myself out of it really”) reinstate an autonomy discourse, which appears in tension with the therapist’s attempts to invite vulnerability and couple interdependence discourses.

These MU events illustrate how cultural and professional values have an influential presence in MU events, as in couple therapy generally (Fife & Whiting, 2007). MU may be particularly sensitive to cultural agendas, as mutual attunement and the expression of emotional vulnerability are inextricably linked to gender patterns and power imbalances (Knudson-Martin, 2013). Conflicts between therapist and partners’ discursive agendas may hold an important role in inhibiting MU processes in couple therapy, and may require considerable
therapist sensitivity to navigate successfully. Further clinical and research implications are discussed below.

**Discussion**

This analysis of five MU event extracts should be viewed as a discursive construction in itself, which can be deconstructed and reinterpreted in turn (Avdi & Georgaca, 2007). I am cautious not to draw generalizable claims based on these findings. However, the analysis was subjected to review by a DA psychologist and by an expert EMCT therapist, thereby adhering to DA validity criteria of coherence and fruitfulness (Jørgensen & Phillips, 2002; Potter & Wetherell, 1987). The extracts provide clinical insights into moment-by-moment conversational interactions that contribute to the co-construction of MU in EMCT.

**Clinical Practice Implications**

The analysis suggests that the therapeutic agenda of developing empathic connection between partners can have a powerful function in initiating MU events. Explicitly formulating this nonblaming systemic agenda can invite MU conversation. However, this attempted neutral position can be problematic for the therapist due to alliance dynamics, and may be experienced by clients as attributing blame, as has been noted in family therapy research (Patrika & Tseliou, 2015). In fact, couple therapy discourse carries values, such as interdependence and mutuality (Johnson & Lebow, 2000; Knudson-Martin & Mahoney, 2005), which can clash with clients' individual or shared cultural references (Sinclair, 2007). In the last two extracts this appeared to inhibit the MU process, as therapists' values of partner mutuality and interdependence
were faced with autonomy and disability discourses. In clinical terms, a positive therapeutic alliance needs to be established with both IC and partner, through validation and therapist empathy (Elliott, Bohart, Watson, & Greenberg, 2011), before effective MU can occur. As alliance tends to remain stable over the early sessions of couple therapy (Glebova et al., 2011), this represents a considerable challenge for therapists.

Positive contributions, such as finding positives, positive reframing, and empathic validation techniques (Reibstein & Sherbersky, 2012b), were shown to have a significant role in orienting therapy talk towards MU. In EMCT for depression, the IC’s partner holds a key role in this regard, as the depressed and/or silenced client may feel unable to voice observations of this type. Partners’ supportive positive change observations can allow greater IC agency, inviting MU. In such instances, changes in partner referencing from “s/he” to “you” constitute noteworthy language shifts, which therapists should highlight to help improve communication patterns.

In the analysed extracts, systemic-behavioural and systemic-empathic talk often overlapped, for example when charting a circularity prompted the therapist to elicit vulnerability. A secure attachment between partners may enable this dual process. Couples who are insecurely attached, which is more likely when one partner experiences long-term depression (Whiffen, Kallos-Lilly, & MacDonald, 2001), may find this type of move more challenging. Eliciting vulnerability was a technique that performed a significant function in facilitating MU, which fits both with EMCT and extensive EFT research (Greenman & Johnson, 2013). Interestingly, findings suggested that this technique was used with persuasive insistence (extracts 2 and 3), contributing to MU.
One issue that emerged in extract 3 relates to how therapists address partners’ conditional empathic statements. While some clients may find it challenging to show open empathy in the therapy room, awkward attempts may benefit from being both confronted for their shortcomings and validated for their worth. Previous research has demonstrated the fundamental value of injurer responsiveness to their partner’s pain and nondefensive heartfelt apology for successful reconciliation following emotional injuries (Meneses & Greenberg, 2011; Zuccarini, Johnson, Dalgleish, & Makinen, 2013). Empathic statements may equally require emotional processing markers to adequately communicate MU between partners, which therapists can encourage and reframe.

The study findings highlight the following clinical practice implications for EMCT:

- Explicitly clarifying the nonblaming systemic EMCT agenda can invite MU. However, partners’ blaming talk and conflicting discourses between couple and therapist can limit this stance, for example by silencing a partner.
- Charting circularities can encourage MU by clarifying the nonblaming agenda, which can address discourse conflicts that inhibit therapeutic alliance at the beginning of therapy.
- Communication skills training, such as active listening enactments, can incite partners to practice MU in the therapy room.
- Eliciting vulnerability is a key EMCT technique for orienting therapy talk towards MU. In this respect, a positive alliance with
the IC partner is important to invite positive contributions on their part.

Relevance to Couple Therapy Research

This study also has research implications. First, it offers an example of DA research in couple therapy, which is poorly represented in the literature compared to DA in the companion field of family therapy (Tseliou, 2013). This approach is suited for examining how models such as EMCT translate into the therapy room, by embracing interactional complexity through micro-analysis (Elliott, 2010, 2012). Second, the study demonstrates the value of the EMCT manual (Reibstein & Sherbersky, 2012b) for sequential process research. By manualising systemic techniques in couple therapy for depression, EMCT invites exploration of transtheoretical processes such as MU, through the analysis of specific therapist interventions or therapy events. Finally, this study of MU provides findings that focus on therapist and couple co-construction of therapy process, which contrasts with most couple therapy studies that either examine therapist interventions or couple variables.

