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Therapeutic assessment with couples: An intervention to enhance healthy relational and marital practices

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Therapeutic Assessment with Couples:
An Intervention to Enhance Healthy Relational and Marital Practices

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Table of Contents

List of Tables

Abstract

This dissertation details the creation and implementation of a new model of psychological assessment with partnered dyads, Therapeutic Assessment with Couples (TAC). As research continues to document the link between individual and relational/marital well-being (Jaremka, Glaser, Malarkey, & Kiecolt-Glaser, 2013; Kiecolt-Glaser & Newton, 2001; Sollenberger, et al., 2013), the cultivation of healthy practices from an interpersonal, romantic context becomes ever more crucial. Reviews of the shifting landscape of love and marriage in the U.S. are offered, along with compelling data concerning both the positive and negative implications associated with processes of partnering as well as relevant literature concerning Collaborative / Therapeutic Assessment models and techniques. Measurements within the assessment battery are then introduced, as is the four-session outline of the intervention. Based on constant comparison and word count analyses, the TAC program appears to enhance relational and marital practices vis-à-vis increased awareness of self, other, and relationship, various forms of intimacy, communication skills, and feelings of hope. Findings indicate that the TAC method can be utilized with a range of couples (i.e. non-distressed and distressed) presenting with various treatment goals, such as relationship enhancement, conflict identification, and / or tailored guides to begin couples therapy. Following the presentation of results, implications, limitations, and future directions are discussed.

Keywords: therapeutic assessment, couples, couples therapy, healthy relational / marital practices, intimacy, communication, awareness, hope

Therapeutic Assessment with Couples:

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Love and Marriage Today

The plate tectonics of the romantic relational landscape have been significantly shifting over the last 50 years, and continue to do so. Developments in Western society (e.g., technologies of connection, more women in the workforce, the revival of cities, legalization of same-sex marriage, distant extended families, etc.), and the implications of such changes have placed increasing primacy on the companionate relationship, the pressure of which has led to an ever rising standard of quality to which ordinary couple relationships are routinely compared (Odell, 2000). As Finkel (2017) notes, "In contrast to our predecessors, who looked to our marriage to help us survive, we look to our marriage to meet our needs for passion and intimacy and to facilitate voyages of self-discovery and personal growth" (p. 13). As we sit in this "self-expressive era" of coupling, we often expect that our partners fulfill the many and varied life domains that constitute a modern and expansive conceptualization of well-being: physical, emotional / psychological, interpersonal, professional, vocational, financial, sexual, meaning-making, spiritual, and so forth.

Despite these demands, many individuals are not able to put forth the time and energy required to make partnerships work at such a high level of functioning. Researchers have suggested that the amount of time married persons spend alone with their spouses has decreased over the last several decades, as more individuals engage in intensive parenting and participate in the paid labor force (Amato, Booth, Johnson, & Rogers, 2007; Bianchi, Robinson, & Milkie, 2006). For example, Dew (2009) found that

couples (married dyads with and without children) in a 2003 cohort lost, on average, 45 to 75 minutes of spousal time on weekdays in comparison to their 1975 counterparts.

When we look at the consequences of many Western developments, we again see a significant fluctuation in dynamics present within coupling partners. According to the Pew Research Center, one-in-six newlyweds (17%) were married to someone of a different race or ethnicity in 2015, about four-in-ten U.S. citizens (39%) who have married since 2010 have a spouse who is in a different religious group, and four-in-ten new marriages involve remarriage. From a more general perspective, the median age of first marriage has reached its highest point on record (30 years for men and 28 for women; Geiger & Livingston, 2018). Although the divorce rate for older U.S. citizens (age 65+) has roughly tripled since the 1990s, evidence also indicates that divorces in the U.S. are declining from a peak of nearly 50% in the 1980s to around 40% at present, but for a smaller and more select group of individuals who have the means and inclination to be married (e.g., Luscombe, 2018; Stepler, 2017).

While the divorce rate seems to have plateaued for most of the population within the last decade, the marriage rate for adults over 18 continues to decline from 72% in 1960 to 50% in 2015 (Geiger & Livingston, 2018). This trend captures two facts: 1) many Americans are marrying later in life; and 2) the share of Americans who never marry has risen. Many of those who do not marry are of lower socioeconomic status, as marriage rates now negatively correspond with education (i.e., as one's educational background decreases, so does the likelihood of being married; Parker & Stepler, 2017). Meanwhile, the number of U.S. citizens cohabiting with a significant other is on the rise, with 18 million unmarried partners living together in 2016, up 29% since 2007 (Geiger &

Livingston, 2018).

Not only has the terrain of martial and romantic relationships shifted, the categorization of what it means to be a "couple" has also changed. Conceptually, the traditional couple, two opposite-gender, adult parents in a committed, marital relationship with two children, no longer captures the majority of who constitutes romantic dyads and their families. Only 25% of all domiciles in the United States are composed of this more conventional configuration. The other 75% are composed of singles, long-term partners, remarried individuals, persons not married but living together, same-gender couples, consensual non-monogamous marriages / relationships, children living with grandparents, grandparents living with adult children, adult children living with their parents, and / or children alternating in living with divorced parents (Casper & Hofferth, 2007; L'Abate, 2012; Matsick, Conley, Ziegler, Moors, & Rubin, 2014).

Marital and Relational Health

Despite major alternations in the U.S. love landscape, what is not changing, however, is the fact that coupling and all its associated processes, particularly child rearing, are fundamental and legitimate public health issues. Although "relationship ill health" – defined as "the serious physical, mental, and emotional effects associated with marital [relational] distress" (Sollenberger et al., 2013, p. 197) – does not correspond with a Western and individualized approach to health, abundant evidence suggests that our partnering relationships are intimately intertwined with every other aspect of our overall well-being (Jaremka, Glaser, Malarkey, & Kiecolt-Glaser, 2013; Kiecolt-Glaser & Newton, 2001). This intertwinement has the potential to work in profound favor of healthy couples, and wreak havoc on dyads in distress.

Positive Implications of Healthy Romantic Relationships

In addressing the positive implications of healthy romantic relationships, it may be helpful to begin with the Michelangelo phenomenon, a model that integrates concepts from interdependence theory and the self tradition to illuminate the means by which close partners can promote one another's movement toward ideal-self goals (Drigotas, Rusbult, Wieselquist, & Whitton, 1999). Although people sometimes achieve ideal-relevant goals solely through their own actions, the acquisition of new skills, traits, and resources in meeting ideal-self goals is also shaped by interpersonal experiences (Higgins, 1987; Markus & Nurius, 1986). More specifically, positive change is most probable, powerful, and enduring in highly interdependent relationships, as the mutual dependence involved in close romantic partners provides good opportunities for exerting strong, frequent, and benevolent influence across diverse behavioral areas (Kelley et al., 1983; Kelley et al., 2003). For example, Kelley and colleagues (2003) write that:

> …when increases in interdependence involve (a) temporally extended interaction in situations with (b) moderately to highly corresponding interests, such increases tend to be accompanied by shifts in self-concept involving movement from "me-ness" to "we-ness." Such shifts in self-representation have been examined in the empirical literatures regarding cohesiveness (e.g., Cota, Evans, Dion, Kilik, & Longman, 1995), self-other merger (e.g., Aron & Aron, 1997), cognitive interdependence (e.g., Agnew, Van Lange, Rusbult, & Langston, 1998), and commitment (e.g., Rusbult, Drigotas, & Verette, 1994)…members of cohesive, committed dyads and groups frequently take action to sustain stable membership (e.g., Levine & Thompson, 1996), engage in costly or effortful prosocial acts to

> benefit the group or dyad (e.g., Batson, 1998), and exert pressure on one another to conform to group or dyad-relevant roles and norms (e.g., Cialdini & Trost, 1998). (p. 139)

As noted, romantic relationships with a commitment to ongoing interdependence can yield a positive sense of togetherness that impacts both partners and the relationship itself.

Numerous studies have revealed that partner enhancement is beneficial to both individual and relational health. For example, when partners perceive one another more positively than each person perceives him or herself, relationships tend to function better (Murray, Holmes, & Griffin, 1996). Along similar lines, one's experience within a romantic partner during adolescence or adulthood has the ability to alter the internal working models of attachment styles (Bowlby, 1988; Bretherton & Munholland, 1999; Davila, Karney, & Bradbury, 1999). The act of falling in love is also correlated with increased change in one's self-concept, increased diversity of domains included in the self-concept, and increased self-esteem (Aron, Paris, & Aron, 1995). Fincham, Stanley, and Beach (2007) note that "forgiveness (a transformation of motivation), commitment (a powerful influence on motivation), valuing sacrifice (a potent means of shifting the cost / reward ratio and so influencing motivation), and sanctification (tying marital behavior to a broader motivational system)" (p. 282) are significant constructs that should be further examined concerning their positive impact on those in romantic relationships. Lastly, having supportive, loving, and responsive partners enables us to confront difficult but important truths about who we are (Caprariello & Reis, 2011; Kumashiro & Sedikids, 2005; Oishi, Krochik, & Akimoto, 2010; Weeks & Pasupathi, 2011). In short, as this

brief overview indicates, the transformative capacity of love, particularly within the context of marriage, is a well-documented phenomenon.

Negative Implications of Unhealthy Romantic Relationships

Given that the lifetime probability of divorce in the United States is between 40% and 50%, and about 20% of committed couples are experiencing significant distress at any given time (Cherlin, 2010), a large percentage of our population is impacted by the many risks correlated with the effects of divorce and relationship stress. Though several studies note that divorce may have positive implications (Bourassa, Sbarra, & Whisman, 2015; Hasselmo et al., 2018), more often than not, divorce – conceptualized as a process rather than a discrete event – involves a significant amount of conflict and distress for both adults and children. For adults, Amato (2000) documents the following negative consequences of divorce: an increase in disruptions in parent-child relationships, continuing discord between former spouses, loss of emotional support, economic hardship, difficulties with solo parenting, and an increase in other negative life events, such as moving. Separated and divorced individuals also have a heightened risk for physical and mental illness compared to their married counterparts (Hughes & Waite, 2009; Sbarra & Nietert, 2009). Marital separation and divorce are even associated with increased risk for early death, the magnitude of which rivals many well-established public health factors (Sbarra, Hasselmo, & Nojopranoto, 2012).

Physiological Variables. Even if one's post-divorce reality is headed in a healthy and positive direction, most pre-marital separations processes involve conflict and hostility, the impact of which may be profound at multiple levels of analysis, from economic to physiological. Regarding the latter implications, Burman and Margolin

(1992) argue that the most convincing way to document a causal relationship between marital functioning and health status is to first confirm that marital interaction had direct effects on physiological processes and then show that individuals who exhibited physiological changes are more likely to develop health problems. This rigorous approach to analyzing cause and effect is difficult to replicate, which means that few studies examine the direct links between relationship health to physiological change to morbidity.

Although direct effects on etiology have yet to be demonstrated using Burman and Margolin's (1992) "gold standard" approach to analysis, Kiecolt-Glaser and Newton (2001) report that, "marital functioning unquestionably has consequential influences on symptom expression (a key component of disability)" (p. 491). These authors propose that the marital interaction literature could be examined with an alternative question: "Are the physiological alterations that have been demonstrated to date large enough to have clinical significance?" (p. 491). The answer is a resounding, "yes," particularly concerning the relationship between marital functioning and health status illnesses that have immunological and cardiovascular components due to the endocrine system's involvement in the development of stress-related disease processes. Kiecolt-Glaser and Newton (2001) report that, "Cortisol facilitates the vasconstrictive effect of catecholamines; accordingly, the combination of the catecholamine and cortisol response is important for pathogenesis in cardiovascular disease...and immunological dysregulation" (p. 492). Indeed, the consequences of relationship discord include an amplified risk for inflammation-related disorders such as metabolic syndrome (Gallo et al., 2003), diabetes (Joseph, Kamarck, Muldoon, & Manuck, 2014), poor wound healing

(Kiecolt-Glaser et al., 2005), as well as depression (Beach, 2014; Whisman & Bruce, 1999). Hostile behaviors are also related to alterations in immunological and cardiovascular systems (Ewart, Taylor, Kraemer, & Agras, 1991; Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Orth-Gomér et al., 2000; Zhang & Hayward, 2006), and poorer health overall (Burman & Margolin 1992, Kiecolt-Glaser & Newton, 2001). Similar to negative health outcomes associated with processes of divorce, relational conflict also is associated with increased risk for abuse of partners (O'Leary & Cano, 2001) along with alcohol problems (Murphy & O'Farrell, 1994).

Gender as a Moderating Variable. More specifically, the physiology studies of marital interaction provide convergent evidence that gender is an important moderator from negative marital conflict behaviors to physiological functioning. The impact of partner conflict and divorce are associated with a spectrum of negative health outcomes for both men and women in varying ways. For example, many studies show that women's emotional reactivity and physiological changes following marital conflict show greater persistence than men's (Kiecolt-Glaser, et al., 1993; Kiecolt-Glaser, et al., 1997; Kiecolt-Glaser & Newton, 2001; Lorenz, Wickrama, Conger, & Elder, 2006; Malarkey, Kiecolt-Glaser, Pearl, Glaser, 1994). Similarly, relationships between physiological change and negative behaviors are typically stronger for women than for men (Ewart et al., 1991; Fehm-Wolfsdorfetal, Groth, Kaiser, & Hahlweg, 1999; Kiecolt-Glaser, 2018). Lastly, research consistently demonstrates that the economic consequences of divorce are greater for females than for males (Bianchi, Subaiya, & Kahn, 1999; Hao, 1996; Marks, 1996; Sharma, 2015; Teachman & Paasch, 1994).

Though the relationship between a variety of negative health outcomes and marital quality is stronger among women than men, separated men are at an increased risk of developing suicidality during the marital separation process when compared to separated women, even after adjusting for age, education, employment, and children with the separated partner (Kõlves, Ide, & De Leo, 2010). More specifically, divorced males are 9.7 times more likely to kill themselves than comparable divorced females (Kposowa, 2003). However, it should be noted that although females are about 1.5 times more likely than males to attempt suicide, males are about 3.5 times more likely to be "successful" in their suicidal attempts (American Foundation for Suicide Prevention, 2020). In short, although females may experience a wider range of deleterious impacts from divorce (e.g., chronicity of economic, emotional, and physiological effects), epidemiological studies also illustrate that the protective factors of marriage are notably stronger for men than for women (Berkman & Breslow, 1983; House, Landis, & Umberson, 1988; Litwak & Messeri, 1989; Umberson, 1992), findings that interact further with overall rates of suicide lethality.

Impact of Conflict and Divorce on Children. Prior to addressing the impact of partner conflict and divorce on children, we make a clear connection between dyadic well-being and children outcomes. Abundant evidence indicates a robust relationship between the quality of the parenting dyad and offspring adjustment (Buehler et al., 1997; Cummings & Davies, 2010; Emery, 1982). In particular, relational / marital discord is related to nearly every domain of children's functioning, from social and emotional problems (Amato, 1986; Cummings, Schermerhorn, Davies, Goeke-Morey, & Cummings, 2006; Stroud, Meyers, Wilson, & Durbin, 2015), to impairments in cognitive

functioning (Grych & Fincham, 2001), to disruptions in physical health and biological functioning (Buckhalt, El-Sheikh, Keller, & Kelly, 2009; Cherlin, et al., 1991; El-Sheikh, Buckhalt, Mize, & Acebo, 2006).

What phenomenon explains such relationships? The spillover hypothesis refers to "the transfer of mood, affect, or behavior from one setting to the next" (Almeida, Wethington, & Chandler, 1999, p. 49). In the context of family interactions, spillover occurs when tension, negative affect, or conflict in the parenting dyad is transferred to tension, negative affect, or conflict in the parent-child dyad. Spillover relations have been reported in both cross-sectional (Nelson, O'Brien, Blankson, Calkins, & Keane, 2009; Ponnet et al., 2013) and short-term longitudinal studies (Davies, Sturge-Apple, Woitach, & Cummings, 2009; Gerard, Krishnakumar, & Buehler, 2006; Lindahl, Clements, & Markman, 1997; Shek, 1998). Overall, then, positive parent-child interactions are strongly associated with positive child outcomes (Erel & Burman, 1995; Feinberg, 2003; Krishnakumar & Buehler, 2000; Linville, et al., 2010). In this regard, and harkening back to the discussion of gender, evidence suggests that fathers may be more vulnerable to transferring their mood and behavior from the parenting partnership to the parent-child relationship as evidenced by stronger spillover relations for fathers compared with mothers (Coiro & Emery, 1998; Cummings, Goeke-Morey, & Raymond, 2004; Nelson et al., 2009; Stroud, Durbin, Wilson, & Mendelson, 2011).

The impact of partner conflict and divorce (among other variables) on children was most famously captured by the Adverse Childhood Experiences (ACEs) study. This investigation assessed the long-term impacts of abuse and household dysfunction regarding a variety of health outcomes for adults (Felitti et al., 1998). Findings show that

almost two-thirds of study participants reported at least one ACE, and one in five persons reported experiencing three or more ACEs, important findings since the higher the number of ACEs, the greater the risk for the following outcomes: alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease, liver disease, poor work performance, financial stress, risk for intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, unintended pregnancies, early initiation of smoking, early initiation of sexual activity, adolescent pregnancy, risk for sexual violence, and poor academic achievement (Felitti et al., 1998).

Overall, a large number of studies continue to find that children with divorced parents score lower than children with continuously married parents on measures of academic success (Astone & McLanahan, 1991; Frisco, Muller, & Frank, 2007; Sun & Li, 2001), conduct (Doherty & Needle, 1991; Simons & Associates, 1996), psychological adjustment (Forehand, Neighbors, Devine, & Armistead, 1994; Strohschein, 2005), self-concept and well-being (Sun & Li, 2002; Wenk, Hardesty, Morgan, & Blair, 1994), social competence (Beaty, 1995; Brodzinsky, Hitt, & Smith, 1993), and long-term health (Hango & Houseknecht, 2005; Tucker, et al., 1997). Most grave are studies that indicate a link between parental divorce and offspring suicide risk (Lizardi, Thompson, Keyes, & Hasin, 2010; Thompson, Alonzo, Hu, & Hasin, 2017). It also should be noted that the above reverberations may not be associated with only the first divorce since statistically speaking, the odds of subsequent marriage dissolution also increases after the first divorce at the rate of 60% to 67% after the second marriage and 73% to 74% for the third dissolution (“Divorce Statistics,” n.d.). Unfortunately, additional parental divorces may

be even more stressful for children than first divorces. For example, participants in Amato and Booth's study (1991) on parental divorce and marital unhappiness who experienced multiple parental divorces appeared to be "generally worse off than respondents who experienced a single divorce" since those with a parental history of multiple divorces had less contact with their own mothers as children as well as greater marital instability and higher rates of divorce as adults (p. 907).

Efficacy of Assessment-Based Interventions

Before introducing the principle procedures of the Therapeutic Assessment of Couples (TAC) program, it may be helpful to provide additional context regarding the efficacy of assessment-based interventions within varied perspectives of couples work (i.e., educational, enhancement, targeted, therapeutic, etc.; Beckerman, 2004; Bradbury, 1994; Busby, Ivey, Harris, & Ates, 2007; Des Groseilliers, Marchand, Cordova, Ruzek, & Brunet, 2013; Fentz & Trillingsgaard, 2016; Kelly, Strassberg, & Turner, 2006; MacNeil & Byers, 2005; Miller, Sovereign, & Krege, 1988; Worthington, McCullough, Shortz, Mindes, Sandage, & Chartrand, 1995).

In terms of setting the stage, couples therapy literature consistently suggests that the outset of couples work should begin with a well formulated assessment of how the couple is functioning, a process that precedes the generation of a treatment plan (Week & Treat, 2001; Long & Young, 2007). Several authors agree that assessment functions as a quick and efficient means of collecting substantial information and data that can assist with clarifying and addressing key issues (Sperry, 2012a). Assessment also helps identify individual, interpersonal, and environmental factors that may affect intervention outcomes (Williams, Edwards, Patterson, & Chamow, 2011), determine which mode of

treatment seems most appropriate for the presenting couple (i.e., primary, secondary, or tertiary), and create shared goals for all involved with the therapeutic process (Floyd, Haynes, & Kelly, 1997).

