CLIENT LEVELS OF EMOTIONAL EXPERIENCING IN INDIVIDUAL AND CONJOINT THERAPY SESSIONS

by

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ABSTRACT

Despite numerous studies comparing individual and conjoint therapy, there has been no research that looks at the differences between the modalities. Research has found that emotional experiencing is an essential element in the therapeutic process. This exploratory study examines the level of emotional experiencing in clients in individual and couple sessions. There were 20 people that participated in the study, not necessarily married to each other. Each participant was involved in an individual and conjoint session with his or her spouse, and three segments were selected from each session. Each segment had two scores, the modal and peak level of experiencing. The levels of experiencing were measured using the Patient Experiencing Scale (Klein, Matheiu, Gendlin & Keisler, 1969), which is an ordinal scale ranging from one to seven. It was hypothesized that levels of experiencing would be higher in individual sessions than in couple sessions. It was also hypothesized that the levels of experiencing would increase across segment and that there would be no difference in the level of experiencing between gender. The findings indicated that experiencing was higher in individual than couple sessions for both modal and peak scores. The results also showed that levels of experiencing did not increase across segment, and that there were no differences in levels of experiencing between genders. These findings suggest that therapists need to focus more on the emotional experiencing of clients, the importance of considering the use of individual therapy with couples, and focusing more on increasing the level of emotional experiencing in couple therapy sessions.

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CHAPTER I

INTRODUCTION

There have been numerous debates regarding the most effective therapeutic modality (Becvar & Becvar, 1996; Gurman & Kniskern, 1991; Nichols & Schwartz, 1998). A great deal of research has compared different modalities of treatment, including the comparison of individual, group, family, and couple therapy modalities. Since individual psychotherapy and group psychotherapy were established first, proponents of conjoint couple and conjoint family therapy had to make a case, either through theory or research or both, that conjoint therapy was as good as or better than individual or group therapies (Gurman & Kniskern, 1991; Nichols & Scwhartz, 1998). Although most research on the effectiveness of conjoint therapy compares conjoint therapy conditions with one or more individual or group therapy conditions, the theoretical assumptions of why conjoint therapy might be better have not been tested directly in these studies.

The purpose of this study is to examine one process variable, the level of client emotional experiencing (Klein, Matheiu, Gendlin, & Kiesler, 1969; Klein, Mathieu-Coughlan, & Keisler, 1986; Wiser & Arnow, 2001), by comparing the individual's level of experiencing in a conjoint couple session with the level of emotional experiencing of the same person in an individual therapy session. Even though a comparison of individual and conjoint therapy at the level of process addresses important questions about why conjoint therapy may or may not be effective, such a study has not yet been attempted.

One of the possible reasons such a study has not been attempted is that the researchers and theorists tend to conceptualize modality of therapy as an "either- or" dichotomy, either conjoint or individual therapy. In reality many therapy cases involve a combination of different modalities. For example, in one week, an individual may be seen with a child, another week with a partner, and another seen alone. A further issue is that most often in research, modality has been confused with the focus of therapy. It has been assumed that the modality of individual or group therapy is focused on intrapsychic problems and conjoint therapy is focused on couple or family problems. In reality, individual therapy can focus on relational issues (c.f. Hastings & Hamberger, 1988; Holsworth- Munroe, Beatty, & Anglin, 1995), and conjoint therapy can focus on intrapsychic issues (c.f. Foley, Rouansville, Weissman, Sholomaskas, & Chevron 1989; Jacobson, Dobson, Fruzetti, Schmaling, & Salusky, 1991; O' Leary & Beach, 1990).

The proposed research rests on the assumption that it is important to distinguish the construct of modality (individual and group versus conjoint), from the construct of focus (intrapsychic versus relational problems). In this research, a comparison, at the level of process, will be made of individual and couple sessions in which the couples came for therapy for help with couple issues. The purpose of this study is to compare conjoint therapy with individual therapy with a systemic foundation, rather than individual psychotherapy. Both individual and conjoint therapy can be systemic, because it is an orientation rather than a technique. The difference between systemic individual therapy and individual psychotherapy is that systemic sessions focus not only on the individual, but also take into account the systemic factors affecting the individual and in turn how the individual