These findings call for further EMCT and couple therapy research:

- Micro-analytic process research could utilise the EMCT manual to investigate the conversational contexts of specific techniques. For example, by examining circularity events, studies could demonstrate how these can be successfully introduced, and how they shift partners’ relational talk.

- DA studies of MU in later EMCT sessions would improve our understanding of empathic consolidation talk, and the techniques
that facilitate it. Such “acceptance” work is important for gains to be maintained over time (Gurman, 2013), and therefore deserves further research.

- Future research could help clarify the conceptual and clinical distinction in MU events between empathy talk in the couple, and therapist alliance with each partner. This would help differentiate therapist systemic-empathic techniques from empathy between partners in MU events. These studies would require separate screening of these processes.

- By incorporating measures of attachment, DA studies could offer important micro-analytic findings regarding variability in MU events relative to partner’s attachment patterns. These studies would complement EFT studies that rely on coded therapy processes (e.g. Makinen & Johnson, 2006).

**Researcher Reflexivity**

The deconstructive nature of DA calls for reflexivity on the part of researcher and therapist alike (Sinclair & Monk, 2004). As a white male clinical psychologist, I may have overlooked certain discursive acts and focused on others. The systematic screening process for MU events aimed to reduce possibilities of bias. DA criteria of coherence and fruitfulness were also adhered to, meaning that the reader can examine how findings provide coherent meaningful interpretations of the data (Wiggins & Potter, 2008). I realise that in this study the constructionist approach has been stretched by my attempts to reconcile positivist aspects of clinical psychology research with DA’s
deconstructive approach. This balancing act is familiar to many systemic researcher-practitioners (Larner, 2004; Roy-Chowdhury, 2003).

Limitations

This study has a number of limitations. The screening of therapy sessions for MU events could have been more extensive, for example by examining the totality of couples' therapy sessions. This would have provided more variability in the data, as MU events towards the end of therapy are probably qualitatively different to early MU events. For example, there may be less overlap with systemic-behavioural EMCT techniques. Time and resources prevented further screening. Missing data also limited the screening process, although this is often inevitable with video recordings.

Positioning and discourse approaches to DA were prioritised in the analysis, leaving other levels of analysis unexplored. I encourage future MU research to include other levels of analysis, such as institutional and power dimensions present in MU talk. From this perspective, the analysis of depression talk events would be of particular interest, as the IC can be positioned as powerless by disempowering depression discourses (Avdi, 2005). Moreover, conflicting understandings of depression may alter the alliances between the therapist and each partner, leading to couple allegiance versus therapist alliance struggle (Symonds & Horvath, 2004). Future research could build on therapeutic alliance and therapist empathy research (Anker, Owen, Duncan, & Sparks, 2010; Elliott et al., 2011; Smith, Msetfi, & Golding, 2010), exploring how these processes relate to MU in EMCT.
MU as a research and clinical concept is not unproblematic. It aims to capture the complexity of the process, making it challenging to operationalize. The concept has a broad focus as it follows the common factors position (Benson et al., 2012). To increase specificity, MU events were defined based on precise, time-bound criteria. However, MU may also occur within longer time scales, for example during whole session tasks such as genograms (e.g. Chrzastowski, 2011) or sculpts (Papp, Scheinkman, & Malpas, 2013).

Conclusion

This study’s conceptualisation and investigation of MU provides clinical and research contributions to the field of couple therapy. It also offers an example of sequential process research using DA, an approach that I argue could benefit couple therapy research. Findings are theoretically and clinically relevant to the development of EMCT. Specifically, the analysis offers insight into how therapist techniques translate into therapy talk, with suggestions concerning processes that enhance and those that inhibit MU. Future research should continue to examine how specific change processes occur in couple therapy. Utilising DA will provide robust analytic methods to generate both critical and clinically relevant findings.
References