Overall, several empirical studies indicate that assessment-based programs can help couples understand and attend to their problem areas (Halford et al., 2010), increase awareness of strengths and challenges (Larson, Vatter, Galbraith, Holman, & Stahmann, 2007), improve partner communication, and prevent future relationship problems (Snyder, Cavell, Heffer, & Mangrum, 1995; Snyder, Cozzi, Grich, & Luebbert, 2001). Assessment can also serve an intervention function by actively inviting couples into the process at hand by validating concerns, providing feedback, and engendering hope through shared perspective-taking and more complex thinking about relational processes and prospects (Epstein & Baucom, 2002; Halford, 2001; Sperry, 2012a).

From a more practical point of view, Jordan (2003) notes that assessments of couples also are conducted for purposes of diagnosis and treatment planning. Treatment planning has become increasingly important, as HMOs, PPOs, and insurance companies require that mental health services be more time and cost effective, as well as problem-specific. Additionally, appropriately administered assessment instruments allow individuals to disclose sensitive information (e.g., sexual functioning, suicidal ideation, experience of abuse, etc.), and express their feelings and perceptions about their relationship and / or partner more freely (Lavee & Avisar, 2006). Lastly, evaluations can serve as valuable outcome measures, the use of which is associated with a range of pragmatic benefits: identification of effective treatments, immediate feedback to clinicians and case managers as a source of appropriate action (i.e., termination, treatment

adjustment, or continuance of intervention), and determination of specific changes that will most likely move an unimproved couple toward more positive trajectories (Sperry, 2012b). As Sperry aptly summarizes, "Whatever their perspective, clinicians must contend with the reality that therapeutic accountability and clinical outcomes assessment in particular have become a core feature of clinical practice today and will be in the future" (p. 116).

Research Questions

In this project, we propose that a couple's participation in a Therapeutic Assessment of Couples (TAC) program will 1) increase self and other-awareness, 2) facilitate greater intimacy, and 3) enhance relationship satisfaction. Toward such means and ends, a fundamental proposition of the TAC approach is that couples tend to benefit from the illumination of underlying communication and relational patterns that emerge when competing, complementary, or disparate life histories and worldviews are activated and engaged via intimate relational commitments. There are a variety of both "old" and "new" psychological theories and therapeutic approaches that are effective in their focus on the origin, motivation, and sustainment of particular interpersonal processes (see Greenberg & Mitchell, 1983). When individual interpersonal patterning is named and held in a curious and accepting way by both partners, one's ability to understand and be empathetic become easier (Kabat-Zinn, 1994). The problem then becomes, not either person, but the interaction of each individual's intrapersonal processes and interpersonal patterns. In short, the internal problem becomes an external "it." There is empirical evidence documenting that couples who talk about their problems as a shared "it" rather

than projecting consternation and blame are more satisfied following a course of couples therapy (Cordova, Jacobson, & Christensen, 1998).

Our conceptualization of intimacy is informed by Cordova and Scott's (2001) understanding that intimacy is a "behavioral phenomenon" (p. 75), defined as 1) individual behavior (e.g., self-disclosure), 2) interactions between partners (e.g. rewarding of interpersonal vulnerability), and 3) specific feelings (e.g. connection, love, care, etc.). We propose that increased self and other-awareness will facilitate greater expression of all three phenomena, resulting in healthier and more rewarding relational and marital patterns, such as engaging in forms of adaptive communication, enhancing the friendship within the romantic relationship, turning and responding to partner bids, creating shared meaning, and increasing fondness and admiration, among other salutary processes and outcomes (Gottman & Silver, 2015).

Theoretically, intimacy processes are self-perpetuating (Cordova & Scott, 2001). We speculate, therefore, that facilitating intimate events within each TAC session will increase the probability that intimacy processes (i.e., relational and marital healthy practices) will continue to emerge at a higher rate following the intervention itself, both in and out of the therapeutic space. Finally, based on extant literature (Davis & Oathout, 1987; Long & Andrews, 1990; Long, Angera, Carter, Nakamoto, & Kalso, 1999), we propose that increased actions of intimacy will lead to greater relationship satisfaction felt by both individuals who comprise the couple. Various researchers have found that a direct connection exists between marital intimacy and the experience of marital satisfaction (Dandeneau & Johnson, 1994; Greeff & Malherbe, 2001; Merves-Okin, Amidon, & Bernt, 1991; Robinson & Blanton, 1993; Tolstedt & Stokes, 1983; Waring,

1981; Waring & Chelune, 1983). We speculate that this association exists for non-married dyads as well.

Program Goals: Therapeutic Assessment with Couples

Beyond the specific research questions concerning the intervention itself, we believe that the TAC program has the ability to function as a multi-faceted intervention, regarding characteristics of both client population and duration of treatment. Mental health interventions geared toward couples need to be differentiated according to three levels of engagement: primary (educational or enhancement approaches that deal with functional or semi-functional couples), secondary (interventions created for identified, targeted, or at-risk couples), and tertiary (uniquely tailored approaches to guide in-depth work with stressed couples; Cordova, 2014; L'Abate, 2012). Oftentimes, couples are seeking external assistance with their relationship when distress is already at secondary and tertiary levels. Furthermore, many couples who suffer from severe relational dysfunction never seek treatment at all (Johnson, Stanley, Glenn, Amato, Nock, & Markman, 2002). Following an approach similar to Cordova's (2014) Marital Checkup, we propose that this therapeutic program will successfully attract dyads who are looking to engage in preventative relational health practices, those in need of targeted interventions, and couples experiencing global relational hardship.

In terms of duration, the course of the TAC program will depend largely on relationship functioning as captured by the assessment data. In anticipating a range of presenting concerns, we developed two tracks through which this intervention can be used therapeutically. The first track consists of four-sessions with relatively stress-free couples who are interested in relational enhancement. The second track functions as a

means of beginning couples therapy, with evaluation results being shared across a longer span of time alongside a more traditional approach to couples therapy that is committed to attending to processes and goals unearthed via assessment.

Lastly, this project was created in order to fill an existing gap in couples literature regarding what couples interventions are considered to be efficacious versus effective (Pinsof & Wynne, 2000). As summarized by Halford, Pepping, and Petch (2015):

> While the randomized controlled trial has long been regarded as the gold standard for establishing the effects of a treatment (Nezu & Nezu, 2008), it is also evident that interventions that are efficacious in randomized trials do not necessarily translate well into effective routine practice (Society for Prevention Research, 2004). (p. 35)

Along similar lines, the current approach essentially is a pilot project that suits the initial development of the TAC program. New or experimental treatment packages should be tested using single case or small *N* designs to first determine the treatment's utility at an individual level, allowing time and space for modifications to treatment components to be made prior to engaging in randomized control trials, if such research is indicated (Baucom & Crenshaw, 2019).

Lavee and Avisar's (2006) study reveals that the majority of marital therapists in the U.S. do not use any kind of structured assessment method when beginning an intervention with new dyads. Instead, most practitioners appear to depend primarily on clinical interviews. Such data are consistent with previous findings that clinicians tend to rely, primarily, on their own judgments regarding the nature and status of couple relationships as well as the interventions that they subsequently implement (Bray, 1995;

Floyd, Weinand, & Cimmarusti, 1989). While clinical judgment is integral to the therapeutic process, there are many well-documented types of inferential bias to which all therapists are susceptible: availability and representativeness heuristics, fundamental attribution error, anchoring, prior knowledge, labeling, confirmatory hypothesis testing, and reconstructive memory (Morrow & Deidan, 1992).

In order to avoid such pitfalls, the use of empirically validated assessment to complement clinical judgement is recommended strongly, mainly because such instrumentation has the ability to improve the accuracy, generalizability, and success of couples treatment. In the current approach, a mixed methods design was employed as a way of bridging extant gaps in research and practice by gathering both qualitative and quantitative data in an ecologically valid manner, which also helps illuminate a more comprehensive understanding of complex processes at play within the therapeutic context (Coates, Hanson, Samuel, Webster, & Cozen, 2016; Weisner & Fiese, 2011).

Program Pillars: Therapeutic Assessment with Couples

Meyer and colleagues (2001) note a distinction between psychological testing and psychological assessment. As Coates et al. (2016) elaborate:

> …psychological testing is a categorical and definitive process involving the application of descriptive meaning to scale scores. Psychological assessment, in contrast, includes considerations such as the clinician's interpretation of data, the integration of life history, and the inclusion of other variables and information in order to strengthen nosological scaffolding and address referral questions and recommendations in a rich and ecologically valid manner. (p. 373)

TAC, as a program of psychological assessment, facilitates processes through which clinicians continually invite coupled individuals to reflect on why and how they experience themselves, others, and the larger world as they do. Such process-rich assessment allows both partners to engage in "phenomenological knowing," an opportunity to come to terms with the "various dimensions, inner tensions, contradictions, and potentialities" (p. 130) that are operative for both themselves and their significant other (Bradford, 2010). This methodology encourages the sharing of meaningful reactions to and feedback about assessment results (both positive and negative). It also conforms to the principles underlying informed consent, requiring clients to be more active participants throughout the evaluation of their relationship (Levak, Siegel, & Nichols, 2011; Pawlowski, 2002).

Psychological Assessment as a Therapeutic Intervention

Both Fischer's Collaborative Assessment (CA; 2000) and Finn's Therapeutic Assessment (TA; 2007) are models that promote client introspection. Though C / TA models differ in their degree of procedural flexibility, each approach is dedicated to working with clients in better understanding life meanings and facilitating transformative change through the assessment process (Fischer, 2000; Finn, 1996; Finn & Tonsager, 1992, 1997; Smith, Handler, & Nash, 2010; Tharinger et al., 2008). More specifically and by design, clinicians who in engage in Therapeutic Assessment of Couples (TAC) as described in more detail below – like those who employ C / TA in general – are mindful of their professional roles and obligations, but also strive to approach their clients with an attitude of mutuality and respect, adopt a relational and process-based stance vis-à-vis psychological assessment, emphasize compassion and curiosity over judgment and

classification, and seek to engage clients flexibly and openly (Finn, Fischer, & Handler, 2012). Such models of "assessment as intervention" serve as seminal guides in the conceptualization of the TAC program's approach to relationship evaluation.

More specifically, the methodologies and philosophies of C / TA models (and others) might be best captured under the aegis of Psychological Assessment as a Therapeutic Intervention (PATI; Coates et al., 2016). The efficacy of PATI models continues to be demonstrated via improvements in mental health and treatment accessibility, alterations in attitudes essential for client change, increased desired change within the therapeutic context, and the generation of a more contextual view of the client, relationships, and presenting concerns (Finn & Tonsager, 2002; Hanson & Poston, 2011; Poston & Hanson, 2010; Tharinger et al., 2008). Though much of the literature with PATI themes demonstrates success with children, adolescents, adults, and families, the use of PATI models with couples has increased over the last decade (Aschieri, Chinaglia, & Kiss, 2018; Cordova, et al., 2014; Finn, 2015; Miller, Cano, & Wurm, 2013; Miller-Matero & Cano, 2015).

Motivational Interviewing

The TAC program also relies heavily on the use of motivational interviewing (MI), as developed by Miller and Rollnick (2002). This directive and client-centered therapeutic technique seeks to motivate clients to alter their behavior by exploring and resolving their ambivalence to change, and then prompting and reinforcing statements of self-change intent (Miller & Rose, 2009; Halford, Chen, Wilson, Larson, Busby, & Holman, 2013). As Cordova (2014) observes, MI invites couples to "lean forward together" in a gesture that joins partners "in relation to the issue at hand with a greater

sense of collaborative cohesion" (p. 43).

Miller and Rollnick (2002) proposed that a person's motivation to change may increase through their engagement in a psychoeducational therapeutic interview designed to clarify the nature of the problem and their emotional relationship with it along with attendant interpersonal implications and applications. This approach is believed to help an individual see an issue about which they might feel ambivalent from a perspective that both validates their ambivalence and clearly connects the person with the undeniable consequences of not changing. MI organically draws a person's attention to the problematic nature of an issue, thus increasing intrinsic motivation to adjust their thoughts, emotions, and / or behaviors accordingly (Cordova, 2014). For several reasons, then, MI helps identity and enhance individual and relational strengths, and is thus a key component of the TAC program, specifically during the single and conjoined intake interviews and the co-construction of integrative summaries and recommendations for the TAC report that emerges from this process.

Assessment Battery: Therapeutic Assessment With Couples

Just as the TAC intervention is multifaceted in its target population and duration of treatment, the assessment battery itself is one created with multidimensionality in mind. No single method provides a complete picture of relational functioning. As such, a more comprehensive evaluation of presenting partnerships should be obtained through the utilization of a more expansive battery (Cromwell, Olson, & Fourinier, 1976; Cromwell & Peterson, 1983; Olson, 2000). Lavee and Avisar (2006) write, "Several assessment methods are used in couple and family therapy, including interviews, qualitative assessment methods, behavioral observations, clinical rating scales, and self-

report instruments" (p. 234). TAC capitalizes on the range of types of measurements found in relational therapy by including the following in its core battery of assessments: Couples Questionnaire (CQ; Kenny, Shealy, & Henriques, 2018), Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1997), Beliefs, Events, and Values Inventory (BEVI; Shealy, 2016a), and the Sentence Completion Series: Marriage (SCS:M; Brown, & Unger, 1992; adapted as Sentence Completion Series: Romantic Relationship (SCS:RR)).

Couples Questionnaire

The Couples Questionnaire is an extended life information survey that queries about the dyad's relationship, current concerns, and strengths, as well as individual histories, symptoms, strengths, and current functioning (see Appendix A). The structure and content of the CQ is informed by extensive clinical usage and was modified for this project to facilitate PATI-type couples collaboration. The majority of questions are posed open-endedly as to engage client participation and self-reflection, allowing clients to be "experts" on themselves. The therapist actively reviews the questionnaire with partners during the first session's single and conjoined interviews. As mentioned, motivational interviewing is a technique used to explore the contents of this intake.

While parts of the CQ are dedicated to evaluating relational issues, the bulk of the survey is purposefully geared toward evaluating individual partners. Representative surveys of the U.S. population show a moderate-to-strong association between relationship distress and common psychological disorders in partners – notably depression, anxiety disorders, and drug and alcohol abuse (Whisman, 2007). Thus, it should not be a surprise that there exists a high rate of individual disorders in those who present for couples therapy. Baucom, Whisman, and Paprocki's (2012) review

demonstrates that adapting couples therapy to address psychopathology in one partner can enhance outcomes in terms of both relationship distress and individual symptomology. Such literature illustrates the importance of fully assessing partner-specific developmental histories, interpersonal landscapes, and self-concepts.

Since some of the strongest data indicate that relational conflict may be both a precursor and a consequence of alcohol and drug abuse (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998), the CQ includes questions related to individual and familial substance use. Studies of intimate partner violence in couples seeking couple therapy show that 36–58% of couples report male-to-female violence in the past 12 months, and 37–57% report female-to-male violence in the past 12 months (Jose & O'Leary, 2009). Given these statistics, it is recommended that screening and assessment guidelines for intimate partner violence be available in the forms of both self-report and partner report as to allow individuals to self-disclose in safety (Stith, Penn, Ward, & Tritt, 2003). Thus, the CQ (and along with the Marital Satisfaction Inventory-Revised) includes several questions concerning the presence of intimate partner violence.

Lastly, the CQ provides space for individuals to write about their strengths, a practice that has been shown to decrease stress, and increase self-esteem, vitality, and positive affect (Seligman, Steen, Park, & Peterson, 2005; Wood, Linley, Maltby, Kashdan, & Hurling, 2011). Including these positive traits within the written report offers a multitude of benefits, including helping clients to recognize "positive aspects to [their] ongoing life issues, recalling some previous coping successes (i.e., benefit reminding; Tennen & Affleck, 2002), and reclaiming some of the personal worth that may have been depleted" (Snyder, Ritschel, Rand, & Berg, 2006, p. 42) Lastly, conducting and writing a

balanced report is likely to facilitate the cultivation of clients' hopes, a process which has been shown to have a clear relationship with having a stronger therapeutic alliance (Horvath & Greenberg, 1989; Magyar-Moe, Edwards, & Lopez, 2001; Snyder et al., 1991).

Marital Satisfaction Inventory-Revised

Bagarozzi and Sperry (2012) suggest that couples assessment should begin "…with the therapist selecting some tried and true, empirically tested measure of relationship quality to get a fairly accurate appraisal of the couple's level of distress and dissatisfaction" (p. 152). The Marital Satisfaction Inventory-Revised serves the purpose of broadly assessing a couple's romantic relationship, married or otherwise. Each partner responds to 150 true–false items (or 129 true–false items if they have no children) written at a 6th grade reading level. This evaluation takes between 20 and 25 minutes to complete. Each partner's results are displayed on a single, comparative profile that provides a cutoff frame in which there is no distress, moderate distress, and / or severe distress concerning each of the 13 subscales: global distress, affective communication, problem-solving communication, aggression, time together, disagreement about finances, sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children, and conflict over child rearing.

There exist many relationship assessments, with some of the more popular ones being the Revised Dyadic Adjustment Scale-Revised, Couple Satisfaction Index, and Locke-Wallace Marital Adjustment Test. We chose to select the MSI-R for a variety of reasons. The MSI-R was standardized on 1,020 couples stratified across age, geographic location, education, and ethnicity with reliability coefficients that suggest its scales are

relatively stable over time. Excluding the inconsistency scale, the test–retest reliability coefficients range between .74 and .88 with a mean of .79 (Snyder, 1997). This self-report inventory can be used to assess the nature and extent of conflict and distress within both traditional and nontraditional couples (Means-Christensen, Snyder, & Negy, C, 2003; Snyder et al., 2004). The MSI-R is also available in Spanish, several studies of which have validated its intra-lingual validity and reliability (Negy & Snyder, 2000; Negy, Snyder, & Diáz-Loving, 2004; Reig-Ferrer, Cepeda-Benito, & Snyder, 2004; Valenzuela & Caamano, 2011). The visual profiles assist with client comprehension as they clearly indicate any differences in each partner's perceptions of the nature and extent of conflict within the relationship. Lastly, the MSI-R serves as a secondary means of screening for intimate partner violence due to the risk that undetected violence has on individual partners.

Beliefs, Events, and Values Inventory

As will become clear from the below results, the Beliefs, Events, and Values Inventory (BEVI), as the second measure in this battery, emerged as a particularly salient and facilitative test in the context of the TAC intervention. Many assessment-based, couples interventions at primary, secondary, and tertiary levels, focus on surveying and addressing shared, relational domains. However, since couples are comprised of and created by single persons, psychological factors affecting individuals are important in assessment. Successfully changing a dyad requires that you understand each partner within the system (Williams et al., 2011). TAC is unique in that it responds to this notion by comprehensively assessing both persons within the dyad, the results of which are then presented via a comparative couple profile.

The BEVI is a web-based, analytic tool that examines, from a mixed methods approach, how and why individuals come to see themselves, others, and the larger world as they do (e.g., how life experiences, culture, and context affect beliefs, values, and worldviews). This measure also considers the influence of such processes across multiple aspects of human functioning (e.g., transformational learning, being in relationships, personal growth, emotional / attributional processes, pursuit of life goals, etc.). The BEVI consists of 185 items with a four-point scale (Strongly Agree, Agree, Disagree, and Strongly Disagree), and takes approximately 30 minutes to complete. Formal evaluations of the BEVI suggest it is not face valid (Shealy, 2004, 2015), meaning that it is has the ability to "…tap into psychological phenomena and emotional dynamics that are readily susceptible to cognitive screening and impression management processes" (Shealy, 2016a, p. 144).

This standardized and mixed methods measure has two validity scales, three experiential reflection items, and 17 construct scales, the latter of which are grouped into the following domains: formative variables, fulfillment of core needs, tolerance of disequilibrium, critical thinking, self access, other access, and world access. Assessment results can be translated into multiple types of scale scores and / or written reports for individuals, couples, families, groups, communities, organizations, and institutions (About the BEVI, 2020). The TAC program has a couple review a visual report in which scale scores of each partner are set alongside one another in a comparative format. The scale scores are presented via a series of colored bars along with a number within each bar, the number of which corresponds to the percentile score, a number between 1 and 100, for each individual respondent (Shealy, 2016b).