affects the system. Marital therapy translates human and family differences into relational terms. This translation leads marital and family therapists to keep the whole system or systems in view when interacting with any part of the system (Wampler, 1997). Even when marital and family therapists hold to individual symptomology (e.g., depression, schizophrenia, and alcoholism), the focus is more on the interaction of the couple instead of individual symptomology. Individual psychotherapists have fully recognized the importance of family life in shaping personality, but they assumed that these influences are internalized and that intrapsychic dynamics become dominant forces that control and affect behavior (Nichols & Schwartz, 1998). Individual psychotherapy is predicated on relative stability of the environment (Nichols & Schwartz, 1998). Otherwise trying to change and return the client to a destructive environment would not make much sense. Systems theory as applied to human relationships does not make the same assumption, and holds that changing the system or the environment may change the individual, at the same time changing the individual may change the environment. Where traditional psychotherapy does not take into account outside relationships, societal factors, and family dynamics, systems theory does. For example when a person is seen individually and talks about constant arguments with the spouse, the systemic therapist may focus on working with the client to change the interaction with the spouse, which inherently changes the spouse and the relationship. This is similar to the ripple effect; one part of the system cannot change without the entire system changing.

CHAPTER II

REVIEW OF LITERATURE

Research on Individual Versus Conjoint Therapy

The majority of research in marriage and family therapy has focused on the comparison of individual psychotherapy versus conjoint therapy in general, for child problems, adult problems and couple problems. As stated earlier, this research came out of a need for family therapy to prove to the mental health field that conjoint family and couple therapy was as effective, if not more so, than individual therapy.

A meta-analysis by Shadish, Ragsdale, Glaser, and Montgomery (1995) found that in 23 studies that compared MFT with individual psychotherapy within the same study, the differences in outcome were small or insignificant. They also noted that only two out of the 23 studies had either traditional marital or family therapy problems. Rather, the problems in the studies included anxiety, phobias, affective disorders, substance abuse and medical problems. This finding implies that a majority of couples and families come into therapy with an array of individual, marital and family problems.

Individual approaches have been well documented in the treatment outcome literature in addressing adult intrapsychic problems (Prince & Jacobson, 1995). However, there is strong outcome evidence for treating adults with bipolar depression in psychoeducational family context (Nichols & Schwartz, 1998). Indeed, it is widely believed that family psychoeducation is more effective than individual therapy for those with

psychotic problems. In addition, a review article by Prince and Jacobson (1995), found three studies (Foley, Rouansville, Weissman, Sholomaskas, & Chevron 1989; Jacobson, Dobson, Fruzetti, Schmaling, & Salusky, 1991; O' Leary & Beach, 1990) that suggest conjoint marital therapy may be helpful when applied to the population of depressed clients who are also maritally distressed. However, the studies also showed that conjoint treatment does not result in improved rates of recovery or the maintenance of treatment (Prince & Jacobson, 1995). Marital and family therapy interventions have not proven to be more effective than standard individual treatments in alleviating symptoms of affective illnesses (Prince & Jacobson, 1995). However, conjoint therapy is as effective as individual treatment for a specific subset of depressed patients who are also experiencing marital distress (Prince & Jacobson, 1995). The Prince and Jacobson (1995) article also found that for unipolar depressed inpatients, conjoint marital and family therapy appears to be less effective than the standard treatments. Overall it seems the severity of the affective illness may indicate the effectiveness of conjoint, marital or family therapy, where therapy may be more effective with less severe affective illnesses. The primary advantage of conjoint marital therapy in dealing with depression and other affective illnesses lies in its capacity to resolve the symptoms and marital distress.

Szapocznik and his colleagues (1983, 1986) also compared individual family therapy and conjoint methods. In addressing other adult problems such as alcoholism and substance abuse, several studies have demonstrated the superiority of family therapy over individual therapy for achieving short-term sobriety (Nichols & Schwartz, 1998). The substance abuse literature does not consistently support the use of family interventions to motivate adults to

seek treatment and that they are not superior to traditional individual approaches (Liddle & Dakof, 1995). With regards to dealing with child problems, research has found that family support approaches have not been supported in dealing with chronic eating disorders (Campbell & Patterson, 1995) or core features of attention deficit hyperactive disorder (ADHD) (Estrada & Pinsof, 1995).