# Appendix A: Exeter Model Techniques

<table>
<thead>
<tr>
<th>Technique</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systemic-Behavioural</strong></td>
<td></td>
</tr>
<tr>
<td>Circularities</td>
<td>Tracking</td>
</tr>
<tr>
<td></td>
<td>Interrupting</td>
</tr>
<tr>
<td></td>
<td>Finding Positives</td>
</tr>
<tr>
<td></td>
<td>Establishing New Circularities</td>
</tr>
<tr>
<td></td>
<td>Active Listening</td>
</tr>
<tr>
<td></td>
<td>Clear and direct simple statements</td>
</tr>
<tr>
<td></td>
<td>Encourage Positives</td>
</tr>
<tr>
<td></td>
<td>Behaviour Exchange</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>‘I’ Statements</td>
</tr>
<tr>
<td>Training</td>
<td>Provide Context for Safe Communication</td>
</tr>
<tr>
<td></td>
<td>Structuring</td>
</tr>
<tr>
<td></td>
<td>Problem-solving</td>
</tr>
<tr>
<td></td>
<td>Negotiation Skills</td>
</tr>
<tr>
<td></td>
<td>Emotional Regulation in Problem Solving</td>
</tr>
<tr>
<td>Action Methods</td>
<td>Enactments</td>
</tr>
<tr>
<td></td>
<td>Role-Plays In-session</td>
</tr>
<tr>
<td></td>
<td>Sculpts</td>
</tr>
<tr>
<td>Homework Tasks</td>
<td>Homework enactments</td>
</tr>
<tr>
<td></td>
<td>Practicing new positive forms of communication</td>
</tr>
<tr>
<td><strong>Systemic Empathic</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Empathic Questioning</td>
</tr>
<tr>
<td></td>
<td>Validation</td>
</tr>
<tr>
<td></td>
<td>Eliciting Vulnerability</td>
</tr>
<tr>
<td>Therapist Empathic</td>
<td>Making links between each partner’s vulnerabilities</td>
</tr>
<tr>
<td>Bridging Manoeuvres</td>
<td>Creating Safe Space</td>
</tr>
<tr>
<td></td>
<td>Normalising</td>
</tr>
<tr>
<td></td>
<td>Translating Meaning</td>
</tr>
<tr>
<td>Method</td>
<td>Techniques</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Circular Questioning</td>
<td>Blame reduction and revealing each other's perceptions about the other</td>
</tr>
<tr>
<td>Life-Space Explorations</td>
<td>Scripts</td>
</tr>
<tr>
<td></td>
<td>Genograms</td>
</tr>
<tr>
<td></td>
<td>Interviewing Internalised Other</td>
</tr>
<tr>
<td>Attachment Narratives</td>
<td>Develop shared formulations of central relationship themes</td>
</tr>
<tr>
<td>Reframing</td>
<td>Reconceptualising the positives</td>
</tr>
<tr>
<td></td>
<td>Creating shared positives</td>
</tr>
</tbody>
</table>
## Appendix B: Mutual Understanding

Summary of theoretical and clinical contributions of IBCT, EFT, and EMCT to the concept of Mutual Understanding

<table>
<thead>
<tr>
<th>Model</th>
<th>Process conceptualisation</th>
<th>Couple behavioural outcomes</th>
<th>Therapist techniques</th>
<th>Moment-by-moment interactions that constitute an MU event*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IBCT</strong></td>
<td>Acceptance</td>
<td>Compassion &amp; Understanding</td>
<td>Encouraging partners to express soft emotions (e.g., sadness)</td>
<td>Partners engaged in a nonblaming discussion about a mutual problem without engaging in the problem, blaming the other partner or urging the other partner to change</td>
</tr>
<tr>
<td></td>
<td>Empathic joining</td>
<td>Intimacy &amp; Emotional closeness</td>
<td>Helping couples learn to talk about their problems rather than engage in those problems directly</td>
<td></td>
</tr>
<tr>
<td><strong>EFT</strong></td>
<td>Empathic connection</td>
<td>Self-disclosure &amp; Understanding</td>
<td>Empathic tracking and reflection</td>
<td>Expression of strong emotion (anger, hostility, critical blaming)</td>
</tr>
<tr>
<td></td>
<td>Affiliative statements</td>
<td>Intimate sharing &amp; Trusting</td>
<td>Validating each person’s experience</td>
<td>Disclosures of vulnerability (fear of abandonment and rejection, remorse, regret, empathy, responsibility, apologies)</td>
</tr>
<tr>
<td></td>
<td>Blamer softening</td>
<td>Comforting</td>
<td>Evocative responding &amp; Heightening and interpreting (e.g. through metaphors)</td>
<td></td>
</tr>
</tbody>
</table>
### Mutual Emotion Connection (EMCT)

**Mutual empathy**
- Seeing or feeling things from other’s perspective
- Emotional connection to and identification with partner

**Empathy**
- Empathic bridging manoeuvres
- Circular questioning
- Life-space exploration
- Attachment narratives
- Reframing

**Therapist empathic bridging questions:**
Making links between partners’ vulnerabilities, eliciting expression of vulnerable feelings that may underlie emotional reactions, conveying empathy for these feelings, identifying and articulating relationship themes that lie behind specific behaviour

Descriptions of attachment patterns in family and relationship history for each partner

**Partners talking to each other about respective hopes and fears they have about their relationship**

**Establishing and noting partners’ daily rituals of connecting with each other**

---

*Note:* * Moment-by-moment interactions in **bold** were used as core criteria to identify MU events. Two of the five criteria needed to be present for a therapy event to qualify as an MU event. IBCT = Integrative Behavioural Couple Therapy (Cordova et al., 1998; Jacobson & Christensen, 1996); EFT = Emotion focused couple therapy (Johnson & Greenman, 2006; Johnson, 2007; Zuccarini et al., 2013); EMCT = Exeter Model Couple Therapy (Reibstein & Sherbersky, 2012a, 2012b).
## Appendix C: Seven-Step Methodology

Seven-step approach to DP methodology (adapted from Wiggins & Potter, 2008)