The goal with BEVI assessment is to understand the *why's* behind the *what's*, which are illuminated through one comprehensive, integrative, and depth-based measure. For example, why is there such a discrepancy concerning XX and XX's capacities to communicate affectively? As Halford and colleagues (2015) write:

> A common challenge in couple therapy is that distressed couples tend to attribute relationship problems to stable, negative characteristics of their partner (Bradbury & Fincham, 1990; [Blanchard-Fields, Hertzog, & Horhota, 2011; Brody, Arias, & Fincham, 1996; Manusov & Harvey, 2001; Moskowitz, 2005]). Furthermore, holding these partner blaming attributions is associated with couples being unable to identify specific things they can do to enhance their relationship (Halford, Lizzio, Wilson, & Occhipinti, 2007). Benson, McGinn, and Christensen (2012) argue that a common element to evidence-based couple therapy is altering the couple's view of the presenting problem to be less partner blaming and to become more objective, contextualized, and dyadic. It is argued that such a change in attributions assists partners to commit to making individual efforts to enhance the relationship (Halford, 2001). (p. 38)

In this regard, the BEVI served as both an important source of assessment information as well as a facilitative intervention by illuminating a dyadically focused and shared conceptualization of the couple relationship and its associated problematic and ameliorative patterns. It does so by helping all involved to understand better how each partner's beliefs and values are acquired as well as the intra- and interpersonal implications of their maintenance. In this way, this BEVI is highly congruent with, and facilitative of, PATI's emphases on the activation of deep and sustained self / other

reflection (Finn, 2007; Hanson, Claiborn, & Kerr, 1997).

Sentence Completion Series: Marriage / Romantic Relationship

The final measurement for the TAC battery is the Sentence Completion Series: Marriage / Romantic Relationship. The Sentence Completion Series is a semi-projective method of gathering information associated with current client concerns and specific areas of distress. The test has 50 sentence stems and eight different content areas – the marriage content area is used in the TAC battery (the language of which has been slightly modified for same-gender partnerships). Rogers, Bishop, and Lane (2003) posit that, "The indirect means of sentence completion measures may permit a more emotionally engaged and less guarded production of information, which may be useful in initial assessment for the formulation of treatment goals and direction in psychotherapy" (p. 241). The popularity of sentence completion measures is due to ease and speed of administration, acceptability to clients (Aiken, 1989; Katz, 1985), and flexibility and adaptability to a wide range of psychological concerns, theories, and settings (Aiken, 1989). According to Holaday, Smith, and Sherry (2000), the open-ended nature of the items on these tests permit the production of a wider range of responses pertinent to diagnosis, treatment planning, and report writing compared to other projective or personality tests.

Because there exists variability concerning the scoring and use of sentence completions in general (Aiken, 1989; Holaday et al., 2000; Lah, 1989), we briefly explain the TAC program approach to scoring the SCS:M / RR. The primary therapist utilized an inferential approach, using client responses, information gathered from other resources, and expertise regarding relevant psychological process to generate the most salient

themes (referencing the Topic Groups offered by the test developers) and response styles or patterns. Striking responses, often highlighting "situational, historical, or psychological difficulties" (p. 4), were discussed with the couple during the informing session (Brown, & Unger, 1992).

Additional Measures

The TAC program followed guidelines offered by Bagarozzi and Sperry (2012) concerning concluding operations of the assessment process:

> The fourth and final step in this procedure is refinement. Specific instruments are selected that can be used for in-depth analysis and exploration of the problems, conflicts, and concerns included in a particular category. Depending on the breadth and scope of a given category, more than one measure may be required if coverage is to be adequate, if not comprehensive. (p. 153)

Fortunately, there is no shortage of empirically validated measures that assess nearly every component of intimate relationships, including their functional aspects (Odell, 2003). The following are just a sampling of what types of measures exist concerning romantic partnerships: Areas of Change Questionnaire, Intimacy Needs Survey, Sexual Desire Inventory, Justification for Extramarital Involvement Questionnaire, Trust Scale, Emotional Sensitivity Scale, Substance Abuse Subtle Screening Inventory-3, Revised Conflict Tactics Scale, Meaning of Sexual Behavior Inventory, and Marital Instability Index.

We view this step as an additional, and at times, necessary, part of the TAC program. For example, the primary therapist in this study administered the Gay and Lesbian Relationship Satisfaction Scale (Belous & Wampler, 2016) to two participating

dyads as to account for the stigma and lack of social support that same-gender couples often experience compared to those in opposite-gender partnerships (Frost, 2011; Otis, Rostosky, Riggle, & Hamrin, 2006). While quaternary evaluations may be included in the initial packet sent to clients prior to the first session, more often than not, specialized measures are administered in subsequent sessions for dyads utilizing the TAC program for secondary and tertiary levels of relational care (i.e., couples therapy). In short, the gestalt represented by TAC measures (i.e., semi-structured intake, domain-specific self-report, quantitative and qualitative evaluation, and a semi-projective method) affords both clients and therapists the opportunity to enter into this intensive and reflective process at multiple and synergistic levels of analysis and engagement.

Participant Demographics

Five couples (i.e., 10 individual partners) participated in this exploratory study. Two of the five were same-gender pairs while the remaining three were opposite-gender dyads. Couples were recruited via informational emailing through several local institutions (i.e., university, church, and hospital). The TAC intervention was advertised as a program to help couples better understand how each of their constellations of values and vulnerabilities interacted within a romantic, relational context. It was proposed that such an understanding would work to facilitate more hopeful and effective relational, marital, and / or familial processes and outcomes over the short- and long-term. We purposefully did not use the words “treatment” or “therapy” in our recruitment materials as “…many people, particularly men, have poor treatment-seeking attitudes and…the concern is that it is difficult enough to get many men to attend to their [relational and] marital health without the added burden of potentially threatening words like *treatment*”

(Cordova, 2014, p. 100). Moreover, we wanted to encourage couple participation from across a range of relational functioning. We posited that even relatively stress-free dyads could benefit from viewing and engaging with TAC as a transformative learning experience.

Inclusion criteria for the study were that couples (both distressed and non-distressed) were in committed relationship. For those who self-identified as distressed, the TAC intervention was offered as a means of starting couples therapy in an informed and thorough manner. For couples who did not endorse relational distress, the program was framed as a means of relationship / marriage enhancement. Participants needed to be able to read and write in English, have a functional mailing address, and access to the Internet. Participants also needed to be available to meet for a minimum of four, face-to-face sessions at a local community clinic, and able to pay $10.00 per session (excluding the intake) for therapeutic services ($30.00 total). The men's mean age was 41 years, with a range from 25 to 57. The women's mean age was 35.7 years with a range from 20 to 52. The mean duration of the relationship was 11.4 years with a range from 19 months to 29 years. Three (60%) couples were married and two couples (40%) were in committed relationships. Lastly, of the ten individuals, two identified as African American, one identified as biracial (African American, Puerto Rican, and Native American), and seven identified as Caucasian.

Intervention Procedure

Pre-Intervention

This study was conducted in compliance with appropriate guidelines and procedures (e.g., IRB, HIPAA). Once initial contact was made with a dyad, including the

scheduling of a first session meeting, we mailed out or arranged a pick-up of the assessment battery. Research has shown, at an elemental level, that immediate previous experience (generally defined as previous test items) influences the various stages of the response process, including the final response itself (Knowles, 1988; Steinberg, 1994; Tourangeau & Rasinski, 1988). In following this line of research, we designed this study to gather information (via our selected assessments) as "cleanly" as possible, meaning, that we opted to have clients take the TAC measurements prior to any "contact" with the intervention itself.

We put together two packets in separate envelopes with a welcoming introductory letter, instructing partners to complete the measures separately, without consulting one another. We emphasized that it would be most helpful if individuals completed the assessments on their own as it would be likely that they would both have different perspectives on their relational concerns and strengths, differences that we would want to be able to address and process. Most couples requested a week to complete all the measurements, estimating that it took two hours to take all four evaluations.

Session #1

One day prior to the first session, participants were emailed a reminder to bring in all of their completed assessments to their scheduled appointment. The initial session consisted of three parts: 1) a 15-minute introduction to the TAC process and the filling out of required community clinic forms; 2) two, individual semi-structured, therapeutic intake interviews as guided by the Couples Questionnaire that each took 40 minutes; and 3) a conjoined semi-structured, therapeutic interview that took about 25 minutes. On average, this first session lasted two hours, and included a strong emphasis on

motivational interviewing techniques.

Prior to reviewing the CQ, we asked each partner to comment on their experience of the TAC battery and reflect on any interesting or surprising features (Finn, 2015). This extended inquiry TA strategy was also used after reviewing scored measures and associated data (Finn, 2007). As with many individual intake interviews, the clinician worked with each partner to identify and explore primary concerns and associated therapy goals, obtain data related to the patient's interpersonal style, social skills, and psychosocial history, and assess current life situation and functioning (Sommers-Flanagan & Sommers-Flanagan, 2014). In reflecting on questions from the CQ that were especially useful for the lead therapist, the following have been identified:

- In your own words, please describe any issues of concern or ways in which you would like to enhance your relationship. If you are citing a relational issue, please provide information about when the problem(s) began, and what (in your opinion) is causing the problem(s). Try and be specific in your answer.
- What areas or topics are most difficult to be open about with your partner? Why?
- What are your biggest strengths as a couple?
- Describe who your biological father is / was like as a person (separate questions existed for "biological mother" and "primary caregiver").
- Describe both your past and present relationship with your biological father (separate questions for "biological mother" and "primary caregiver").
- Please list members who are a part of your family of procreation / romantic relationship (including yourself), write their approximate age, role within the

system from your perspective (i.e., husband, partner, daughter, stepson, etc.), occupation, and two to three words you would use to describe that person.

- What are some of the words important people in your life might use to describe you?
- Is there any relevant information you wish to provide concerning personal and important social demographics (i.e., age / generation, developmental disability, diability (acquired), religion, ethnicity and race, socioeconomic status, sexual orientation, national origin and language, and gender; [Hays (1996)])?
- What expectations do you have concerning this assessment process?

During the conjoined interview, the primary assessor utilized intimacy-promoting techniques adapted from several sources. For example, at the start of the couples interview, the therapist asked each partner to summarize what was shared during their individual sessions. Such summations assisted clients in exercising self-reflective practices and enhanced communication styles, as the therapist was readily available to help with the articulation of difficult topics. As a secondary example, we asked partners about the earliest part of their relationship, including how they met, what attracted them to one another, and, if applicable, stories related to their decision to marry and any associated ceremony. All of these inquiries were adapted from Gottman's (1994) Oral History Interview. Cordova (2014) engages in a similar process and writes that such questions:

> …have a surprisingly therapeutic effect in that answering them can be an affirming and validating experience for partners, even partners in distressed relationships who have become narrowly focused on their problems. These

> questions also have an important assessment dimension in that there is good evidence in the research literature (Buehlman, Gottman, & Katz, 1992; Carrère, Buehlman, Gottman, Coan, & Ruckstuhl, 2000) that how couples tell the story of their early history is predictive of their marital health trajectory. (p. 98)

In addition to such questions, we also asked each partner to name and tell stories about the strengths of both their significant other and their partnership. The therapeutic goal of this technique is to give couples the opportunity to reconnect with their assets, and to spend some time seeing each other through the lens of what they value most, both personally and relationally. In this regard, an essential feature of this first TAC session is to spend some time deliberately considering, acknowledging, and celebrating the individual strengths of each partner and their unique, relational strengths as a dyad.

Toward the end of the session, most often, the therapist would assist both individuals in identifying one or two actions that they would like to take to enhance their relationship over the next two weeks. Again, motivational interviewing strategies were used, including prompting and reinforcing change talk, and helping build each partner's efficacy to make the self-identified changes (Halford et al., 2013). Consistent with an overarching focus on the value of assessment, this first session concluded with the administration of a short feedback form to each partner that evaluated the satisfaction of the session experience while also soliciting suggestions for how processes might be improved going forward (see Appendix B). Such feedback is important because client monitoring has not been routinely incorporated in couples therapy efficacy trials. As such, the TAC approach deliberately integrated "assessment about assessment" into the process. Literature shows that the monitoring of each partner's experience of couples

interventions is an important aspect of preventing attrition and enhancing the therapeutic outcome (Anker, Duncan, & Sparks, 2009; Reece, Toland, Sloane, & Norsworthy, 2010). More specifically, it has been found that when improvement occurs in couples therapy, such improvement tends to occur most strongly in the early sessions (Behrens, Sanders, & Halford, 1990; Doss, Thum, Sevier, Atkins, & Christensen, 2005). We, therefore, were especially committed to closely monitoring the beginning phases of the TAC program.

Session #2

During the two-week span between the first and second sessions, the lead therapist scored both the MSI-R and the SCS:M / RR; the BEVI automatically generates its scores and reports. During this timeframe, the clinician also is responsible for writing up several pieces of the TAC report. As a quick breakdown, the TAC report consists of the following sections:

- Reason for referral
- A list of evaluation procedures and tests administered
- Background Information
    - Initial Presentation – Partner #1
    - Life History – Partner #1
    - Initial Presentation – Partner #2
    - Life History – Partner #2
- Test Results
    - Marital Satisfaction Inventory-Revised
    - Beliefs, Events, and Values Inventory
    - Sentence Completion Series: Marriage / Romantic

Relationship

- Additional measures administered

- Integrative Summary
- Recommendations

Each TAC report consists of five written sections (excluding the list of procedures and assessments). The first provides a client demographic summary and succinct outline of key concerns as expressed by both partners. The second section presents each partner's perspectives of both dyadic and individual issues and strengths as well as brief life histories. The third reports out each person's scores on the assessment measures. The fourth section offers a comprehensive and cohesive synopsis of the primary issues identified in this process, narratives of explanation concerning such issues, and how both personal and relational strengths can be harnessed to cultivate greater awareness, understanding, and intimacy. The final section includes an extensive and co-created list of recommendations (e.g., literature, media, exercises, referral sources) based on what needs to be enhanced within the partnership.

In returning to the assessment / intervention approach, we found it helpful to write up all report sections except the final two during the two-week scoring break. While paper copies of these reports are not given to dyads during the second session, the primary clinician noted that the process of report writing increased their familiarity and confidence in presenting the material. Information gathered from the intake interviews and assessment results can provide both a broad and detailed map concerning clinical diagnoses of existing relational problems, such as commitment to the relationship, emotional expressiveness, attributional tendencies, sexual functioning, shared goals and

aspirations, gender roles and / or role functioning, communication skills and styles, perception of intimacy, conflict management, and so on (Duffy and Chenail, 2012). This written map has been shown to be invaluable to the therapist, clients, and other relevant stakeholders (see also Intervention Procedure: Session #4 and Discussion below).

Though not commonly addressed in the C / TA literature, we purposefully selected measures that had visual aids to help communicate data results. Garcia-Retamero and Cokely (2017) conducted a systematic review of the benefits of visual aids in risk communication for persons with different levels of numeracy and graph literacy. They found that transparent visual aids greatly improved risk understanding in diverse individuals by "encouraging thorough deliberation, enhancing cognitive self-assessment, and reducing conceptual biases in memory" (p. 582). From a more general health outcomes perspective, improvements in risk understanding consistently produced beneficial changes in attitudes, behavioral intentions, trust, and healthy habits. Moreover, visual aids were found to be particularly beneficial for vulnerable populations (Garcia-Retamero & Cokely, 2017). We view our inclusion of visual aids within the TAC assessment battery as adhering to PATI techniques.

The visual profiles offered by both the MSI-R and the BEVI were helpful on two levels: data comprehension and comparative practice. Several clients noted the positive impact that these assessments' visual profiles had concerning the interpretation of test scores. For example, one study participant noted, "It was helpful to see the results mapped out along with the written and verbal explanations of the findings. Having it in picture form combined with explanation and discussion created a deep level of

understanding" (TAC1-M)[1]. Furthermore, a few individuals shared that comparing their scores with their partner's scores was much easier to do when test results were presented in a visual format. For example, one individual (TAC1-F) shared:

> The graphs were extremely helpful in showing the comparison between our scores. They provided a quick visual method to see where there were common points and where there were areas that may need to be addressed. It was more meaningful to see data points that are close together or far apart versus simply seeing numbers listed.

While readability is a commonly noted factor regarding client accessibility, visual profiles may increase the effectiveness of assessment-based interventions as they make findings more accessible by complementing or illuminating feedback that is presented in written or oral form.

While all TAC sessions may be considered interventive, the feedback session most closely aligns with the TA conceptualization of an intervention session (Provenzi, Menichetti, Coin, & Aschieri, 2017):

> Intervention sessions consist of using assessment results to plan and conduct a brief therapeutic intervention with clients, actively engaging them in applying testing data to real-life challenges (Michel, 2002). The aim of the intervention session is to provide clients with the opportunity to play with testing results and to co-create new meanings around their life problems (Finn, 1996; Tharinger, et al., 2008). (p. 91)

This session can run from one hour and thirty minutes to two full hours. The clinician

[1] For purposes of this study, client observations are identified through their assigned TAC number as well as self-reported gender (e.g., TAC1-M refers to the first TAC case as well as the fact that this specific observation was provided by a self-identified male).

verbally reviews test results from both the MSI-R and BEVI as clients view their visual profiles. The therapist then asks both partners about their experience taking these measures, their opinions regarding the accuracy of the assessment results, and any lived experienced narratives (past or present) that relate to testing data (Finn, 2007, 2015). Studies have shown that when an assessor provides the opportunity for their clients to collaboratively discuss their assessments results, symptom reduction is more likely (Aschieri & Smith, 2012; Poston & Hanson, 2010) as is higher satisfaction with the evaluative procedure overall (Luzzo & Day, 1999; Poston & Hanson, 2010).

In reviewing the SCS: M / RR, the clinician identified a completed stem that captures each of the themes generated for both individuals. As an example, the following completed stem was chosen for the theme of "tension concerning individual needs and relational responsibilities" (TAC2-F1): ***I want my partner to understand*** *I don't want to feel trapped / crowded/boxed in – I need space for myself, for my mind.* The therapist then asked the "writing" partner to read their completed stem out loud. Both individuals are then asked to share "what's going on for them" as they either read or hear each statement. Such a practice may be evocative as individuals often complete the SCS:M / RR in an uncensored fashion. Therefore, the stem that represents the identified theme should be strategically selected.

That being said, using the SCS:M / RR in this way provides a number of therapeutic potentials. First, some of the identified themes may be related to a couple's perpetual problem(s), which may invite partners to engage in problem-solving communication. Second, as discussion about completed stems emerges, the therapist can intervene and assist partners in practicing healthy communication (e.g., not speaking on

behalf of one's partner, eliminating the "four horseman of the apocalypse," learning how to actively listen, etc.; Gottman, Gottman, Greendorfer, & Whabe, 2014). Third, the presentation of SCS:M / RR completed stems invites partners to make themselves vulnerable. If the therapist effectively manages such invitations, the act of becoming vulnerable may become facilitative of intimacy. Indeed, a number of clients found this interactive process of reviewing assessment results to be memorable. As one participant (TAC1-M) noted:

> It made me think about some about my, maybe, gut reactions, and kind of, like, what was I thinking at the time, and do I still agree with things. It was more than just a number…it felt more meaningful to me. I kind of like that we did it in front of each other, to gauge reactions and see responses, and to hear her responses. I had no clue what XX was going to say.

A short transcript of therapy during a feedback session captures a similar perspective of another participant, "With the sentence completion, it was good hearing the things you wrote. The way I worded things in there isn't necessarily how I would have said them face-to-face to you, but it's helpful to get it out" (TAC1-F). Yet another stated. "We went through the sentence completion and it touched on some really heavy topics like family and trust issues, but the emotional piece was good" (TAC3-F2). In short, purposefully chosen sentence stems can help activate communication and reflection processes that are integral to the facilitation of awareness, connection, and intimacy.

