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Task Analysis of SERT: Exploring the Efficacy of Feminist Therapy

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by

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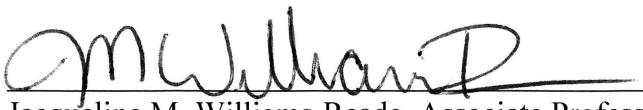
Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.



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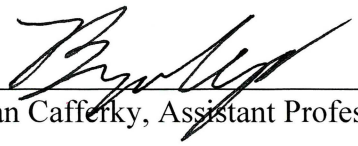

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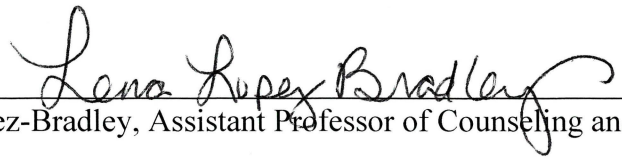

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CONTENT

FIGURES

TABLES

CHARTS

APPENDICES

ABSTRACT OF THE DISSERTATION

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Feminist theorists have begun to view gendered power as a core component of relational distress (Knudson-Martin & Mahoney, 2009; Moradi, 2012). Leading couples toward equality is a social justice ethic and is arguably a stand-alone clinical outcome (Evans, Kincade, Marbley, & Seem, 2005; Fitzgerald & Betz, 1994). Leading couples toward mutual support brings relational stability and long-term relationship satisfaction in both men and women (Acitelli & Antonucci, 1994; Buunk & Mutsaers, 1999; Mahoney & Knudson-Martin, 2009; Sprecher, 2001). SERT [Socio-emotional Relationship Therapy] was designed to integrate feminist theory as a core component to bringing power change in couples (Knudson-Martin & Huenergardt, 2010). This research utilized task analysis to locate the tasks of therapists guiding couples toward mutual attunement and shared relational responsibility. The study discovered that therapists who were successful in reaching the outcome resolution would first attune to male clients, then direct those men toward relational language and mindsets, invite the female client's perspective and finally guide an enactment of this new and mutually supportive process with the couple. This study gives clarity on the process of implementing SERT which can guide the training process of new feminist therapists.

CHAPTER 1: INTRODUCTION

Although family therapy attends to a variety of issues, one of the most vague and complex issues is couple relational distress. Along with the emerging trend of egalitarian values in Western culture (Sullivan, 2006), researchers have found that incorporating social justice issues in therapy can increase physical and mental health functioning across multiple areas of life for women (Moradi, 2012). Couples who exhibits traits consistent with equality also see increased levels of relationship satisfaction and see longer lasting relationships (Buunk & Mutsaers, 1999; Mahoney & Knudson-Martin, 2009; Sprecher, 2001). The opposite end of the relational spectrum is also researched. Power imbalances perpetuated by social expectations of masculinity and femininity create the stage for disempowerment and relational distress (Silverstein, Buxbaum, Tuttle, Knudson- Martin, & Huenergardt, 2006).

Addressing power imbalances in therapy is easier said than done. Gergen (1994) found that these societal messages are so deeply connected to acceptance and attachment that to challenge these cultural discourses may be emotionally perceived as a threat to survival. The ingrained and subtle nature of these discourses of gender make it difficult for client and therapist alike (ChenFeng & Galick, 2015; Knudson-Martin & Huenergardt, 2010). Even with extended training in recognizing these gender dynamics, therapists can inadvertently continue to perpetuate power imbalances by either failing to interrupt the power processes or unknowingly participate in the dynamic themselves (Ward & Knudson-Martin, 2012).

In addition, it has been difficult to branch out of feminist theory into the world of clinical practice. Many therapists may consider themselves feminists, or even feminist

therapists, but how that impacts therapy for them is less clear (Moradi, Fischer, Hill, Jome, & Blum, 2000). SERT [Socio-emotional Relationship Therapy] is one of the first devised models to incorporate feminist theory into practice as a stand-alone model for address couple distress rather than an addition to another model (Knudson-Martin & Huenergardt, 2010; Knudson- Martin et al., 2015).

Problem Statement

Since SERT is in the initial stages of theory development, further steps taking it into practice and preparing for efficacy and outcome research are needed. Qualitatively, many constructs have been identified both in terms of operationalized outcome areas: (a) mutual attunement, (b) shared vulnerability, (c) shared relational responsibility and (d) mutual influence (Knudson-Martin & Huenergardt, 2010). Seven common competencies were identified as skills used when working with gender discourses in couples therapy: (a) identify enactments of cultural discourse, (b) attune to underlying socio cultural emotion, (c) name underlying power processes, (d) facilitate relational safety, (e) foster mutual attunement, (f) create a model of equality, and (g) facilitate shared relationship responsibility (Knudson- Martin et al., 2015). Although these constructs have been identified, they have not been sufficiently connected to each other in research. If the four categories of mutual support are the aim of SERT and theoretically much of feminist theory for couples, then the seven competencies can be correlated to those aims as outcomes.

Purpose of the Study

Utilizing the constructs already identified within SERT research, the aim of this study is as follows:

1. To identify patterns and interaction events of client couples in the problem state *lack of mutual attunement*.
2. To identify patterns and interaction events of client couples in the problem state of *relational responsibility being placed on female partner*.
3. Track therapeutic interactions until the problem state is resolved or the event continued unresolved.
4. Create a synthesized model of change based on patterns of interaction between therapists and client couple in the problem state.

Since the theory has already been established by SERT, task analysis will be utilized to verify the presents of both the problem states and therapist interventions theorized to be a part of couples change toward mutual support. Assuming the verification can be established, the analyzed components of stages of change discovered in the data can be the next stepping stone for developing a comprehensive training model for future SERT therapists or any therapist hoping to address gender, power, and culture in couple therapy. If there is not enough data to verify the accuracy of the SERT theorized model, then the findings can be used to pinpoint areas of deviation and open the model for researcher discussion as to future directions of research.

Brief Overview of Conceptual Framework

This study is grounded in how feminist therapists have utilized the Socio-emotional Relationship Therapy [SERT] modality to guide couples toward equality. On the meta level, Social Construction will aid the researchers in understanding that there are dominant discourses constructed through evolving experiences and interactions (Berger & Luckmann, 1966; Weingarten, 1991) These discourses include common values and

norms which guide behaviors. Couple interactions are guided by the social context in which they reside and interact. Knowing that there are discourses, this study will look closely at the common values and norms behind gender, equality, and power.

The feminist lens will be used to guide the discourses of equality and power. Equality is a worthy therapeutic goal with previous research suggesting that couples with equal power can lead to better relational outcomes, specifically relational satisfaction from both men and women (Buunk & Mutsaers, 1999; Sprecher, 2001). The feminist lens also provides a framework for the concepts of power. Developing awareness of these constructs and questioning their validity would feel as a threat to ones understanding of life and their place in society (Gergen, 1994). Creating lasting change through therapy would be even more difficult as their daily context would continually reinforce the previously agreed upon social constructs. In this study's case, the therapist is challenging the construct of gender norms and roles (Knudson- Martin et al., 2015). This is asking a great deal for a couple to stand apart from society's norms and interact in a new way that may seem counter to their cultural identity, which would explain resistance to identifying and altering social constructs, such as gender (Gergen, 1992; Gergen & Ness, 2016; Guyer & Rowell, 1997). SERT gives the final piece of the puzzle connecting theory to practice through a comprehensive guide for therapists applying a feminist lens to therapy (Knudson-Martin & Huenergardt, 2010)

Brief Overview of Methodology

Because there are few models created for the express purpose of addressing power differentials and guiding couples toward equality, task analysis is the research method being used to further explore therapist adherence to competencies of the Socio-Emotional

Relationship Therapy (SERT). Task analysis breaks a model into step by step change events which track therapeutic change (Greenberg, 2007). Greenberg outlines two phases of analysis starting with the discovery phase in which the researchers uncover the factors surrounding an event and begins to track it and ending with the validation which tests the theory of change created in the discovery phase. This phase will still be accomplished according to task analysis but the researchers will be comparing findings against the current theory of change established by SERT (Knudson-Martin & Huenergardt, 2010).

Task analysis takes a goal-oriented stance by looking at the flow of states and resulting in the completion of a task (Pascual-Leone, Greenberg, & Pascual-Leone, 2009). The researcher is tracking the pattern of change while, presenting the observable components while exploring the hidden mechanisms which drive the change to create a causal model. Pascual-Leone describes that change doesn't occur in isolated incidents, but rather within the "interplay between hidden (causal) properties and manifest (descriptive) experience" (Pascual-Leone et al., 2009, p. 528). This study will assume that the dominant discourse of gender will bring to light the hidden (causal) properties that motivate client interactions as well as therapist interactions with the couple.

Examples of the problem state will be identified. In this study, the problem states are *lack of mutual support* and *relational responsibility being placed on female partner*. These two problem states are based on two of the mutual support subcategories and line up with the chosen competencies under analysis which are *foster mutual attunement* and *facilitate shared relational responsibility*. These sets of data in the theory were chosen because of their assumed correlations in the data. The competencies should pair well to lead the problem state to successful resolution. In task analysis, looking for perfect

examples of problem and outcome can be helpful when initially tracking the process of change.

Limitations

Most notably, this study is limited to a specific research group and supervisors within the SERT therapy model. Factors related to geographic location, supervision relationship, training model applied, the presence of pre-licensed therapists, and setting of a university clinic setting are not uniquely tracked and observed. Although not a requirement for involvement in the study, only heterosexual couples populated the study. This theory, as of yet, is unable to speculate how the theory and model impacts the power dynamics of LGBTQIA+ couples.

There was no control in place regarding presenting problem other than relational distress. Many couples who self-referred to this program were suffering from additional couple and individual struggles such as chronic illness, low SES, addiction, mental health diagnosis, trauma symptoms, etc. The model and research designs of the original study did not track for the unique impact of these factors on couple distress or power dynamics, but there is research present to extrapolate theories as to the impact of these factors. In addition, task analysis does not attempt to pursue generalizability at this stage of research, only to hone in on the unique components of change between therapist action and client resolution of problem state.

Summary of Introduction

This chapter is designed to introduce the concepts of power dynamics, socialized gender and how feminist theory has been adapted to couple therapy. This study will address what the researcher perceives to be the next step toward SERT efficacy research.

Since SERT is still in the initial stages of research, this study will utilize task analysis to explore connections of SERT competencies with SERT theorized problem states. The next chapter will explore how feminist theory and social construction has informed SERT therapy as well as how terms and concepts are understood.

CHAPTER 2: LITERATURE REVIEW

This study is grounded in how feminist therapists have utilized the Socio-emotional Relationship Therapy [SERT] modality to guide couples toward equality. On the meta level, Social Construction will aid the researchers in understanding that there are dominant discourses constructed through evolving experiences and interactions (Berger & Luckmann, 1966; Weingarten, 1991) These discourses include common values and norms which guide behaviors. Couple interactions are guided by the social context in which they reside and interact. Knowing that there are discourses, this study will look closely at the common values and norms behind gender, equality, and power.

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great deal for a couple to stand apart from society's norms and interact in a new way that may seem counter to their cultural identity, which would explain resistance to identifying and altering social constructs, such as gender (Gergen, 1992; Gergen & Ness, 2016; Guyer & Rowell, 1997). SERT gives the final piece of the puzzle connecting theory to practice through a comprehensive guide for therapists applying a feminist lens to therapy (Knudson-Martin & Huenergardt, 2010).

In this chapter, the conceptual frameworks of Social Constructionism, Feminist Theory, and the concepts propelling SERT will be explored more thoroughly. After a brief explanation of each framework in the context of this study, individual concepts of power and gender will be defined using the conceptual lenses. Concluding comments will explore how therapy has implemented feminist theory and the challenges related to challenging power.

Social Construction from a Feminist Lens

Couples bring expectations and assumptions about the reality of the relationship and what it "should be" based on societally created knowledge (Gergen, 1988, 2011; Haslanger, 1995). Many of these constructs have been built from constant comparison with other individuals and interactions with the person's culture. A refined reality consensus is built over time within each individual based on who and where they've interacted (Gergen, 2009). As therapists work with communication, power dynamics are inevitable (Knudson-Martin & Huenergardt, 2010). If a therapist is not aware of the cultural constructs of power and gender, they may be inadvertently imitating the dominant cultural discourse (Ward & Knudson-Martin, 2012). According to Ward and Knudson-Martin (2012), "In most cases, therapist actions that perpetuated power

imbalances were passive; that is, the therapist did not interrupt the usual flow of power" (Ward & Knudson-Martin, 2012, p. 233). Their work continued the progress towards uncovering the subtleties of this dominant gender discourses, even among therapists.

Developing awareness of these constructs and questioning their validity would feel as a threat to ones understanding of life and their place in society (Gergen, 1994). Creating lasting change would be even more difficult as their context would continually reinforce the previously agreed upon social constructs. In this study's case, the therapist is challenging the construct of gender norms and roles. This is asking a great deal for a couple to stand apart from society's norms and interact in a new way that may seem counter to their cultural identity, which would explain resistance to identifying and altering social constructs, such as gender (Gergen, 1992; Gergen & Ness, 2016; Guyer & Rowell, 1997).

Feminism provides key insights into how each gender is influenced by cultural structures and pressures. A feminist perspective would define resistance to therapeutic challenges of gendered power as a culturally driven process within the couple to preserve patriarchy. Feminist theory would consider this challenging of social power to be a social justice obligation of any therapist rather than one option for couple's therapy. Goodman et al. affirms this point by asserting feminist "consciousness raising as [a] fundamental ethical and professional responsibility" (2004, p. 824). However, this is made difficult in couples because men will likely be resistant to giving up their position of power and privilege to work toward equality.

Mutual Support

SERT would postulate that gender, power, and privilege are co-occurring constructs (Knudson-Martin & Huenergardt, 2010; Knudson- Martin et al., 2015; Rothenberg, 2008). True connection and individual wellbeing within couples can be blocked by power dynamics (Scheinkman, 2005; Weingarten, 1991). It is neurobiologically suggested that individual happiness is linked to couple satisfaction (Siegel, 2001) and relationally fulfilled couples are oriented toward a relational mindset and increasing each other's wellbeing (Coontz, 2005; Silverstein et al., 2006).

Within mutual support, the ability to influence each other is shown in research to improve the quality and length of marriages (Gottman, Coan, Carrere, & Swanson, 1998). Mutual support has four core constructs, called the circle of care, or sub-goals by which the therapist can achieve mutual support: mutual influence, shared vulnerability, shared relationship responsibility, and mutual attunement (Knudson-Martin & Huenergardt, 2010).

Competencies

Due to the invisible nature of these constructs that align with the dominant discourse, SERT therapists but abandon neutrality and actively interrupt these power processes (Knudson-Martin & Huenergardt, 2010; Rothenberg, 2008). Patriarchy has been seen to be the driving force behind power in gender (Dickerson, 2013) and this power in gender can be seen across ethnic, racial, and socio-economic categories (Perry-Jenkins, Newkirk, & Ghunney, 2013). The seven competencies in this study (identify enactments of cultural discourse, attune to underlying socio cultural emotion, name underlying power processes, facilitate relational safety, foster mutual attunement, create a

model of equality, and facilitate shared relationship responsibility) were specifically identified as ways therapists can interrupt power disparities and lead couples toward mutual support (Knudson- Martin et al., 2015).

Gendered Power

Relational power can be viewed as the capacity to influence the relationship in a way that builds long-term, personal well-being (Knudson-Martin & Huenergardt, 2010). Imbalances in this ability to mutual influence the relationship is shown to damage emotional bonds (Greenberg & Goldman, 2008). Although there is evidence of a Western shift toward relational equality (Sullivan, 2006), power dynamics are so deeply imbedded into the cultural discourse that they can be difficult to recognize for both clients and therapists alike (Knudson-Martin & Mahoney, 2009; Rothenberg, 2008; Ward & Knudson-Martin, 2012).

One area of distinct power difference lies in the societal assumptions and value of masculine and feminine traits. Masculine traits, for instance, hold greater value in Western society and shown to be preferential to feminine traits (McGoldrick, Anderson, & Walsh, 1991; Walsh, 1989). In a general description, research has identified Western masculinity to describe traits of independence, autonomy, action-oriented, providers, and hierarchical (Silverstein et al., 2006). On the other hand, Western feminine traits are associated with nurture, support, others-orientation, and emotional expression. (Maciel, Van Putten, & Knudson- Martin, 2009; Walters, Carter, Papp, & Silverstein, 1991). Feminine traits are more likely to see deprecation and can result in lowered self confidence in women and men alike who exhibit these traits. This has propelled many women to pick up this perceived value slack by increasing their levels of responsibility

both within the relationship and within home tasks (Almeida, Dolan-Del Vecchio, & Parker, 2008). Within the realm of tasks and household responsibilities, men are given greater levels of appreciation for the same tasks expected of women (Mahoney & Knudson-Martin, 2009). Schulman (1990) described masculinity as encouraging men to ignore and minimize their own emotions as well as the emotions of others. This lack of awareness leaves much of the relational responsibility on the female partner.

Two Sides of Awareness. As therapists work with communication, power dynamics are inevitable (Knudson-Martin & Huenergardt, 2010). If a therapist is not aware of the cultural constructs of power and gender, they may be inadvertently allowing the dominant discourse to guide therapy or even participating in its dynamics (Ward & Knudson-Martin, 2012). According to Ward and Knudson-Martin (2012), "In most cases, therapist actions that perpetuated power imbalances were passive; that is, the therapist did not interrupt Power he usual flow of power" (Ward & Knudson-Martin, 2012, p. 233). Their research continued the progress towards uncovering the subtleties of this dominant gender discourses, even among therapeutic interventions.

Help seeking behaviors and how problems are solved are markedly different between the genders. "Men acknowledge problems but prefer to keep them to themselves. They are culturally conditioned to solve their problems on their own" (Moynehan & Adams, 2007, p. 42). There is a current debate among professionals, surrounding the awareness men have about their own relational problems. Moynehan and Adams (2007) study suggests that men are able to identify problems equally when compared to their wives but deal with it themselves. In simple terms, men are taught to self-regulate and women are taught to co-regulate. However, during times of emotional upset, it is key for

men to shift from "'self-protective brain states to those mediating nurture and sorrow" (Atkinson, 2007, p. 35). The masculine traits related to interdependency impact both addressing problems in the relationship but also seeking medical health support (McKelley, 2007).