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1    | **Devising a research question**  
Guided by an interest in a particular form of interaction |
| 2    | **Gaining access and consent**  
Ethical and practical considerations for accessing the data |
| 3    | **Data collection and building a corpus**  
DP requires a thorough examination of a collection of similar instance |
| 4    | **Transcription**  
Features of talk that are relevant are represented (emphasis, overlap, pauses, intonation etc.) |
| 5    | **Coding**  
Iterative process of sifting through the data for instances of a phenomenon. Issues may emerge or disappear at this point |
| 6    | **Analysis**  
Focus on how discourse is constructed, constructive of different versions of events, situated in interaction, and bound up with actions |
| 7    | **Application**  
Analysis and findings are linked to the context under study |
Appendix D: Ethics Documentation

NRES Committee Ethical Approval

NRES Committees – North of Scotland
Summerfield House
2 Elgray Road
Aberdeen
AB15 8RE

Telephone: 01224 558458
Facsimile: 01224 508609
Email: nres@nhs.net

23 April 2014

Mr Theo Roberts
Washington Singer Laboratories
School of Psychology
University of Exeter
Perry Road
EXETER
EX4 4QG

Dear Mr Roberts

Study title: Unravelling mutual understanding in couples’ therapeutic conversations: A discourse analysis
REC reference: 14/NS/0068
Protocol number: N/A
IRAS project ID: 152962

The Proportionate Review Sub-committee of the NRES Committees: North of Scotland (2) reviewed the above application on 23 April 2014.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Karen Gauld, kgauld@nhs.net.

Ethical opinion

On behalf of the Committee, the Proportionate Review Sub-Committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see
“Conditions of the favourable opinion” below).

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

**Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.**

Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.rdfunding.nhs.uk](http://www.rdfunding.nhs.uk).

Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

**Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are compiled with before the start of the study or its initiation at a particular site (as applicable).

**Approved documents**

The documents reviewed and approved were:
Membership of the Proportionate Review Sub-Committee

The members of the Proportionate Review Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website. Information is available at National Research Ethics Service website > After Review
We are pleased to welcome researchers and R & D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee’s best wishes for the success of this project.

Yours sincerely

[Signature]

Pp’d on behalf of
Dr Alex Johnstone
Chair

Enclosures: List of names and professions of members who took part in the review

"After ethical review – guidance for researchers" [SL AR2]

Copy to: Ms Gail Seymour
Exeter Psychology Department Ethical Approval

<table>
<thead>
<tr>
<th>PSYCHOLOGY DEPARTMENT ETHICAL APPROVAL FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tick one box: STAFF Project X POSTGRADUATE Project UNDERGRADUATE Project ROUTINE EXTENSION TO PRE-APPROVED STUDY</td>
</tr>
<tr>
<td>Title of Project: Unravelling mutual understanding in couple's therapeutic conversations: A discourse analysis</td>
</tr>
<tr>
<td>Name of researcher(s): Tahia Roberts</td>
</tr>
<tr>
<td>Name of supervisor (for student research): Dr. Janet Smithson</td>
</tr>
<tr>
<td>Date: 30.04.2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Will you describe the main experimental procedures to participants in advance, so that they are informed in advance about what to expect?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Will you tell participants that their participation is voluntary?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Will you obtain written consent for participation?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>If the research is observational, will you ask participants for their consent to being observed?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Will you tell participants that they may withdraw from the research at any time and for any reason?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>With questionnaires, will you give participants the option of omitting questions they do not want to answer?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

If you have ticked No to any of Q1-8, but have ticked box A overleaf, please give any explanation on a separate sheet. (Note: N/A = not applicable)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Will your project involve deliberately misleading participants in any way?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is there a realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g. who they can contact for help).</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

If you have ticked Yes to 9 or 10 you should normally tick box B overleaf; if not, please give a full explanation on a separate sheet.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Does your study involve work with animals? If yes, and your study is purely observational, please tick box A. All other studies should tick box B and provide supporting information.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines, and tick box B overleaf. Please note that you may also need to gain satisfactory CRB clearance or equivalent for overseas participants.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

There is an obligation on the lead researcher to bring to the attention of the Departmental Ethics Committee projects with ethical implications not clearly covered by the above checklist.
PLEASE TICK EITHER BOX A OR BOX B BELOW AND PROVIDE THE DETAILS REQUIRED IN SUPPORT OF YOUR APPLICATION, THEN SIGN THE FORM.

Please tick:

A. I consider that this project has no significant ethical implications to be brought before the Departmental Ethics Committee.

In less than 150 words, provide details of the experiment including the number and type of participants, methods and tests to be used (i.e. the procedure).

The aim of the study is develop evidence of therapeutic interventions and techniques that facilitate empathy between partners in couple therapy for depression. Specifically, it explores how clients’ and therapists’ communication promotes mutual understanding between partners in couple therapy, using data from the AccEPT clinic. It will identify how techniques from the Exeter Model of Couple Therapy for Depression are effective and how they are used in therapy. This study is using retrospective qualitative data. The data come from therapy sessions which were video recorded and stored onto DVD. The data from six couples will be transcribed and analysed. Participants will be selected based on relationship discord at onset of therapy. Transcripts of sessions 1-4 and the final session will be analysed using a qualitative method: Discourse Analysis. This method offers a robust approach to analysing language interactions in depth.