This second session is replete with content. One individual shared, "I enjoy hearing what's going on inside of her because she doesn't share that often. I mean, we've been together seven years and I just learned so many new things about her in the last

hour" (TAC2-F2). Couples are inundated with new and sensitive pieces of information. The fullness of this experience is designed to be significantly informative. As the depth and breadth of content within the assessment setting increases, the more likely clients are to consider factors and forces that affect who their partners are and why (Cummings, Davies, & Campbell, 2002). That being said, because information overload is possible, the TAC clinician should strive to bring this session to a close in a way that generates continuity and hope. At a metacognitive level, simply noting the amount of data shared can be helpful as can offering a frame of what future sessions will entail. For example, the primary assessor found it fruitful to ask each partner a final, open-ended question about what was most "interesting" or "surprising" about their in-session experience and then to link their observations to potential future steps or recommendations. At the conclusion, clients were given the same feedback form as administered in the first session to complete prior to the end of this meeting.

It should be noted that couples who began the TAC process utilizing the couples therapy track, or for couples who emerged from this session (or the next) as dyads needing further support, the feedback timeline may be different. For example, in reviewing just the MSI-R with one of the couples in this study during the second session, we came to an agreement that their TAC experience was going to be longer than the relationship enhancement route. With this new timeframe in mind, the following three to four sessions were dedicated to working on some of the areas of concern made clear from the MSI-R test results. Once this dyad felt more secure in their understanding of one another, we reviewed data from the SCS:M / RR. For this couple, this pattern of actively engaging test results – and then attending to the emergent issues – continued for six

months until a mutually agreed upon termination with the primary therapist occurred.

Session #3

The third session of the TAC program consists of three components: 1) reviewing any remaining data results from the previous meeting; 2) engaging partners in self-reflective awareness as a means of increasing their understanding of one another; and 3) co-creating the final two sections of the TAC report (integrative summary and recommendations). While most test scores are reviewed during the second session, there were several couples with whom processing such results was time-consuming (often an indicator of needing additional support in the form of couples therapy). If that happens with a dyad who wants to stay on the four-session track, finishing up the feedback portion of this intervention occurs during session three. Oftentimes, individuals come to the third session with a desire to share new reactions to and reflections of the scores presented during the last meeting. It proved most beneficial for the clinician to, again, utilize motivational interviewing techniques to encourage continued contemplation and meaningful actions of change. With this momentum, clients and therapist join together in co-creating certain aspects of the TAC's report integrative summary and recommendation sections.

In terms of proposed best practices, it seems helpful for TAC clinicians to have a written draft of the TAC integrative summary going into the third session. While the therapist does not need to have a hard copy of the report draft in-hand, having the content of this section (i.e., individual case conceptualizations, mutually constructed couple patterns, individual and relational strengths, etc.) accessible makes this session flow more smoothly. Case formulation is a core competency within the field of psychology and

greatly contributes to a clinician's understanding of the development and maintenance of mental health problems (Benjamin, 2018; Hill, 2014; Kinderman, 2005; Tarrier, 2006). Relatedly, strong conceptualizations of etiology, functioning, and recommendations have been found to lower clients' anxiety and encourage more adaptive ways of coping with distress (Horowitz, 1997; Persons & Tompkins, 1997), increase client motivation, and instill hopefulness and improve therapeutic alliance (Needleman, 1999; Pain, Chadwick, & Abba, 2008)

Moreover, in the context of couples therapy, a clinician must be able to formulate clear case conceptualizations of each partner so that conscious and unconscious motivations (Henriques, 2016) driving problematic intrapersonal patterning may be accurately identified. This identification, often associated with self and other-awareness, was usually followed by an increase in behavioral demonstrations of intimacy within the dyadic system. In short, the clinician's cognitive understanding of each partner's case conceptualization (including an idea of what happens when these two formulations interact) is integral to the TAC intervention. More on the importance of the written case formulation from the client perspective is presented below (e.g., see Intervention Procedure: Session #4 and Discussion).

Although pieces of the integrative summary are co-created by the couple and therapist, the recommendations section is where much of the collaborative construction takes place. The clinician is encouraged to have a drafted outline of the couple's categories of conflict. Bagarozzi and Sperry (2012) offer the following perspective, which informed our development of the TAC recommendations section:

> Once all areas of conflict, issues of disagreement, problems, and so on, in the marriage or relationship have been identified, they are categorized so that they can be dealt with more effectively…One way to categorize issues of concern, problems, and conflicts is to assign them to theoretically meaningful categories, for example, couple cohesion, communication patterns, relationship structure, power, rules, hierarchies, and boundaries. Once categories have been determined, they are hierarchically ordered and ranked according to their importance, severity, urgency, and so on, depending on the needs of a given couple and the nature of the presenting problem. The couple, in conjunction with the therapist, then agrees on a sequence in which these categories will be addressed in therapy. (pp. 152-153)

Once this categorization has been derived, the therapist will derive several working suggestions regarding observed dynamics and conflicts. That is because it is helpful to offer a menu of strategies from which couples can choose, which may increase the likelihood that each individual will follow-through with one or more recommendations (Cordova, 2014). The processes by which both partners creatively address areas of concern together can be a positive and intimate experience, generating feelings of efficacy and hope. Studies have noted that clients change for the better during the assessment phases of therapy, and most of the changes have seemed to occur in instances in which clients were included and an active part of the assessment process (Allen, 1981; Butcher, 1990; Des Groseilliers et al., 2013; Finn, 1996, 2007). Our experience indicates that partners appreciated the opportunity to work conjointly in generating a list of

recommendations. Per usual, this session concludes with the administration of the short feedback survey.

Session #4

The fourth and final meeting of the relational enhancement track of the TAC program (as opposed to continuing on in therapy) is a summary session. From a C / TA perspective, summary sessions are dedicated to assisting clients with the integration of information that they already know about themselves, information that is only partially available to them, and new insights about aspects of their lives that are not accessible via conscious awareness (Provenzi et al., 2017). The TAC summary session functions to enhance self and other-awareness, while catalyzing momentum from the entire process in order to facilitate healthier and most sustainable relational / marital practices over the short- and long-term. This overarching goal is actualized through several methods: 1) distribution of hard copies of the TAC report; 2) reading report sections aloud; 3) inviting individual and dyadic feedback; and 4) encouraging final reflections.

As with previous session descriptions, it may be helpful to outline the process of this final meeting. The clinician brings a hard copy of the TAC report for each partner and one for him or herself. The therapist may begin by reading or summarizing the "Reason for Referral" section to the couple. This step re-orients all parties to original and primary concerns, which, over the course of couples therapy, is especially useful. Initial presentation and life history sections are simply acknowledged as their inclusion is primarily for the clients and any future mental health professionals. Since individuals have already processed the data, the middle section of the report – consisting of the assessment scores and related information – can be quickly referenced (or, if needed,

briefly reviewed).

As previously written, the integrative summary section of the TAC report contains information regarding individual case conceptualizations, mutually constructed couple patterns, and individual and relational strengths. Clients are asked to read their individual case conceptualizations aloud – to themselves, their partner, and the therapist. That is because substantial literature attests to the fact that the production effect (i.e., saying words aloud) has been shown to increase one's ability to recognize and recall information (Bodner & MacLeod, 2016). Not only does this experiential technique assist with memory-enhancing functioning, but the emotional impact of reading accurate and meaningful case conceptualizations can serve as a significant part of one's process of self-understanding (Butler, 1998; Ryle, 1990). For these reasons, we have incorporated this strategy within the summary session. As both clients and therapist move through the integrative report, the clinician routinely asks about the accuracy of the report as well as each partner's experience of hearing such information presented.

The final section, "Recommendations," is clinician-led, and also functions as a collaborative discussion. The therapist explains the couple's categorization of conflict based on the entire TAC process, highlighting consensus-based areas from previous sessions and the report itself, while emphasizing ways in which both individuals can work towards managing concerns, hopes, and possibilities for them as individuals and as a couple. Again, each partner is consulted about the accuracy of the classification of both past and current issues. To be clear, report recommendations are derived from various mediums of information processing, including written exercises, experiential activities, articles, books, YouTube videos, podcasts, movies, meet-up groups, and so on. L'Abate

(2012) suggests that the inclusion of such materials is a way to augment both assessment and talk-based therapy in an actionable, accessible, and efficient manner. Hard copies of all materials associated with the TAC report are brought to this final session and organized in folders created for each partner. A couples therapy referral may be part of the recommendations section, the possibility of which is reviewed thoroughly. After all categories of concern are addressed, the couple is invited to reflect on the entire TAC process in verbal and written form.

In particular, a long version of the feedback survey is then administered to both individuals (see Appendix C). This form queries about participant satisfaction concerning the intervention as a whole, the TAC report, increased awareness and understanding, and ability to pursue positive relationship potentials. It also invites commentary concerning the most useful components of the program, lessons learned, summative impressions, and ways to improve the approach. Partners are also asked to rate their satisfaction regarding their romantic / marital relationship. Oftentimes, minor adjustments need to be made to the integrative summary and recommendations sections based upon client feedback in this last session. As such, two confidential copies of the final TAC report are either mailed to the couple or a pick-up at the location for their reports is arranged. If dyads decide to pursue couples therapy, the TAC report can also be sent to the selected clinician after appropriate release of information forms have been signed. As a follow-up, a final longitudinal feedback survey also was administered both five months and one year after each dyad's conclusion of the TAC program (see Appendix D). Similar to the long version of the feedback survey, this form re-assessed what was learned from engaging in the TAC process, ways to improve the intervention, summative impressions, and

relationship satisfaction.

Results

Constant comparison analysis and word count were employed to examine feedback data from a quantitative perspective. Using multiple, qualitative data analyses enhanced the strengths of each qualitative data analysis tool involved, and offered us a better understanding of the constructs at hand in a way that increased both the rigor and trustworthiness of our findings (Leech & Onwuegbuzie, 2007). The primary researcher conducted a constant comparison analysis in an abductive fashion – codes were identified prior to analysis and emergent from the data – with all forms of programmatic feedback (i.e., short, long, and longitudinal survey forms) constituting the dataset. Table 1, below, presents the findings of the constant comparative data analysis.

Table 1

Constant Comparative Analysis Findings

Rank	*Coded Theme	Code Count	*Representative Comments
1	Intimacy (self-disclosure, intrapersonal interactions, feelings)	85	• We were both vulnerable and honest (TAC4-F). • I think we have both gotten better at pointing out, in a gentle, way when the other is not so clear (TAC1-F). • I learned that XX and I really love each other…(TAC2-F2) • I have room also to be more available for intimacy (TAC2-F2). • …I feel like this program helped us to better understand one another…(TAC4-F)

2	General Satisfaction (sessions, program impact, overall experience)	75	• This was a rewarding session (TAC2-F1). • I am very pleased with the way this program is done (TAC5-F). • Thanks to the couples program we are developing beyond what we could have done on our own (TAC2-F2). • This program has been invaluable in our growth (TAC5-F). • We couldn't have asked for a better experience (TAC2-F1)!
3	Self-Awareness (life history, core growth edges, habits)	53	• I learned the effect that my past and my family history has on my ability to trust…(TAC3-F2) • I am a caregiver and when rejected from being able to do that I take it personally…(TAC5-F) • I have learned that I often talk for him, so I'm continuing to work on that (TAC1-F).
4	Other-Awareness (partner, family of origin, family of procreation)	40	• … lots of new information came to light from my partner…(TAC4-M) • There are ways we intersect that we have never thought about and also some clear cultural differences that lie at the root of our differences (TAC2-F1). • This experience has helped me realize that we need to make to discuss our grief with each other and our boys (TAC1-F).
5	Positive Experience of Therapeutic Alliance (gratitude, ability, personal style)	32	• Thanks Ali – you're great (TAC2-F1)! • Our counselor was very insightful and her communication style was gentle and direct, as was needed (TAC5-F). • You were extremely flexible and communicative with scheduling, which was amazing (TAC2-F1).
6	Meaningful Dialogue (new content, space, facilitation)	29	• I like having a place to get things out in the open (TAC1-F). • Our therapy helped to get my doubts and concerns on the table, when I might not have shared that if we weren't in this experience (TAC4-F). • Maybe this will open the door to

			more discussions about it in the future (TAC3-F1).
7	Positive Experience of Therapeutic Approach (space, process, techniques)	28	• It was a safe, open environment (TAC2-F2). • I think the guided and probing questions opened me up in an unfamiliar but freeing way (TAC2-F1). • I liked the [genogram] grandparent review (TAC2-F2).
8	Hope (positive future orientation, excitement, progress)	25	• I am open and excited to see where this goes and how much progress we can make (TAC3-F1). • It wasn't until this program that I felt any true deep hope for our relationship (TAC5-F). • …but so far I've seen change (TAC3-F2).
9	Communication Skill Building (tool, importance, enhancement)	25	• Learning to communicate effectively (speaking from our own perspective, minimizing contempt, stonewalling, ultimatums, and sarcasm) (TAC3-F1). • Open communication is very important (TAC1-M). • I feel participating has really helped our communication skills (TAC4-M).
10	Relationship-Awareness (problems, goals, mutual learning)	24	• When emotions are involved we are on very opposite ends of the scale. I have too much for him, he has too little for me (TAC5-F). • …and work as a better team (TAC1-F). • We learned a lot from each other…(TAC3-F2)
11	General Data Review (conflict identified, usefulness)	23	• The breakdown of individual strengths and weaknesses helped me learn more about myself and XX (TAC4-M). • I really like getting the results and hearing what areas are causing some conflict (TAC1-F). • I also found the data compared to my partner's to be helpful and a conversation starter (TAC3-F1).

12	Informative (new information, insight generation)	22	• It got me thinking about some concepts I never thought about…(TAC1-M) • A few "aha" revelations (TAC5-F). • Today's session was enlightening – self discovery (TAC5-M).
13	Intense (hard, challenging, difficult)	20	• This was a pretty intense session for me…(TAC2-F1) • Parts of it were painful for me…(TAC4-F)
14	Emotional (degree, general opinion)	16	• It was more emotional than I expected (TAC1-M). • …and also touched some of those emotions that have been concealed for years (TAC3-F1).
15	Report (reading, recommendations, resources)	14	• It was beneficial reading the recommendations together (TAC1-M). • I know that even if we don't do all of them right away we have a wonderful list of things to do to keep improving our marriage (TAC1-F).
16	Individual Sessions (helpfulness)	12	• I like the one-on-one then meeting as a couple format (TAC1-M). • …I believe XX took something away with her individual session (TAC3-F1).
17	BEVI (accuracy, positive experience)	11	• It was interesting to see how values aligned and where there were some differences and overall it was accurate (TAC3-F2). • …I learned something new in the BEVI which was pretty enlightening (TAC3-F1).
18	Personal Requests (topics to address)	10	• …I would have liked to have an assignment after each session…(TAC4-F) • I still want to talk about moving and how that will affect me on an identity side of things (TAC4-M).
19	Key Issues (access)	8	• I think we were able to bring to light some of our root issues and challenges…(TAC2-F1)
20	More Time or Sessions	8	• I wish we had been introduced to this program sooner so that we would

	(increase in both categories)		have the benefit of the full treatment instead of the condensed version (TAC5-F).

Notes. All codes with three or less data points were eliminated from this analytic process. Only the top 20 codes are presented in this table. The remaining themes include: Negative (therapy, partner difficulty, work ahead) (8), Same-Gender Feedback (hetero-normative assessments) (5), and More Individual Time (4). Also, several sample phrases include more than the coded data points for readability purposes.

Complementing the above thematic analysis from Table 1, the primary researcher also conducted a word count analysis (via Microsoft Word) with all forms of programmatic feedback (i.e., short, long, and longitudinal survey forms) constituting the dataset. As noted by Miles and Huberman (1994), there are at least three reasons for counting themes: a) to identify patterns more easily, b) to verify a hypothesis, and c) to maintain analytic integrity. Table 2, below, presents the findings of the word count data analysis: Table 1

Constant Comparative Analysis Findings

Count	Word
52	Help(ed / ful)
49	More
47	Learn(ed)
47	Session(s)
37	Very
35	Other(s)
33	Think(ing)
33	Communicat(e / ion)
30	Client name
29	Ali (therapist)
29	Emotion(al /ally / s)
29	Relationship
25	Need(ed / s)
24	Time(s)
24	Really

23	Partner
22	Program
22	Understand(ing)
21	Work(ing)
21	(My)self
20	Feeling(s)
19	Better
19	Issue(s)
18	Good
18	Each other
17	Open
16	New
15	Great
15	Lov(e / ing)
15	Experience
15	Differen(ces / t)
15	Couple
14	Together
13	Family
13	Talk
13	Forward
12	Hard
11	Thank(s)
11	Individual
11	Thought(s)
11	Benefi(cial / t)
10	Much
9	Definitely
9	Important
9	BEVI
9	Enjoy(ed)
9	Informa(tion / tive)
8	Connect(ion)
8	Comfortable
8	Continu(e / ing / s)
7	Question(s)
7	Safe
7	Space
7	Discuss
7	Plan
7	Positive
7	Therapy
7	Share(d)
7	Deep
6	Counselor

6	Effectively
6	Interest(ed / ing)
6	Aware(ness)
6	Marriage
5	Guide(d)
5	Accept(able / ance / ing)
5	One another
5	Useful
5	(In)direct
5	Honest(ly)
5	One another
5	Assessment(s)
5	Challeng(e / es / ing)
5	Sex
5	Insight
5	Recommendations
5	Listen
5	Grow(n / th)
5	Perspective
4	Strong(er)
4	Conversation(al)
4	Activit(ies / y)
4	Identify
4	Progress
4	Hope(fully)
4	Productive
4	Ourselves
4	Skill
4	Tool(s)
4	Truth
4	Review(ing)
4	Sensitive
4	Intense
4	Topics
4	Future
4	Same
4	Nice
4	Fun
4	Husband
3	Car(e / ing)
3	Feedback
3	Ability
3	Excited
3	Encourag(es / ing)
3	Change(d / s)

3	Intimacy
3	Style
3	Data
3	Results
3	Questionnaire(s)
3	Grateful
3	Eye-opening
3	Clarity
3	Difficult
3	Written
3	One-on-one
3	Key
3	Full
3	Invaluable
3	Approach
3	Find
3	History
3	Vulnerable
3	Empathy
Note. Words appearing two times or fewer were not reported in this analytic process.	

To interpret results with greater detail, additional explication is provided regarding the top ten constant comparison codes by 1) noting the affirming (or disaffirming) data points within the word count analysis, 2) including illustrative quotes from session transcripts of, and/or 3) processes related to case conceptualizations that were included in the final version of the TAC reports.

Awareness. Findings from the constant comparative analysis indicate that participants cited increased "awareness" of self and other as among the most prominent outcomes of the TAC experience (i.e., self awareness was ranked third and other awareness was ranked fourth, which together resulted in very high prominence). By awareness, participants are referring to greater understanding of a wide range of issues and factors (e.g., life history, core issues, habits, etc.) as indicated by the following two quotes from a single participant (TAC4-F) on the relational enhancement TAC track at

two points in time listed respectively below, immediately following the intervention and then five months later:

> I have learned that I have a lot to work on in our relationship, especially in my part of being open about my feelings and being more vulnerable with my emotions. I have a tendency to please others, so I also need to work on doing things for me and taking care of myself as much as, or more, than I take care of others.

> I have learned that I need to continuously work on my communication skills to better our relationship. There are times where I still keep feelings to myself and I don't share them with XX, making it easier for us to be on different pages because I am expecting him to cater to my needs and wants when he doesn't know what those are. When I do make a point to communicate my feelings, concerns, and thoughts, I find that XX is more accepting and understanding of them than I thought he would be, which increases my chances of sharing them right-out the next time.

As illustrated, from her perspective, the self-awareness stated at the immediate conclusion of the TAC program led to reported healthier forms of communication, which resulted in a greater tendency to express and experience empathy, a positive feedback loop that led to more of what she wanted in the relationship.

The interrelationship in this regard between self / other awareness is worth emphasizing not only because of the evident synergy between these processes, but because increased awareness extended beyond the dyad itself. In other words, although

increased awareness concerning one's significant other comprised the majority of this coded theme, many individuals noted that they better understood members within their families of origin and families of procreation because of their engagement with the TAC program. We view this expansion of "other" as indicative of the impact that this therapeutic intervention has cut across a variety of relational domains, a finding that aligns with literature presented in this written work about a healthy and generative version of the spillover effect (i.e., harmony, positive affect, and / or agreement in the parental dyad is transferred to harmony, positive affect, and / or agreement in the parent-child dyad).