It is then the challenge of the therapist to teach men the skill of co-regulating with their partner and staying engaged even when they feel the neurobiological instinct to run or culturally feel it's not their responsibility (Fishbane, 2007; Knudson-Martin & Huenergardt, 2010). Since there is often a gender difference in a couple's empathic ability, "the therapist needs to manage their differences, respecting each partner's experience" (Fishbane, 2007, p. 409).

Four Core Power Disparities Between the Genders. Within intimate relationships, SERT identifies gendered power as affecting couples' ability to have *mutual influence, shared vulnerability, shared relational responsibility* and *mutual attunement* (Knudson-Martin & Huenergardt, 2010). These four components are deemed necessary for mutual support to be present and are considered the circle of care. Mutual influence is the ability of both partners to bring about change in the other to meet the individual needs. This requires both a willingness to accommodate the needs of the other as well as active awareness to their needs. Since the more powerful partner has the freedom to openly express their needs, the less powerful person is left to use indirect means to meet their own relational and individual needs (Steil, 1997). Shared vulnerability takes both skill and willingness to express deep emotions, letting down the walls of protection, and taking risk toward a connection with the partner.

This can be problematic for the less powerful person who fears the rejection of their needs based on traumatic experiences (Johnson, 2005; Weingarten, 1991). Men are socialized to discount their own emotions and as a result pull away from the emotions of others, leaving the responsibility of the relationship's emotional health with the female partner (Almeida et al., 2008; Schulman, 1990). Shared relational responsibility connotates a 'we' mindset in opposition to the 'me and you' mindset. This is not only in doing tasks, but also being aware of how each action effects the family and relationship as a whole. Finally, mutual attunement is empathizing with each other's experiences. This level of empathy requires the other person to feel felt (Siegel, 2007) by their partner.

Socialized Neurochemistry. Patriarchy has a way of socializing men toward dominance (Fishbane, 2011). The benefit to men is the increased power and resources to see his choices and desires advance. The downside is the pressure to self-sustain and the societal discouragement of male vulnerability. Women are then socialized to be more adept at emotional awareness and expression and can become frustrated at their male counterpart's lagging behind the process (Doss, Atkins, & Christensen, 2003; Gottman & Driver, 2005). Because of men's inexperience in staying engaged during emotional crisis, "stonewalling can be seen as an attempted solution for flooding, a temporary refuge from biological overarousal" (Fishbane, 2011, p. 346). However, stonewalling can also come across as abandonment to the partner, triggering similar neurobiological responses of retreat or often aggression.

Although cultural discourses have a powerful hold over the reactions and social instincts, neuroplasticity gives hope that clients can re-wire their brain to perceive and react differently (Fernandez & Goldberg, 2009). Social interactions have created a lifetime of neuro-clusters which fire together such as girls being chastised for not helping someone else or boys being made fun of for crying. New knowledge and experience will help clients to reconnect and rewire these instinctual responses, but it's not easy (Siegel, 2007). Once the fight or flight responses of the amygdala are triggered, cortisol is released and the sympathetic nervous system gets the body amped up. While this happens, the prefrontal cortex of higher decision making actually gets shut down and the whole reaction can trigger the same response in a partner (Fishbane, 2011; Hatfield, Cacioppo, & Rapson, 1993; J. E. LeDoux, 2003). "The emotional brain overwhelms the

relational brain (LeDoux, 1996), and the couple is off on an escalating cycle of reactivity" (Fishbane, 2011, p. 343; J. LeDoux, 1998).

SERT addresses the main areas of male socialization by making them paramount to couple's therapy: mutual attunement, shared vulnerability, shared relational responsibility, and mutual influence (Knudson-Martin & Huenergardt, 2010). These four areas are often the areas that traditional patriarchy will not affirm in men. Men will need to play "catch-up" and learn these relational skills while avoiding the neurobiological flooding. The therapist is key in assessing the balance between learning and flooding while conducting therapy so that a true and lasting shift toward mutual support can be established. The theorized practice of these principles is covered in the next section of feminist theory in practice.

Feminist Theory in Practice

Women's issues have often been ignored in the practice of marriage and family therapy (Cummings, 1998). Public opinion of its importance is widely stated, but change and implementation has been a much slower process for the feminist movement into therapy (Worell & Remer, 2003). Within the growing pains has emerged an equal struggle as to where feminist theory fits into family therapy – a unique model of therapy? A supplement to another therapy? An awareness competency training for therapists? Female psychopathology has been increasing in many countries and women are expressing dissatisfaction at the current treatments available to them (McBride, 1988; Ohnishi, 1999; Worell & Remer, 2003)

During the third wave of feminism, the individual perceptions of women came into strong focus with an emphasis on the life of single women (Diamond, 2009). In

particular, this wave brought about the praise of the unique aspects of women rather than just aiming toward equality with men. This created a societal push for women to push back expectations of childrearing and marriage to pursue their career passions. Therapy for woman at this time leaned heavily toward career development and career counseling (Evans et al., 2005). For women that were already mothers and wives, however, research shows that women retained the bulk of responsibility for childcare and household work even when working as much as their husbands (Fitzgerald & Betz, 1994). Family therapy has seen desired to bring awareness to these complex issues for women and to broaden empowerment to the full scope of choices for women, wherever those choices ended up on the spectrum of aligning with the dominant discourse or not (Knudson-Martin & Huenergardt, 2010). In addition, According to Moradi (2012), addressing feminist issues combined with other social justice issues will lead clients to optimal functioning across other areas of their lives. Thus, in theory, feminist therapy could be an entire modality of therapy by addressing what is believed to be a 'root' problem behind most other presenting problems such as depression or anxiety.

It has been critiqued that many therapists are calling themselves 'feminist therapists' simply because they personally hold feminist ideals (Moradi et al., 2000). This begs the question: what do feminist therapists *do* differently? Throughout the first, second, and third waves of feminism, feminist therapy was an ambiguous process with each therapist practicing differently and independently (Diamond, 2009). The overall goal seemed to settle on awareness of women's issues with little to no guidelines on how to accomplish this in therapy. According to Moradi (2000), self-ascription as a feminist therapist was enough to increase feminist practice within therapy. This does not

necessarily suggest a uniformity of practice but rather uniformity of mindset among feminist therapists.

SERT aims to build mutual support within a couple and family leading to increased resiliency and flexibility in couples (Knudson-Martin & Huenergardt, 2010; Siegel, 2007). Mutual support has been identified as the benchmark signs of couple equality. With mutual support as the therapeutic goal, SERT has continued to build a competency model as a theorized guide for therapists to facilitate both awareness and new change experiences regarding gender equality and mutuality.

By this theory, traditional gender roles stand in the way of mutual attunement or feeling understood and empowered equally. As with many emerging models involving feminist theory, the efficacy research is minimal. SERT bridges a gap in the feminist clinical research and attempts to bring the *how* into the research and potentially create a verifying and unified feminist model of therapy. This study hopes to place one more piece onto the bridge between theory and practice for feminist therapy by verifying the theory of change within SERT as well as creating a change map to specify the process for therapist training models hereafter.

It should be noted that when the SERT model was created and the data was collected, the fourth wave of feminism was just materializing in theory and research. Much of the SERT language and practice are rooted in the 3rd wave of feminism, which focused on the liberation and exploration of the female psyche and complex new expectations such as mother and work-force manager (Wrye, 2009). This wave specifically aims to bring empowerment and options to women. In the fourth wave, however, the movement broadened it's focus to global responsibility toward gender

equality and a spiritual focus of purpose (Diamond, 2009). One perspective within the panel review of Diamond (2009) stated that gender issues are moving beyond biological sex and are focused more on feminine and masculine traits which can be conditioned to either gender by society. Feminism in the fourth wave is more concerned with marginalized groups, gender, race, etc. and the polities and social mindsets which perpetuate marginalization. With the fourth wave in mind, SERT may continue to incorporate the factors which marginalize both men and women. For instance, men may be marginalized by the societal push toward concrete thinking and lone-wolf emotional regulation which inhibits relationships and help-seeking behavior.

Chapter 2 Conclusions

Feminist theory has been explored from many angles and its intersection with therapy continues to evolve. What started as an equal rights movement has since delved into the complex, lived-experiences of women (Diamond, 2009). Understanding that equality is more complex than legal regulations, family therapy has taken up the call to bring awareness and therefore freedom of choice to couples. Awareness is difficult to garner in the face of continued patriarchal social condition, particularly for men (ChenFeng & Galick, 2015; Knudson-Martin & Huenergardt, 2010). Beyond the morality and ethics of gender equality, research has shown significant gains from egalitarian couple relations, which SERT identifies as mutual support (Knudson-Martin & Mahoney, 2009). These gains include increased marital satisfaction and longevity of relationship.

CHAPTER 3: METHODOLOGY

Research methods should be designed as "planned, cautious, systematic and reliable ways of finding out or deepening understanding" (Blaxter, 2010, p. 5). Because there are few models created for the express purpose of addressing power differentials and guiding couples toward equality, task analysis is the research method being used to further explore therapist adherence to competencies of the Socio-Emotional Relationship Therapy (SERT). Task analysis breaks a model into step by step change events which track therapeutic change (Greenberg, 2007). Greenberg outlines two phases of analysis starting with the discovery phase in which the researchers uncover the factors surrounding an event and begins to track it and ending with the validation which tests the theory of change created in the discovery phase. This phase will still be accomplished according to task analysis but the researchers will be comparing findings against the current theory of change established by SERT (Knudson-Martin & Huenergardt, 2010).

Much of the discovery phase will be grounded in previous research. Grounded theory has already been conducted to theorize and qualitatively analyze the components of client change as well as therapist action to facilitate that change (Knudson- Martin et al., 2015; Ward & Knudson-Martin, 2012). Within this model, the researcher is specifically testing the therapist competency components of *foster mutual attunement* and *facilitate shared relational responsibility*. Since the discovery phase of task analysis has largely been constructed within SERT, this task analysis discovery phase will focus on confirming theory by tracking theorized competencies and making sure the operationalization of terms (ie. Mutual attunement and relational responsibility) are verifiable.

Once operationalization has reached saturation, the full event will be tracked both before and after utilizing the steps of task analysis so that the SERT change model can be verified and more closely articulated by the data. The change event will be guided by the SERT outcome concepts of *Mutual Support* which are divided into (a) mutual attunement, (b) shared vulnerability, (c) shared relational responsibility, and (d) mutual influence (Williams et al., 2013). Events will be categorized, and the model will be broken down into the core components of therapist action which either lead to successful resolution state or failed to lead couples toward a resolution state. Where SERT created the theory of components of therapist action, this task analysis will order the events and look for process patterns within the event as a moment by moment guide for therapists.

Task Analysis Methodology

One of the first assumptions within task analysis is that we can observe the change in either obvious or subtle ways (Pascual-Leone et al., 2009). The change is believed to be wrapped up in subjective beliefs, but that actions and reactions will reflect those beliefs. This assumption supports the SERT assumptions in that what a couples believes about gender and the dominant discourse guides their observable interactions with each other (Berger & Luckmann, 1966; Gergen, 2010; Knudson-Martin & Huenergardt, 2010). Task analysis takes a goal-oriented stance by looking at the flow of states and resulting in the completion of a task (Pascual-Leone et al., 2009). The researcher is tracking the pattern of change while, presenting the observable components while exploring the hidden mechanisms which drive the change to create a causal model. Pascual-Leone describes that change doesn't occur in isolated incidents, but rather within the "interplay between hidden (causal) properties and manifest (descriptive) experience"

(Pascual-Leone et al., 2009, p. 528). This study will assume that the dominant discourse of gender will bring to light the hidden (causal) properties that motivate client interactions as well as therapist interactions with the couple.

Steps to Task Analysis. Task analysis has two phases totaling in 9 steps. Phase one comprises the Discovery Phase and consists of 1) specifying the task, 2) explicating clinicians cognitive map, 3) specifying the task environment, 4) constructing a rational model, 5) conducing empirical analyses, 6) synthesizing the rational- empirical model, and 7) theoretical explanation of the model (Greenberg, 2007). Phase two comprises the Validation Phase which consists of 8) validating the components of the model and 9) relating process to outcome (Greenberg, 2007). This study will use a modified and simplified version of Greenberg's design by Bradley and Johnson (2005). They organized the research process into four phases which are 1) specifying change event parameters, 2) rational model building, 3) empirical analysis and 4) synthesizing rational and empirical observations.

The first phase of this study will involve identifying examples of "problem states" for the couple by observing transcripts and video recordings (Greenberg, 2007, p. 17). All observations in this model are considered theory based which allows both descriptive data and subjective suppositions, which in this case comes from the SERT theory foundations of gender, power, and culture from the lens of feminism. Since the outcome for this study is mutual support, the theorized problem state involves the couple interactions which line up with the dominant gender discourse: (a) male-centered attunement, (b) lack of male vulnerability, (c) female partner relational responsibility, and

(d) male holding greater influence over decisions which stabilize his own well-being (Almeida et al., 2008; Mahoney & Knudson-Martin, 2009; Schulman, 1990).

Once the problem states have been identified and operationalized, the researcher can then investigate the context of the task, which for this research involves the psychotherapeutic setting. The focus of observation will then shift from client outcome to therapist process and interaction with client change. Observation will begin by analyzing the cues which guided therapist intervention followed by theory construction as to the necessary components of couple change (Greenberg, 2007).

The most important portion of task analysis is the dance between rational modeling and empirical analysis (Greenberg, 2007; Pascual-Leone et al., 2009). The researcher will first act as the theoretical liaison to the proposed theory by verifying models based on the proposed theory, in this case feminism through SERT. Then the researcher will attempt to suspend those assumptions by re-analyzing the data objectively attempting to refine and challenge the rational model. Empirical analysis is done by taking the purely observational patterns and categories within the change event and changing the rational model to better fit the observed data (Pascual-Leone et al., 2009). The rational model in this study will first identify the markers defined in the next section. The validation phase of task analysis would be conducted separately after a verified change model is created and then validated with a separate sample. This final stage of validation will not be conducted within this study.

Event markers. Task analysis views therapy as compartmentalized series of events, or tasks, which can be marked or identified qualitatively through this research methodology (Greenberg, 2007). An event in task analysis is a client-therapist interaction

which involved a beginning, an intervention, and an end. The event begins with a problem statement, called the marker, which then leads the therapist to interact with this statement and subsequent statements toward a therapeutic end. The event then has an end, either successful in that the client was lead in a therapeutic direction or unsuccessful in that the client did not attain the therapeutic direction.

To construct the marker, the researcher should locate three examples of the client in the believed problem state (Pascual-Leone et al., 2009). Three examples simply mark an introductory number representing a unit of analysis. This study will locate a minimum example number of 15. Three examples allow the researcher to suggest that the examples of the problem state are not similar due to coincidence. In addition, the researcher will also locate three examples of the client *not* in the problem state to better articulate the aspects which operationalize the problem state (Greenberg, 2007). Once distinct features of the marker can be articulated, three more examples of the marker are located and analyzed, repeating the comparison until saturation. Saturation in task analysis is when, despite continued analysis, the data is no longer yielding new information. Client will then move from the marker (problem state) toward either an unresolved state or a resolved state. The following and more important part of analysis for this research is deconstructing the therapeutic task between the marked problem statement and either the resolved or unresolved state, paying exclusive attention to the therapist actions which influenced either direction of change.

Therapeutic task. Once these states have been characterized and identified, the next broader unit to be analyzed is the episode (Greenberg, 1986). Within the episode is the series of speech acts or language and non-verbal communications which interact with

the problem state of the couple to create change. These interactions are steeped in roles, rules, and guidelines crafted through societal agreements – particularly gender, culture, and power (Knudson-Martin & Huenergardt, 2010; Knudson-Martin & Mahoney, 2009). The episodes can vary in length from a few minutes to nearly an hour depending on the complexity of interaction being observed and time between the marker and the unresolved or resolved state. As stated, the episodes of interest will be the therapist interventions and how they interact with client change processes. Since the researcher will be tracking both successful and unsuccessful change events, both therapist actions and inactions will be categorized and placed in a therapy sequence of change.

This research will utilize previous change process research. Once the SERT model was developed, therapists and researchers involved in the ongoing practice and theory building continued to study the necessary components to addressing gender in therapy through the SERT model. This continued research discovered 7 therapist competencies for therapists intending to utilize the SERT model (Knudson- Martin et al., 2015). Within these 7 competencies, this research will limit the focus of analysis to therapeutics tasks of: (a) foster mutual attunement and (b) facilitate shared relational responsibility. These two competencies were chosen because of their direct correlation to two subcategories of mutual support. Fostering mutual attunement should lead to change moments of mutual attunement. Facilitating shared relational responsibility should lead to change moments of shared relational responsibility. These two competencies were also chosen because the researcher views them as the more advanced competencies to enact compared to the other two and areas of potentially greatest resistance within both men

and women. Previous research described examples of these competencies as follows from Knudson- Martin et al. (2015):

- **Competency 5: Foster mutual attunement**
  - Recognize and interrupt enactment of gender stereotypes
  - Encourage powerful partner to take initiative in attuning
  - Reinforce exceptions to gender stereotypes
  - Help partners see what works
- **Competency 7: Facilitate shared relational responsibility**
  - Work with powerful person first
  - Focus on relational meanings, desires, and outcomes
  - Facilitate mutual engagement
  - Validate and reinforce shared responsibility

The next section will cover the researcher statement followed by the research questions and aims. The statement is a way to place the self of the researcher into the context of the research so that readers can better locate and judge potential bias and reliability for themselves. The researcher will attempt to set aside bias, particularly in the theory critique phase of task analysis, but blending of experience particularly within these concepts of gender, culture, and power is inevitable (Charmaz, 2005; Daly, 2007; Lincoln & Guba, 1985). In addition to the constant reflection of bias through journaling and peer analysis, the researcher includes the researcher statement of self so that where bias could not be eliminated, transparency of the bias is provided where possible.

Self of the Researcher

I am the primary researcher for this study. I recognize that I am considered at the epicenter of power and privilege as a white, male, Christian, able-bodied, 30-year-old, married and middle-class U.S. citizen. I have personally felt the subtle power of cultural influences in my life both in my childhood beliefs and adult relational decisions. These invisible messages have influenced my actions with survival instinct intensity. Even in my childhood context of a single mother and two older sisters, these messages saturated my upbringing in a way that taught me to expect power but hindered relational and emotional development. I avoided seeking help at all costs and I expressed my emotions through actions or I simply soothed them by myself. I believe that men have oppressed women on many levels throughout history and continue to do so despite the egalitarian gains of Western culture. I hope to be a part of a continued shift to minimize gender distinctions and simple help all people to become strong for those around them, conscientious and compassionate.