There has also been extensive comparison research focused on couple problems. Gurman and Kniskern (1978) compared the two modalities in the first major literature review of family therapy research and nonsystemic individual therapy. It has been repeatedly concluded that conjoint couple therapy reduces marital distress and increases marital satisfaction more effectively than individual therapy (Baucom & Hoffman, 1986; Bradbury & Fincham, 1990; Dunn & Schwebel, 1995; Gurman et al., 1986; Hahlweg & Markman, 1988; Jacobson & Addis, 1993; Nichols & Schwartz, 1998; O'Leary & Smith, 1991; Shadish et al., 1995). Regrettably, however, little research is available to shed light on whether conjoint direct participation adds to the ability for the clients to conceptualize the relationship (Sprenkle et al., 1999).

However, not all of the literature on couple problems indicates that conjoint therapy is preferable. The domestic violence literature addresses the constellation of individual therapy as a better option in dealing with couple issues (Hastings & Hamberger, 1988; Holsworth-Munroe, Beatty, & Anglin, 1995). Conjoint therapy may implicitly blame the victim and may send the message that the wife is responsible for the violence. Additionally, in couple therapy the wife's safety may be jeopardized and it may be difficult with both spouses present for each partner to self- disclose sensitive information. (Hastings &

Hamberger, 1988; Holsworth-Munroe et al., 1995). Partners may be fearful to express concerns honestly, which hinders the progress of the relationship. Overall, there have been strong claims made for individual psychotherapy, as there have been equally strong claims made for conjoint therapy, however all the cited studies emphasize the "either- or" dichotomy, instead of seeing the combination of both modalities in therapy.

Research Similarities Regardless of Modality: Common Factors

In spite of the research literature comparing the modalities and the assumptions made at the process level about the similarities and differences between the modalities, some authors argue that it is the characteristics of the client and therapist that make the difference in therapeutic success. Findings show in all of psychotherapy science, that very different systems of therapy produce very common outcomes (Prochaska, 1999). Any type of modality, whether individual or couple, has common factors or variables that are involved in therapy. For many techniques and variables are common to individual psychotherapy that are also common to couple therapy (Sprenkle, Blow, & Dickey, 1999). These common factors include client variables, and therapeutic relationship factors. Based on his review of literature, Lambert (1992) concluded that as much as 40% of the improvement in clients is attributed to client variables (i.e., motivation, ego strength, current stressors, social support networks, and a diverse array of disorders) and extratherapeutic variables.

Another common factor studied has been relationship factors, especially the therapist- client relationship. Lambert's (1992) empirical findings suggest that relationship factors account for approximately 30% of improvement in therapy. Findings from past

research studies (Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Luborsky & Auerbach, 1985) suggest that the therapeutic alliance is one of the crucial factors in client improvement. The therapist-client bond is critical in therapy. Negative feelings between the therapist and the client usually lead to less improvement in therapy or premature termination (Shapiro, 1974). Empathy, warmth, sincere regard, trust in one another and genuiness are the essential components involved in a positive therapeutic bond.

Regardless of the modality, each therapist brings certain qualities into therapy. Therapists provide an emphatically supportive environment in which clients can become vulnerable in a safe place, which allows for therapeutic growth and change. Therapists also provide interpersonal activity, with procedures that focus on opportunities where self-healing and direct experiential learning take place (Tallman & Bohart, 1999). A comfortable environment that fosters less anxiety and increases self-disclosure compounded by a strong therapeutic alliance, provide the foundation for emotional connection to experiences (Nichols & Schwartz, 1998).

In summary, literature has shown that regardless of the type, all of the modalities have common and essential elements that attribute to therapeutic change. Because these similarities or common factors in therapy attribute to a majority of client improvement, there is an evident "tie" between the two modalities.

Assumptions About Differences Behind Conjoint and Individual Psychotherapies

In addition to theoretical and technique- oriented differences between the modalities, there have also been numerous assumptions made about process-level differences between the two modalities. Overall, systemic theory and MFT literature assumes that conjoint therapy sessions are most effective in bettering couple relations (Gurman & Kniskern, 1991; Nichols & Sewhartz, 1998). Whereas individual psychotherapy proponents state that individual therapy can provide the concentrated focus, to help people face their fears and to learn to become more fully themselves (Nichols & Schwartz, 1998). As stated earlier, there are instances with affective illnesses where marital and family therapy is not as beneficial in cases where one client has suicidal ideation, schizophrenia or other disorders. It is difficult for both therapists and clients to focus on the enhancement of relationship, rather than the immediate focus of the partner's presenting problem.