Ethical approval has been obtained from an NRES committee (see attached letter).

This form (and any attachments) should be submitted to the Departmental Ethics Committee where it will be considered by the Chair before it can be approved.

B. I consider that this project may have ethical implications that should be brought before the Departmental Ethics Committee, and/or it will be carried out with children or other vulnerable populations.

Please provide all the further information listed below in a separate attachment.

1. Title of project.
2. Purpose of project and its academic rationale.
4. Participants: a) Human research: Recruitment methods, number, age, gender, exclusion/inclusion criteria.
   b) Animal research: location of study site, method of obtaining / marking / identifying subjects, handling procedures for field experiments.
5. Consent and participant information arrangements, debriefing. (Not relevant for animal research) Please attach intended information and consent forms.
6. A clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them.
7. Estimated start date and duration of project.

This form should be submitted to the Departmental Ethics Committee for consideration.

If any of the above information is missing, your application will be returned to you.

I am familiar with the EPS Guidelines for ethical practices in psychological research (and have discussed them with other researchers involved in the project.)

Signed ____________________________ Print Name: THEO ROBERTS Date: 12.08.2014
(UG/PG Researcher(s), if applicable) Email: tr265@exeter.ac.uk

Signed J. Smith
(Lead Researcher or Supervisor) Print Name: Janet Smithson Date: 22/08/14.
Email: jsmithson@exeter.ac.uk

This project has been considered using agreed Departmental procedures and is now approved.

Signed ____________________________ Print Name: Tim Kuz Date: 21-10-14
(Chair, Departmental Ethics Committee)
Patient Information Sheet and Consent Form

University of Exeter AccEPT Primary Care Psychological Therapies Service

Client Information Sheet and Consent Form

You have been referred to the AccEPT Clinic at the University of Exeter. This form explains what you can expect from attending the AccEPT Clinic.

The AccEPT Clinic is a partnership between the University of Exeter and the NHS, with the goal of providing a centre for mood disorders research, practice, and training that benefits people who suffer from mood disorders. These goals will be achieved directly through the provision of a clinical service providing an assessment and treatment service to people with depression and indirectly through research into understanding depression and its treatment.

The first stage of a referral to the AccEPT Clinic is an assessment. The interview will discuss your symptoms, any relevant background, your strengths and your difficulties. The purpose of this interview is to help us and to help you understand your depression and to consider what treatment options would be most suitable for you.

Currently, the therapists within the clinic offer several forms of cognitive-behavioural therapy and this assessment will also be used to determine if your difficulties seem a good match with any of these therapies. If there is a good match between your difficulties and the therapies we provide, you will then be offered further therapy. If there is not such a good match, we will make a recommendation for future treatment to yourself and the person who referred you to us.

As a therapy research clinic, we carefully evaluate the assessments and therapy we offer, which involves collecting information from you by questionnaire and interviews. We can only find out more about depression and develop more effective treatments if you are willing to take an active part in this ‘audit’ when you attend the AccEPT Clinic. It would be particularly helpful to us if you are willing to keep in touch over a number of years as we are particularly interested in how well people do in the longer term.

The therapy offered at the Mood Disorders Centre

The therapy offered by the AccEPT Clinic is called “cognitive-behavioural therapy.” This therapy is structured so that it helps you to learn new skills to deal with problems. In cognitive-behavioural therapy, depression and other emotional problems are understood as developing from the way people see and react to events. In therapy, your therapist will help you learn new skills to recognise and challenge thoughts that are unhelpful to you. Learning these problem-solving skills help you to cope better with difficulties that you may face in the future. You will receive the same type of therapy right throughout the course of your treatment. There are several forms of cognitive behavioural therapy currently offered by the AccEPT Clinic and these are described in full on our web page at: www.exeter.ac.uk/mooddisorders/acceptclinic/. There will be an opportunity to discuss these therapies at your assessment appointment.
It is important to note that you are free to withdraw from therapy at any point. If possible we would like you to discuss this with your therapist first. If you decide to stop attending before your therapy course finishes, we will ask you to complete some measures for us. We keep a copy of your file and all the measures you complete to 'audit' the work within the AccEPT Clinic. This means we will be carrying out research to make sure that the work we do in the AccEPT Clinic is effective and to determine what factors are associated with effective therapy.

It is our normal practice to record therapy sessions either with audio-tape or video-tape. We aim to record all therapy sessions in order to 1) ensure that the therapists can have good supervision from each other to make sure we provide high quality therapy, 2) to help us to research in great detail what happens in therapy and which aspects of a therapy are more helpful and less helpful. Furthermore, within the individual Cognitive-behaviour therapy recording of sessions is part of the therapy as clients are given copies of sessions to take home and use. However, we cannot record sessions without your signed consent. We hope that you are willing to provide this consent. You may ask for your tapes to be destroyed at any time if you choose for them not to be used for research purposes.

**People you will deal with at the clinic**
The Intake Co-ordinator will arrange the assessment interviews and provide you with information about the appropriate therapy. If you have any problems with your appointments, you would contact either the Intake Co-ordinator or the person you have an appointment with. Any questions or concerns you have about the therapy itself should be raised with your therapist.