Research Aims

Now that general competencies have been established through other qualitative studies (Knudson- Martin et al., 2015) and additional data has been developed to track the difficulties of this modality (Ward & Knudson-Martin, 2012), this study aims to verify both the presence of mutual support outcomes and then track the process of therapist interaction with the client problem state toward the outcome according to the SERT model. In theory, the successful utilization of competencies should result in a greater number of resolved change events. To accomplish this, task analysis will first track the problem state of client couples until saturation, followed by analyzing episodes of therapeutic interaction after the problem statement until the client state is either

resolved or unresolved. These episodes will be analyzed for patterns and compared against the existing theories of SERT. Specifically, the **research aims** are as such:

1. To identify patterns and interaction events of client couples in the problem state *lack of mutual attunement*.
2. To identify patterns and interaction events of client couples in the problem state of *relational responsibility being placed on female partner*.
3. Track therapeutic interactions until the problem state is resolved or the event continued unresolved.
4. Create a synthesized model of change based on patterns of interaction between therapists and client couple in the problem state.

The primary aim of this study is to explore the therapist interventions and locate therapist actions that either lead to mutual support change or inhibit it. Although client problem states are being tracked, this is only a necessary step to locate therapist actions within the change process. This study does not attempt to explore factors related to alliance or explain client response but rather to study the therapist interventions related to the two competencies. Limitations of the study are explored in further detail within the strengths and limitations section.

Data Collection and Participants

This study incorporates secondary data, in this case the researcher's sampling process will be theoretical sampling taken from the data obtained from the SERT group. The original study (Knudson-Martin & Mahoney, 2009) was a part of an action research project where the members of the group were relatively fluid in that doctoral students would practice and study their own work under supervision as well as two faculty

members. Sessions were usually observed live by use of a one-way mirror by team members not in session and frequently were utilized as a reflection team.

The goal of the original research was to "identify and document the skills involved in working with gender and power issues so that we are better able to apply and teach them" (Knudson- Martin et al., 2015, p. 3). Couples were either self-recruited or referred to the project by the criterion of having relational distress or male disengagement. With the goal of staying conscious of diversity (McDowell & Fang, 2007), couple sessions and therapists involved in this research study will be selected from the secondary data set specifically to represent various ages, ethnicities, educational levels.

Sample

Since the goal of the sample is to reach saturation of event or episode markers, there will not be a set number of videos to be analyzed. Researcher will begin looking for event markers as identified through previous research article markers of clients in problem states. Randomly selecting videos from the secondary data set, the researcher will be preferencing videos selected to highlight both therapist and couple diversity, presence of event markers, examples of both resolved and unresolved problem states, and saturation of the data. No fewer than 15 event markers will be selected for analysis. In order to best understand change, the researcher must have examples and therefore samples of both outcomes, resolved and unresolved (Pascual-Leone et al., 2009). Task analysis is not as concerned with generalizability in this stage of research since "if we wish to discover the essential features of a change process, we try to pick the purest possible examples" (Greenberg, 2007, p. 20).

A limited number and diversity of therapists are represented in the study. Only three couples were eligible for the Task Analysis and therefore only the therapists who participated in those couples' sessions are analyzed. Overall, there are nine therapists who rotated in and out of sessions. Of those nine, 7 are female, 2 are male, 6 are Caucasian, 1 is African American, 1 is Middle Eastern and 1 is Hispanic.

Implications

The results of this study should bring light to the complex interactions between SERT interventions and couple mutual support. The data reveals a model for how to introduce certain techniques and show how these techniques may or may not lead to resolution. In particular, stages 2 and 3 of SERT have additional clarity of interventions, methods and order of therapeutic tasks which increase the likelihood of reaching the intended outcome. This will not only increase the efficacy of this modality for client outcomes, but also the efficacy of training new feminist therapists to replicate the process.

Institutional Review Board

This study received initial approval by the Loma Linda Institutional Review Board (IRB, #57327) in December 2007 (Appendix A) renewed annually and currently approved through December 2018. Therapists provided couples with a detailed Informed Consent form (Appendix B) as well an Authorization for Use of Protected Health Information form (Appendix C). SERT therapists trained to verbally explain the consent process including assuring participants that they can choose to withdraw their participation in the study or approval at any time without negatively impacting their therapeutic experience. Therapists maintained confidentiality by ensuring all video

sessions are saved on a protected server or placed in a locked and password protected external hard drive in a locked cabinet or storage container. Therapists also maintained confidentiality by removing protected or identifying information during the transcription process. And lastly, data will be destroyed at the end of three years after publication of the study. All couples provided consent to videotape and transcribe couple sessions and to utilize data for research and presentations (Appendix D) that advance clinical practice. All researchers utilizing data from this study signed an affidavit for Ethical Treatment of PHI (Appendix E) as well.

Limitations

The first limitation of this proposed research involves the original data having a sample that is not generalizable as a sample of convenience. Couples were self-referred to the SERT clinic and were also struggling with a variety of other relational and personal issues such as chronic illness, low SES, addiction, as well as relational distress. Every couple in the research data was heterosexual. These other issues present with the couples can often aggravate relational distress but the impact of these factors on the data is not able to be determined in this study. The therapists involved are also a part of a similar theoretical and methodological standing. Information about the transferability of these competencies to other modalities would be limited. Next, due to the limited number of therapists for analysis, the results of this study are likely skewed by the individual differences and proficiencies of the therapists. In future studies, it is highly recommended to increase the sample size of therapist participants in order to account for these variances.

Another limitation is limited units of measurement. In this study, therapist gender, client SES, race, and similar factors are not considered. The emphasis is on client gender and how therapists addressed power in session. Further studies should account for variance of these other factors. Lastly, this research is grounded in the research and mentality of the third wave of feminism. The third wave emphasized freedom for women to express their gender freely and exploring the psychological impact of gendered pressure on women. The fourth wave opens the freedom to any marginalized group and places pressure for global equality. With this in mind, the SERT model may continue by incorporating the marginalized factors of men as well as women, liberating gender stereotypes completely and empowering men and women to become both masculine and feminine individuals.

Chapter 3 Conclusions

This chapter outlines the methodology and theory behind methods used to such a detail as to allow other researchers enough clarity to repeat the study. The researcher's statement is made available as an attempt to state potential bias as transparently as possible and allow the reader to judge the analysis of data for themselves along the way. This study hopes to provide a guide from competencies to outcomes and allow clinicians and researchers a chance to peer into the progression and efficacy of SERT. IRB documentation was provided, and limitations discussed aim to allow the research to make accurate and humble attributions of findings. These methods will be utilized and depicted throughout the next chapter which will lay out the findings.

CHAPTER 4: RESULTS

A task analysis was conducted to answer the questions; 1) What therapeutic interventions are used to facilitate shared relational responsibility in SERT? and 2) What therapeutic interventions are used to facilitate mutual attunement in SERT? According to Bradley and Johnson (2005), task analysis of change events in couples therapy can be divided into four stages: (a) specifying change event parameters, (b) rational model building, (c) empirical analysis and (d) synthesizing rational and empirical observations. Thanks to the large body of literature already surrounding Socio-Emotional Relationship Therapy (SERT), the first two stages of task analysis of this study have been gleaned from these previous studies (Knudson-Martin & Huenergardt, 2010; Knudson- Martin et al., 2015; Mahoney & Knudson-Martin, 2009; Samman & Knudson-Martin, 2015; Ward & Knudson-Martin, 2012; Williams et al., 2013) and utilized to inform the empirical analysis phase.

After a brief overview of SERT and task analysis, this chapter will outline this study's procedures by the first three stages of task analysis. First, even though the parameters for the change events of this study are being taken from previous literature, the researchers will show how those parameters were used to locate events within this study's data. The researchers will then summarize the rational model already built in the SERT literature. Lastly, the results from the empirical analysis will be outlined in detail including coding processes and examples. These results will include a combination of quantitative data to help make sense of the qualitative findings. The fourth stage of task analysis, synthesizing rational and empirical observations, will be covered in Chapter 6.

SERT Overview

This study is grounded in how feminist therapists have utilized the Socio-emotional Relationship Therapy [SERT] modality to guide couples toward equality. Couple interactions are guided by the social context in which they reside and interact (Berger & Luckmann, 1966). The importance of context drives this study to look closely at the common values and norms behind gender, equality, and power.

Equality is a worthy therapeutic goal with research suggesting that couples with equal power can lead to better relational outcomes, specifically relational satisfaction from both men and women (Buunk & Mutsaers, 1999; Sprecher, 2001). The feminist lens provides a framework for the concepts of power. Relational power can be viewed as the capacity to influence the relationship in a way that builds long-term, personal well-being (Knudson-Martin & Huenergardt, 2010). Imbalances in this ability to mutual influence the relationship is shown to damage emotional bonds (Greenberg & Goldman, 2008).

Developing awareness of these constructs and questioning their validity would feel as a threat to ones understanding of life and their place in society (Gergen, 1994). This is asking a great deal for a couple to stand apart from society's norms and interact in a new way that may seem counter to their cultural identity, which would explain resistance to identifying and altering social constructs, such as gender (Gergen, 1992; Gergen & Ness, 2016; Guyer & Rowell, 1997). SERT connects feminist theory and clinical practice through a comprehensive guide for therapists navigating the resistance related to power displays and shifts in session (Knudson-Martin & Huenergardt, 2010).

SERT therapy has set its sights on decreasing power imbalances in couples by using culturally sensitive therapeutic interventions to bring awareness to couples and help

them break free from any damaging social behaviors. This study takes two out of the five competencies and, utilizing task analysis, aims to articulate the specific tasks involved as SERT therapists guide couples toward equality.

Methodology Overview

Now that there is already a body of literature describing the theory and a small amount outlining its theoretical components based on observation, task analysis was chosen for this study as the next step toward outcome research. Task analysis breaks a model into step by step change events which track therapeutic change (Greenberg, 2007). This is an important evolution in clinical research when taking a theorized model toward exploring the potential efficacy.

Within the SERT model, the researchers are specifically testing the therapist competency components of *foster mutual attunement* and *facilitate shared relational responsibility*. The research aims are the as follows:

1. To identify patterns and interaction events of client couples in the problem state *lack of mutual attunement*.
2. To identify patterns and interaction events of client couples in the problem state of *displaced relational responsibility*.
3. Track therapeutic interactions until the problem state is resolved or the event continued unresolved.
4. Create a synthesized model of change based on patterns of interaction between therapists and client couple in the problem state.

With these in mind, identifying when the problem state has occurred is the first step. Descriptors have been taken from previous literature and are used as markers to look out for in the client responses. The problem states of this study are *lack of mutual attunement* and *displaced relational responsibility*. Once a problem state is identified, the researchers then begin observing the interactions between the therapist and the problem state.

Pascual-Leone describes that change doesn't occur in isolated incidents, but rather within the "interplay between hidden (causal) properties and manifest (descriptive) experience" (Pascual-Leone et al., 2009, p. 528). The hidden experiences of this study are the cultural discourses and subtle influences of power both between the clients and between the therapists and clients. The feminist lens guides the researchers in identifying when power and gender discourses influence the actions or responses they observe in therapy. The descriptive experiences of this study are the observable interventions and responses.

For this study, the researchers will describe the problem states, then the following interactions between therapist and client, and lastly what factors signal a resolved problem state or an unresolved problem state. Once the descriptions, or coding, of these observations are completed, the researchers will formulate a step-by-step roadmap of how therapists were successfully able to lead clients from the problem state to successful resolution. Based on the rational model gleaned from SERT theory research, the road map should look similar to their theory. Where is differs, the discussion section will propose new theory potentially explaining the differences and then offer future direction suggestions for both researchers and practitioners of SERT based on the results.

Three couples were eligible for this study based on the requirement of more than 8 sessions conducted. This requirement was set because of the targeted outcome to be analyzed. The targeted outcome is theorized to present in late stages of therapy, therefore warranting the limitation of analyzing only those sessions that continued for 8 or more sessions. In addition to this limitation, only the therapists who participated in those selected couples' sessions were analyzed. Overall, there were nine therapists rotated in and out of sessions. Of those nine, 7 were female, 2 were male, 6 were Caucasian, 1 was African American, 1 was Middle Eastern and 1 was Hispanic.

Task Analysis Phase 1: Specifying Change Event Parameters

The beginning of a change event is called the problem state (Greenberg, 2007; Pascual-Leone et al., 2009). The problem state of this study is gained by taking the reverse of the SERT outcome goals of *Shared Relational Responsibility* and *Mutual Attunement*: (a) lack or deflection of relational responsibility and (b) lack of or block against mutual attunement. For instance, SERT observed that men who don't exhibit *Shared Relational Responsibility* will often come across as though "their needs and perspectives are more important than [their family's]" (Knudson-Martin & Huenergardt, 2010, p. 6).

The descriptions and parameters of the change events, including specifying the problem state, was taken from SERT descriptions of the target outcome. The two outcomes under analysis in this study are *Mutual Attunement* and *Shared Relational Responsibility*. So the researchers, for instance, outlined several descriptions of client attunement such as "listening, noticing and responding" to the other's feelings and needs (Knudson-Martin & Huenergardt, 2010, p. 7). The researchers then took these

descriptions and postulated that a lack of attunement might look like ignoring or discounting partner's emotions and pressing one's own position with little to no room for the other person to be understood. When these moments were seen in therapy, it triggered the researchers to log the signs of the problem state observed and continue to track the interaction between the therapist and client problem state.

This tracking of therapeutic interaction continued until either (a) the event reached resolution in the form of clients expressing *Mutual Attunement* and/or *Shared Relational Responsibility* or (b) the event continued for at least 20 therapist interactions with no resolution. At either of those junctures the researchers would deem the event as resolved or unresolved and begin again looking for signs of the problem state.

Task Analysis Phase 2: Rational Model Building

The rational model building process of task analysis involves the researchers taking previous research and constructing a logical assumption of findings before the analysis even begins. This study takes its rational model from previous SERT research and theories. According to the SERT competencies' research (Knudson- Martin et al., 2015), therapists who wish to lead couples toward *Shared Relational Responsibility* and *Mutual Attunement* should obtain and practice the following competencies and corresponding skills. For the competency of *Facilitate Shared Relational Responsibility*, these skills are (a) work with powerful person first, (b) focus on relational meanings, desires, and outcomes, (c) facilitate mutual engagement and (d) validate and reinforce shared responsibility. For the competency of *Foster Mutual Attunement*, these skills are (a) recognize and interrupt enactment of gender stereotypes, (b) encourage powerful

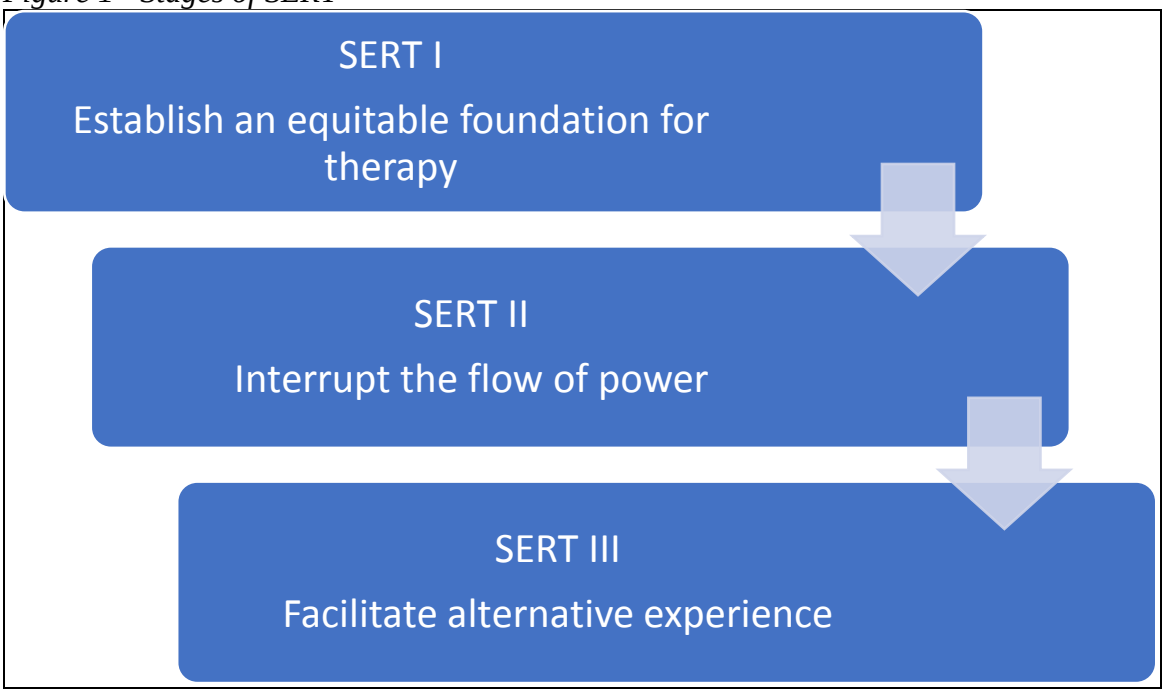
partner to take initiative in attuning, (c) reinforce exceptions to gender stereotypes and (d) help partners see what works. See *Table 1*.

Table 1
SERT Competencies and Corresponding Skills

Facilitate Shared Relational Responsibility	Foster Mutual Attunement
1. Work with powerful person first	1. Recognize and interrupt enactment of gender stereotypes
2. Focus on relational meanings, desires, and outcomes	2. Encourage powerful partner to take initiative in attuning
3. Facilitate mutual engagement	3. Reinforce exceptions to gender stereotypes
4. Validate and reinforce shared responsibility	4. Help partners see what works

The rational model involving the stages and progression of SERT therapy was also taken from previous SERT research which provides the framework shown in *Model 1 (Knudson-Martin & Huenergardt, 2010)*. *Mutual Attunement* and its competencies fall into the second stage of SERT while *Shared Relational Responsibility* and its competencies fall into the third stage. The first stage of therapy aims at rapport building and understanding each client's unique cultural history and context. Therefore, since this study focuses on goals from stages two and three, this study assumes a preexisting rapport and contextual understanding of the clients. At later stages, the therapists are expected to take a directive approach to identify and interrupt power imbalances in the relationship (Knudson- Martin et al., 2015). Once power is interrupted, the therapist can then guide client's toward new experiences and writing new behavioral scripts which facilitate shared responsibility moving forward.