In addition to general assumption differences about the effectiveness of conjoint and individual modalities, there have also been assumptions made about other process level variables. For example, there may be differences in the anxiety level of the client. Some assume that some individuals may be more anxious in therapy with their partner. This anxiety and fear may elicit hostility and defensiveness in conjoint therapy. Others assume that the presence of the partner may provide support and alleviate anxiety within the individual client providing for a more open communication between each partner and the therapist. Other assumptions are in the areas of safety, self- disclosure and honesty. Marriage and family therapeutic approaches assume that conjoint therapy provides a safe environment for the couple to express support and empathy, which enhances couple

communication. This environment may elicit more self-disclosure because of the reduced fear and anxiety when present with others in the session. Honesty may be more elicited in couple sessions because the other partner may hold the client accountable for being truthful in session. On the other hand, domestic violence literature sees individual therapy as providing safety for the victim, as well as providing an environment that elicits more self-disclosure, honesty, and reduces anxiety and fear for the victim and perpetrator. A partner may be less honest in a conjoint session, because of fear of repercussions following the disclosure of a secret or feelings. The issue of responsibility and blaming in session is another assumed difference between conjoint and individual therapy. In conjoint sessions, some assume that clients may take less responsibility for their actions, being tempted to render more blaming and become defensive. However, some assume that clients may take less responsibility and render more blaming behavior in individual session, because their partner is not present to either defend himself or herself or hold the other partner accountable for their responsibility. No research to date has confirmed either position.

In addition to assumptions focused on self-disclosure, anxiety, and safety in session, there have also been assumptions focused on the therapeutic alliance between the modalities. "While the average couple is likely to improve in couples therapy, the relationship may continue to be distressed" (Nichols & Schwartz, 1998, p. 514). Because of the concentration of individual symptomolgy in conjoint therapy, therapists may find it harder to form a therapeutic alliance with both partners. For example one client may view the therapist as warm, empathetic and genuine whereas the other partner may not. This difference in perception may cause a rift in therapy. If a split develops in the alliance, then broadening the

direct system may turn into a liability, which could end in premature termination (Bachelor & Horvath, 1999). On the other hand, some assume that seeing both at the same time can help develop a relationship with both partners and prevent coalitions.

Almost any mental health problem can be treated with either individual or conjoint therapy, however, proponents for individual therapy and conjoint therapy have made a case that their particular approach fosters the most conducive environment for therapeutic success, and a stronger therapeutic bond. However, there has been no research done that actually compares individual and conjoint therapy at the process level holding the client and therapist constant.

Level of Emotional Experiencing as a Possible Difference Between Individual and Conjoint Couple Sessions

Level of emotional experiencing (Alden, 1987; Chenne, 1973; Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Johnson & Greenberg, 1988; Mahrer, Lawson, Stalikas, & Schacter, 1990; Watson & Greenberg, 1996) has been identified in many research studies as a key aspect of therapeutic process related to successful outcome of therapy. Yet no study has examined whether the level of emotional experiencing differs in conjoint or individual therapy. Therapeutic alliance and emotional experiencing are the two critical variables related to improvement (Asay & Lambert, 1999). No matter how problems occur, clients resolve them by actually searching and exploring these issues in their life both inside and outside of therapy. Experiencing is important because real change appears to involve shifts in understanding at the bodily level and the intellectual level (Tallman & Bohart, 1999). Because emotional experiencing is such a key element in therapeutic progress, the level of

experiencing may be a variable that could account for differences, at the process level, between the modalities.

Emotional experiencing (Klein et al., 1986), the main dependent variable used in this study, is defined as the quality of a person's participation in therapy, in other words, the extent to which inner feelings and emotions become the focus of attention. Experiencing is made up of what one feels and senses. It involves but is not simply emotions, words, concepts and even muscle movements. It is the ability to connect emotionally to one's experiences, and to be aware and accept those feelings. The awareness and connection of these feelings are used in further thought, self- exploration, as well as in future action (Klein et al., 1986). Client-centered therapy (Rogers, 1951) provided the context in which experiencing became defined. Experiencing is crucial to personal growth and development, and is one key process that leads to change within therapy.