**Confidentiality**
Normally, the AccEPT Clinic staff will have access to the details that have been collected about you. This includes all the forms and questionnaires you have completed as well as the notes kept by your therapist. As in any NHS setting, we will liaise with other people involved in your care on an as needed basis. The assessment / therapy file will be kept in a secure location in line with normal practice in the NHS.

Published reports arising from the research materials are prepared to ensure the anonymity of all participants. Similarly, if AccEPT Clinic staff members communicate with researchers in other settings they would ensure your anonymity in the same way. The research files are the property of the University of Exeter.

**Contact with other people involved in your care**
We will write to others involved in your care to ensure they know that you are coming to the clinic for therapy. We will write to these people again after the end of therapy to let them know how your therapy went and keep them up to date with how you are getting on. It is our normal practice to involve you / copy you into these communications.

**Suicidal feelings, plans and other difficulties**
The AccEPT Clinic is not a 24-hour service and cannot respond to emergencies. If at any stage you need to speak to someone urgently, you should do this in the normal way. If you have a Care Coordinator / Key Worker this person would be the first point of contact. If you do not have a Care Coordinator / Key Worker, your GP would be the person to contact. Out of hours, your practice should have access to an "out of hours service" or alternatively Accident and Emergency Departments are always open.
Consent
Please complete and sign one copy of the following to indicate that you understand and freely give you consent to the therapy and research procedures we have described. The second copy is for you to keep for your own records.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have read and understood the information for clients sheet, and had the opportunity to ask questions if I wish. This includes the clinic’s policy on managing suicidal feelings, plans and other difficulties.</td>
<td></td>
</tr>
<tr>
<td>2. I understand I am free to withdraw from the AccEPT Clinic at any time without giving a reason and without affecting my future care</td>
<td></td>
</tr>
<tr>
<td>3. I agree to the assessment and therapy sessions being audio and video recorded for the purposes of therapy, supervision, assessment and feedback for therapists. I understand that I may order the recordings to be destroyed when my therapy is complete if I do not wish them to be used for research/training purposes.</td>
<td></td>
</tr>
<tr>
<td>4. I agree to my recordings being used for training purposes. I understand that the trainers would be staff and students of the University of Exeter bound by their professional codes of conduct.</td>
<td></td>
</tr>
<tr>
<td>5. I agree to my contact details being added to the AccEPT Clinic database so that I might be invited to take part in research conducted by Mood Disorders Centre staff and postgraduate students.</td>
<td></td>
</tr>
<tr>
<td>6. I would like to receive copies of any correspondence related to me from the AccEPT Clinic</td>
<td></td>
</tr>
</tbody>
</table>

Signature of client
Date
Name

Signature of member of centre staff
Date
Name
## Appendix E: Screening Procedure

Screening summary by couple and session with identified MU events

<table>
<thead>
<tr>
<th>Couple</th>
<th>Session</th>
<th>Process / content</th>
<th>MU events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple 1</td>
<td>J &amp; T</td>
<td>Presenting problem. T dominates discussion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>46’00”: TH identifying shared hopes + J expression of vulnerability</td>
<td>46’00”: MU event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reframing / reconceptualising the positives</td>
<td>TH initiated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mapping circularity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>16’50”: expression of vulnerability. T feels lied to about J’s depression</td>
<td>Event did not meet MU criteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23’15: TH referring to shared experience of depression</td>
<td>23’15”: MU event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exploring shared vulnerabilities + nonblaming discussion of mutual problem</td>
<td>TH initiated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol issue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4’50”: Revisiting goals for future</td>
<td>No MU event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychoeducation about depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>32’20: T’s complaints about J – TH communication patterns</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion of attachment relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1h00”: Impact of alcohol on relationship – further argument</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Exploration of partner needs (homework)</td>
<td>No MU event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DVD errors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final (5)</td>
<td>T health issues</td>
<td>No MU event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of current concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>13’00”: TH relationship themes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>29’30”: Relationship themes e.g. dependence/independence</td>
<td></td>
</tr>
</tbody>
</table>
**EMPATHY IN COUPLE THERAPY**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1h20’</td>
<td>Discuss planned holiday together</td>
</tr>
<tr>
<td>33’10”</td>
<td>Story of couple meeting</td>
</tr>
<tr>
<td>51’20”</td>
<td>History of depression / relationship issues</td>
</tr>
<tr>
<td>14’00”</td>
<td>Presenting problems, lack of mutual support</td>
</tr>
<tr>
<td>23’20”</td>
<td>TH: interviewing internalised other w/ P re previous conflict</td>
</tr>
<tr>
<td>38’00”</td>
<td>Disclosure of historical sexual abuse</td>
</tr>
<tr>
<td>43’00”</td>
<td>TH articulating relationship theme + Partners</td>
</tr>
</tbody>
</table>

### Couple 2

**N & P**

1. **14’00”** Presenting problems, lack of mutual support
   - Health problems
   - 33’10” story of couple meeting
   - 51’20” history of depression / relationship issues
   - TH: limited intervention

2. *Missing*

3. **Housing / financial issues**
   - 23’20” TH: interviewing internalised other w/ P re previous conflict
   - P complaint about work
   - 47’50” feedback from reflecting team / supervisor
   - 57’15” TH empathic bridging?