Figure 1 - Stages of SERT



Task Analysis Phase 3: Empirical Analysis

During this phase of research, the researchers begin searching the data for event markers and begins to organize the observations into categories. Since this research focused on therapeutic interactions, the event markers included baseline categories such as therapist interventions and client responses. The goal is to gather as much information from the transcribed interactions as possible to aid in the fourth stage when a model is created which explains patterns revealed in the observations.

Forty-one videos from the original data set have been reviewed by the researchers. Within those videos reviewed, the researchers used the event parameters to identify problem states with the primary aim of locating "sessions that contain the purest possible examples of clients working to resolution on the task of interest" (Greenberg, 2007, p. 20). With this in the mind, the researchers prioritized sessions in which the

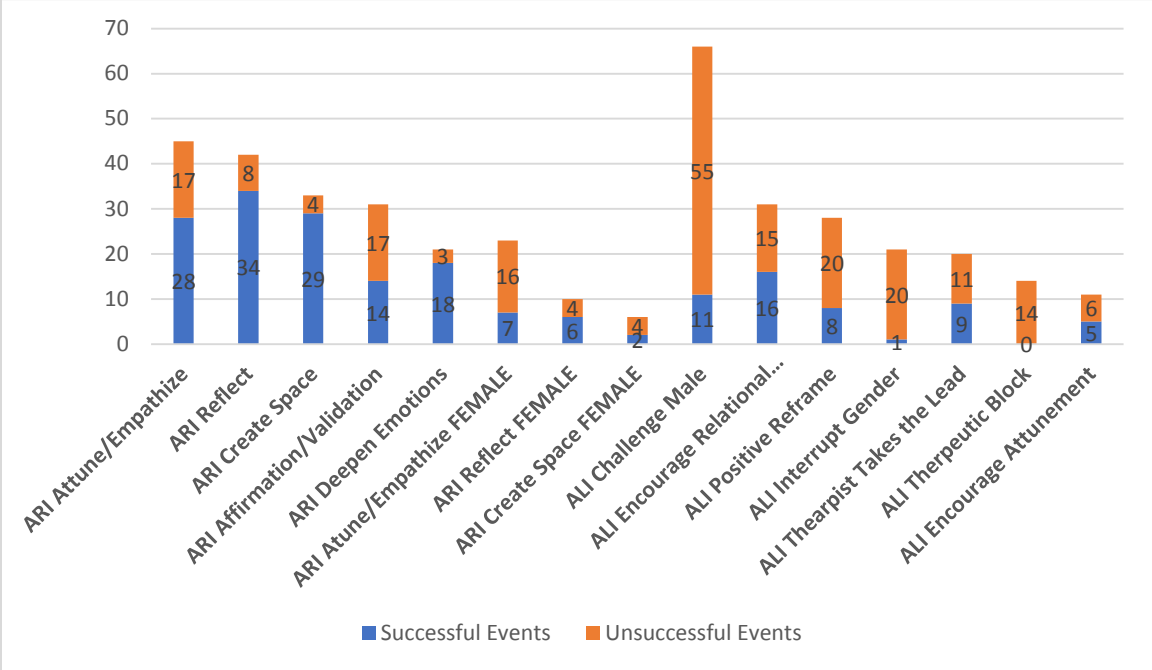
clients exhibited the desired outcome versus a more randomized selection of observation. Of those 41 sessions observed, 20 events were transcribed for further analysis.

Intervention overview. Therapeutic interventions were divided into two categories: (a) *alliance reinforcing interventions* and (b) *alliance leveraging interventions*. Alliance reinforcing interventions (ARI) contained 5 primary interventions most commonly used by therapists to reinforce alliance in session: (a) *reflect*, (b) *create space*, (c) *attune/empathize*, (d) *affirmation/validation* and (e) *deepen emotions*. Alliance leveraging interventions (ALI) contained 7 primary interventions which leveraged the current alliance between the clients and therapist in order to direct clients toward their therapeutic goals: (a) *challenge male*, (b) *encourage relational responsibility*, (c) *positive reframe*, (d) *interrupt gender*, (e) *therapist takes the lead*, (f) *therapeutic block* and (g) *encourage attunement*. See *Table 2*. Each of these categories and subcategories will be described in detail in regards to distinctive features and examples.

Table 2
SERT Task Analysis Interventions Overview

Alliance Reinforcing Interventions (ARI)	Alliance Leveraging Interventions (ALI)
(a) Attune/empathize	(a) Challenge male
(b) Reflect	(b) Encourage relational responsibility
(c) Create space	(c) Positive reframe
(d) Affirmation/validation	(d) Interrupt gender
(e) Deepen emotions	(e) Therapist takes the lead
	(f) Therapeutic block
	(g) Encourage attunement

Chart 1 – Interventions Data in Successful and Unsuccessful Events



The desired outcomes (event resolution) under analysis consist of *Shared Relational Responsibility* and *Mutual Attunement* as operationalized by previous studies (Knudson-Martin, 2010). The operationalizations of these constructs from previous research was consistent with this study's findings. *Shared Relational Responsibility* was present in eight of the 20 events observed throughout the 41 sessions. Out of these eight events, only four events observed expressions of shared relational responsibility for more than one occurrence. *Mutual Attunement* was present in five of the 20 events. Of those five, only two events observed expressions of attunement for more than one occurrence.

Throughout the 20 events, 405 therapeutic interventions were observed and coded. In addition, 327 male client responses and 74 female client responses were also observed and coded. Therapists in this study directed 332 of 405 (82%) of their interventions exclusively at men which accounts for the larger percentage of male responses overall. In those events where therapists were successful in achieving a desired

change outcome, 137 of 188 (72%) interventions used were ARI. In those events where therapists were unsuccessful in achieving a desired change outcome, 74 of 217 (34%) interventions used were ARI. This means that in events which lead to successful changes toward *Shared Relational Responsibility* and *Mutual Attunement*, therapists were using two times more alliance reinforcing interventions than were those therapists who were unsuccessful in reaching the desired changes.

Problem state identification. In this study, 20 problem states are identified. Problem states are defined as a response of the client which blocked or resisted relational responsibility as well as a response of the client which lacked relational attunement. Lack or deflection of relational responsibility was seen often in the form of sentences like "Her reaction to me is what made everything come back around to the good." In the previous statement, the male client is referring to his spouse' reaction to his upset mood. Statements like this placed the expectation on the female to react in such a way that prioritizes the male emotional needs. Another example is an occasion when the therapist asked the male how he knew the fight resulted more positively than usual and he replied, "Well, she didn't yell at me." This places the female as necessary to hold up relational outcomes and that her reaction defines outcome, not the male. Other times a more passive approach resulted in the same outcome. Male responses such as "It's like sometimes I know there's things I need to do and sometimes I can't do them. That's frustrating" diverts responsibility away from themselves onto an external factor such as stress, work or their partner. The male partner in that statement was referring to household work such as taking out the garbage and getting the kids ready for school and how his low energy prevents him from completing those tasks which now the female must accomplish alone.

Whether active blocking of responsibility or passive avoiding, these phrases became the markers to signal the start to a problem state or event in this study.

To signal the lack of or block of attunement, the researchers looked for any responses that did not leave room for influence or another's perspective. For example, one male client stated "I'm just stating how I feel. I mean facts are the facts." The couple had been fighting about when to list their house for sale and the previous statement was the conclusion of the male listing his reasons why waiting to sell the house was better. This statement placed the male's own opinion as fact and therefore insinuates the absoluteness of its superior status. Similarly, one male client said in response to his wife's expression of relational hurt, "Okay, that's where the problem lies. Because I never wanted you to feel that." Instead of taking the opportunity to understand their partner, because the hurt wasn't intended, the male is suggesting he doesn't have to attune to the hurt because it shouldn't have been there in the first place. Statements and sentiments like these were used to signal the start to problem states or events.

Once the event was identified, the researchers tracked the sequences of interventions and client responses. This tracking continued until either (a) the client successfully exhibited signs of the targeted outcome, (b) the client was either unable to or unwilling to engage in the change process or (c) the therapist failed to utilize SERT competencies resulting in an unsuccessful client change. When the problem state persisted, the researchers allowed a minimum of 20 subsequent interventions before categorizing the event as unsuccessful. When either *Shared Relational Responsibility* and *Mutual Attunement* were identified in an event, the researchers continued to track interactions, testing for a sustained change state. In some cases, instances of *Shared*

Relational Responsibility and *Mutual Attunement* were momentary, and interventions were unsuccessful in sustaining therapeutic change beyond one statement or comment. Each code will now be listed in detail with examples to explain the researcher's rationalization.

Client responses overview. Lastly, for the client responses, the researchers observed two general directions of responses: (a) defensive and (b) relational. Defensive Client Responses (D-CR) were observed in these 3 ways: (a) *defensive,* (b) *withdrawn* and (c) *content focus*. Relational Client Responses (R-CR) were observed in these two ways: (a) *individual vulnerability* and (b) *relational vulnerability*. Each of these categories and subcategories will be described in detail in the following sections.

Task Analysis Category Descriptions

The following section will begin with the findings of the therapist intervention categories, followed by the findings of the client responses Each category and subcategory will have numerical values displayed as well as feature descriptions by which the researchers identified and delineated each category and subcategory. Following each section, a table and chart will be provided for viewing the larger data points.

Alliance Reinforcing Interventions (ARI). These interventions focused on building rapport with the client. The primary goal of interventions centered around building safety and creating a collaborative environment. Five subcategories were identified as follows.

Attune/empathize intervention. Attunement and empathizing were the most commonly used ARI accounting for 32% (n=68) of all ARI used. Since gender plays such a crucial role in this modality, *attune/empathize* was divided by gender with 66 (n=45)

directed toward men and 33 (n=23) directed toward women. Of those 45 interventions directed toward male clients, 62% (n=28) were used in successful events and 38% (n=17) were used in unsuccessful events. Of those 23 interventions directed toward female clients, 30% (n=7) were used in successful events and 70% (n=16) were used in unsuccessful events.

In this intervention, the therapists were attempting to better understand the client's experiences and/or allow the client to feel understood. This was achieved through statements such as "Hard moments like that seem to leave you confused with your emotions. That sounds exhausting for you (Event 3)." In this case, the therapist is imagining what it would be like to be in the client's shoes and expressing how they might feel. Another example is the therapist saying, "I'm getting the sense that this is a very vulnerable spot for you (Event 2)." Again, the therapist attempts to tune into the client's experience and strengthen the understanding between client and therapist.

Reflect intervention. Reflection accounts for 25% (n=52) of all ARI used. Since gender plays such a crucial role in this modality, *reflection* was divided by gender with 81% (n=42) of uses directed toward men and 19% (n=10) uses directed toward women. Of those 42 interventions directed toward male clients, 81% (n=34) were used in successful events and 19% (n=8) were used in unsuccessful events. Of those 10 interventions directed toward female clients, 60% (n=6) were used in successful events and 40% (n=4) were used in unsuccessful events.

Reflection was used by therapists to clarify understanding by either using client's same words or expanding the description. For instance, a therapist would respond with, "So you're feeling a bit broadsided and like he's not staying true to what you both agreed

to (Event 8).” This statement was a direct response to the client sharing a recent negative experience in her relationship. The therapist is summarizing key portions of her experience to check for accuracy and clarification of the therapist’s understanding. The intention of this intervention was not to redirect the client in a particular direction but a way to elucidate the client’s experience. Another example would be the therapist saying, “So I’m hearing that you think life can be unfair a lot of the time (Event 14).” Many times, the therapist used their own language to reflect their understanding of the client’s statement, giving the client space to confirm or correct their assumption.

Create space intervention. *Create space* accounts for 18% (n=39) of all ARI used. Since this intervention was directed toward both males and females, *create space* was divided by gender with 84% (n=33) of uses directed toward men and 15% (n=6) uses directed toward women. Of those 33 interventions directed toward male clients, 88% (n=29) were used in successful events and 12% (n=4) were used in unsuccessful events. Of those 6 interventions directed toward female clients, 33% (n=2) were used in successful events and 66% (n=4) were used in unsuccessful events.

The creation of space was usually represented by questions or statements that invite additional information. For instance, a therapist would say, “tell us more about that (Event 1)” or ask, “when you say, ‘I should do more,’ where does that come from? (Event 16).” The therapist is stepping back and asking the client to fill the space with more information or emotion. It is important to note that these interventions could be directive in nature, honing in on details that the therapist deemed especially pertinent. However, the direction always utilizes words or implications given by the client and expands the experience rather than narrowing the conversation toward a specific goal.

Open ended questions were an important facet of this intervention such as asking 'how' something happened.

Affirm/validate intervention. *Affirm/validate* accounts for 15% (n=31) of all ARI used. This intervention was used primarily with males and therefore the data regarding the *affirm/validate* intervention only represents its use with males. Of those 31 interventions directed toward male clients, 45% (n=14) were used in successful events and 55% (n=17) were used in unsuccessful events.

The therapist uses this intervention to establish and express a positive position toward either a particular client or both clients. However, in this case, the data represents predominately male directed interventions of this category. For example, the therapist would say, "I really like that you suspended your own judgement and used your wife as the litmus test to how she's feeling (Event 19)." This statement places the therapist in approval of a particular thing that the client said or did in hopes to encourage it. Another form of validation is normalization. In this intervention, the therapist expresses the appropriateness of a client's emotion in a particular situation in order to positively reinforce the expression of that emotion. This happens when the client feels ashamed or withdrawn about an emotion. An example of this is, "I think it would be pretty normal for anyone who's been under that level of distress to feel numb from time to time (Event 19)."

Deepen emotions intervention. *Deepen emotions* accounts for 10% (n=21) of all ARI used. This intervention was used primarily with males and therefore the data regarding the *deepen emotions* intervention only represents its use with males. Of those

21 interventions directed toward male clients, 14% (n=3) were used in successful events and 86% (n=18) were used in unsuccessful events.

This intervention identifies and amplifies the emotions of the client. Especially for the male clients in these sessions, emotions seemed difficult to express and articulate. Male clients tended toward concrete or content explanations for emotions and were more likely to express opinions. In these moments, therapists would take small emotional expressions and encourage the client to take a deeper step. For instance, the following therapeutic interaction shows the therapist push the client to deeper emotions:

Therapist:	What's happening for you right now?
Male client:	I mean… I can't say it because it would end our relationship.
Therapist:	You mean if you're honest about these things then she would walk away?
Male client:	Maybe.
Therapist:	It makes you sad to think about that because you don't want to lose her?
Male client:	I mean maybe. I don't know how I… I don't know if I feel sad.
Therapist:	You don't know if you feel sad?
Male client:	Well, I guess I do feel sad. I feel responsible for our baseline and I know it's my responsibility.

(Event 2)

In this example, the therapist takes a situation and inserts an emotion that seems appropriate. The client is then pushed towards exploring the emotion and practices emotional articulation. The therapists offers additional emotional descriptors, such as 'disappointed,' 'worried' or 'pained,' and metaphors to assist the client toward primary emotions.

Alliance Reinforcing Interventions (ARI) Overview. The first of the two categories of therapist interventions observed is *Alliance Reinforcing Interventions.* These interventions were designed to bolster the therapeutic alliance between therapist and client. The most frequently used Alliance Reinforcing Interventions were (a) *attune/empathize* (32%), (b) *reflect* (25%), (c) *create space* (18%), (d) *affirm/validate* (14%) and (e) *deepen emotions* (10%). *See Chart 2 and Table 3*. The remainder ARI that did not fall into these categories made for <4% of the ARI.

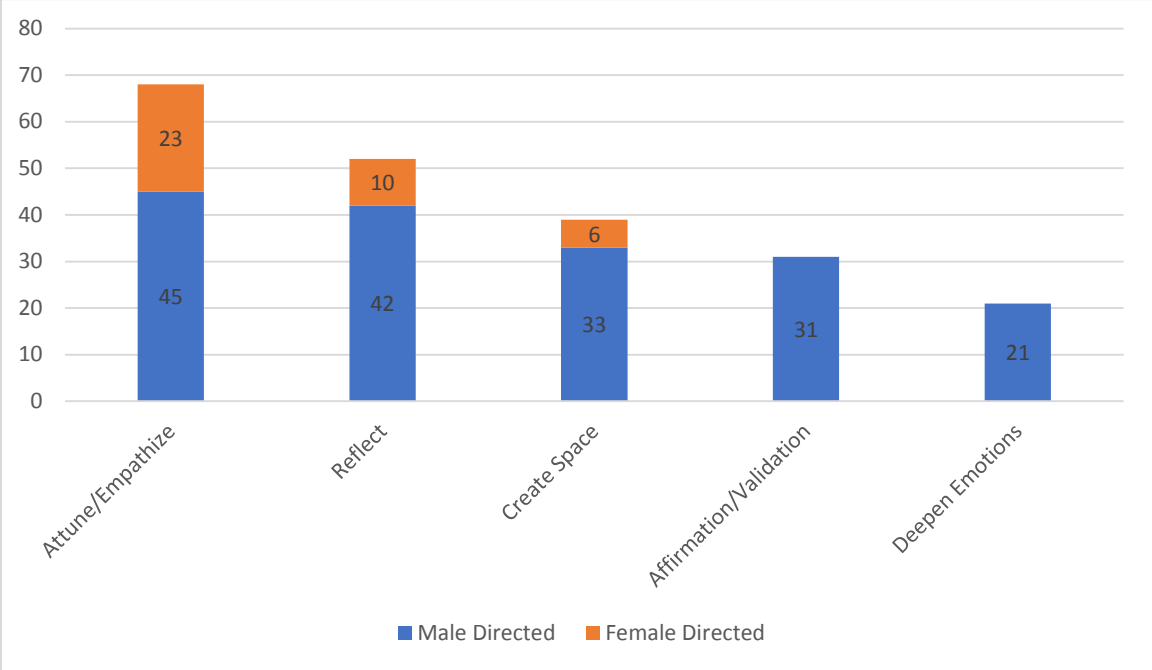
Table 3

Descriptive Statistics for Alliance Reinforcing Interventions

ARI Intervention	Total	In Successful Events	In Unsuccessful Events
Attune/empathize male	45	28	17
Attune/empathize female	23	7	16
Reflect male	42	34	8
Reflect female	10	6	4
Create space male	33	29	4
Create space female	6	2	4
Affirm/validate male*	31	14	17
Deepen emotions male*	21	18	3

**Affirm/validate and Deepen emotions did not have enough occurrences directed toward female clients to warrant inclusion in the data.*

Chart 2 – Most Frequently Occurring Alliance Reinforcing Interventions



Alliance Leveraging Interventions (ALI). These interventions leveraged previously gained alliance to direct clients toward a potentially uncomfortable but meaningful direction. Because of the strong influence of gender, therapists used direct and directive interventions to acknowledge and alter gendered power in the session. These interventions often strained the therapeutic alliance. Seven different subcategories were identified and are described as follows.