Another unexpected form of awareness – designated for present purposes as "relationship awareness" – also emerged as a mid-range factor in terms of coded frequency. We conceptualize relationship awareness as an epiphany regarding the gestalt resulting from two individuals coming together and creating a relational whole that would not exist without the contributions from each individual partner, which interacted further to produce an awareness that would not otherwise have been possible.

Here is such "relationship awareness," as described by one partner to the other during a summative session (i.e., the last session in which the TAC report is reviewed and discussed):

TAC5-M: But I mean, what do you mean? Explain that to me.

Therapist: Good clarification question.

TAC5-F: Well, it talks about in here about how you had the two extreme models of what it meant to engage with one's emotions.

TAC5-M: Right.

TAC5-F: And one was "stuff it" and the other one was your emotions overtake you.

TAC5-M: Right.

TAC5-F: And it says that you chose the former in fear of the latter.

TAC5-M: Right.

TAC5-F: And so when I became emotional and was becoming emotional [referring to her parasuicidal gestures], then I'm thinking those feelings of you trying to avoid or being scared of what happened to your mom were coming up because maybe some of what I was portraying might have reflected some of the stuff your mom was portraying.

TAC5-M: Oh. Yeah. Possibly. I never really thought of that. Wow.

This insight was not a part of the original draft of the TAC report. After discussing this observation during the session, all three participants (spouses and therapist) agreed to include this information in the integrative summary in the final report. This very outcome (i.e., awareness resulting from the review of TAC report content) speaks to the organic and iterative nature of this process when attended to sufficiently and is central to the "therapeutic assessment" paradigm (e.g., Coates et al., 2016).

As a final observation regarding all three types of awareness (self, other, relationship), the word count analysis results appear to be in agreement with the relevancy of these coded themes as many words related to self, other, and relationship-awareness constituted a significant amount of the highest occurring words in the dataset: "more" (49), "learn(ed)" (47), "other(s)" (35), "think(ing)" (33), "client name" (30), "relationship" (29), "need(ed/s)" (25), "really" (24), "partner" (23), "(my)self" (21),

"each other" (18), "couple" (15), "family" (13), "individual" (11), "one another" (5), and "ourselves" (4).

Intimacy. Intimacy was the number one raked outcome in the dataset. As noted previously, intimacy is understood here as a phenomenon made manifest though individual behavior (e.g., self-disclosure), interactions between partners (e.g. rewarding of interpersonal vulnerability), and specific feelings (e.g. connection, love, care, etc.; Cordova & Scott, 2001). Examples of reported intimacy included increased understanding, patience, empathy, compassion, honesty, love, vulnerability, and compromise, making room for one's partner, engaging in active listening, being mindful of one's partner regarding communication, feeling connected or united with one's partner, and so on. Word count analyses attested to the wide variety of words (some occurring at lower levels because of their range) used that relate to intimate behaviors in this dataset: "emotion(al / ally / s)" (29), "understanding" (22), "feeling(s)" (20), "open" (17), "lov(e / ing)" (15), "together" (14), "enjoy(ed)" (9), "connect(ion)" (8), "deep" (7), "accept(able / ance / ing)" (5), "honest(ly)" (5), "listen" (5), "truth" (4), "nice" (4), "fun" (4), "vulnerable" (3), "empathy" (3), "car(e / ing)" (3), and "intimacy" (3). As may be clear, intimacy was inextricably related to multiple other themes that emerged from this analysis, particularly self / other awareness as well as relational awareness.

To illustrate these dynamics, here is a sample transcript of a dyad that utilized the TAC couples therapy track during the feedback session. This dialogue is a prime example of how various forms of awareness invite a bid of intimacy from one partner that is, eventually, responded to by the other partner, as highlighted in italics below:

Therapist: Where are we at now? This was a lot. Let's start with you, XX. What's going on for you? What was this like?

TAC3-F1: Um, it was just a lot of what…it's just different to see a lot of what I experience or what I know written down on paper. And for it to be, it's kind of like, like when you feel sick, but it's completely different when the doctor gives you a diagnosis; it changes your mental state. It just makes it more realistic to see it on paper; it makes me realize why I think the way I think or why I do the things I do. It helps me to be able to go back and read it again so that I know how to correct it. So, I think overall it was really positive, *but it also does hit me, especially the last part, making me feel overly guilty for not being able to provide what she's always wanted* [a close, mother-in-law relationship].

[Crying.]

[Long pause.]

Therapist: XX, what about you?

TAC3-F2: A lot of these things I kind of knew, but I guess hearing and seeing someone else actually make that connection as well is like, "Wow." For someone to put it, to put it, to have it made sense of. It does make sense, you know, especially how it connects to what I think. Um, you know, I think the exact same thing, how, like, the past, and like, untouched emotions play a part, and I've tried to hide them purposefully. Um, that's what's hitting me, especially those parallels that you pointed out, between my relationship with my mom. Um, I don't know…*I actually just want to say to XX,* [turning to partner], *I don't want you to feel guilty about that cuz it's not something that you can control.*

Learning how to communicate in a clearer and more direct manner was a large part of this dyad's work in couples therapy. TAC3-F1 had a difficult time being vulnerable with TAC3-F2 as TAC3-F2 often communicated in extreme ultimatums and contemptuous language, or completely shut down when discussing emotionally provocative content. Here, TAC3-F1 creates vulnerable space when noting the guilt she felt concerning her own mother's disinterest in having a relationship with TAC3-F2. Though it took her several minutes, TAC3-F2 looped back around to TAC3-F1's bid and offered kind words of assurance. Again, this is a clear example of how various forms of awareness can lead to moments of intimate connection, which are further related to relationship satisfaction, which was not coded as a separate theme but rather subsumed under other categories (e.g., intimacy, hope).

Therapeutic Alliance and Approach. Another strongly manifesting theme emerged around the "therapeutic alliance and approach," indicating the centrality of these features to the successful impact of the TAC intervention. Content speaking to this theme centered around gratitude, comments around ability and style, and spaces that were created, therapeutic processes, and techniques utilized (e.g., experiential, mindfulness, and multi-contextual-based exercises). Word count analysis results appear to be in accord with this qualitatively coded theme, constituting a large portion of the highest occurring words in the dataset, including: "help(ed / ful)" (52), "session(s)" 47, "Ali" (29), "time(s)" 24, "program" (22), "better" (19), "good" (18), "great" (15), "experience" (15), "thank(s)" (11), "benefi(cial / t)" (11), "much" (10), "comfortable" (8), "safe" (7), "space" (7), "positive" (7), "therapy" (7), "counselor" (6), "effectively"

(6), “useful” (5), “guide(d)” (5), “activit(ies / y)” (4), “productive” (4), “ability” (3), “grateful” (3), “invaluable” (3), and “approach” (3).

Below is a transcript of an individual sharing certain aspects of their positive experience of the intervention and its associated therapeutic process during the final session:

> **TAC2-F1:** I guess what surprised me the most was how well this worked. [Laughs.]
>
> **Therapist:** [Laughs.] Cool. So that was a surprise?
>
> **TAC2-F1:** In the sense that I feel like when we came in we were really at a crossroads, almost, in some sense, like we were kind of at, you know [gesturing to partner]…and I think that, um. I don’t know. I wasn’t sure, I wasn’t sure what, not what the point was, but, I wasn’t sure what the goal was going to be, and I was prepared for, like, whatever, like, OK, like, this is a bad idea. [Laughs.] Or, I don’t know, I just, I don’t know, I just, I wasn’t sure what to expect. And I think the clarity that we’ve sort of gotten around, uh, just all these different aspects…I mean, I even felt it from, like, the first time, we’re like, “Oh.” Having dumped that out, it’s like, it was so much easier to be together. And then that continued, and then that just cleared the way. I guess I had been thinking, again, I was thinking more diagnostic, right. Like we were going to get a, this is my simplistic view, here’s the prescription for your problem. Or here’s a diagnosis, you know. But I think it was more like, more of a shared process that had a result that continues to have an effect.

This transcript excerpt is particularly notable since it was expressed by a TAC participant who approached the entire endeavor from a pessimistic standpoint. Overall, this finding suggests that the therapist's belief in the process and one's clients may be key to the effectiveness of the overall intervention, particularly with otherwise resistant or skeptical clients.

Meaningful Dialogue, Hope, and Communication Skill Building. The remaining three, top ten coded themes are "meaningful dialogue," "hope" and "communication skill building." Meaningful dialogue ranked sixth among coded themes and referred to the importance of setting aside space where open dialogue was encouraged and facilitated in-session. Interestingly, it would seem that the therapeutic assessment paradigm of TAC led to the creation of such spaces since clients were actually reacting to information they were provided. The idea that assessment data can be as, if not more, facilitative of therapeutic engagement than therapeutic processes and content alone is a core finding from this entire study. In other words, assessment processes and the presentation of assessment data often are conceptualized as separate from the therapeutic process itself and / or as a discrete therapeutic event, characterized by the informing process. In contrast, the TAC intervention illustrates that cleaving assessment from therapy is neither necessary nor helpful in terms of facilitating processes of learning, growth, and development.

In particular, many study participants observed that assessment results offered new and powerful information related to self, other, and the relationship (e.g., see themes #13, #14, and #8) by directly inviting vulnerability, honesty, understanding, and intimacy. As with other qualitative themes, word count analysis helps operationalize this

theme as follows: “issues” (19), “new” (16), “differen(ces / t)” (15), “important” (9), “informa(tion / tive)” (9), “discuss” (7), “question(s)” (7), “share(d)” (7), “insight” (5), “assessment(s)” (5), “perspective” (5), “conversation(al)” (4), “identify” (4), “sensitive” (4), “topics” (4), “data” (3), and “results” (3).

The theme of hope ranked eighth in our constant comparative data analysis, an unexpected but welcomed outcome that centered around a positive future orientation, excitement about the process of engagement, and a sense of progress or momentum. Related words that surfaced in the word count analysis include: “work(ing)” (21), “forward” (13), “continu(e / ing / es)” (8), “plan” (7), “grow(n / th)” (5), “progress” (4), “hope(fully)” (4), “future” (4), “encourag(es / ing)” (4), and “change(d / s)” (3).

The final, top ten theme not yet discussed is communication (ranked ninth). While this theme surfaced often in relation to interpersonal intimacy, communication was also described as a skill that couples in both TAC tracks developed. Word count analysis revealed that “communicat(e / ion)” occurred 33 times in the dataset, one of the higher individual frequencies that emerged. Study participants shared that they learned several communication tools that enhanced their own capacity to listen more deeply and respond more effectively to their partners.

Beliefs, Events, and Values Inventory. Although the focus here has been on the top ten qualitative themes, a final observation regarding the centrality of assessment to the TAC intervention is worth emphasizing. As noted above, in clinical practice generally, assessment often is seen as a separate and separable aspect of the therapeutic enterprise, a dichotomy that seems artificial at best if not counterproductive from PATI approaches overall (e.g., Coates et al., 2016) and the present study in particular. That is

because so much of what emerged from the TAC program flowed directly from the presentation, interpretation, and discussion of assessment results and what they indicated regarding both the etiology and nature of underlying relational dynamics while also pointing the way forward. In short, assessment instruments and data were integral to the deepest and most impactful aspects of this entire intervention, a fundamental outcome that should help us reappraise the purpose and place of measurement as therapists.

This essential point – about the transformative power of depth-based assessment to the facilitation of learning, growth, and development – was exemplified by client comments about the Beliefs, Events, and Values Inventory (BEVI), the only instrument that was explicitly referenced by individuals in terms of meaning and impact. As such, the BEVI received its own qualitative thematic code and also was substantively referenced nine separate times via word count. Prominently cited descriptors included the BEVI's accuracy, ability to create space for difficult conversations, facilitation of emotional awareness and expression, and overall appeal. As one client summarized, "This was extremely interesting. Reviewing the BEVI presented some surprising numbers but also accurate. It brought on some emotion and also created room for self and couple analysis and a look at things from a different light and also connected some dots and created a list of things to be mindful of."

To understand why the BEVI was emphasized and experienced in this way, consider the below excerpt from a session transcript, which was prompted by a review of Religious Traditionalism, one of the BEVI's 17 scales.

> **TAC3-F2:** [Tearful.] Me becoming an adult, and of, like, building that mindset on my own instead of having it influenced by my grandparents. It's, like,

things…my perspective has changed and I'm currently in the process of, personally, building my faith back up.

Therapist: Hmm-mm.

TAC3-F2: So yeah, it's a touchy topic.

Therapist: Hmm-mm. Did you know that it was a touchy topic for XX?

TAC3-F1: No, cuz it's not something we really talk about, ever.

TAC3-F2: It's complicated. Like, my mindset is complicated. Like, sometimes it makes me wonder if all the things that are happening, that have happened to me in the past, like, couple years, whether it's my financial troubles, with my grandma getting cancer a couple years ago, stuff like that, I feel like if…it makes me question, like, [crying], if God is punishing me for liking women.

Therapist: Hmmm.

TAC3-F2: If He just decided to…[crying]…I guess a lot of my struggle has made me question why I had to have such a rough past, that somehow I got through, but it makes me question…why do I have to be so, like, broken right now. [Crying].

[Silence.]

[TAC3-F1 hands TAC3-F2 a box of tissue.]

TAC3-F2: Cuz a lot of my past has affected my relationship. And it sucks cuz I didn't choose it. [Crying.]

[Silence.]

TAC3-F1: [Crying.]

This powerful session was evoked by a real time review of similar and contrasting scores on the BEVI, with Religious Traditionalism in particular illuminating deep dilemmas around issues of life history, identity, despair, longing, and hope (Brody, Stoneman, Flor, & McCrary, 1994). It is doubtful that such core issues would have emerged in this way, or with such intensity, without the benefit of the BEVI's visual representation of how core needs and self structure were impacted by family history, with all of the attendant implications for relational intimacy. Although the focus in this particular excerpt was on religion, and its relevance to familial and cultural processes, the BEVI invites dialogue on many other important realms as well, such as identity diffusion, sociocultural awareness, ecological resonance, gender traditionalism, emotional capacity, and attributional tendencies. By illustrating and illuminating underlying structures of identity and self, why core needs are experienced and expressed as they are, and how such interactions affect the perception of others, multiple avenues for therapeutic intervention become clearer and more accessible for clients and therapists alike.

Discussion

Based upon evaluative feedback, study participants reported advancements in a number of domains, including increases in self and other-awareness, which led to corollary increases in more interpersonal and intimate exchanges. Two other components of the TAC program also appeared to impact each couple's ability to engage more authentically, compassionately, and healthily – an overall satisfactory experience with the intervention and a positive experience of the lead clinician. As consumer-driven advocacy movements and national policy recommendations have

encouraged mental health care service systems to move toward a patient-centered model, measuring patient consumers' physical and psychological needs is becoming more commonplace (Klingaman et al., 2015). Consumer satisfaction, from the lens of clients engaging with therapeutic services, is a significant variable concerning more positive recovery outcomes among consumers with serious mental illnesses and substance abuse issues, and better engagement in treatment for a variety of clientele (Dearing, Barrick, Dermen, & Walitzer, 2005; Lanfredi et al., 2014). The results of this study add to this research, specifically, that client satisfaction has the potential to play a critical role in facilitating healthy relational and marital practices.

As presented in "Program Pillars" above, models of assessment that purposefully incorporate PATI approaches, like this one, often are efficacious at a number of important levels. Similar to the C / TA literature, this study suggests that clients experienced improvement in mental and relational health, adopted attitudes essential for client change, and gained a more nuanced and multi-contextual understanding of themselves and important others. Of particular significance is the finding that four out of the five couples who engaged with the TAC intervention pursued or continued with couples therapy within the one-year, follow-up window. The act of seeking out additional clinical services may be a key indicator of previously effective treatment (e.g., De Saeger et al., 2014; Smith, Eichler, Norman, & Smith, 2014).

As the PATI literature suggests, "assessment includes the therapist" (Williams et al., 2011, p. 9). Since the assessor functions as an inseparable part of the evaluation process, it would make sense that the top positive outcomes (general satisfaction, increase in self-awareness, other-awareness, and intimacy) would correlate with the

final, top-five theme, positive experience of the therapeutic alliance. Most scholars and clinicians would agree that creating and maintaining a strong therapeutic alliance is integral to any therapeutic intervention. The process of developing a good therapeutic alliance with couples can represent a distinct challenge. For example, it can be difficult to be empathic with two people who might have very different perspectives regarding the most salient relational concerns (Davis, Lebow, & Sprenkle, 2012). Anecdotally, the lead clinician affirmed that TAC, as an assessment-based intervention, helped to promote a positive therapeutic alliance with both partners, findings also documented by Epstein and Baucom (2002) and Halford (2001).

There are secondary factors concerning the success of this study that seem to correlate with several of the primary coded themes. For example, the increase in relationship-awareness appeared to impact the increase in intimacy. Clients also reported a positive experience with the therapeutic approach, a process that most certainly included the coded themes of meaningful dialogue and communication skill building. Having a safe space, a trusted facilitator, and new content with which to practice healthy forms of communication are key ingredients to initiating self-perpetuating behavioral exchanges of healthy relational and marital practices. Lastly, hope made a special and consequential appearance in the qualitative data analysis. Research has shown that hope positively influences both physical and psychological health, and is related to positive treatment outcomes (Cheavens, Michael, & Snyder, 2005; Hanna, 2002). Our data show that looking to incorporate certain aspects of hope, such as the four properties identified by Ward and Wampler (2010) – options, action, evidence, and connection – in the context of couples interventions may be particularly important.

Limitations

As with many therapeutic interventions targeting couples, the potential reach and impact of the TAC program is hindered by common barriers pertaining to both dyad recruitment and retention, including the lack of motivation or of self-identifying as needing help (Cordova et al., 2014), the couples' preference to solve their own problems (Uebelacker, Hecht, & Miller, 2006), the social stigma associated with mental health services, and the necessary investment of time and money (Burr, Hubler, Gardner, Roberts, & Patterson, 2014).

When addressing issues of effectiveness, one of the main drawbacks of the TAC program is the length of the written report. Reports ranged from 13 to 18 pages (with the longer reports being of the dyads who utilized the TAC couples therapy track). Such writing requires substantive time and energy, which may not be reimbursed monetarily via insurance agencies or affordable for low-income clients. On the other hand, the report did emerge as an important coded theme within our constant comparison analysis (ranked fifteenth). Study participants noted its usefulness concerning the recommendations section, specifically reading it out loud with their partner and its accompanying resources. As most couples chose to pursue or continue couples therapy, several transferring clinicians also mentioned the importance of the report. For example, as the transfer therapist of the TAC2 dyad shared:

> The TAC report provided a wonderful foundation for engaging in therapeutic work and offered a shared language between myself and the couple I am working with. This was and is especially impactful when considering how their personal narratives and cultural beliefs and values shape their experiences within their

> relationship. Having the report also eased the transition between their previous clinician and myself as I entered the process with a depth and breadth of understanding of the couple and their needs from reading the report. Both individuals in the couple have referenced insights they gained from the assessment process that continue to inform how they navigate their understanding of their partner and their relationship dynamics.

Regarding the length issue, it may be possible simply to list scores with a general description of what associated scales are meant to assess rather than addressing each and every score of potential relevance. Another potential solution would be to substantially reduce life history and framing information. In this way, the key pieces of the report, namely, the integrative summary and recommendations, would constitute the majority of the report's generated content. The downside of such potential reduction, however, is to eliminate much of the important context and background, which is important for interpretation of findings as well as development of the formulation and recommendations.

Some clinicians have expressed concern regarding how individuals might find completing comprehensive measurements too cumbersome of a process and / or delaying the start of treatment (Halford et al., 2015). However, in this study, participants explicitly emphasized the importance of this assessment-based approach as they were able to immediately clarify their concerns and had access to a wide range of information about self and other. In short, regarding a perception that C / TA models are time-consuming and challenging (Finn, 2007), evidence suggests that PATI can be successfully integrated into assessment procedures without adopting a completely new

approach to daily practice (Provenzi et al., 2017).