4. **11’20”** N’s genogram
   - Links made with P’s family

5. **12’40”** Charting circularity of recent event
   - 27’30” P expression of 2nd emotion (resentment)
   - End: active listening training

**Final (16)**

- Positive change / new house
- Review of positive changes and planned strategies for communication

### Couple 3

**G & L**

1. *Missing*

2. **13’00”** searching for goal
   - **16’15”** TH normalising – discussion of mutual problem without engaging in it
   - **38’00”** disclosure of historical sexual abuse

**43’00”** TH articulating relationship theme + Partners

Event did not meet MU criteria

No MU event
engaged in a nonblaming discussion about a mutual problem without engaging in it

<table>
<thead>
<tr>
<th>Time</th>
<th>Description</th>
<th>Initiator</th>
</tr>
</thead>
<tbody>
<tr>
<td>54'00&quot;</td>
<td>TH preparing circularity work for next session</td>
<td></td>
</tr>
<tr>
<td>2'00&quot;</td>
<td>Discussion of recent crisis in couple</td>
<td>TH initiated</td>
</tr>
<tr>
<td>16'10&quot;</td>
<td>TH validation + naming emotions</td>
<td></td>
</tr>
<tr>
<td>27'00&quot;</td>
<td>TH charting circularity (recent crisis)</td>
<td></td>
</tr>
<tr>
<td>31'15&quot;</td>
<td>L expression of vulnerability + partners talking about fears + nonblaming talk about problem</td>
<td></td>
</tr>
<tr>
<td>47'40&quot;</td>
<td>TH linking circularity behaviours to depression &amp; relationship theme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31'15&quot;: MU event</td>
<td>MU initiated</td>
</tr>
<tr>
<td>15'00&quot;</td>
<td>Discussion of life transition + partner empathy</td>
<td>Events did not meet MU criteria</td>
</tr>
<tr>
<td>27'00&quot;</td>
<td>Disclosure of psychological abuse from grandfather</td>
<td></td>
</tr>
<tr>
<td>29'40&quot;</td>
<td>Empathy from G</td>
<td></td>
</tr>
<tr>
<td>42'00&quot;</td>
<td>positive relationship eg. cousins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>27'00&quot;: Disclosure of sexual abuse in family</td>
<td></td>
</tr>
<tr>
<td>39'10&quot;</td>
<td>L feedback on genogram</td>
<td></td>
</tr>
<tr>
<td>40'20&quot;</td>
<td>Disclosure of sexual abuse (story)</td>
<td></td>
</tr>
<tr>
<td>49'30&quot;</td>
<td>G’s story of abortion (pregnant with L)</td>
<td></td>
</tr>
<tr>
<td>54'00&quot;</td>
<td>TH links story to relationship theme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Event did not meet MU criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(extended MU event?)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Final (9) Review of highlight moments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G pregnant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive feedback about therapy</td>
<td></td>
</tr>
</tbody>
</table>

**Couple 4**

<table>
<thead>
<tr>
<th>E &amp; K</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>K’s genogram</td>
</tr>
<tr>
<td>2</td>
<td>K’s genogram</td>
</tr>
<tr>
<td></td>
<td>46'45&quot;: Eliciting appreciative observation from E regarding K and daughter: circular questioning</td>
</tr>
<tr>
<td></td>
<td>Discussion of parenthood – lack of model in family?</td>
</tr>
</tbody>
</table>
EMPATHY IN COUPLE THERAPY

Couple 5
H & L

1 Presenting problems in relation to depression / relationship
52'20": discussion of individual fears
1h13": Introduce each other

2 Missing

3 5'40": Previous experience of help (GP)
12'00": Discussion of depression / impact on H’s identity
Issue of medication / psychoeducation about depression
41'00": H’s fears / links to early life experiences
Individual focus on depression

4 Impact of past on current relationship
22'00": H’s fear of abandonment by L
EMPATHY IN COUPLE THERAPY

36'20": H’s genogram

5
19’00”: Review of genogram
27’40’: H disclosure of historic sexual abuse
Disclosure with L present

Final
Review of positive changes

No MU event

TH mention of attachment in relationship

Final
(21)

Couple 6
C & R
1-5 and final

Screening problems due to numerous DVD errors

No MU event

Couple 7
P & L
1

Presenting problems. Depression / relationship issues
Presentation of EMCT understanding of depression
46’00”: Discussion of work related problems – ongoing dispute

2-3
Missing

4

7’00”: L noticing P’s apology. L & P nonblaming discussion + TH identifying relationship theme
19’00”: TH charting circularity about discipline with daughter
48’30”: TH exploring alternatives in circularity

5

Ongoing work dispute issues re sick leave
26’20”: P explaining links with childhood experience

52’30”: MU event
TH validation

50’00”: expression of empathy towards partner
52’30”: L tells TH that partner of changed pattern
Nonblaming discussion of problem + TH noting rituals of connection

Final
Review of positive changes (e.g. circularities)

(12)

18’00”: exploring alternative responses with children
Review of skills (e.g. problem-solving)

Note: MU = mutual understanding; IC = identified client; P = partner; TH = therapist. MU events highlighted in bold.
Appendix F: Transcript Notations

Transcript notations were adapted from Jefferson (2004).