Challenge male intervention. *Challenge male* accounts for 34% (n=66) of all ALI used. This intervention was used primarily with males and therefore the data regarding the *challenge male* intervention only represents its use with males. Of those 66 interventions directed toward male clients, 17% (n=11) were used in successful events and 83% (n=55) were used in unsuccessful events.

The researchers witnessed this category more than any other leveraging intervention. The purpose was to confront the perspective, words or actions of the male in order to reinforce the balance of power. Often when the male would exhibit signs of overt gendered power, the therapist would use an intervention to confront it directly.

Male client: I'm not even trying to fix the problem. I think it's like 50% my arrogance or whatever, but that right is right. I'm just trying to tell her how it is.
Therapist: You're still defining her pain and what's true and real for her. [Prolonged silence]
Therapist: She may see what is right a little differently.

(Event 5)

Challenging male as an intervention brings a wall against power in a very direct and forthright way. Another example is:

Male client: It doesn't mean that I'm not onboard. It just means that I'm not going to push on the extremes to cause the relationship to fall apart.
Therapist: But the relationship on some level has been falling apart.
Male client: Yeah, I know.
Therapist: Because you've been silent. And people have still been blowing up on each other even when you don't push on the extremes.

(Event 18)

Encourage relational responsibility intervention. *Encourage relational responsibility* accounts for 16% (n=31) of all ALI used. This intervention was used primarily with males and therefore the data regarding the *encourage relational responsibility* intervention only represents its use with males. This is consistent with the design of SERT. The therapist should work with the powerful partner, who is traditionally male, to increase expressions of relational responsibility (Knudson-Martin,

2010). Of those 31 interventions directed toward male clients, 52% (n=16) were used in successful events and 48% (n=15) were used in unsuccessful events.

Mirroring the SERT competency of reinforcing shared relational responsibility, this intervention directs the clients toward equality in their power dynamics. For example, equality of relational responsibility involves distributing household tasks, initiating relationship repairs, decision making, etc. This direct approach, however, often placed a strain on the therapeutic relationship and required high levels of pre-existing rapport for the client to engage cooperatively. For example:

Male client: Other stuff comes up and if I'm not paying close attention, I won't even know that she's upset.

Therapist: You almost have to go out of your way and get out of whatever the things you'd like to do right then to see what your wife needs right then instead.

(Event 11)

In this example, the therapist is pushing the male client to own and recognize moments of relational responsibility. The therapist is pointing out that he needs to think of their relational needs instead of only his personal needs. Another example is:

Male client: It becomes a lot harder to connect with my family now because I'm not working and money stuff stresses me out. When money isn't an issue I tend to be able to enjoy being with them.

Therapist: So you enjoy being with them more when money is not an issue?

Male client: I mean, it shouldn't be like that, but it is. Money stuff gets me overthinking and worrying too much.

Therapist: So, the question to ask is what kind of relationship do you want with your family? Do you want money to stand in the way of your connection with them or do you want to connect regardless of these types of conditions?

(Event 17)

The therapist is attempting to empower the male client by pointing out that he has more power over his circumstances than he realizes. By focusing on the responsibility, the circumstances become irrelevant. This intervention came up after a string of circumstantial excuses on the part of the male client in his attempts to distance himself from relational responsibility.

Positive reframe intervention. *Positive reframe* accounts for 14% (n=28) of all ALI used. This intervention was used primarily with males and therefore the data regarding the *positive reframe* intervention only represents its use with males. This is consistent with the design of SERT. The therapist should work with the powerful partner, who is traditionally male, toward egalitarian expressions (Knudson-Martin, 2010). Of those 28 interventions directed toward male clients, 71% (n=20) were used in successful events and 29% (n=8) were used in unsuccessful events.

This intervention is used to direct the clients toward positively reframing their experiences. The therapist uses client's statements, particularly negative statements, and rewords them positively. The intervention attempts to push clients toward progress and away from previously withdrawn or defensive client responses. In other words, if the clients frequently get stuck in negative patterns, reframing parts of those patterns in a positive way, attempts to move the therapeutic direction forward again. For instance:

Female client: I've asked myself before 'is this really what I want to do?' We got in this argument one time and I just got in the car and thought about what I want in my life and what I want for my kids. I had to make sure that I was sure of what I really wanted.

Therapist: Did you know, George, that she had made this major commitment to you? This recommitment to you?

The therapist in this situation is taking a previously negative statement and reframing it into a positive, commitment-focused statement. The therapist is pointing out that the female client stayed in the relationship, insinuating that she has committed to it, even after questioning it. This intervention was used by the therapist to continually redirect the negative pattern of the couple, who were frequently questioning the commitment level of the other. Another example of this is:

Therapist: So when asked if you were moving away from isolation and more toward connection you [male client] said 'I hope so.'

Male client: I'm kind of wishy-washy about things at times, but that's because in a lot of the situations I can say 'yeah, I'm all onboard,' but in the everyday practice I have to feel it out and see how it's going to work. I can commit to it and say yeah, the whole isolation thing is done and buried and stuff like that but I have to see how it turns out.

Therapist: So, I hear you saying that you hope to be more present more often and that you have this vision of commitment where you're actively working towards it on a day to day basis.

(Event 18)

In this instance, the therapist is reframing the male client's hesitation to make a broader commitment to the relationship. This is moving the client toward focusing on a stronger commitment on a day-by-day basis, instead of the client's insinuation of 'waiting and seeing' day-by-day. The therapist is honing in on a sense of hope and a vision of commitment that the client may be on the fence about, attempting to encourage the client in a positive direction.

Interrupt gender intervention. *Interrupt gender* accounts for 11% (n=21) of all ALI used. This intervention was used primarily with males and therefore the data regarding the *interrupt gender* intervention only represents its use with males. This is

consistent with the design of SERT. Since gendered power traditionally increases the power of men in a heterosexual relationship, the nature of male power is sometimes overt and warrants interruption (Knudson-Martin, 2010). Of those 21 interventions directed toward male clients, 5% (n=1) were used in successful events and 95% (n=20) were used in unsuccessful events.

As evidenced in the competencies of SERT, interrupting gender stereotypes and gender typical behavior is seen as a foundation to reinforcing relational responsibility (Knudson- Martin, 2015). In this case, the therapists were often observed actively interrupting males when they seemed to be enacting gendered power or a gender stereotype. For example:

Male client: I know I need to get better at not bringing up the past. But then she starts doing all this stuff without talking to me first –

Therapist: Wait, Jacob, wait a minute. Stop and see what you're doing. Listen to what your wife is trying to say.

(Event 4)

In this case, the therapist interrupts the client mid-sentence in order to prevent a perceived imbalance of power. The male client had just spoken over his wife and the therapist interrupted the male client to bring attention to the power dynamic. The therapist then encourages the male client to incorporate his wife's perspective. In another example, the therapist interrupts a male bid for power in the session:

Therapist 1: Probably for both of you in a stressful situation that's a little bit harder to compromise and not say we have to do it this way –

Male client: I'm not the one saying that we have to do it. She's the one saying that we have enroll right now because –

Therapist 2: Now wait a minute. Keep going, Therapist 1.

Therapist 1: Well I'm only responding to how you're talking right now. Which is that you're hearing it as I either we have to do it her way, or my way.

(Event 6)

Often males will compete for power and perspective in the therapy session and it is up to the therapist to interrupt this process and balance the power dynamic. In these examples, the therapist perceived the male enacting gendered power and actively interrupted and redirected in order to rebalance power. In every case, this intervention strained the therapeutic alliance between the male client and the therapist, as evidenced by the male client responding defensively or withdrawing.

Therapist takes the lead intervention. *Therapist takes the lead* accounts for 10% (n=20) of all ALI used. This intervention was used primarily with males and therefore the data regarding *therapist takes the lead* intervention only represents its use with males. Of those 20 interventions directed toward male clients, 5% (n=11) were used in successful events and 45% (n=9) were used in unsuccessful events.

A directive intervention was observed that decreased room for the clients to deviate from the therapeutic direction. When clients were not cooperating or engaging in a positive therapeutic direction, therapists would sometimes prescribe specific language to the clients. In these instances, the therapist offers examples of positive reframes for the clients to enact. For instance:

Therapist: I'm wondering if you can talk to her about feeling bad about this level of distance and how that leaves her responsible for the relationship.

Male Client: I don't know what exactly you want me to say – you want me to say how I feel?

Therapist: Well on some level you just said it to me, right? Help your wife know and to feel that you understand the pain she's been in and that you don't want her to be in that place.

Male client: [turns to her] I don't want you to be in the pain that you're in [laughs a little]. I don't want you to be in that place. [both laugh]

(Event 18)

Similarly, the therapist intervenes like this:

Male client: Yeah, because she feels that if I'm in it and committed to it versus just not giving a shit, that it's worth her putting the time and the effort in making things better for us. So, I get that, yeah.

Therapist: [To wife] Do you feel that that's true? That with him being more present both emotionally and physically that it takes some of the pressure off you? Could you talk to me about that pressure and how that taken off of you has affected you health-wise? Emotionally and physically?

(Event 15)

The therapist is placing strategic parameters around the client's responses to guide them towards a positive direction. Similar to other leveraging interventions, these parameters place a strain on the therapeutic alliance. Clients often would push back against the parameters and react defensively or withdraw.

Therapeutic block intervention. *Therapeutic block* accounts for 7% (n=14) of all ALI used. This intervention was used primarily with males and therefore the data regarding *therapeutic block* intervention only represents its use with males. Of those 14 interventions directed toward male clients, 0% (n=0) were used in successful events and 100% (n=14) were used in unsuccessful events.

Therapeutic block is a category that was separated from *interrupt gender* further into analysis. With *interrupt gender,* gender is being interrupted as a means of guiding males toward relationally equal interactions and not allowing imbalances to remain unnoticed. *Interrupt gender* had a psychoeducational approach, standing beside the male

client as a mentor, while *therapeutic block* has a social justice approach, standing between the male client and the female client. *Therapeutic block* came up when the therapist sensed a threat to the female client and would stand in defense of her. Gender is still being interrupted, but *therapeutic block* was observed as a means of limiting harm or distress from impacting the female client in session. For instance:

Male client: That was extremely stupid to – our house is scratched up by the dogs. Every corner is all screwed up. So now—
Therapist: Wait, wait, wait, wait, wait. You just called her stupid?
Male client: Well, not on the whole, just –
Therapist: That her thinking is stupid?
Male client: Yeah. Yes. She was –
Therapist: Wait. Stop. You can have a different perspective but – I'm confused as to why you would need to call her stupid.

The therapist comes to the defense of female client specifically when a threat was perceived, in this case calling his wife's perspective or thinking 'stupid.' In each case, this was directed at the male and uses a confrontational stance. Another example is:

Male client: I don't feel the regret from her. I don't feel, I never have felt. Cause she was madly in love with him and she would have left me. She told me.

Female Client: [Sobbing]

Therapist: I have heard her express the regret. I have heard her express the pain. And—

Male client: I'm just saying that's my problem. I don't feel it.

Therapist: It's in the past and I don't think it's something that can be resolved between the two of you. I don't think there's anything she can do. She can't undo, she probably wishes she could, but she can't.

(Event 10)

In the previous intervention, the therapist senses the female client's distress and defends her without prompting from the female client. With phrases like, "she probably

wishes she could," is a statement of assumption (not previously stated by female client in couple sessions) for the purpose of defending her without exposing her to more distress.

Encourage attunement intervention. *Encourage attunement* accounts for 6% (n=11) of all ALI used. This intervention was used primarily with males and therefore the data regarding *encourage attunement* intervention only represents its use with males. Of those 11 interventions directed toward male clients, 46% (n=5) were used in successful events and 54% (n=6) were used in unsuccessful events.

In line with the SERT competencies, the researchers observed the therapists directing male clients toward attunement regularly. This was often done in a prescriptive and teaching manner. It would often sound like, "tell her that you understand how she feels" (Event 18) or "do you ever wonder what your wife feels about this? (Event 11)" Another approach is modeling attunement such as:

> Therapist: Maybe you have a little more flexibility in the way you're thinking about that agreement. It really triggers something in you, Mary, that maybe my voice is never going to matter to him? Or something like that?
> Female client: Yeah. Cause he knows better.
> Therapist: Cause he knows better.
> Female client: And he's got the answers and my viewpoint is stupid.
> Therapist: So, Richard, when you listen to her feeling, her painful feeling - and we know that's an ongoing issue for you - but knowing that she doesn't think you value her opinion, what is it like to know that now?
>
> (Event 7)

The therapist asks the female client how she feels, modeling attunement, and brings it back to the male client to process what it's like for him to hear her feelings. If the therapist did not bring this modeling example back to the male client, it was

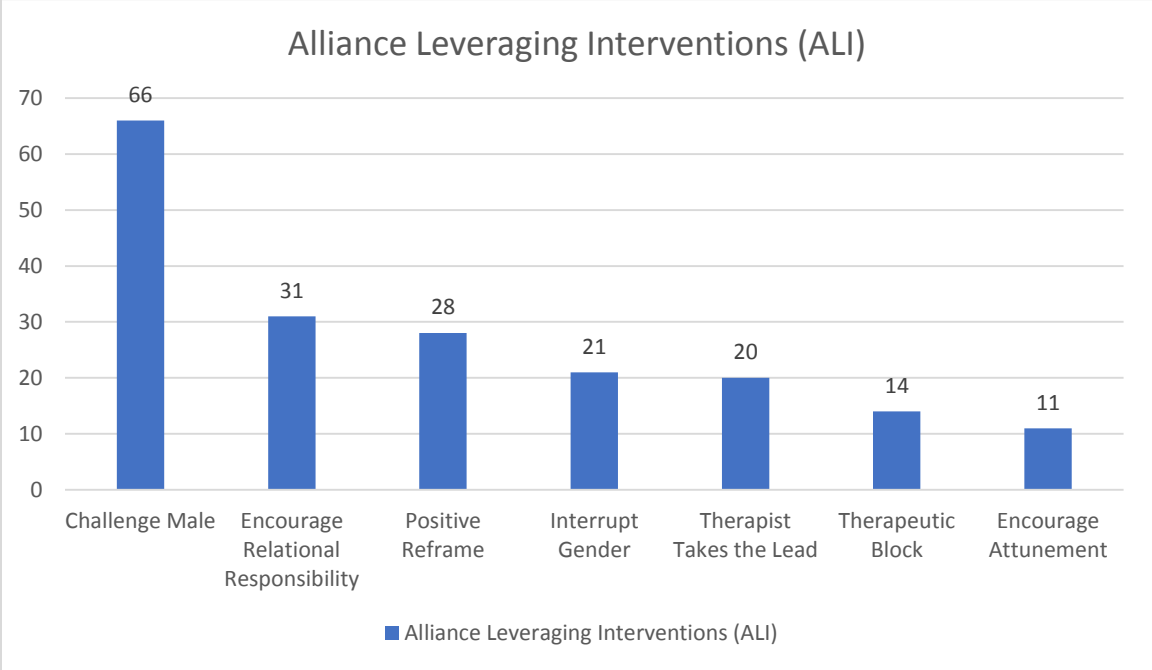
considered *attune to female* rather than *encourage attunement*. Either method from the therapist, teaching or modeling, was directed at guiding male clients toward attunement.

Alliance Leveraging Interventions (ALI) overview. The most frequently occurring Alliance Leveraging Interventions (ALI) were (a) *challenge male* (34%), (b) *encourage relational responsibility* (16%), (c) *positive reframe* (14%), (d) *interrupt gender* (11%), (e) *therapist takes the lead* (10%), (f) *therapeutic block* (7%) and (g) *encourage attunement* (6%). *See Chart 3 and Table 4.* All the rest of the ALI that did not fall into these categories equals <6% combined. Although *therapist takes the lead* and *therapeutic block* have less numbers warranting their inclusion, the impact of these interventions seemed to be greater than many of the others. This observation will be expanded upon in the discussion section following.

Table 4
Descriptive Statistics for Alliance Leveraging Interventions

ALI Intervention	Total	In Successful Events	In Unsuccessful Events
Challenge	66	11	55
Encourage relational responsibility	31	16	15
Positive reframe	28	8	20
Interrupt gender	21	1	20
Therapist takes the lead	20	9	11
Therapeutic block	14	0	14
Encourage attunement	11	5	6

Chart 3 - Most Frequently Occurring Alliance Leveraging Interventions



Relational client responses (R-CR). These client responses brought attention and care toward the relationship needs or toward vulnerable expression. These reactions were more likely to be paired with Mutual Support. Two subcategories were identified and are described as follows.

Relational vulnerability client response. *Relational vulnerability* accounts for 62% (n=46) of all R-CR found. Since this response was observed in both males and females, *relational vulnerability* was divided by gender with 59% (n=27) of observed in men and 41% (n=19) observed in women. Of those 27 responses observed in male clients, 59% (n=16) were observed in successful events and 41% (n=11) were observed unsuccessful events. Of those 19 responses observed in female clients, 53% (n=10) were observed in successful events and 47% (n=9) were observed in unsuccessful events.

In both males and females, a *relational vulnerability* response was an open and honest description of their relationship experiences, whether positive or negative. Many

times, the vulnerability expressions from the clients were either relational desires or distress surrounding disconnection. It focused primarily on the impact of a relational event on the individual and often involved primary emotions. A client would say, “I’m afraid. I’m afraid that she’s going to find someone else again (Event 10),” or “Most of the time I just feel like he doesn’t want to be there or is just waiting for time to pass (Event 16).” Even a statement of empathy such as, “It makes me feel terrible when she’s hurting like this” (Event 3), shows a relational honesty and exploration that moves towards a relational mindset.