Future Directions

Research has shown that couples with less education have a quickly declining marriage rate (Geiger & Livingston, 2018) and that low-income couples experience more relational distressed compared to their high-income counterparts (Lundberg, Pollak, & Stearns, 2016). This study attempted to make the TAC program accessible to clients of all backgrounds by soliciting participants from a variety of settings, offering reduced-priced services, and selecting measures with appropriate readability levels and visual aids. That being said, all of this study's participants had, at least, earned a college degree. As has been documented (Halford et al., 2006; Sullivan & Bradbury, 1997), the development of interventions created specifically for dyads of lower SES status continues to be necessary in the field of relationship science.

Though the theme of relationship satisfaction, and related word count analyses, did not emerge as an anticipated major theme, the increase in reported intimacy aligns with Cordova's (2014) astute observation concerning relational intimacy and relationship satisfaction:

> At the heart of the M[arital] C[heckup] is the intention to cultivate intimacy between partners as the basis for a healthy relationship and as the heart of relationship satisfaction. At the same time, my expectation given previous results has been that relationship satisfaction is not identical with intimacy and is likely to vary differently in response to treatment. My hunch is that satisfaction can vary more than intimacy, based on a variety of factors, and that it is possible for

> day-to-day satisfaction to wax and wane even while intimacy remains steady or grows. (p. 242)

Cordova's extensive and ongoing research within the field of relationship science makes his "hunch" worthy of serious consideration. In resolving some of the uncertainty concerning the TAC program's impact on relationship satisfaction, it would seem that measuring intimacy via the many evaluations dedicated to this behavioral phenomenon would provide more appropriate and meaningful data. For example, future researchers might consider utilizing questions that constitute the intimacy scale within Cordova's (2014) Marriage Checkup Questionnaire as an evaluation to be administered pre-, post- and post-post-intervention.

Likewise, the current approach deliberately integrated satisfaction measures into the assessment process itself including a question about the therapeutic alliance on relevant feedback forms (i.e., short and long). This addition was prompted by the consistent finding that a strong therapeutic alliance with both partners in couples therapy predicts greater improvement in couples' relationship adjustment (Anker, Owen, Duncan, & Sparks, 2010; Davis et al., 2012). As assessment always includes the therapist (Williams, et al., 2011), the quality of the therapeutic alliance should be a part of what is measured. Based on recommendations from Halford and colleagues (2015), we also decided to add a question to the Couples Questionnaire clarifying whether partners wanted to continue or improve their romantic relationship. The inclusion of such inquiry allows therapists to tailor couples therapy according to each person's goals, and might well enhance the effectiveness of therapy, as a mismatch of goals between therapist and client predicts poor therapy outcomes (Norcross & Wampold, 2011).

Feedback from this evaluative process proved extremely helpful not only in understanding what was working, but how matters of pacing and tailoring were progressing, which allowed the lead clinician to adapt approaches in real time in order to emphasize what was of most relevance to clients. Additionally, it may prove valuable to more fully investigate the impact of other-awareness concerning family of origin and / or procreation, either through more focused qualitative data analyses or the measurement of participants' relationships with members of those various family systems. Thus, a key recommendation is to incorporate a process of soliciting client feedback regularly into assessment-based interventions and to act upon such feedback insofar as appropriate in terms of modifications or refinements to one's approach.

Finally, in addition to replication and expansion of the sample size – deliberately small and intensive for this pilot project – it would be useful to examine core findings from the present study in greater depth and detail (e.g., the importance of relationship awareness, hope, and BEVI usage).

A Concluding Case Study

Overall, this exploratory study demonstrated that the TAC method is an effective intervention that can improve 1) healthy relational and marital practices (e.g., increased awareness of self, other, and relationship, various forms of intimacy, communication skills, and feelings of hope) 2) across a diverse range of couples (e.g., non-distressed and distressed, heterosexual and homosexual, non-Caucasian and Caucasian) with 3) treatment goals corresponding with primary, secondary, and tertiary processes and outcomes (e.g., relationship enhancement, conflict identification, a customized guide to begin couples therapy). To illustrate these promising results, and by way of conclusion,

it may be helpful to present one of the cases in greater detail in order to illuminate the changes that one of the couples experienced through their participation in the four-session, relationship enhancement TAC track.

Kim and Brett[2] were in their mid-20s when they self-referred to the TAC program's lead clinician. They had been married for five months, dating seven months prior to their wedding. Kim was a middle school counselor, and Brett was a semi-professional athlete, working seasonally for his father's business. The couple sought assessment and therapy through a shared interest in improving their "communication skills" and current sexual relationship. For 10 months, Kim had been experiencing pain and bleeding during intercourse. She had visited two physicians several times, and neither doctor was able to find a medical or biological cause to her physiological symptoms. Although both spouses noted that their sexual life was not mutually satisfying, Brett more directly expressed his "frustration" regarding this aspect of their marriage.

During their individual interviews, Kim described her childhood as "very happy," noting that her religious community informed some of her parents' more conservative values (i.e., disapproval of substance use, adherence to traditional gender roles, etc.). While Kim shared that her parents "always seemed to have a strong relationship," their partnership was limited in certain ways. Her parents "never" actively disagreed with one another, leaving Kim without a template of healthy conflict

[2] The de-identified presentation of assessment or clinical material are informed by the March 2012 Special Section of the journal Psychotherapy, entitled "Ethical Issues in Clinical Writing," Volume 49, Issue 1, pp. 1–25, as well as the Health Insurance Portability and Accountability Act (HIPAA) regulations, American Psychological Association (APA) ethical guidelines, and other best practices for reporting such information. In this regard, although all assessment and report results are consistent with original patterns and profiles, key information may have been modified on occasion (e.g., specific scores) in order to ensure the anonymity of respondents.

management, and “rarely showed affection.” Kim is a middle child, and one that was often charged to “watch” her older sister, a young woman who experimented with various substances, went to counseling for depression, and engaged in various episodes of rebelliousness during high school and college. Within the last year, Kim also had discovered that her oldest sister was sexually abused by her father’s brother. Kim’s openness, introspection, and psychological-mindedness were quite present during her intake. Contrastingly, Brett’s suspicion, anger, and avoidance made it difficult for him to engage openly in the interview process or to report substantive information at the outset.

More specifically, Brett started by sharing that his wife “signed him up” for this therapeutic experience without engaging in much dialogue regarding his thoughts about the commitment. Brett described his father as an “alcoholic, with massive anger issues, abusive, a terrible money manager, and a good coach.” He also reported that his father had a Bipolar I Disorder diagnosis, that his parent’s marriage was “hostile,” and that they divorced when he was 11 years old. Brett’s father remarried approximately three years after his divorce to a woman whom Brett described as “mean and snooty.” For several years during adolescence, Brett lived with his father, his stepmother, and her son, moving four times because of his stepmother’s work. Later in high school, he moved in with his father’s sister, an arrangement that prevailed throughout the rest of high school and college.

In looking at the data points related to this couple’s presenting concerns, a large discrepancy in their dyadic scores emerged on the MSI-R’s Sexual Dissatisfaction (Kim = 45; Brett = 58). Indeed, one of the most salient topics throughout the evaluation process was Kim’s current difficulty with intercourse (i.e., pain, bleeding, feelings of

guilt, pressure, etc.). Complicating matters, the marital lifecycle stage in which these two individuals found themselves focused on the management of transitions: moving from single to couple life, the realignment of relationships with family members and friends to include spouses, adjustment of career decisions, and the negotiation of new issues or "old" issues experienced in a "new" way. While increased sexual intimacy is often associated with this honeymoon phase of marriage, the significant shift of marital responsibilities and the exploration of those can impact a couple's ability to remain grounded and connected. In Kim and Brett's situation, Kim's physical issue with sex – now complicated by psychological factors – made sexual intimacy and all its complexities even more fraught.

Although Kim self-identified as a "pleaser," Brett reported excitement that someone was finally on his "team." Kim's tendency to adopt the "team player" mentality interacted with Brett's enjoyment of such unconditional support to create a cycle where Kim often lost her sense of self in the marriage, including her own wants and needs, which tended to be subordinate to those of her new husband. To understand better each spouse's proclivities, we juxtaposed Kim's struggle to access her emotional self with Brett's reported history of family dysfunction and distress. Indeed, Kim's scores on Basic Openness and Emotional Attunement scales of the BEVI (11th and 20th percentile respectively) indicated that she found it especially difficult to acknowledge, value, and express her basic feelings and needs. Sources of this relatively constrained intra- and interpersonal style were not difficult to ascertain (e.g., influence of the church, lack of modeling regarding both confrontation and affection, her middle child status, taking care of an older sibling, salient memories of being disciplined for verbal

expression, etc.). Although Kim had the experience of being valued within her family system, such valuation appeared highly conflated with the perception of her relative "helpfulness" to others combined with an internalized eschewal of any critical appraisal of, or differentiation from, such internalized roles.

In contrast, as inferred by his scores on both the MSI-R's Family History of Distress (significantly elevated at 66) and BEVI's Negative Life Events (81st percentile) – as well as his reported history – Brett appeared not to have been known, valued, or seen as a child. Compounding matters, his father's abuse of alcohol and unpredictable / violent tendencies – and inconsistent maternal presence – left Brett feeling on a "team" without any "game-ready" players. Brett has worked hard to differentiate from his father (e.g., to be less angry, more affectionate with his spouse, a better money manager, develop a healthier relationship with alcohol, etc.). However, his high scores on the Needs Closure (74th percentile) and Basic Determinism (86th percentile) BEVI scales suggest that Brett has not yet come to terms with the consequences of very difficult familial dynamics on his present functioning. Specifically, as such scores indicated, he appeared to have adopted a rather black and white set of assumptions about who he and others are (probably as a result of having to adapt to highly conflictual and non-empathic responses of his caregivers to him) along with an overall resistance to contemplating the full impact of these life events on him and his relational processes with others. At his worst, Brett's "hard-headedness" impeded his ability to think complexly and compassionately about self, others, and the larger world. He thus reverted to overemphasizing self-reliance, which had the effect of cutting off himself and others to his own internal experiences.

Complicating matters – and arguably making them even more interesting from a clinical perspective – it seemed as though Brett was able to remain connected to Kim in general. However, during times of stress and conflict, Kim's reflexive lack of openness and emotionality – a direct result of her own history as a "pleaser" and witnessing her parents affectionless marriage – both contributed to her husband's tendency towards simplistic explanations for complex phenomena while simultaneously heightening his own unmet needs to be wanted. In others words and importantly, Kim's relatively low level of emotional expressiveness was experienced by Brett as a negation of his own internal experience, which he himself tended to disavow. Inadequate and dissatisfying attempts to communicate about needs and feelings that were very real, but underestimated and devalued, left little room for genuine engagement. Exacerbating the dynamic further, Brett tended to seek comfort through the one means he deemed acceptable – physical intimacy – placing Kim in an untenable situation, since she did not permit herself to experience or express her own internal states. Instead, she sought to match Brett's desire for physical intimacy, and to mitigate self-consciousness on his part, despite the fact such experiences actually felt alienating for her to the point that she experienced physical (and psychological) pain during such encounters.

Once these complex interactions were illuminated through the therapeutic assessment process, Kim was encouraged to experience, explore, identify, and express aspects of her internal self that had been "shut off" to her for the benefit of others. Likewise, Brett worked on enhancing his awareness of his tendency to derogate complexity of thought and feeling in self and other, to grapple with the impact of his life

history upon him (as was the case for Kim as well), and to acknowledge his needs to be known and valued.

The recommendations section of their TAC report offered specific guidance and resources to them both for pursuing such a path, starting with a more honest reckoning with their own family of origin issues (Kift, 2016; Olsen & Stephens, 2001). As another example, each partner was encouraged to understand better their own sexual history and preferences (e.g., using guidance from Timm, 2009, and associated resources). Among other facets of this process, the plausible relationship between Kim's experience of painful sex and the discovery of her older sister's sexual abuse also were considered. Lastly, resources concerning communication and understanding emotions were shared and recommended (e.g., Chlipala, 2017; Schwartz Gottman, & Gottman, 2015; Henriques, 2017; Jones, 2015). From the perspective of the TAC intervention, the focus here was on more deeply understanding the etiology and nature of emotions as well as communication and interpersonal patterns, with alternatives explored, rather than seeking to implement short-term solutions or problem-solving strategies.

In terms of how both Kim and Brett experienced their engagement with the TAC program, Kim's comments (see pp. 56 and 57 above as TAC4-F) are illustrative of her increased self awareness concerning her unsatisfying and sacrificial self / other orientation, with a concomitant focus on actively changing her approach toward communication and intimacy. For his part, Brett entered the TAC process by writing short, and sometimes, sarcastic answers in the Couples Questionnaire. For example, in response to the prompt, "In your own words, please describe any issues of concern or way in which you would like to enhance your relationship. If you are citing a relational

issue, please provide information about when the problem(s) began, and what (in your opinion) is causing the problem(s). Try and be specific in your answer," Brett wrote, "More sex." Similarly, in answering the question, "What have you already done to resolve the issue that you and your partner are experiencing?", he penned, "Tried to have more sex."

Given such a point of departure, the prognosis for this couple might have been limited if not grim. However, as they both observed via feedback as the process unfolded, the sharing and explanation of data – and linkage to their own familial histories and present goals – made it all very real and immediate for them as individuals and as a couple. Perhaps the best illustration of the constructive changes, both intrapsychically and interpersonally, was revealed via the following excerpt from Brett's longitudinal feedback form, administered five months after the TAC intervention concluded.

> I have started to learn how to better approach my partner for intimacy. I have realized that it is not totally dependent on physical feelings and action. Sex has more layers than the physical side. Playing to Kim's emotional side and having her feelings attended to and understood makes the intimacy much more desirable for her physically. I am learning new ways to approach intimacy. Some of the approaches involve everyday tasks to please Kim's emotional side, or even talking about her day to let her know that I care about her feelings and not just her body.

In fact, both partners expressed a new awareness of self and other, along with a deeper understanding of emotional needs in general and their relationship in particular.

Indeed, when asked about the quality of their sexual relationship during the final interview, six months after starting the TAC program, both Kim and Brett shared smiles that could be characterized as good naturedly sheepish. “It’s good,” Kim responded, “really, really good.” Brett enthusiastically concurred: “She sure knows what she’s doing! She’s amazing.” Importantly, Kim reported that her vaginal pain and bleeding had ceased, with a corresponding increase in her desire for consistent sex. In short, Brett and Kim were now enjoying the many benefits of marriage, including the delightful romance of what it can mean to be newly wed.

Appendix A

COUPLES QUESTIONNAIRE

This survey is designed to give your clinician a more complete picture of your background and current situation. By providing this information, you will help ensure that you, your needs, and your situation are better understood. Please answer each of the following questions in the space provided. In most cases, you should try and give more information than a simple "yes" or "no" answer. If you don't want to answer a question, simply leave the answer space blank.

_____

I. BACKGROUND INFORMATION

Name:_____

Current Address:_____

_____

Phone Number:_____

Age:_____ **Date of Birth:**_____

Gender:_____

Race/Ethnicity:_____

Name of Partner:_____

Relationship Status (check all that apply):

☐ Dating ☐ Remarried

☐ Cohabitating ☐ Separated

☐ Engaged ☐ Divorced

☐ Married ☐ Living apart

Length of time in current relationship:_____

Do you have (or have had) any health or medical issues?

_____
_____
_____
_____
_____

Are you currently taking any medication(s)? If yes, please list and include dosage.

_____
_____
_____
_____

Do you have (or have had) any legal problems?

_____
_____
_____
_____
_____
_____

Do you drink alcohol to intoxication or take drugs to intoxication? ☐ Yes ☐ No

If yes for either, how often and what drugs or alcohol? (Please include amount.)

_____
_____
_____
_____
_____
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_____
_____

Please describe your religious orientation or personal life philosophy.

_____
_____
_____
_____
_____
_____
_____
_____

Have you experienced any recent significant life changes (i.e. birth, adoption, death, job change/loss, family member moving out/in, retirement, etc.)?

_____
_____
_____
_____
_____
_____
_____
_____

II. PRESENTING ISSUE(S)

What is your main goal in beginning this assessment process at this point?

☐ Clarifying whether or not you want to continue your relationship with your partner.

☐ Seeking to improve your relationship with your partner.

In your own words, please describe any issues of concern or ways in which you would like to enhance your relationship. If you are citing a relational issue, please provide information about when the problem(s) began, and what (in your opinion) is causing the problem(s). Try and be specific in your answer.

_____
_____
_____
_____
_____
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_____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern	***Frequency***
☐ No concern	☐ No occurrence
☐ Little concern	☐ Occurs rarely
☐ Moderate concern	☐ Occurs sometimes
☐ Serious concern	☐ Occurs frequently
☐ Very serious concern	☐ Occurs nearly always

What have you already done to resolve the issue that you and your partner are experiencing?

_____
_____
_____
_____
_____
_____
_____

Have you received couples counseling related to any of the above concerns?

☐ **Yes** ☐ **No**

If yes, when:

_____

Where:

_____

By whom:

_____

Length of treatment:

_____

Issues addressed (include any relevant diagnoses):

_____
_____
_____
_____
_____
_____

Have you been in individual counseling before? ☐ Yes ☐ No

Issues addressed (include any relevant diagnoses):

_____
_____
_____
_____
_____
_____

Have either you or your partner struck, physically restrained, and / or used violence against or injured the other person? ☐ Yes ☐ No

If yes for either, who, how often and what happened?

_____
_____
_____
_____
_____
_____

If married, has either of you threatened to separate or divorce as a result of the current relationship problems?

If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

If yes, who? ___Me ___Partner ___Both of us

What areas or topics are most difficult to be open about with your partner? Why?

_____
_____
_____
_____

What are your biggest strengths as a couple?

III. FAMILY HISTORY

Biological father's name:_____

Living or deceased:_____

If deceased, how old were you at the time of his death:_____

Cause of death:_____

Biological father's age (now or at time of death): _____

Biological father's occupation: _____

Describe biological father.

Describe both your past and present relationship with your biological father.

Biological mother's name: _____

Living or deceased:_____

If deceased, how old were you at the time of her death:_____

Cause of death:_____

Biological mother's age (now or at death):_____

Biological mother's occupation:_____

Describe your biological mother.

_____
_____
_____
_____
_____
_____
_____
_____

Describe both your past and present relationship with your biological mother.

_____
_____
_____
_____
_____
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_____
_____

Other primary caretaker's name:_____

Living or deceased:_____

If deceased, how old were you at the time of his/her death:_____

Cause of death:_____

Other primary caretaker's age (now or at time of death): _____

Other primary caretaker's occupation: _____

Describe your other primary caretaker.

_____
_____
_____
_____
_____
_____
_____
_____

Describe both your past and present relationship with your other primary caretaker.

_____
_____
_____

Other primary caretaker's name:_____

Living or deceased:_____

If deceased, how old were you at the time of his/her death:_____

Cause of death:_____

Other primary caretaker's age (now or at time of death): _____

Other primary caretaker's occupation: _____

Describe your other primary caretaker.

Describe your current relationship with your other primary caretaker.

Has either of your parents and / or primary caretakers been married previously? If yes, please describe the circumstances of the previous marriage(s).

How would you describe the relationship of your parents and / or primary caretakers?

If you have any siblings, please provide their name(s) and age(s).

Have you had (or currently have) any significant problems with one or more of your siblings? If so, describe the issue and its effect on the relationship.

Describe how your parents and / or primary caretakers disciplined you when you were growing up.

Please share any information you have regarding <u>your</u> conception, birth, and / or infancy.

Please identify if there is a family history of any of the health issues listed below. If yes, please indicate the family member's relationship to you (including yourself) in the blank space provided (father, grandmother, uncle, etc.).