? Indicates a questioning tone to preceding speech.

– Indicates a brief hesitant pause (<0.5 sec).

(...) Indicates a medium to long pause in speech (0.5 – 1.5 sec).

[ ] Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.

(()) A description enclosed in a double bracket indicates a non-verbal activity.

Under Underlined fragments indicate speaker emphasis.

°° Degree signs are used to indicate that the talk they encompass is spoken noticeably quieter than the surrounding talk.

(inaudible) Indicates speech that is difficult to make out.
Appendix G: Dissemination statement

Preliminary dissemination of this study's findings has already taken place through discussions and email exchanges with the two leading therapists and researchers in EMCT, Professor Janet Reibstein and Hannah Sherbersky.

The findings from this study will also be disseminated to fellow clinical psychologists and practicing therapists during a presentation for colleagues within Dorset Healthcare NHS Foundation Trust Psychological Therapies Service. This presentation will take place in June 2015.

Findings will be disseminated to researchers and practitioners through publication of this study in a peer-reviewed journal. A shortened and adapted version of this article will be submitted to Family Process after acceptance of the thesis by the Examiners’ Boards.
Appendix H: Family Process Author Guidelines

http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1545-5300/homepage/ForAuthors.html

All submissions to Family Process are electronic. Authors should submit manuscripts to the Family Process submissions website at http://mc.manuscriptcentral.com/fp and follow the directions there for submitting manuscripts. By accessing this website you will be guided stepwise through the creation and uploading of files. For assistance, contact Scholar One technical support at 888-503-1050 (US based number) or 434-964-4100, or via email at mcsupport@thomson.com. The submission form requires the name, mailing address, email address, telephone number, and Fax number of all authors including the corresponding author. The letter that accompanies the manuscript submission should include the total word count of the paper including references. All correspondence, including Editor’s decision and request for revisions, will be by email. Manuscripts must be in English and submitted with the understanding that they are not being submitted simultaneously to another publication or have not already been published in whole or substantial part elsewhere. All case reports should protect patient confidentiality. If accepted, papers become copyright of the Family Process. Authors must give signed consent for publication by submitting a license agreement, but permission to use material elsewhere (e.g., in review articles) will normally be granted on request.

Manuscripts—Family Process follows the Publication Manual of the American Psychological Association (6th ed.). Additional information is available at www.apastyle.org. Specifically:

• Electronic manuscripts must be
double spaced in 12 point font throughout, including the abstract and references. Pages should be numbered consecutively with the title page as page one and include abstract, text, references, and visuals. • **Manuscripts should not exceed 30 pages or 6,000 words, including title page, abstract, text, references, tables, and figures.** • Do not underline; use the italic font. • A separate title/cover page must include full names of authors in order of their contribution, author affiliation and location, title, author note, byline, and grant support. Because Family Process uses a masked review system, the cover page should be used to provide identifying information about the authors. The authors’ names should not appear on subsequent pages and every effort should be made in the text for the authors’ identity to remain anonymous.

  - Abstracts should be approximately 200-250 words in length.

  - Headings must be short. Three levels of headings are used within the text, as follows:

    - **Main heading:** Centered, Boldface, Uppercase and Lowercase Heading

    - **Main subhead:** Flush Left, Boldface, Uppercase and Lowercase Side Heading

    - **Minor subhead:** Indented, Boldface, lowercase paragraph heading ending with a period.

  - **Tables and Figures**—Limit the use of tables to data that correlate specifically to article content or communicate large amounts of data efficiently. All tables and figures should be submitted on a separate page, have a separate
title, and be cited within the text with placement indicated. For figures, high contrast glossy prints or camera-ready copies must be supplied. Type title, legend, and notes for figures double-spaced on a separate page.

**Submission/Contacts:** Jay Lebow, Ph.D. Editor: Family Process Family Institute at Northwestern 618 Library Pl. Evanston IL 60201 USA Tel: (847)733-4300 extension 676 Fax: (847)733-0390 Email: j-lebow@northwestern.edu

**Copy Editing, Proofs, and Off-print/Reprint Orders:** After an article has been accepted for publication, it is copy-edited for literary style, conformity to the style of this journal, clarity of presentation, coherence, punctuation, standard usage of terms, spelling, bias free language, etc. After the article is typeset authors may be charged for any changes they wish to make. The author will receive page-proofs from the typesetter, together with an Off-Print/Reprint order form that must be returned within 3 days of receipt. Occasionally, and with the author’s permission, an article that has been accepted will be followed by an invited commentary to which the author may submit a rejoinder. The author’s unwillingness to participate in this process will in no way affect the publication of an accepted article.

**Supplemental Materials:** Authors can place supplemental materials on line on the journal’s website. To submit such materials, please upload them with the manuscript to ScholarOne. For further information and guidelines about submissions in Spanish and Mandarin, please visit the Family Process author guidelines at: http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1545-5300/homepage/ForAuthors.html.