Individual vulnerability client response. *Individual vulnerability* accounts for 38% (n=28) of all R-CR found. Since this response was observed in both males and females, *individual vulnerability* was divided by gender with 89% (n=25) of observed in men and 11% (n=3) observed in women. Of those 25 responses observed in male clients, 64% (n=16) were observed in successful events and 36% (n=9) were observed unsuccessful events. Of those 3 responses observed in female clients, 66% (n=2) were observed in successful events and 33% (n=1) were observed in unsuccessful events.

This response is unique from relational vulnerability in that it is more generalized and does not incorporate the relationship dynamic. Most often this response is seen when a client is exploring past history or experiences that are unique from their spouse. For instance, statements like, “I know I could really use help with this. You know how my brain works. It’s like then this happened, then this, then this. I don’t like this anxious place I fall into” (Event 10), show that the client is opening up about a personal experience that is emotional and vulnerable. Another example is, “We didn’t plan to have so many kids. I felt like I wasn’t ready to take care of everyone. Like I couldn’t provide

like I should" (Event 16). Even though the previous example was relational in nature, it's distinction from the spousal relationship kept these expressions in the *individual vulnerability* category.

Relational client responses overview. Of the relational client responses (R-CR, n=74), the most common were (a) *male relational vulnerability* (36%), (b) *male individual vulnerability* (34%), (c) *female relational vulnerability* (26%) and (d) *female individual vulnerability* (4%). *See Table 5 and Chart 4.* The remaining responses that could be considered relational represented <2% of the total relational responses.

Chart 4 - Most Frequently Occurring R-CR

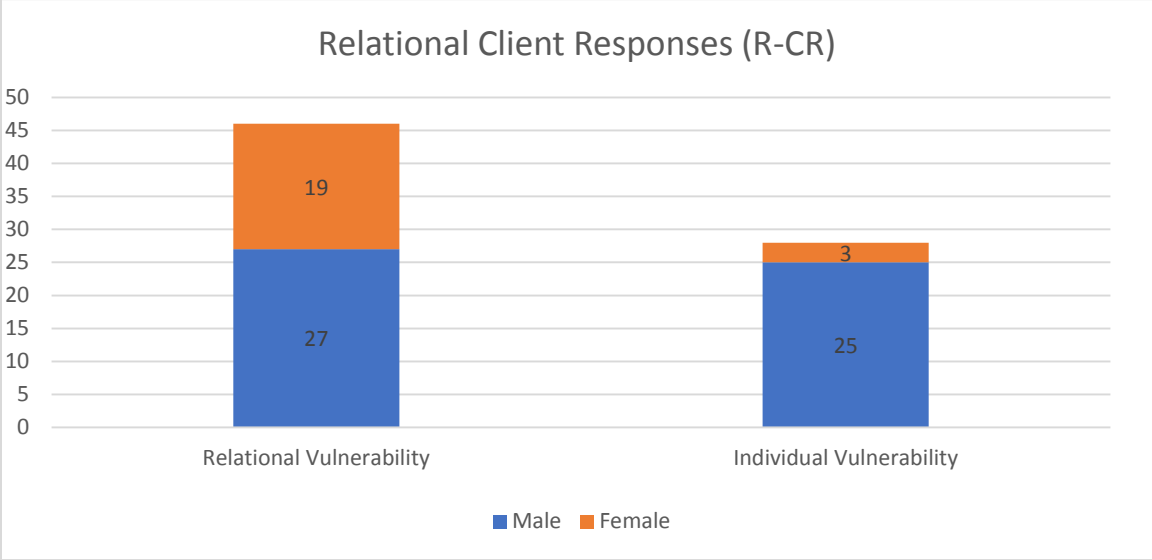


Table 5

Descriptive Statistics for Relational Client Responses

Response	Total	In Successful Events	In Unsuccessful Events
Individual vulnerability male	25	16	9
Individual vulnerability female	3	2	1
Relational vulnerability male	27	16	11
Relational vulnerability female	19	10	9

Defensive client responses (D-CR). These responses placed self-protection of the individual as the highest priority and often lead to continued damage to the relationship health. The purpose of these responses was to influence another or block influence of self as a means of building individualized safety. Three subcategories were identified and are described as follows.

Defensive client response. *Defensive* accounts for 49% (n=161) of all D-CR found. Since this response was observed in both males and females, *defensive* was divided by gender with 70% (n=112) of observed in men and 30% (n=49) observed in women. *See Chart 3*. Of those 112 responses observed in male clients, 18% (n=20) were

observed in successful events and 82% (n=92) were observed unsuccessful events. Of those 49 responses observed in female clients, 86% (n=42) were observed in successful events and 14% (n=7) were observed in unsuccessful events.

This was the most common response throughout the entire research study. This response displayed resistance to either the therapeutic process or to the relational dynamic as it unfolded in session. An example would be:

Male client: I don't feel like I was given an option in life. I feel like it was set out for me.

Therapist: Okay, well now that you know more, you have an option with your life.

Male client: No, I don't really think so. I mean, if I wanted to hurt my family I could just leave, but I don't want to do that.

(Event 15)

Statements like this show a resistance to the therapeutic process. This resistance could come from many sources, such as misunderstandings, discomfort with emotions, logical disagreements, etc. Other interactions that are common in identifying *defensive* include:

Therapist: Whatever it is in the moment, your wife doesn't feel like you value her opinion.

Male client: Well I do. It's not a matter of valuing her opinion. I just don't agree with her.

(Event 7)

The male client could show resistance to therapeutic direction or to the statements of his spouse. Female clients were more likely to show resistance and give a defensive response to the male client's statements. Defensive statements and responses were also observed as blaming, disagreeing and/or deflecting.

Content focus response. *Content focus* accounts for 34% (n=111) of all D-CR found. Since this response was observed in both males and females, *defensive* was divided by gender with 68% (n=76) of observed in men and 32% (n=35) observed in women. Of those 76 responses observed in male clients, 22% (n=17) were observed in successful events and 78% (n=59) were observed unsuccessful events. Of those 35 responses observed in female clients, 3% (n=1) were observed in successful events and 97% (n=34) were observed in unsuccessful events.

Particularly in cases where men struggled to articulate their emotional positions, male clients would use content information to justify their emotions or emotional reactions. In these responses, clients would often bring a great deal of circumstantial evidence to validate themselves. For instance, phrases like "When you invite friends over without talking to me, and on a holiday no less, it's disrespectful (E14)," or "I don't check out when I'm stressed. Even when I'm upset I get up and help the kids get ready for school and take the trash out" (NHUT27), provide circumstantial evidence as a justification for behavior or feelings. These content pieces involve secondary emotions but often include no reference to emotions at all. These responses pull on the logic and "facts" of situation and usually provide a case blaming the other person for harm done or hurts felt.

Withdraw response. *Withdraw* accounts for 17% (n=55) of all D-CR found. Since this response was observed in both males and females, *withdraw* was divided by gender with 82% (n=45) of observed in men and 18% (n=10) observed in women. Of those 45 responses observed in male clients, 38% (n=17) were observed in successful events and 62% (n=28) were observed unsuccessful events. Of those 10 responses observed in

female clients, 40% (n=4) were observed in successful events and 60% (n=6) were observed in unsuccessful events.

The researchers observed moments where clients would restrain their responses or sometimes not even respond at all. Most commonly, clients would give one-word answers like “yeah” or “okay.” In lieu of a word, a sound would often replace an answer such as “mhmm.” Moments of silence happened, as well, even when the therapist opened space for a reply. Clients would also answer questions in shortened sentences and give minimal detail usually in conjunction with having been defensive.

Lastly, clients would sometimes stutter or fumble over their words, particularly when challenged. For instance, “I’m trying. I mean, I’m pretty good except when I’m, like I told you, like when I’m emotional” (Event 5). These statements were usually spoken in a haltingly rushed manner.

Defensive client responses overview. Of the defensive client responses (D-CR, n=327), the most common were (a) *male defensive* (34%), (b) *male content focus* (23%), (c) *female defensive* (14%), (d) *male withdraw* (14%), (e) *female content focus* (11%) and (f) *female withdraw* (3%). *See Table 6 and Chart 5*. The remaining responses that could be considered defensive represented <1% of the total defensive responses.

Chart 5 - Most Frequently Occurring D-CR

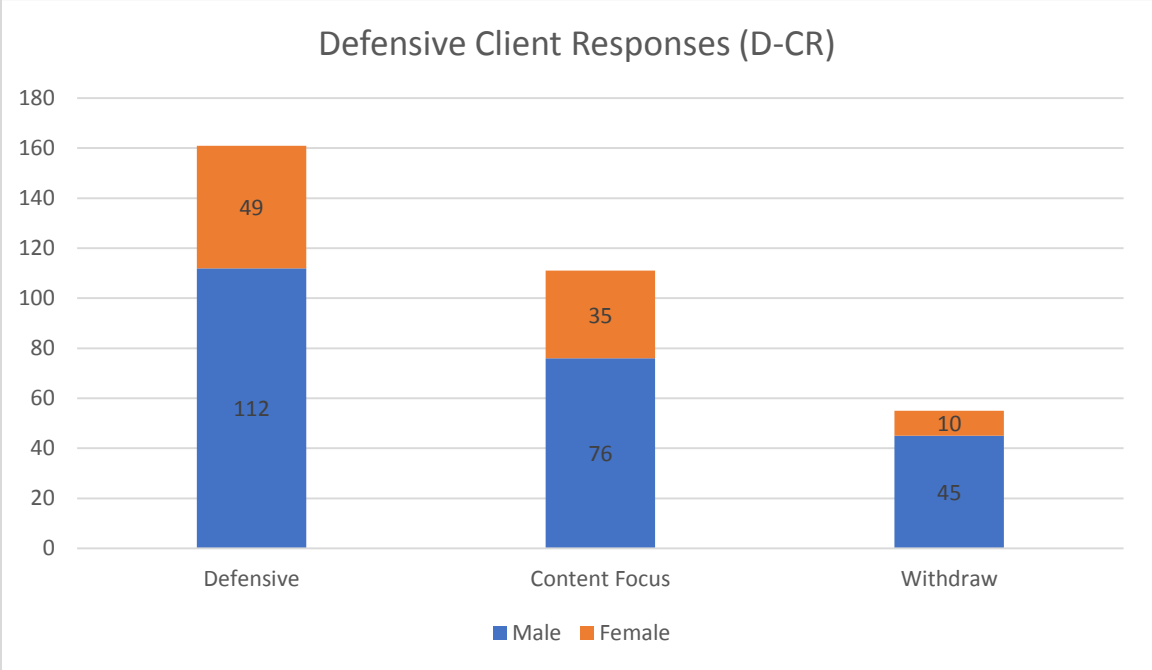


Table 6

Descriptive Statistics for Defensive Client Responses

Response	Total	In Successful Events	In Unsuccessful Events
Defensive male	112	20	92
Defensive female	49	7	42
Content focus male	76	17	59
Content focus female	35	1	34
Withdraw male	45	17	28
Withdraw female	10	4	6

Summary of Chapter 4

This chapter covered the descriptive observations of the study. The first part of the results took findings from previous literature to identify and code the problem state parameters. Congruent with the previous data, the problem states of this study were observed as defensive statements and/or blaming the spouse or circumstance for relationally harmful behaviors. The SERT literature provided a rational model which offered a theorized map of anticipated results. The SERT model postulates that therapists

should 1) establish an equitable foundation for therapy, 2) interrupt the flow of power and then 3) facilitate alternative experience. The observations of this data were mostly congruent with this rational model, however, successful methods used to interrupt the flow of power are given more clarity by the data in this study.

In the third stage of task analysis for this study, the observations were coded and separated into categories. For the therapist interventions within the events, *Alliance Reinforcing Interventions* (ARI) and *Alliance Leveraging Interventions* (ALI) were the two main categories. For the client responses, *Relational Client Responses* (R-CR) and *Defensive Client Responses* (D-CR) were the two main categories. Each sub-category was listed and detailed, bringing clarity to which interventions and responses were noticed most often and if they were more often in successful events or unsuccessful events. Gender separations were important when coding since power is displayed differently by gender according to SERT research and feminist theory (Knudson-Martin & Mahoney, 2009).

During analysis, more alliance reinforcement interventions were observed in successful events. These events were successful due to the presence of the client's *Mutual Attunement* and *Shared Relational Responsibility*. The data suggests that although an interruption of gender is a part of successful client change, a significant amount of alliance building and emotional engagement is necessary for success, particularly with males. As SERT research suggests, working with the more powerful partner first was an observable piece of successful events. This data allows for a task by task model to be formulated. This model is presented in the following chapter along with a discussion and conclusions of this study.

CHAPTER 5: DISCUSSION

After building a rational model from the SERT literature (Knudson-Martin & Huenergardt, 2010; Knudson-Martin & Mahoney, 2009; Knudson- Martin et al., 2015), the researchers used the empirical data of this research study to create the fourth stage of task analysis: a synthesized model from rational and empirical observations (Bradley & Johnson, 2005). This chapter will present the model in its four steps, followed by the key findings in the data which may be helpful to clinicians and future researchers. These key findings include (a) prioritize the powerful partner, (b) challenging gender gently, (c) content walls around emotions and (d) keys to sustainable change.

A Synthesized Model of SERT Attunement and Relational Responsibility

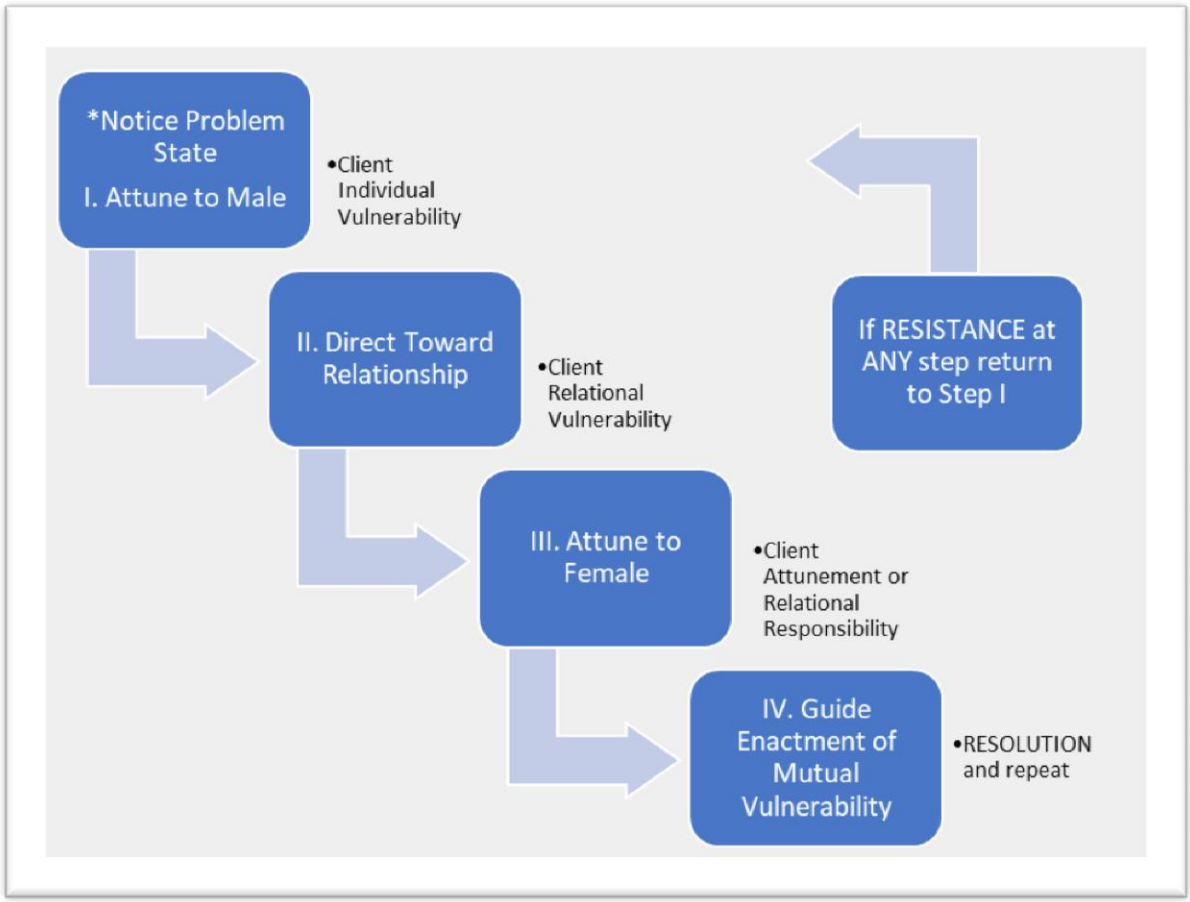
In this final stage of analysis, the researcher developed four steps (See *Figure 2*) to take clients from the problem states, (a) lack or deflection of relational responsibility and/or (b) lack of or block against mutual attunement, toward the SERT resolution of *Shared Relational Responsibility* and/or *Mutual Attunement*. Prior to Step I, the therapist needs to recognize the signs of the client in the problem state. To best allow for this, the therapist should be trained and knowledgeable about how power dynamics impact couples therapy. At the core of the problem state seemed to be an underlying emotional dysregulation which the client is either unable to or unwilling to express in the form of relational needs. This is congruent with literature surrounding the neurochemistry of connection (Fishbane, 2007; Siegel, 2001).

As was previously stated, this model is grounded in the language and mindset of the third wave of feminism. Incorporating the fourth wave of feminism, this model would trade gender distinctions for behavior and role distinctions. For instance, it is not

guaranteed that the male has more power or that the male has less emotional intelligence. Accounting for any individual who is being marginalized, the model would state: Step 1 – Attune to Powerful Partner. This opens the language beyond biological sex but toward those benefiting from or being marginalized by societal power. Therapists would need additional training and bias checking before incorporating a gender-liberated, fourth wave feminist model.

Step I: Attune to male. Attuning refers to an emotional connection with and empathy surrounding the male's experience. All the men of this study had difficulty expressing their emotions and therefore, when successful in doing so, were more likely to dive deeper into emotions when supported by the therapist(s). Because power is often displayed in the form of defensiveness and blocking vulnerable expression, therapists were more likely to challenge the male and confront power directly. When the therapists challenged power without first empathizing and attuning to the male client, the therapeutic relationship suffered and often lead to the male client withdrawing or reacting defensively. This finding corresponds to Fishbane's (2007) article suggesting that men have differing levels of emotional intelligence and therefore need a customized level of therapeutic attunement to keep them engaged.