Alcohol/substance abuse		
Anxiety		
Depression		
Domestic violence	☐ Yes ☐ No	
Eating disorder	☐ Yes ☐ No	
Sexual abuse		
Personality disorder	☐ Yes ☐ No	
Suicidal actions	☐ Yes ☐ No	
Legal problems	☐ Yes ☐ No	_____
Other:		_____
Other:	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
		_____
		_____
		_____

IV. CURRENT FAMILY STRUCTURE

Please list members who are a part of your family of procreation / romantic relationship (including yourself). Write their approximate age, role within the system from your perspective (i.e., husband, partner, daughter, stepson, etc.), occupation, and two to three words you would use to describe them

- **Name:**____
  - **Age:**____
  - **Role:**____
  - **Occupation:**____
  - **Descriptors:**____
- **Name:**____
  - **Age:**____
  - **Role:**____
  - **Occupation:**____
  - **Descriptors:**____
- **Name:**____
  - **Age:**____
  - **Role:**____
  - **Occupation:**____
  - **Descriptors:**____
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  - **Descriptors:**____
- **Name:**____
  - **Age:**____
  - **Role:**____
  - **Occupation:**____
  - **Descriptors:**____
- **Name:**____
  - **Age:**____
  - **Role:**____
  - **Occupation:**____
  - **Descriptors:**____

Please write which family members (including yourself) who are particularly close with one another.

Please write which family members (including yourself) who are in conflict with one another.

V. PERSONAL HISTORY

Place of birth:_____

Where did you live while you were growing up?

How would you describe your childhood?

What was it like for you to go through puberty and adolescence?

Please share your educational history (higher education institutions and associated degrees).

How would you describe yourself as a person?

What are some of the words important people in your life might use to describe you?

What do you know about yourself that makes you not the easiest person with whom to be in a relationship?

What would you describe to be your greatest strengths?

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current occupational position?

Please describe how you feel about your occupation.

Is there any relevant information you wish to provide concerning and important social demographics (i.e., age / generation, developmental disability, diability (acquired), religion, ethnicity and race, socioeconomic status, sexual orientation, national origin and language, and gender)?

VI. SUICIDE/HOMICIDE SCREEN

Have you <u>ever</u> had thoughts of harming or killing yourself? ☐ Yes ☐ No

If yes, what thoughts did you have? When was the last time you had these thoughts? When was the most intense period of self-harm / suicidal thinking you have had?

Have you ever acted on your suicidal thoughts, that is, made a suicide attempt or were particularly reckless because you were thinking about dying? If yes, please describe the most recent situation.

Have you felt suicidal recently? ☐ Yes ☐ No

If yes, please describe.

_____
_____
_____
_____
_____
_____
_____

Have you ever had thoughts of hurting someone else? ☐ Yes ☐ No

If yes, please describe.

_____
_____
_____
_____
_____
_____

VII. GOALS AND EXPECTATIONS

Please rate your overall level of satisfaction concerning your romantic relationship by circling the corresponding number.

1 2 3 4 5 6 7

(Unsatisfied) (Moderately) (Satisfied)

How are things going in your relationship?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What is working well in your relationship?

_____
_____
_____
_____
_____
_____

What would you like to improve in your relationship?

What expectations do you have concerning this assessment process?

Please take a final moment to think about yourself, your needs, and your situation. Is there anything else that you have not already mentioned that your clinician should know about?

THANK YOU!

Appendix B

THERAPEUTIC ASSESSMENT WITH COUPLES
FEEDBACK SURVEY-SHORT

Name: _____
Date: _____ Session Number:_____

I am satisfied with this session.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I am satisfied with my relationship with our therapist.

1	2	3	4	
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

How did you experience this session (i.e., what was it like for you)?

_____
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Do you have any suggestions or requests as we move forward with this process?

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Appendix C

THERAPEUTIC ASSESSMENT WITH COUPLES
FEEDBACK SURVEY-LONG

I am satisfied with my experience of the Therapeutic Assessment with Couples Program.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I am satisfied with the Therapeutic Assessment with Couples Report that I received.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

As a result of the Therapeutic Assessment with Couples Program, I have greater awareness and understanding about myself, my partner, and our relationship.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

As a result of the Therapeutic Assessment with Couples Program, I have greater confidence in my ability to pursue the full potential of our relationship.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

I am satisfied with my relationship with our therapist.

1	2	3	4	
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

From your perspective, please list up to five of the most useful aspects or components of the Therapeutic Assessment with Couples Program (i.e., what made the greatest impact upon you and why)?

1. _____

2.

3.

4.

5.

Do you have any suggestions for how we might improve the Therapeutic Assessment with Couples Program in the future? If so, please describe below.

What have you learned about yourself, your partner, and your relationship because of this process (e.g., what are the "take away" points that you have discovered)?

Overall, what is your summary impression and / or experience of the Therapeutic Assessment with Couples Program (i.e., any final comments or observations)?

Please rate your overall level of satisfaction concerning your romantic relationship by circling the corresponding number.

1 2 3 4 5 6 7

(Unsatisfied) (Moderately) (Satisfied)

THANK YOU ONCE AGAIN FOR YOUR PARTICIPATION!

Appendix D

THERAPEUTIC ASSESSMENT WITH COUPLES
FEEDBACK SURVEY-LONGITUDINAL

Name: _____
Date: _____ Session Number:_____

What have you learned about yourself, your partner, and your relationship because of this process (e.g., what are the "take away" points that you have discovered)?

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Do you have any suggestions for how we might improve the Therapeutic Assessment with Couples Program in the future? If so, please describe below.

_____
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Overall, what is your summary impression and / or experience of the Therapeutic Assessment with Couples Program (i.e., any final comments or observations)?

Please rate your overall level of satisfaction concerning your romantic relationship by circling the corresponding number.

1	2	3	4	5	6	7
(Unsatisfied)			(Moderately)			(Satisfied)

THANK YOU ONCE AGAIN FOR YOUR PARTICIPATION!

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Annotated Bibliography[3]

Amato, P.R. (2000). The consequences of divorce for adults and children. *Journal of Marriage and Family, 62(4),* 1269-1287.

This article summarizes and organizes the empirical literature on the consequences of divorce for adults and children. Specific issues that are addressed include: the difference

[3] The following annotated bibliography is not intended to include or provide a rationale for all refences, but rather to highlight perspectives on materials that were particularly relevant to the current study for purposes of future research and practice.

in well-being of married and divorced families, the role of divorce versus selection, short term versus chronic stress of divorce, and mediating and moderating factors of individual adjustment. I used this article in my dissertation research as evidence that divorce and separation within the context of coupling and marriage can have profound, negative impacts on the well-being on those involved in such processes, both adults and children. As the marital dissolution rate has increased over the 19th century, interventions targeting the marital relationship and its effect on offspring becomes ever more important.

Bagarozzi, D.A., & Sperry, L. (2012). Couples assessment strategy and inventories. In L. Sperry (Ed.), *Family assessment: Contemporary and cutting-edge strategies* (2nd ed.) (pp. 137-162). New York, NY: Routledge Taylor & Francis Group.

This book chapter begins with brief reviews of seven couples assessments that have been more recently developed and are concise in nature: Locke-Wallace Marital Adjustment test, Dyadic Adjustment Scale, Spousal Inventory of Desired Changes and Relationship Barriers, Marital Disaffection Scale, Areas of Change Questionnaire, Intimacy Needs Survey, Sexual Desire Inventory. The following section offers details for evaluations assessing marital infidelity, trust, family dynamics, and client perception of goal attainment. The final section of this chapter outlines the process for selecting and using couples assessments within a therapeutic context.

I used the last section within this chapter as a template by which to organize the entire Therapeutic Assessment with Couples (TAC) intervention. I first evaluate marital quality using the Marital Satisfaction Inventory-Revised (MSI-R) to get an accurate appraisal of the couple's level of distress and dissatisfaction. The second step is the performance of a more comprehensive assessment to identify potential relationship

conflicts and why those might exist. I use the Couples Questionnaire and Beliefs, Events, and Values Inventory to do this. Thirdly, I assess concerns in a specific category that has yet to be addressed or needs further evaluation. Lastly, I categorize conflict and disagreement, which then become the subsections within the recommendations part of the TAC report.

Busby, D.M., Ivey, D.C., Harris, S.M., & Ates, C. (2007). Self-directed, therapist-directed, and assessment-based interventions for premarital couples. *Family Relations, 56(3),* 279-290.

This article investigates the effectiveness of three models of premarital education: workbook-only self-directed program, a therapist-directed (unstructured) program, and an assessment-based (RELATE) relationship enhancement program. In their literature review, authors note that many premarital education programs assume a "one size fits all" approach to skill training, and that assessment may be an effective means by which to tailor the experience of each couple participating in such workshops. In terms of pre- and posttest results, the workbook-only condition had scores that stayed relatively stable across the time periods, the therapist-directed group had scores that stayed the same between pre- and posttest and then dropped at the follow-up period, and the assessment-based group had scores that showed improvement across the three measurement periods. One explanation for such outcomes may be that assessment-based programs have the ability to help the couples quickly understand their problem areas and then move beyond the problems to the underlying processes. Authors then discuss various structures by which assessments may serve in the premarital education realm.

This article speaks directly to the effectiveness of assessment-based programs in

comparison to both workbook only self-directed and therapist-directed interventions. I utilize several key assertions that these authors put forth regarding the long-term success of assessment-based programs and possible explanations for such success. I hope to broaden the scope of this article by demonstrating that assessment-based interventions with couples need not be restricted to premarital processes, but such programs can be useful for both married couples and couples with no desire to get married.

Coates, M., Hanson, W., Samuel, D.B., Webster, M., & Cozen, J. (2016). The Beliefs, Events, and Values Inventory (BEVI): Psychological assessment implications and applications. In C.N. Shealy (Ed.), *Making sense of beliefs and values: Theory, research, and practice* (1st ed.) (pp. 373-405). New York, NY: Springer Publishing Company.

This chapter begins with a review of why utilizing assessments can prove fruitful to both clients and clinicians. This section is smartly followed by a thorough reminder of the challenges that inevitably arise when attempting to conduct ecologically valid assessments in a variety of contexts. The third portion of this chapter explains the "therapeutic assessment" movement. The remainder of the text is dedicated to describing how the EI Theory and BEVI look to bridge traditional and therapeutic assessment approaches to by explicating a number of underlying variables that appear to mediate assessment processes and outcomes.

This chapter provided me with a solid foundation upon which to expand my argument that the BEVI has the ability to function as a connector between traditional and therapeutic approaches to assessment. With citation, I adapt and / or excerpt the language of the succinct review of the "therapeutic assessment" paradigm included in this chapter

in my dissertation. I also utilized several key points offered in this text as part of my explanation of the TAC program and several of its major intervention-based aspects: the promotion of transformative learning, increased mutual understanding, and the mobilization of change.

Cordova, J.V. (2014). *The marriage checkup practitioner's guide: Promoting lifelong relationship health*. Washington DC: American Psychological Association.

This book is an accessible yet thorough guide to effectively conducting regular relationship health checkups in the service of promoting lifelong relationship health for all committed couples. The author begins this text with an overview of the concept of the Marriage Checkup (MC) and the basic of working with couples. Next, he introduces the adaption of assessment, motivational interviewing, and integrative couples therapy within his particular MC frame. The final chapters include details regarding the conduction of an MC session, writing an MC report, providing feedback regarding both relational strengths and concerns, and future direction for relationship health checkups.

This seminal writing is one of the most important resources that I came across in my literature review. Much of the structure of the TAC program is based on Cordova's Marriage Checkup, including: mailing the assessment packet prior to the first session, the utilization of motivational interviewing, specific relational areas of assessment, the outline of the written report, incorporation of therapeutic assessment techniques and theory, multi-faceted use with a range of couples, and focus on the enhancement of healthy marital practices via the development of intimacy and interpersonal pattern awareness.

Cordova, J.V., & Scott, R.L. (2001). Intimacy: A behavioral interpretation. *The Behavior Analyst, 24*(1), 75-86.

This article was crucial in creating the research questions for this study. Authors posit that intimacy is a "behavioral phenomenon"; defined as individual behavior (e.g., self-disclosure), interactions between partners (e.g. rewarding of interpersonal vulnerability), and specific feelings (e.g. connection, love, care, etc.). Such a framework of intimacy makes it easier to quantify and then study from a psychological perspective. The vulnerability that is innate to such processes of intimacy can also be used in a punishing fashion. This article posits that the punishment of interpersonally vulnerable behavior is an integral part of intimate partnership formation and that intimate partnerships can create patterns of reinforcing behavior that may be detrimental to both the couple and others.

We propose that participation in TAC will increase (a) both self and other-awareness in a way that will generate greater (b) intimacy, which in turn, will heighten each partner's sense of (c) relationship satisfaction. We infer that increased self and other-awareness will bring about all three behavioral phenomena cited in Cordova's article (i.e., individual behavior, interactions between partners, and specific feelings). We used constant comparative data analysis to code behaviors of intimacy that appeared in all feedback forms administered in the TAC program, with some examples being: engaging in better forms of communication, enhancing the friendship within the romantic relationship, turning and responding to partner bids, create shared meaning, increasing fondness and admiration, and so on. Results indicate that intimacy is one of the top ranked findings in this study, confirming part of our three-part proposal.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M.,

Edwards,…Marks, J.S. (1988). Relationship of childhood abuse and household dysfunction to many leading causes of death in adults. *American Journal of Preventative Medicine, 14*(4), 245-258.

This article was a decisive turning point in the medical field concerning the impact of psychosocial issues on physical health. A questionnaire about adverse childhood experiences was completed by 9,508 individuals associated with a large HMO. Ten categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; emotional or physical neglect; violence against mother; parents divorced/separated; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Findings show that almost two-thirds of study participants reported at least one ACE, and one in five persons reported experiencing three or more ACEs. Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, greater than or equal to 50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. Authors rightfully conclude that a strong graded relationship exists between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

In discussing how a distressed parental relationship negatively impacts the well-being of children, I used information from this article to clearly demonstrate the

connection between psychosocial circumstances and physical health. While I cite other literature concerning the specific consequences that violence against mother and processes related to parents divorcing or separating have on children exposed to such ACEs (i.e., lower academic achievement, self-concept and well-being, psychological adjustment, etc.), I include this article in my dissertation to clearly illustrates the causal relationship between long-term health consequences and one's social and physical environments. Prior to this study, the relationship of health risk behavior and disease in adulthood and exposure to childhood abuse and household dysfunction during childhood had not previously been described. Results from this work increased the medical field's understanding of the system/ecological perspective and encouraged continued interprofessional dialogue.

Fentz, H.N., & Trillingsgaard, T. (2016). Checking-up on couples – A meta-analysis of the effect of assessment and feedback on marital functioning and individual mental health in couples. *Journal of Marital and Family Therapy, 42(1),* 31-50.

Authors conducted a meta-analysis of studies that utilized a relationship checkup approach, which included both assessment and intervention elements, regarding marital functioning and individual mental health. Fentz and Trillingsgaard offer a compelling summary of barriers that many couples encounter regarding relationship support and maintenance (i.e., lack of motivation, preference to problem solve without external assistance, recidivism, social stigma associated with therapy, investment of time and money, etc.). Results of this article indicate that relationship checkups seem to have some positive impact on both healthy and more distressed couples. Additionally, this study's meta-analytic evaluation points to a small positive overall effect on couples marital

functioning and a moderate overall effect on individual measures of mental health.

This article has introduced me to the concept of relationship checkups, including its various components, key authors regarding this type of therapeutic intervention, and results of its effectiveness concerning marital functioning, individual mental health, and client population. The program that I developed for my dissertation project can be considered a relationship checkup. The emerging practice of conducting assessment and feedback as a brief therapeutic couple-oriented intervention seems to be a viable approach to relationship enhancement, and helped frame my dissertation research in a way that made it more attractive to external parties.

Flamez, B., Froeschle Hicks, J., & Clark, A. (2015). Effectively using research and assessment in couples and family therapy. In D. Capuzzi & M.D. Stauffer (Eds.), *Foundations of couples, marriage and family counseling* (pp. 71-100). Hoboken, NJ: John Wiley & Sons, Incorporated.

This chapter provides a succinct and accessible overview of various approaches to research and types of assessment utilized within the field of counseling. Authors assert that there currently exists a gap of research between researchers and clinicians in many of the social science professions. As such, the importance of research and assessment must work towards integration. It would seem that mix method designs serve as systematic merging of both numbers and words to provide a more comprehensive understanding of any given phenomenon. Several sections of this chapter are dedicated to issues of assessment administration, interpretation, and reporting, and still more offer helpful reviews of a variety of measures.

I used pieces of this chapter to illustrate the usefulness of my mixed methods research design, particularly in relation to couples therapy. The review of the Marital Satisfaction Inventory-Revised is one that is written concisely and favorably, which will help me to articulate why I chose this specific measure of broad relational functioning over other assessments. Other key points mentioned in this chapter include the importance of individually assessing partners concerning domestic violence and substance use.

Fincham, F.D., Stanley, S.M., & Beach, S.R.H. (2007). Transformative processes in marriage: An analysis of emerging trends. *Journal of Marriage and Family, 69(2),* 275-292.

This article posits that marital literature has, historically, focused exclusively on marital discord and conflict as a means of studying marital health. Authors offer a more nuanced and positive approach to understanding marital health, through the emphasis of various transformative processes of marriage. Such new foci include forgiveness, commitment, sacrifice, and sanctification. The belief that dyadic processes are iterative in nature is part of the author's argument that harnessing the potential of aforementioned foci could assist researchers in creating new and powerful methods for protecting and improving marital relationships.

A distinct feature of my dissertation project is the assertion that romantic relationships, particularly marriages, have transformative capabilities. Holding this perspective means that the cultivation of marital relationships not only "avoids the bad" (as extensively documented in the relationship science literature), but can enhance the

positive outcomes for both adults and children. I used this article as support of my perspective, and the overarching idea that marital health can have positive implications.

Finkel, E.J. (2017). *The all-or-nothing marriage: How the best marriages work.* New York, NY: Dutton.

In this comprehensive examination, Finkel traces the evolution of marriage from the earliest days of our late ancestors to modern times. He begins his book by outlining the three stages of marriage: as a tool to survival via financial unity and laboring offspring, to a partnership based on love and passion, to our current stage in which marriage is expected to facilitate voyages of self-discovery and personal growth. Finkel's explanations are supported from a variety of social and psychological studies, data, and graphs. The middle section of the book is comprised of "love hacks," quick fixes for the more manageable issues that often arise in marriage. The latter part of the book is dedicated to more long-lasting strategies concerning current, perpetual problems that have arisen out of the self-expressive era of marriage.

I use the first part of this book to help describe the current marital landscape. I offer a quick overview of the various stages of marriage, specifically noting that the current "self-expressive era" of coupling moves us to expect that our partners should fulfill many and varied life domains of well-being. Despite these increasing demands, trends like time-intensive parenting and increased participation in the paid labor force mean that we spend less alone time together with our spouses. This information, in conjunction with other shifts within the relational and marital landscape, demands that we dedicate more time to cultivating healthier partnerships.

Finn, S.E. (2015). Therapeutic assessment with couples. *Practiques psychologiques, 21,*

345-373. http://dx.doi.org/10.1016/j.prps.2015.09.008

This article documents the first complete case study of Therapeutic Assessment (TA) with couples. The author describes how steps that are common to all forms of TA differ when applied to couples. The case example involves a young heterosexual couple married for 12 years who were at an impasse in couples therapy. Each partner completed the MMPI-2 and Family Assessment Measure-III, and then conjointly engaged in a Consensus Rorschach with the evaluator. The author reports that assessment helped the partners explore mutual conflicts around the expression of anger and dependency needs, and to resolve a power imbalance within the couple. Long-term follow-up showed that TA helped the couple have more compassion for each other and allowed them to move beyond the destructive role-lock in which they had fallen.

This article served as a template from which I based my initial conceptualization of my TAC intervention. While I did not use the measures that this author employed, I did adopt many of the Therapeutic Assessment principles in that I view the process of assessment as transformational and prioritizing client change, and hold a relational review of psychological assessment, a stance of compassion and curiosity rather than judgment and classification, a desire to help clients directly, and a special view of tests. I also utilized TA's general approach to structuring my program (e.g., initial sessions, extended inquiries, assessment intervention sessions, and summary/discussion sessions).

Geiger, A., & Livingston, G. (2018, February 13). 8 facts about love and marriage in America. Retrieved from http://www.pewresearch.org/fact-tank/2018/02/13/8-facts-about-love-and-marriage/

This short article offers statistics regarding eight current trends concerning love and

marriage in the United States. Authors write that marriage has declined most among individuals with lower levels of education. As the U.S. marriage rate has declined, divorce rates have increased among older Americans (50 or older). With such trends, it is not surprising that remarriage is on the rise, with 23% of married people having been married before their current partnership (a 10% increase since 1960). One of the main takeaways from this article is the diversity now present in processes of partnering: cohabitation is becoming more common, as are interracial and interfaith marriages. Lastly, authors note that a total of 15% of American adults have used online dating sites and/or mobile dating apps. For the most part, the public today view online dating positively.