While most research has focused on individual therapy, experiencing has also been identified as an important part of couple therapy and individual therapy. In Emotionally Focused Therapy, which is based, in part, on Rogerian theory, the key is emotional exploration which expands each partner's experience of self in relation to the other (Johnson, 1996). The experience and expression of these emotions allows the partner's experience of self to evolve beyond the feelings themselves by putting these feelings and reactions in a new perspective for the partner, which creates a new kind of dialogue between the couple (Johnson, 1996). If a client is incapable of emotional experiencing, therapeutic change and progress could be inhibited. This lack of progress could lead to feelings of frustration from both client and therapist. Thus, this frustration may lead to early termination

of therapy by the client. Therefore an important question lies in whether the type of therapy session may also have an effect on the experiencing level of the client.

Though there has been much research comparing conjoint therapy with nonsystemic individual therapy, there is almost none comparing systemically conceptualized individual therapy with conjoint therapy (Sprenkle et al., 1999). Nor have there been any previous studies that have compared the same individuals in two different types of sessions at the process level. In order to remedy this situation this study will combine those factors, by looking at the comparison of individuals in two different types of systemic therapy sessions, at the process level. The purpose of this study is to answer the question: do clients have a higher experiencing level in conjoint therapy, or individual therapy? This question is important to answer, not for the purpose of which modality is better, which has been the focus of past research. Instead the purpose of the study is to help address the questions how do the modalities differ, other than who is present in session, and when is it better to use one modality versus the other?

Currently, no data exists comparing the level of emotional experiencing in clients in conjoint versus individual systemic therapy. There is current literature on emotional experiencing, and the Patient Experiencing Scale (EXP) introduced by Klein et al. (1969). The Patient Experiencing Scale (EXP) is a well-established scale that has been used in both conjoint and individual sessions. The scale has been proven to be effective in assessing the level of emotional experiencing in clients.

Studies have been conducted to examine the relationship between experiencing and therapeutic phenomena. They have shown that emotional involvement is an important factor

in positive and productive therapeutic change in individual therapy (Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Mahrer, Lawson, Stalikas, & Schacter, 1990; Watson & Greenberg, 1996) and in conjoint therapy (Alden, 1987; Chenne, 1973; Johnson & Greenberg, 1988). For example, Johnson and Greenberg analyzed the process of change in Emotionally Focused Therapy (1988). Client performance was rated on depth of experiencing and quality of interpersonal interactions. The findings indicated higher levels of experiencing and more autonomous positive interactions were characteristic of the best sessions of couples that were successful in therapy. As stated earlier, another study that looked at experiencing levels in couple sessions (Chenne, 1973) compared the level of experiencing in response to therapist's and spousal statements. The results found that when the mean experiencing level is considered, the client is equally facilitated by both the therapist and spouse; however when the peak level of experiencing is considered the individual is more facilitated by the therapist. A study by Alden (1987) focused on the type of sessions of couples in Emotionally Focused Therapy (EFT) that showed the most improvement in therapy. The sessions were being compared using a combination of therapist and couple reports of which sessions produced the most progress. The peak sessions were compared with the poorer sessions. Sessions reported as peak sessions showed significantly greater depths of experiencing. These studies provide evidence to support the idea that the level of experiencing is involved in the change process in couple therapy.

The EXP scale (Klein et al., 1969) has also been used in individual psychotherapy. A recent study by Fitzpatrick et al. (1999) reported that client statements in therapy, which contained a good moment, had significantly higher levels of emotional involvement. A

good moment was defined and measured by the Category System of Good Moments (Mahrer, 1988), which consists of 12 nominal categories of client change events. There was also a difference between emotional involvement and the different therapeutic approaches. A study by Mahrer, Lawson, Stalikas, and Schacter (1990) found that emotional involvement is related to significant personality change in therapy sessions. Similarly, Stalikas and Fitzpatrick (1995) reported that the occurrences of in-session changes were significantly related to both higher levels of experiencing and strength of feelings.