Figure 2 – Synthesized Rational and Empirical Model of SERT Outcomes



According to the data, alliance reinforcing interventions comprised 65% of the interventions in the successful events. In contrast, alliance leveraging interventions comprised only 26% of interventions used in successful events. The remaining percentage of interventions were considered neutral, neither reinforcing nor leveraging alliance. This implies a strong correlation of attuning and empathizing as leading to the goal resolution. In particular, challenging the male was the most often used intervention across all events (21%, n=94 out of n=441), but particularly in events which did not reach resolution (31%, n=94 out of n=300). Despite the results, therapists are most likely to challenge males in this study of SERT therapists and challenging males without first

empathizing and attuning drastically decreased the likelihood of reaching the target SERT resolution.

McKelley (2007) found that traits of masculinity lead individuals toward self-regulation and often make those individuals reluctant to seek help. Similar to this study, men become resistant to reaching out to their partners to regulate or even explore their emotions. Presumedly for this reason, successful resolution required therapists to attend to male emotions more acutely than those of women. Moynehan (2007) pointed out that men are more likely to solve problems on their own so teaching the process of co-regulation is an important and often difficulty part of early therapy.

Along the same research assumption, it is important that the therapists attune to the **male** (powerful partner) first. It is important to draw a distinction that in additional studies the powerful partner may be female. According to this study, only heterosexual couples were analyzed and, in each case, the powerful partner was the male partner which is consistent with literature. Further studies should include same sex couples and couples who present as the female being the more powerful partner. In these findings, however, the powerful partner was always the male partner and therefore the terms are interchangeable in this study.

Even when male attunement was present, if the therapists attuned to the female before the male client showed signs of individual vulnerability and relational vulnerability, the response was predictably defensive or withdrawn. This response was also seen and suggested in Fishbane's (2011) and Gottman's (2005) research that men are socialized toward dominance and when men view themselves as inferior in a skill compared to their wife, the male response is as if to a threat. It was tempting for the

therapists of this study to be unsuccessful in achieving an emotionally aware and vulnerable response in the male so they would turn to the female to lead the charge toward vulnerability. Most often the female was successful in being relationally vulnerably followed directly by an increasingly defensive male partner. This process reinforced the cycle of distance between them and it became exponentially harder to attune to the male with successful outcomes.

Lastly, the goal of this step is to see individual vulnerability from the male client. This usually comes in the form of a personal statement of an emotional experience. Most often the client was describing his upbringing or personal beliefs about a general topic. The client's body language should seem somewhat relaxed and open. If any resistance is sensed, then the therapist should remain attuned and explore the resistance and any present emotions until the target of individual vulnerability is witnessed. If the client jumps straight to relational vulnerability (the goal of Step II), make sure to attune and explore it for several responses before moving to Step III.

Step II: Direct toward relationship. Assuming the client has been successful in staying individually vulnerable, the therapist can then move toward relational language. This was most often done by taking an example of turmoil expressed by either member of the couple and encouraging emotional vulnerability about that situation. If non-emotional pieces of information come up, the therapist must side step those details and continue to phrase questions to explore emotions surrounding the events rather than opinions.

It was important that the therapist(s) stayed focused on the male client at this point. If the female client wanted to add details or step in, most occurrences lead to male withdrawal or defensive posturing. If the female client did chime in, the therapist(s)

minimally affirmed the female client and stayed focused on the male, exploring relational emotions. Once the male client was able to successfully express his own emotions regarding a relationship situation in an open and vulnerable way, the therapist(s) could then move on to Step III. However, if even briefly there was a defensive or resistant response, the therapist(s) who succeeded in reaching resolution back-tracked to attunement and sought-after individual vulnerability once again. If the therapist(s) failed to go back to Step I and continued to pursue Step II in the face of resistance, the outcome change dropped significantly.

Step III: Attune to female. This is the riskiest of steps for the therapist, but the most crucial. In order to properly address power and gendered stereotypes, the therapist(s) needed to bring in the female client's perspective into the session. Up until that point, the perspective has been completely biased toward the male. The therapist now attunes to the female perspective and models relational attunement for the male to witness. Without this, the power dynamic is not offered a chance to shift toward equality.

Congruent with the theories of feminism, this study and the SERT model have found that both women and men are heavily guided by social norms (Knudson-Martin, 2010; Diamond, 2009). The previous stages of this model follow the theory that men need to be liberated from the pressures of social norms first so that women can then be freely empowered within the relationship and not just independent of it. Previous models of feminist therapy focused on empowering women but at the expense of relational empowerment. It is for these reasons the first two stages focus on empowering men first individually, then relationally, allowing for this next phase of empowering the female in the relationship.

Once relational vulnerability is achieved and witnessed by the male client (the goal of step II), the therapist(s) should then turn to the female and ask something like, "What is it like for you to hear your husband/partner speak openly like this?" Whichever emotions came up for the male client, the therapist should bring that safely before the female client and ask her to engage with those emotions. For instance, inviting her to engage with his emotions might sound like, "What is it like for you to hear that your husband is afraid of looking weak or even undesirable if he doesn't make more money?" This takes the husband's emotions and offers it for engagement. If the female responds with relational vulnerability in kind, then the therapist will present that back to the husband as in, "Your wife just said she feels a lot closer to you hearing you talk like this. Is that what you expected?"

Mediating this interaction is important while emotions are still unsafe. If resistance comes up at any time from either male or female client, the therapist(s) should again return to Step I and start from the beginning. Ideally, both male and female client will have expressed and exchanged relationally vulnerable statements as mediated through the therapist. Once this has been accomplished, it is safe to move to Step IV.

Step IV: Guide enactment of mutual vulnerability. This is where the therapist steps aside and directs the couple to engage with each other. For the couple, this is a risky engagement and the most likely to trigger a defensive or resistant response. Therefore, it is the job of the therapist to protect each member of the couple from themselves and each other by guiding the vulnerability. In the data, couples, particularly men, tended towards content related complaints rather than emotional vulnerability. To begin, the therapist(s) might say, "Amed, I think it's great how open you're able to express your fear of

disappointing your wife. I'd like you to turn to your wife and tell her exactly what you just expressed, looking her in the eyes." When he seems finished, continue with, "Jessica, in the same way, I'd like you to respond to Amed's fears." Within these enactments, the data showed the greatest numbers of sustained *Mutual Attunement* and *Shared Relational Responsibility*. Both of these outcomes seemed to flow out of *Mutual Attunement*, which is another core goal of SERT therapy (Knudson-Martin & Huenergardt, 2010).

The therapist(s) can then adapt this emotional insight, the process of therapy, to the content and guide the couple toward solving their problem considering the process they just experienced. Again, if resistance shows up on either side, the therapist should immediately move back to Step I. This process can take from 10 to 35 minutes to walk through all four steps, averaging 15 minutes in length.

Prioritize the Powerful Partner

It became clear in the data that seeing *Shared Relational Responsibility* and *Mutual Attunement* was dependent on working with men first and foremost. This was a key difference already postulated and observed in the SERT literature. Many couples therapy guide therapists to work with each member of the couple equally. SERT takes male power into consideration and has learned that is it better for the relationship to encourage men to give away power rather than to empower women to take it.

Men having more power can lead to a deficit in emotional intelligence (Doss et al., 2003; Fishbane, 2011; Gottman & Driver, 2005). Men may need to learn these fundamental emotional regulation skills for the first time. The therapist will need to teach men how to stay engaged and even how to recognize and express their emotions. Male power can come across as demeaning, insensitive and/or emotionally damaging. In this

study, therapists commonly reacted to this power by either focusing on empowering the female first or defending the female client against the power "assaults" of the male client. At certain moments, this may be necessary, but this study shows that the best results of mutual support come about when therapists hone in on the male client, particularly when his behaviors or words are power-driven. The moments of male power in session provided an important opportunity for therapists to de-escalate men and guide toward emotional awareness as an alternative. Of course, cases of abuse should always be carefully assessed and safety takes priority. This study does not account for domestic violence cases.

Challenge Gender Gently

When power is challenged, men often reacted strongly. As was previously written, Gergen (1994) found that these societal messages are so deeply connected to acceptance and attachment that to challenge these cultural discourses may be perceived emotionally as a threat to survival. These reactions from men would often do harm to the relationship and their spouse in the session. Perceiving this harm, many therapists would react in a confrontational manner and challenge the male's expression of power and his defense of it. In the successful events, 83% of the *challenge male* interventions were in the unsuccessful events leaving only 17% in the successful resolution events. Those interventions that lead to reinforcing the bond between therapist and male client overwhelmingly dominated the successful events, greatest of all being *attune/empathize with male* and *reflecting* with 71% of those interventions taking part in the successful resolution events.

From these pieces of information, recognizing the instinct to both empower and protect women in session may be an important bias for therapists to uncover. Although each therapist has their own unique motivations in therapy, the above information paints a picture of cornered and scared men. The data highlights the fear often present in men who are also trapped in a societal discourse. Seeing men in this light might assist therapists toward a softer approach to challenging gender.

In order for this point to take effect, therapists need to actively explore and attune to their own bias. Power dynamics are so deeply imbedded into the cultural discourse that they can be difficult to recognize for both clients and therapists alike (Knudson-Martin & Mahoney, 2009; Rothenberg, 2008; Ward & Knudson-Martin, 2012). With confronting gender, therapists were more adept at recognizing the negative impact on men and potentially viewed men as the embodiment of male oppression. This is an assumption on the part of the researchers but the confrontational nature of the interventions suggests that men were not viewed as equally entrenched and trapped in these gender discourses. Men have more to gain from the current views of gendered traits (McGoldrick, Anderson, & Walsh, 1991; Walsh, 1989), but that gain does not make the process overt and clearly visible for men. It should be noted that some men, after they have been made aware of their power, decided to continue in that injustice toward their significant other. A future study should delineate between how therapists should confront gender when it is understood by the male and when it is unconsciously acted out. For this study, those therapists who treated men as unwitting culprits in gendered power and therefore took a gentler approach saw more success in helping men toward vulnerability.

Content Walls Around Emotions

Content focus was an incredibly common plight of men throughout this research. Over time, it was discovered that there was a fundamental protective aspect to content driven conversations. One male client stated, "I lost my job two days ago and she immediately started demanding that we put the house on the market. Where's the love in that?" It's as though the male is saying, "You see? I have a right to feel this way and you need to tell her that she's wrong. Look at the evidence!" This dynamic happened in almost every event. This was also evident in the literature when Silverstein et al. (2006) described the most notable masculine traits including action-oriented, autonomous and providers. These traits also lend themselves to a concrete type of thinking guiding men toward content rather than abstract emotion.

Men seemed to lack the language to explain their emotions. Observation suggested that using these details and pieces of evidence served as a sort of concrete explanation for their emotions in lieu of more accurate emotional language. Feeling the inability or lack of safety to say something like, "I was really hurt that you didn't show more sympathy and I wanted you to comfort me," the male client would instead gather logical evidence to explain how he felt and use those to justify his emotional reaction.

On the same note, the words, "I feel…" were usually followed a logical opinion rather than emotion. Asking the male client, "and how did that make you feel?" often lead to a response of, "I feel like we should wait longer to sell the house." These opinions served as a safety net for male clients to express emotions in a concrete and content driven way. Therapists who continued to push emotional language and metaphors for males were more successful and avoided becoming trapped in these content nets. For

therapists, this required a very slow and intentional pacing for emotional language and making sure that men could explore and express their feelings accurately before moving on to the next phase.

Keys to Sustainable Change

There were some inconsistencies in the data which took further analysis to formulate a theory. For instance, about half of the events contained sustained change, such as multiple statements of *Mutual Attunement* or *Shared Relational Responsibility*. However, the other half had only one occurrence or statement followed by continued defensiveness or resistance. There were two interventions unique to these inconsistencies: *therapist takes the lead* and *positive reframe*. When *therapist takes the lead* occurred as an intervention, one form was the therapist offering a script for the clients to enact. These scripts were usually direct expressions of *Relational Responsibility* or *Mutual Attunement*. If the clients seemed unwilling to progress in the therapeutic direction or if males seemed unable or unwilling to express these outcomes, the therapist would sometimes offer this script as a way of guiding clients forward. The outcome was that clients repeated the words of responsibility or attunement from the therapist cooperatively but then reverted shortly after with a defense or the spouse would reject the statement as insincere.

The *positive reframe* intervention was more subtle. The therapist would take a solution-centric direction and ignore or block any client responses which were not consistent with the therapeutic direction. The therapists would reframe the client statements, highlighting only the positive pieces. On several occasions, this led to an expression of agreement or statement of attunement or responsibility. However, similar to

therapist takes the lead, these positive outcomes which took place after this directive therapy approach were not sustained. It should also be noted that many of these positive reframes also excluded a client complaint or negative concern. A client-paced and client-centric approach may better guide clients toward equality.

Future Implications

Having only 3 couples in the data set, this study aimed for depth of data. In further studies, having a larger pool of participants would extend the potential for generalizability and reliability. This would also allow for greater diversity of SES, sexual orientation, gender of clients and therapist, race, etc. These factors play a crucial role in the influence of power in session and it would be beneficial for future studies to take each into account and how power is influenced by them.

One of those influences on power is the perspective of the therapist. This model was build on the foundation of the third wave of feminism and the therapists were focused on the empowerment of women. The fourth wave of feminism has since seen the value in liberating any marginalized group, including men who are forced into societal expectations and may suffer from a decrease in emotional awareness. Although these men still have greater levels of power in the relationship, the fourth wave of feminism would view these men as unwitting participants in power and also in need of liberation. This would also imply a shift of language away from "male" and "female" to "more powerful partner" and "less powerful partner." Part of the third wave of feminism is the assumption that males hold the power and have less emotional intelligence. This expansion of language would take the societal assumptions of gender attributes away

from the biological sex and place each person uniquely in terms of held influence. This would be especially helpful with non-heterosexual intimate relationship participant data.

Many therapists used supportive and empathetic interventions. Alternately, many less powerful partners also use supportive and empathetic responses toward the more powerful partner, but this may sustain the original power imbalance. Ward (2010) discovered that therapists often fall into a parallel process of empathizing with the more powerful partner but inadvertently reinforcing the power imbalance. Since empathizing with the more powerful partner is a part of both changing and reinforcing the power imbalance, the internal motivations of the therapists may point to subtle differences in outcomes. Future research should incorporate the unique perspectives of each therapist in session to gather internal motivations behind therapist interventions and analyze that data alongside outcomes. These therapist interviews could provide a dynamic view of the data and give greater clarity as to the factors involved in successful or unsuccessful outcomes.

The final stage of task analysis, the validation phase, is left for future research. During this next phase, researchers will take the synthesized model of this study and test each component for validation. Each of model's stages would be assessed for success by other researchers and rated for the quality of success via a Likert scale. Finally, once each stage was rated for success, this data would be related to the outcome data. This study provides the evidence for the components of the model, leading the way for continued, evidence-based research.

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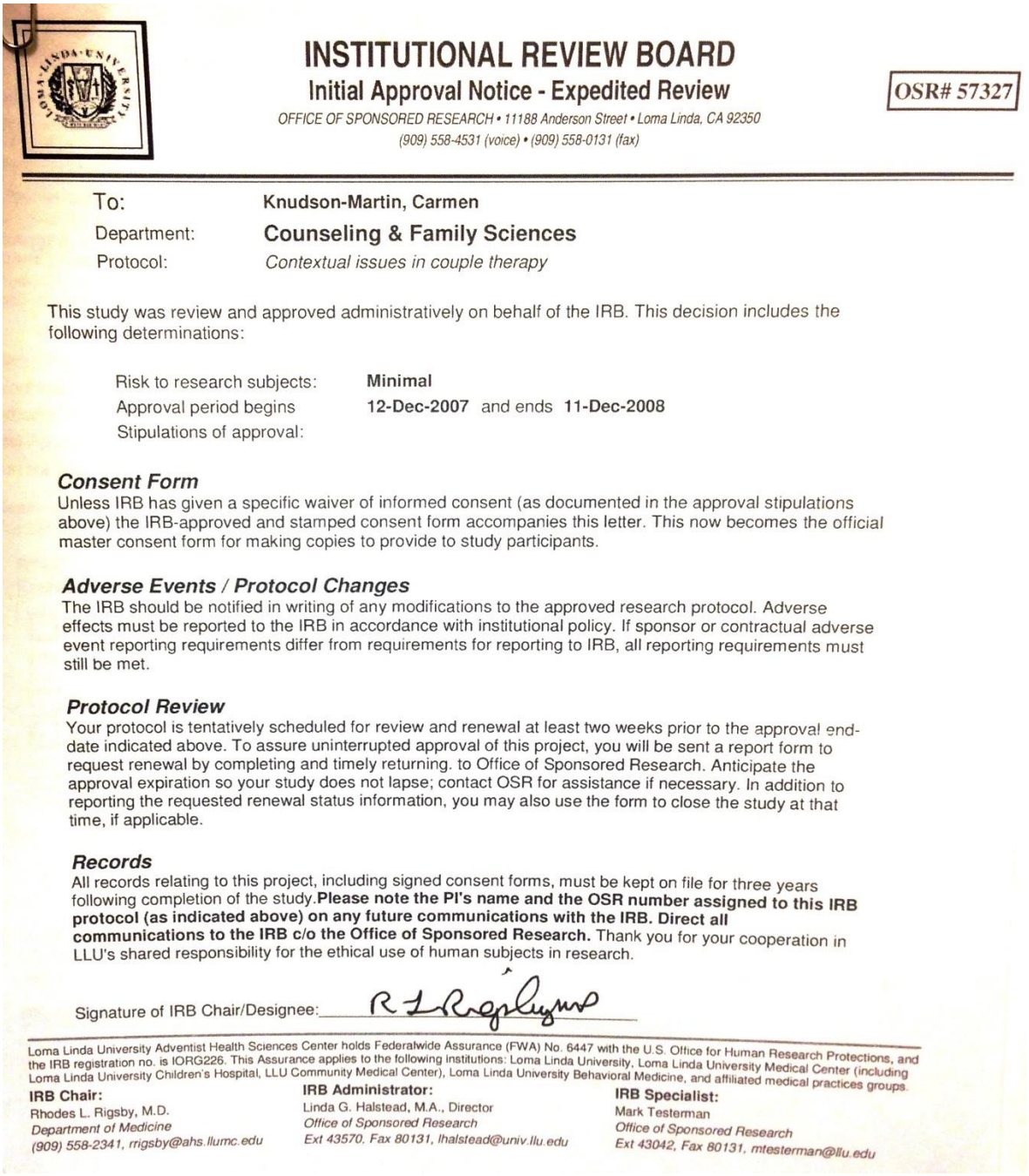
Appendix A: Initial IRB Approval Notice



INSTITUTIONAL REVIEW BOARD

Initial Approval Notice - Expedited Review

OSR# 57327

OFFICE OF SPONSORED RESEARCH • 11188 Anderson Street • Loma Linda, CA 92350
(909) 558-4531 (voice) • (909) 558-0131 (fax)

To: **Knudson-Martin, Carmen**
Department: **Counseling & Family Sciences**
Protocol: *Contextual issues in couple therapy*

This study was review and approved administratively on behalf of the IRB. This decision includes the following determinations:

Risk to research subjects: **Minimal**
Approval period begins **12-Dec-2007** and ends **11-Dec-2008**
Stipulations of approval:

Consent Form
Unless IRB has given a specific waiver of informed consent (as documented in the approval stipulations above) the IRB-approved and stamped consent form accompanies this letter. This now becomes the official master consent form for making copies to provide to study participants.