The trends that this article highlights, with the added bonus of presenting such facts based on a large sample size, are particularly relevant to my dissertation project. In establishing the need for an assessment-driven, relational intervention, I aim to offer a context in which romantic relationships currently exist. This article greatly assisted me in summarizing present trends concerning love, marriage, divorce, and other processes related to coupling. The increase in dyads married to persons of differing racial/ethnic and religious backgrounds must be met with an effective means by which to understand, communicate, and create shared meaning. Along similar lines, the rise in the divorce rate among older Americans demands attention in a way that this population is presently lacking. My dissertation project is multi-faceted in that it can serve as premarital education, assisting distressed couples, and potentially, serving dyads considering or moving forward with separation or divorce.

Halford, W.K., Pepping, C.A., & Petch, J. (2015). The gap between couple therapy research efficacy and practice effectiveness. *Journal of Marital and Family Therapy, 42(1),* 32-44.

The beginning of this article outlines the present gap between efficacy and effectiveness studies concerning couple therapy processes, and then offers several explanations as to why this gap exists. As more conclusive points, the authors make a strong case for the need of additional research on effectiveness of couple therapy specifically assessing the impact of outcomes of systematic evaluation of couples at presentation, formal structuring of therapy goal setting, and monitoring both progress and the therapeutic alliance. Based on the authors' research concerning the gap between the efficacy-effectiveness gap, major recommendations regarding couples therapy include the assessment of whether each partner wishes to clarify whether or not to continue the relationship, or seeks to improve the relationship. This differentiation may prove to be especially meaningful within future research studies.

I used this article in my dissertation as one of the reasons why research like mine (mixed methods, assessment-based intervention within a clinical setting) is important, as it fills a current gap in couple therapy literature. Many of the recommendations within this article are already components of the TAC program (multimodal assessment of individuals and the relationship, screening for substance use and interpartner violence, and the solicitation of feedback). As I look to continue to reshape this intervention to make it more viable, there are several propositions that I find particularly valuable: the clarification concerning each partner's to continue or improve the relationship and the monitoring of the therapeutic alliance.

Halford, W.K., Chen, R., Wilson, K.L., Larson, J., Busby, D., & Holman, T. (2013). Does therapist guidance enhance assessment-based feedback as couple relationship education? *Behaviour Change, 29(4),* 199-212. doi: 10.1017/bec.2012.20

This article investigates the effectiveness of guidance offered by a therapist in processing a report within a couple's relationship education program. More specifically, the present study evaluates the benefits of adding a therapist-assisted feedback session to review the computer-generated RELATE report (RELATE+) compared to a self-interpretation of the RELATE report by couples (RELATE). Authors founds that relationship satisfaction was high and stable across time, and there was no difference between the effects of RELATE and RELATE+ on couple relationship satisfaction. The only significant difference between the two conditions is that the RELATE+ condition was associated with substantially greater consumer satisfaction than the RELATE condition.

This was an important article to read as it invited me to consider how impactful my presence as a therapist was within the TAC program. One of the main limitations of my dissertation project is the amount of time a mental health provider must put forth in reviewing, scoring, interpreting, and reporting out assessment data. While this work is done "behind the scenes," in that it does not fall into the direct service realm of interacting with clients, it is a significant component when considering barriers to providing couples relationship education to socially disadvantaged couples (i.e., cost of therapeutic services). Results of my dissertation are in agreement with the authors when they discuss the hypothetical correlation between customer satisfaction and future participation in couples relationship education or other couples-based therapeutic

services. Is it important to note that this study was conducted with relatively stress-free couples. Distressed and/or high-risk clients may need therapist guidance to a greater degree than dyads with more stable processes a part of their relationship.

Jordan, K. (2003). Couple and family assessment: An overview. In K. Jordan (Ed.), *Handbook of couple and family assessment* (pp. 1-13). Hauppauge, NY: Nova Science Publishers, Inc.

This chapter serves to provide readers with a global review of how couple and family systems (and those within such systems) should be assessed. Several sections are dedicated to understanding the stages and developments had within the coupling process. This author encourages practitioners to utilize a variety of assessment tools and techniques (standardized measures, genograms, interviews, etc.) that are culturally, ethnically, and, more generally, sensitive to a variety of social identifiers. She also invites readers to conceptualize and evaluate clients and client concerns from a multi-contextual frame. Lastly, the idea that multi-method assessment is an ongoing endeavor is promoted as a tool that assists with providing clients top quality, time- and cost-effective therapy.

I used language this chapter offers concerning the benefits that utilizing assessments has within a therapeutic context. Jordan provides several concrete examples of why evaluations are necessary concerning diagnosis and treatment planning, especially as health maintenance organizations, preferred provider plans, and insurance companies require time and cost effectiveness as well as problem-specific treatment. I may introduce the idea that as our healthcare system seems to be moving toward a more integrated model, providing evidence-based therapeutic services will become a more prominent aspect of mental health care.

Kiecolt-Glaser, J.K. (2018). Marriage, divorce, and the immune system. *American Psychologist, 73(9),* 1098-1108.

This article reviews several lines of work to describe how marriage and divorce can provoke health-relevant immune alterations. The author notes the physiological impact of hostile behaviors exhibited by married couples, both newlyweds and long-term married dyads. Partner convergence is discussed from the context of gene expression, immune profiles, and gut microbiome. The interconnection between depression and inflammation is unpacked, and then reviewed from the perspective of gender differences with the conclusion that women appear to be at greater risk in poor marriages.

I use this article as some of the most recent evidence concerning the physiological impact of agitated marriages and typical divorces. The presence of hostile behaviors, often present when discussing a marital conflict, are one of the strongest predictors of physiology and marital distress. Moreover, marital discord's notable consequences include an amplified risk for inflammation-related disorders, depression, cardiovascular disease, metabolic syndrome, diabetes, and poorer wound healing. Such realities touch on the importance of maintaining healthy marital practices. As broader literature suggests that women would be at greater risk in poor marriages than men, the quality of marital relationship becomes a gendered issue.

Kiecolt-Glaser, J.K., & Newton, T.L. (2001). Marriage and health: His and hers. *Psychological Bulletin, 127(4),* 472-503. doi: 10.1037//0033-2929.127.4.472

This articles reviews 64 studies published in the 1990s about the pathways leading from the marital relationship to physical health. Evidence from aforementioned articles indicate that negative dimensions of marital functioning have indirect influences on

health outcomes such as depression and health habits, and direct influences on cardiovascular, endocrine, immune, neurosensory, and other physiological mechanisms. Authors also unpack gender differences concerning the marital relationship and psychological functioning, noting that contemporary models of gender emphasize self-representations, traits, and roles impact men and women at varying degrees within the context of marriage.

As part of my argument asserting that processes of coupling are a bipartisan, public health issue, I used various aspects of this article to demonstrate how marriage and health are related. More specifically, I outline the ways in which unhealthy partnerships have a greater negative impact on the physical and mental health of women. Due to processes of socialization and culture, women's self-construal's are characterized by communion, a trait that motivates attention to and focus on others. In contrast, men, compared with women, are more characterized by agency, a personality trait that motivates separating from others and focusing on the self. Authors write that epidemiological studies of marital status show that being married, as compared with being unmarried, is more beneficial for men's health than women's. This discrepancy will be addressed in my dissertation, along with information concerning same-gendered partnerships.

L'Abate, L (2012). Family assessment: Current and future prospects. In L. Sperry (Ed.), *Family assessment: Contemporary and cutting-edge strategies* (2nd ed.) (pp. 309-328). New York, NY: Routledge Taylor & Francis Group.

This book chapter details the shifts that are occurring within couple and family therapy. Subsequent sections address the importance of homework assignments in psychotherapy

and bolstering face-to-face metal health services with cost-effective supplements. The remaining parts of this chapter are dedicated to the brief review of relational instruments based on Relational Competence Theory: Relational Answers Questionnaire, Self-Presentation Questionnaire, EcoMap, Modalities, Task for the Likeness Continuum, Self-Other Profile Chart, General and Personal Priorities, and Intimacy.

A significant concept from this chapter is the importance of homework assignments in psychotherapy. Several of the short-term TAC participants indicated that receiving homework assignments during the intervention itself would have been beneficial. Similarly, several long-term TAC participants shared that they found homework assignments between sessions particularly meaningful. Both the literature and qualitative data from my dissertation research illustrates the effectiveness of couple homework assignments. I also use this author's understanding of the need for psychological interventions to be differentiated according to levels of prevention (i.e., primary, secondary, and tertiary) as evidence of the need (and ability) of the TAC program to serve clients at all intervention levels.

Lavee, Y, & Avisar, Y. (2006). Use of standardized assessment instruments in couples therapy: The role of attitudes and professional factors. *Journal of Marital and Family Therapy, 32(2),* 233-244.

This study examined therapeutic approach, professional affiliation, training, seniority, and work setting as predictors of attitudes toward standardized instruments and their use in couple therapy. Several sections of this article focused on the extent to which therapists use instrument in assessing couples, with only 27.6% of respondents reported using standardized assessment instruments. The study's findings show that the majority

of marital therapists do not use any kind of structured assessment method and depend primarily on clinical interviews. Logistic regression analysis indicated that positive attitudes, training, and work setting best predict the application of standardized assessment instruments. Such results corroborate previous findings that clinical interviews are the most frequent method used for assessment in couple therapy and that clinicians tend to rely on their own judgment of couple relationships.

One of the goals of my dissertation project is to create a portable yet comprehensive battery of assessments to be used by mental health workers in clinical settings. This article documents the lack of use of assessments by those working with couples in a therapeutic context, with negative attitudes concerning assessment having the largest effect on the likelihood that therapists would use standardized instruments. It is my hope that my research will invite therapists to reconsider the beliefs they have about utilizing assessment measures in a therapeutic setting. Secondly, this article asserts that the argument that therapists tend not to use standardized tools because such measures do not answer the needs of therapists in clinical practice is not a viable one. Findings from this study (and my own experience) suggest that the relative lack of use of standardized instruments is not a reflection of unavailability of adequate instruments for assessing the couple relationship as there are various instruments available for the assessment of nearly all major relationship components.

Odell, M. (2003). Assessing couples: Procedures, tools, and benefits. In K. Jordan (Ed.), *Handbook of couple and family assessment* (pp. 49-66). Hauppauge, NY: Nova Science Publishers, Inc.

This book chapter presents the practical aspects of conducting an assessment with a couple (i.e., who should be present, particular areas in which assessment provides the most useful information, etc.). This author also offered specific descriptions of major evaluations and techniques. Lastly, an illustrative case study was presented to demonstrate the benefits conferred by conducting a thorough couples assessment.

This author offers several compelling and accessible narratives regarding the complexity that exists when assessing a couple, language that I used in discussing the differences between individual and couples assessment. There is also relevant information concerning the developments in Western society that have contributed to the pressure placed on partners to fulfill a variety of needs their significant others, and vice versa. The reviews of the scales in this book chapter were useful in helping me to decide with which broad relationship measure I wanted to work, and several others assessing a certain area that I may utilize in the future.

Provenzi, L., Menichetti, J., Coin, R., & Aschieri, F. (2017). Psychological assessment as an intervention with couples: Single case application of collaborative techniques in clinical practice. *Professional Psychology: Research and Practice, 42(2),* 90-97.

This article provides a single case example of the usefulness of two Collaborative/ Therapeutic Assessment (C/TA) techniques: intervention sessions and summary sessions. Such techniques are said to increase the assessment utility for clients as they provide clients with life-changing, experience-grounded feedback based on data results. In accordance with Finn's TA approach, authors administered, scored, and reported out results on the MMPI-2 and Rorschach with a couple, both as individuals and conjointly.

The collaborative process appeared to have helped both partners to engage empathetically and compassionately, promoted new insights about life challenges, and sustained the development of new narratives and their meanings.

This article provides a literature review that is timely, relevant to my research in its direct, clinical application, and speaks to several of the most salient aspects of my project design. Moreover, the authors offer examples of several graphics that would help to organize the timeline and information a part of the TAC program I created. The "case presentation" section is also an instructive example as to how to write a concise yet thorough couple conceptualization.

Shealy, C.N. (2016). Beliefs, Events, and Values Inventory (BEVI). In C.N. Shealy (Ed.), *Making sense of beliefs and values: Theory, research, and practice* (1st ed.) (pp. 115-173). New York, NY: Springer Publishing Company.

This chapter is dedicated to the thorough unpacking of the Beliefs, Events, and Values Inventory (BEVI). After a broad overview of the measure and the impetus behind its creation, Shealy offers a more in-depth history of the two versions of this assessment, followed by information concerning its validity and reliability. Validity and process scales are then introduced and discussed, as well as key points concerning the BEVI's structure and design (e.g., statements of belief, non-face validity, specifics of how items are worded, etc.). The report system is summarized, and then five practice samples are offered that illustrate the range of what the BEVI can do in a variety of settings.

This chapter was key in helping me to summarize many aspects of the BEVI: main objectives, psychometric properties, process scales, length of administration, current uses, and so on. One a more meaningful level, I make the case that the BEVI is

one of the most distinguishing features within the TAC program because many assessment-based, couple interventions at primary, secondary, and tertiary levels, only survey and address shared, relational domains. However, since couples and families are composed of and created by individuals, psychological factors affecting individuals are important in couples assessment. Thus, successfully changing a couple or family system requires that the therapist understands each individual within the system. TAC is unique in that it includes a comprehensive assessment of both partners within the dyad that is then presented via a comparative couple profile method. The BEVI is the only measure that emerged as a theme from our constant comparative data analysis, with underlying themes attesting to its accuracy and generation of new conversational content. Such a finding demonstrates the compelling nature of this evaluation within a couples therapeutic context.

Snyder, D.K., & Aikman, G. G. (1999). Chapter 38: Marital satisfaction inventory–revised. *The use of psychological testing for treatment planning and outcomes assessment.* 1173-1210.

This article begins with an overview of the Marital Satisfaction Inventory-Revised (MSI-R), including information regarding scale structure, administration and scoring, and foundations of reliability and validity. Middle sections offer basic interpretative strategies for analyzing partner profiles. Other components of clinical-based assessment include incorporating assessment into various parts of the therapeutic process, using the computerized interpretative narrative, findings from several treatment summaries, and a case example highlighting how the MSI-R can be used for an intervention evaluation.

This article contains a lot of information that I used as justification for selecting to use the MSI-R in my dissertation project: 20 years of empirical and clinical study supporting its reliability, validity, and utility, its ability to be used with Spanish-speaking populations, and its multi-faceted nature (can be used as a pre and post-intervention measurement). The authors also offer succinct summarizations of each scale. In terms of clinical utility, the MSI-R has group means for profiles for samples of a variety of client populations.

Sollenberger, J.W., Eubanks Fleming, C.J., Darling, E.V., Morrill, M., Gray, T.D., Hawrilenko, M.J.,…Cordova, J.V. (2013). The marriage checkup: A public health approach to marital well-being. *The Behavior Therapist 36(1),* 197-203.

This brief article outlines the understanding that marital health is just as foundationally important as individual physical and mental health. An introduction of the Marriage Checkup (MC) comprises the body of the text, with authors noting the efficacy and adaptability that this intervention has with a number of different demographics. Lastly, the decrease in funding concerning relationship health is highlighted. I used pieces of this article to summarize the MC intervention as well as strengthen my argument that marital / relationship health must be a priority in conceptualizing individual and communal well-being.

Sperry, L. (2012a). Family assessment: An overview. In L. Sperry (Ed.), *Family assessment: Contemporary and cutting-edge strategies* (2nd ed.) (pp. 1-16). New York, NY: Routledge Taylor & Francis Group.

This book chapter offers a brief overview regarding the shift from individual assessment to the evaluation of systems (i.e., couples and families), along with the differing opinions

concerning such assessment. Five, broad types of assessment are introduced: qualitative, standardized, observational, ongoing, and self-report. The author then presents the general format for the remaining book chapters: issues and challenges of assessment, instruments, and strategies for utilizing assessment results. The final sections of this chapter are dedicated to understanding issues of reliability and validity.

Several passages in this book chapter provide clear and concise summaries of why assessment with couples and families is both useful and necessary. I used such text as part of my argument for why multimodal assessments should be a normative practice when working with dyads in a therapeutic setting. I also utilized this author's categorization of types of assessments to make a case for the broadness of my multi-method approach, in that I employ all types of these evaluations within the TAC program. Lastly, I used language concerning the psychometric properties described in this chapter to address questions of reliability and validity concerning my selection of evaluations.

Sperry, L. (2012b). Ongoing assessment of couples and families. In L. Sperry (Ed.), *Family assessment: Contemporary and cutting-edge strategies* (2nd ed.) (pp. 115-135). New York, NY: Routledge Taylor & Francis Group.

This book chapter documents the clinical utility associated with ongoing assessment of and outcome measures administered to couples and families. Several benefits of outcome measures include: the identification of effective treatments, immediate feedback to clinicians and other helping professional, and the selection of specific changes for an unimproved client. The remaining sections of the chapter provide overviews of commonly used clinical outcomes scales for both families and couples.

I use language from this chapter to frame several elements within the TAC battery as outcomes measures. One of my dyads opted to take the MSI-R several months after their participation in the TAC program, and changes in those scores were helpful in terms of noting and celebrating progress, reminders of specific areas that still needed to be addressed, and clinically beneficial for me as a therapist in understanding both client improvement and stagnation. I think it is important to note that the MSI-R is routinely used as an outcome measure, which makes it inclusion within my TAC program even more desirable and multi-purposeful.

Williams, L., Edwards, T.M., Patterson, J., & Chamow, L. (2011). *Essential assessment skills for couple and family therapists.* New York: The Guilford Press.

This book begins by stating that assessment is fundamentally important to therapy. Another overarching theme in this text is the significance of working from a systems perspective in that therapists must look to understand how problems exist in the context of our client's relationships. In the chapter about assessing couples, these authors outline instruments for evaluating relationship quality, marital stability, psychological issues, and intimate partner violence. Other information that is to be gathered includes a communication sample, relationship history, individual histories, and the "Eight C's for Couple Functioning": communication, conflict resolution, commitment, contract, caring/cohesion, character, culture, and children. Lastly, this book attends to special topics in couples assessment such as sexual disorders, infidelity, and same-sex partnerships.

As with several other resources, I used language from this book to illustrate the importance of assessment within a therapeutic context. Couples evaluation can help

therapists uncover what clients expect from therapy, understand how problems manifest and impact clients' lives, figure out why the problem exists, select the best treatment for clients, and measure how effect therapy is in bringing about change. My TAC program outline follows, quite closely, the recommendations these authors have concerning gathering information at the beginning of couples therapy, so I will point toward the similarities that exist as a means of demonstrating the effectiveness of my approach. Because I worked with two, same-gender dyads, I used information presented in the final chapter to highlight the specific challenges that same-gender couples face.

Worthington, E.L., McCullough, M.E., Shortz, J.L., Mindes, E.J., Sandage, S.J., & Chartrand, J.M. (1995). Can couples assessment and feedback and improve relationships? Assessment as a brief relationship enrichment procedure. *Journal of Counseling Psychology, 42(4),* 466-475.

This article documents the investigation of the effects of individualized relationship assessment and feedback in relation to completing a written questionnaire about the relationship on couples' satisfaction and commitment. Couples in the assessment-feedback condition improved more over time than did couples in the written-assessment-only condition. Authors concluded that assessment and feedback produces small, positive changes in already well-functioning relationships. Those changes may account for a substantial proportion of the changes produced by relationship enrichment programs.

One of the main pieces of information gleaned from this study is that assessment of and feedback given to couples positively affected couples' relationships. Moreover, the amount of assessment and feedback couples received affected the amount of impact. I used such results to demonstrate that assessment interviews, questionnaires, and feedback

offered within a therapeutic context may not only help couples understand their relationship better but may also stimulate couples to act to improve their relationship.