Adverse Events / Protocol Changes
The IRB should be notified in writing of any modifications to the approved research protocol. Adverse effects must be reported to the IRB in accordance with institutional policy. If sponsor or contractual adverse event reporting requirements differ from requirements for reporting to IRB, all reporting requirements must still be met.

Protocol Review
Your protocol is tentatively scheduled for review and renewal at least two weeks prior to the approval end-date indicated above. To assure uninterrupted approval of this project, you will be sent a report form to request renewal by completing and timely returning. to Office of Sponsored Research. Anticipate the approval expiration so your study does not lapse; contact OSR for assistance if necessary. In addition to reporting the requested renewal status information, you may also use the form to close the study at that time, if applicable.

Records
All records relating to this project, including signed consent forms, must be kept on file for three years following completion of the study.**Please note the PI's name and the OSR number assigned to this IRB protocol (as indicated above) on any future communications with the IRB. Direct all communications to the IRB c/o the Office of Sponsored Research.** Thank you for your cooperation in LLU's shared responsibility for the ethical use of human subjects in research.

Signature of IRB Chair/Designee: R L Rigsby MD

Loma Linda University Adventist Health Sciences Center holds Federalwide Assurance (FWA) No. 6447 with the U.S. Office for Human Research Protections, and the IRB registration no. is IORG226. This Assurance applies to the following institutions: Loma Linda University, Loma Linda University Medical Center (including Loma Linda University Children's Hospital, LLU Community Medical Center), Loma Linda University Behavioral Medicine, and affiliated medical practices groups.

IRB Chair:
Rhodes L. Rigsby, M.D.
Department of Medicine
(909) 558-2341, rrigsby@ahs.llumc.edu

IRB Administrator:
Linda G. Halstead, M.A., Director
Office of Sponsored Research
Ext 43570, Fax 80131, lhalstead@univ.llu.edu

IRB Specialist:
Mark Testerman
Office of Sponsored Research
Ext 43042, Fax 80131, mtesterman@llu.edu

Appendix B: Informed Consent

LOMA LINDA UNIVERSITY
School of Science and Technology

INFORMED CONSENT
Couple Therapy Study

Your therapist is participating in a research study about what happens in couple therapy. This form explains this study. In order for your therapist to use information from your therapy sessions in this study, your consent is required.

Purpose and Procedures
Couple therapists need to base their work on research about what works best. In this study therapists are examining video transcripts of their work with couples to identify what is happening in the session and what seems to work best for particular kinds of issues. The focus is on what the therapist does and how clients respond. The purpose is to develop a clearer picture of what therapists should do in order to help couples develop mutually supportive relationships.

If you agree, research team will review segments of your therapy sessions to identify moments of particular interest and determine what happened and why. The researchers will use the information to refine how they practice couple therapy and to develop a model that other therapists can use. Your participation in the study will not change your therapy in any way. However your therapist may use information learned from the analysis of your session to improve his or her work with you.

Risks
Since your therapist already records your sessions and reviews these tapes as part of ongoing training and professional development in the practice of marital therapy, the only risk to you is that the content from one or more sessions will be read by an unauthorized person. However, there is no greater risk of this happening than the usual therapy setting. As described below, this content will be kept in a secure setting and only be available to the research team.

Benefits
The in-depth examination of your therapy session by your therapist and a few other researchers will be beneficial to your therapist in his or her effort to provide you high quality service. It will also help other couple therapists who will learn from the findings of this study. However this extra effort on your therapist's part will not necessarily increase your success in improving your relationship.

Initial_____
Date _____

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved 10/10/12 **Void after** 10/9/2013
57327 **Chair** R L Rasmussen

A Seventh-day Adventist Institution

DEPARTMENT OF COUNSELING AND FAMILY SCIENCES | Loma Linda, California 92350
(909) 558-4547 · *fax* (909) 558-0447 · www.llu.edu

Participants Rights
Your participation in this study is completely voluntary. If you decide not to participate, it will not affect the couple therapy you are receiving now or other counseling services you may seek from this office in the future.

Confidentiality
All personal information regarding your identity and the therapy session will be held in strict confidence. In our analysis of the sessions, you will be known only by a number or pseudonym. All identifying material will be purged when quotes or case examples are used in the presentation or publication of study results. The transcript of your session will be kept in a secure location. Only your therapist and members of the research team will have access to it.

Costs
There is no cost to you for participating in the study.

Reimbursement
You will not be paid for participating in the study.

Impartial Third Party Contact
If you wish to contact an impartial third party not associated with this study regarding any question or complaint you may have about the study, you may contact the Office of Patient Relations, Lorna Linda Medical Center, Lorna Linda, CA 92354, phone (909)558-4647 for information and assistance.

.....

Informed Consent Statement

I have read the contents of the consent form and have listened to the verbal explanation given by investigator. My questions have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities. I may call my therapist/researcher or Carmen Knudson-Martin, PhD, at 909-558-4547 if have additional questions or concerns.

I have been given a copy of this consent form
Signature of Subject _____Date_____

I have reviewed the contents of the consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator _____ Date_____

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved 10/10/12 Void after 10/9/2013
57327 Chair R L Ruglyand

Appendix C: Authorization for Use of Protected Health Information (PHI)

INSTITUTIONAL REVIEW BOARD
Authorization for Use of
Protected Health Information (PHI)
Per 45 CFR §164.508(b)
RESEARCH PROTECTION PROGRAMS
LOMA LINDA UNIVERSITY | Office of the Vice President of Research Affairs
24887 Taylor Street, Suite 202 Loma Linda, CA 92350
(909) 558-4531 (voice) / (909) 558-0131 (fax)/e-mail: irb@llu.edu

TITLE OF STUDY:	**Contextual Issues in Couple Therapy**
PRINCIPAL INVESTIGATOR:	**Douglas Huenergardt, Ph.D.**
Others who will use, collect, or share PHI:	**Counseling and Family Science Couple Therapy Research Team**

The study named above may be performed only by using personal information relating to your health. National and international data protection regulations give you the right to control the use of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or shared as described below.

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this study and may include, but is not limited to: video recordings of your therapy sessions and, in some cases, transcripts of all or portions of the sessions. No names or other identifying information will be associated with the labels the recordings or transcripts made from them.

The individual(s) listed above will use or share this PHI in the course of this study with the Institutional Review Board (IRB) and the Office of Research Affairs of Loma Linda University. The Counseling and Family Science Couple Therapy Research Team listed above is composed of faculty and doctoral students who review records of clinical sessions as part of on-going study to advance the practice of couple therapy. No one else will have access to your records.

The main reason for sharing this information is to be able to conduct the study as described earlier in the consent form. In addition, it is shared to ensure that the study meets legal, institutional, and accreditation standards. Information may also be shared to report adverse events or situations that may help prevent placing other individuals at risk.

All reasonable efforts will be used to protect the confidentiality of your PHI, which may be shared with others to support this study, to carry out their responsibilities, to conduct public health reporting and to comply with the law as applicable. Those who receive the PHI may share with others if they are required by law, and they may share it with others who may not be required to follow national and international "protected health information" (PHI) regulations such as the federal privacy rule.

Subject to any legal limitations, you have the right to access any protected health information created during this study. You may request this information from the Principal Investigator named above but it will only become available after the study analyses are complete.

This authorization does not expire, and will continue indefinitely unless you notify the researchers that you wish to revoke it.

You may change your mind about this authorization at any time. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new personal health information will be used for this study. However, study personnel may continue to use the health information that was provided before you withdrew your permission. If you sign this form and enter the study, but later change your mind and withdraw your permission, you will be removed from the study at that time. To withdraw your permission, please contact the Principal Investigator or study personnel at 909-558-4547 x 47006.

You may refuse to sign this authorization. Refusing to sign will not affect the present or future care you receive at this institution and will not cause any penalty or loss of benefits to which you are entitled. However, if you do not sign this authorization form, you will not be able to take part in the study for which you are being considered. You will receive a copy of this signed and dated authorization prior to your participation in this study.

I agree that my personal health information may be used for the study purposes described in this form.

Signature of Patient #1 *or* Patient's Legal Representative	Date
Printed Name of Legal Representative (if any)	Representative's Authority to Act for Patient
Signature of Investigator Obtaining Authorization	Date

IRB 1/23/2013

INSTITUTIONAL REVIEW BOARD
Authorization for Use of Protected Health Information (PHI)

Per 45 CFR §164.508(b)
RESEARCH PROTECTION PROGRAMS
LOMA LINDA UNIVERSITY | Office of the Vice President of Research Affairs
24887 Taylor Street, Suite 202 Loma Linda, CA 92350
(909) 558-4531 (voice) / (909) 558-0131 (fax)/e-mail: irb@llu.edu

TITLE OF STUDY:	**Contextual Issues in Couple Therapy**
PRINCIPAL INVESTIGATOR:	**Douglas Huenergardt, Ph.D.**
Others who will use, collect, or share PHI:	**Counseling and Family Science Couple Therapy Research Team**

The study named above may be performed only by using personal information relating to your health. National and international data protection regulations give you the right to control the use of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or shared as described below.

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this study and may include, but is not limited to: video recordings of your therapy sessions and, in some cases, transcripts of all or portions of the sessions. No names or other identifying information will be associated with the labels the recordings or transcripts made from them.

The individual(s) listed above will use or share this PHI in the course of this study with the Institutional Review Board (IRB) and the Office of Research Affairs of Loma Linda University. The Counseling and Family Science Couple Therapy Research Team listed above is composed of faculty and doctoral students who review records of clinical sessions as part of on-going study to advance the practice of couple therapy. No one else will have access to your records.

The main reason for sharing this information is to be able to conduct the study as described earlier in the consent form. In addition, it is shared to ensure that the study meets legal, institutional, and accreditation standards. Information may also be shared to report adverse events or situations that may help prevent placing other individuals at risk.

All reasonable efforts will be used to protect the confidentiality of your PHI, which may be shared with others to support this study, to carry out their responsibilities, to conduct public health reporting and to comply with the law as applicable. Those who receive the PHI may share with others if they are required by law, and they may share it with others who may not be required to follow national and international "protected health information" (PHI) regulations such as the federal privacy rule.

Subject to any legal limitations, you have the right to access any protected health information created during this study. You may request this information from the Principal Investigator named above but it will only become available after the study analyses are complete.

This authorization does not expire, and will continue indefinitely unless you notify the researchers that you wish to revoke it.

You may change your mind about this authorization at any time. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new personal health information will be used for this study. However, study personnel may continue to use the health information that was provided before you withdrew your permission. If you sign this form and enter the study, but later change your mind and withdraw your permission, you will be removed from the study at that time. To withdraw your permission, please contact the Principal Investigator or study personnel at 909-558-4547 x 47006.

You may refuse to sign this authorization. Refusing to sign will not affect the present or future care you receive at this institution and will not cause any penalty or loss of benefits to which you are entitled. However, if you do not sign this authorization form, you will not be able to take part in the study for which you are being considered. You will receive a copy of this signed and dated authorization prior to your participation in this study.

I agree that my personal health information may be used for the study purposes described in this form.

Signature of Patient #2 *or* Patient's Legal Representative	Date
Printed Name of Legal Representative (if any)	Representative's Authority to Act for Patient
Signature of Investigator Obtaining Authorization	Date

IRB 1/23/2013

Appendix D: Video Consent

PATIENT CONSENT TO PARTICIPATE IN PROFESSIONAL or ACADEMIC PRESENTATION*

PRESENTATION: _____
Presentation title, venue, topic, or description

AUTHOR/CO-AUTHOR: _____
Therapist's name

_____
Therapist's name

From time to time therapist trainees and interns have the opportunity to make educational presentations at state and national conferences about therapeutic, relational, or cutting edge issues in marriage and family therapy. These presentations may consist of discussions about the process of therapy, portions of therapy session transcripts, or videotape clips. It is our expectation that such presentations will both help improve the skills of mental health clinicians and therapists in training, and will also forward our profession by the dissemination of helpful information.

Additionally, a graduate student requirement is to present a series of video clips of their work with clients to classmates and faculty. This presentation, called a qualifying clinical demonstration, or final case presentation, is held under the direct auspices of the faculty in the Department of counseling and Family Science and occurs once during the student's course of study. You may be asked for permission to include a portion of videotape of you and your therapist working together for this presentation.

The professional report named above may be performed only by using personal information relating to your mental health treatment. National data protection regulations give you the right to control the use and disclosure of your mental health information. Therefore, by signing this form, you specifically authorize your mental health information to be used or disclosed as described below.

Use of your personal information

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this report and may include, but is not limited to: your reason for seeking therapy services; course of treatment; discussion about your participation in therapy. Additionally, PHI may be shared with individuals designated to assist in conducting this study as well as with accreditation bodies. PHI may also be reviewed to ensure that the study meets legal and institutional standards.

* The term "presentation" as used in this consent, shall mean any written material, PowerPoint presentations, and motion picture or still photography in any format as well as video/digital tape, disc, or any other mechanical means of recoding and reproducing images.

Disclosure of your personal information

The main reason for sharing this information is to be able to analyze clinical processes and present or publish the results to other mental health professionals. The results may be presented in educational venues, professional conferences, or in publications. Although information obtained from your mental health record will be disclosed in the publication, we will not publish identifiers such as your name, address, telephone number or government-issued identification number.

Safeguards to protect PHI

All media or printed matter containing any information pertaining to you shall be carried in a locked briefcase to and from the presentation venue and will be in the possession of the abovementioned presenter at all times. If video clips are used, only a portion of the entire recorded session will be selected and transferred onto a CD or DVD for the presentation. Your name, age, and other identifying information will be changed for the presentation. An announcement will be made at the beginning of the presentation requesting that if anyone recognizes individuals in the video to excuse themselves from the presentation immediately.

Risks

Although every precaution will be taken to protect your PHI, risk of theft, destruction of materials, or the possibility that someone at the presentation may recognize you, cannot be entirely eliminated. We will do all in our power to protect your information while it is transported and used at the chosen presentation venue. All privileged information will be returned to the hospital immediately after the therapist returns from the presentation.

I hereby give authorization for the use or disclosure of my personal information for the professional report based on my understanding of the following:
(please initial or designate N/A for each item below)

_____ I understand that you may use my personal information to prepare this report. The scope of the report, however, is limited to the case description indicated above.

_____ I understand that the authorization to use my personal information to conduct this report will expire at the end of the presentation or study. However, I understand that following publication, full articles or abstracts of or from the initial report may be published and continue to be published for an indefinite period of time.

_____ I understand that this authorization does not authorize the use or disclosure of personal information created or obtained after initial publication.

_____ I understand that I do not need to sign this authorization in order to receive health care.

_____ I understand that I may revoke this authorization at any time. However, the revocation will not apply to information that has already been released in response to this authorization.

_____ I agree that my personal mental health information may be used for:

- ☐ student qualifying examination presentation
- ☐ final case presentation
- ☐ professional/educational conference presentation
- ☐ future presentations and other educational purposes at dates and times yet to be determined

_____ I have had the opportunity to ask questions about the purpose and use of the presentation at which my PHI will be used.

_____	_____
Patient Name	Date & time
_____	
Patient Signature	
_____	_____
Parent/Guardian Name	Date & time
_____	
Parent/Guardian Signature	
_____	_____
Staff Name	Date & time
_____	
Staff Signature	
_____	_____
Student Name	Date & time
_____	
Student Signature	
_____	_____
Clinical Supervisor	Date & time

Appendix E: Ethical Treatment of Private Health Information

LOMA LINDA UNIVERSITY
DEPARTMENT OF COUNSELING AND FAMILY SCIENCE
Affidavit for Ethical Treatment of Private Health Information

I, _____ have requested that my clients provide consent to release private health information (PHI) to me for the purpose of

☐ use in qualifying clinical demonstration

☐ use in my final case presentation

☐ inclusion in a classroom presentation at Loma Linda University

☐ inclusion in an educational or professional conference presentation

☐ for presentations at dates and times yet to be determined

☐ for publication purposes

My initials below indicate my understanding and agreement with the following conditions:

_____ I have obtained my client's consent by informing them of risks and benefits, and have offered therapeutic services to them regardless of their willingness to grant consent for the use of their PHI for my purposes:

_____ Client Name

_____ Client Name

_____ Client Name

_____ Client Name

_____ I understand that it is my responsibility to protect the confidentiality of this PHI by using a locked briefcase for transporting it from the clinical site to the presentation venue, and storing it in a secure manner when not in use.

_____ If the consent for use of PHI is for a limited period of time, I will return videotapes to the clinic after the use for which consent has been granted.

_____ If the consent for use of PHI is for a limited period of time and has been on a computer hard drive, flash drive, or other media storage, I will erase and/or destroy the PHI so that I am no longer in possession of any PHI.

_____ I have discussed my possession of, and consent for PHI with my supervisor.

I hereby agree to all of the above conditions related to obtaining consent for use of PHI, storage, transportation, and final disposition of PHI. I understand that failure to comply with these conditions constitutes behavior that may be prosecuted in a court of law.

_____ _____
Intern/Trainee signature Date

_____ _____
Supervisor signature Date

_____ _____
Director of Clinical Training, Counseling & Family Science Date