Studies have also been conducted to examine the relationship between experiencing levels in different therapeutic approaches. A study by Wiser and Goldfried (1998) found that interventions that highlighted non-specific client content were associated with high emotional experiencing; whereas lengthier interventions and interventions rated mildly controlling were associated with low emotional experiencing. An earlier study also by Wiser and Goldfried (1993) examined the extent of affective exploration and therapist views of client states. The findings revealed that experiencing was prevalent in equivalent amounts in both psychodynamic-interpersonal therapeutic sessions and cognitive-behavior sessions. However, the therapists' clinical views of the significance of experiencing were dissimilar. Cognitive- behavior therapists minimized the importance of emotional experiencing in session. Similarly, a study by Watson and Greenberg (1996) examined the pathway from in-session process to final outcome. Two treatments for depression were examined. One implemented client-centered interventions and the other treatment used process-experiential interventions. The process-experiential group showed higher levels of experiencing

compared to the client-centered group. The results also indicated that subject's degree of problem resolution correlated significantly with depth of experiencing.

In summary, research studies have shown that deep emotional involvement is a key element to therapeutic change and process in the session. In an attempt to answer the question: "Do clients have higher emotional experiencing in individual or conjoint sessions, this study will use the Experiencing Scale (Klein et al., 1969), to code the level of experiencing in clients when they are in individual sessions and couple sessions. Higher levels of experiencing was reported to be more facilitated by the therapist than the spouse in conjoint session (Chenne, 1973), and it is assumed that it individual therapy provides an environment for more self- disclosure, honesty and safety than conjoint therapy. Therefore, it is hypothesized that clients will have a higher level of experiencing in individual than in conjoint session with their spouse.

Other Variables That Could Affect the Level of Experiencing

In addition to the type of modality as a possible factor affecting experiencing, it is possible that gender of the client, and where during the therapy session observations are made could be factors affecting experiencing. Klein and her colleagues (Klein et al., 1969, 1986) make no mention of gender differences in experiencing. In addition, past research studies looking at experiencing level differences (Alden, 1987; Chenne, 1973; Fitzpatrick et al., 1999; Johnson & Greenberg, 1988; Mahrer et al., 1990; Watson & Greenberg, 1996; Wiser & Arnow, 2001) do not mention or address gender differences. Past studies of psychotherapy in general that looked at the relationship between gender of the client and

outcome in therapy have not indicated any significant differences (Garfield, 1994). It is hypothesized therefore, that there will be no differences in levels of experiencing between male and female clients.

The time during the session (i.e., the first, second, or third segment) is another factor that may affect experiencing. Klein and her colleagues (Klein et al., 1969, 1986) address the phase therapy sessions are sampled from, indicating that it is better to sample from the midpoint or working phase of therapy, because sampling initial and termination sessions runs the risk of missing therapeutic work and progress. However no research on experiencing examines changes in experiencing within a single session. Assuming that the depth of emotional experiencing develops during a session in response to therapist interventions, it is hypothesized that the level of experiencing will increase during the session.

CHAPTER III

METHODOLOGY

Context of the Research

This exploratory study is process research comparing the level of emotional experiencing in the same clients in individual and conjoint couple sessions. The participants in the study were drawn from a clinic data set in the marriage and family therapy clinic at Texas Tech University. The clinic operates on a sliding fee scale, which enables clients of any socioeconomic status, to participate in therapy. Upon entry into the clinic, clients are informed of being videotaped and observed during therapy as well as possible involvement in future or present research studies. However, participation in research is not mandatory in order to be seen in the clinic. Clients must give their written permission and consent for therapy, but not for the research, before therapy can continue. Due to these criteria, all participants have given prior consent for their involvement in this research study. In addition to giving informed consent, participants also complete an assessment package that includes the Dyadic Adjustment Scale (Spanier, 1976), demographic information and other measures.

Study Sample

This sample is one of convenience. It includes videotapes of conjoint and individual therapy sessions. The cases were obtained from an earlier study on couple attachment (Wampler, 1999). The Wampler sample consisted of thirty couples. Twenty-eight out of the

thirty couples were receiving couple or family therapy at the marriage and family therapy clinic located on the Texas Tech University campus. The remaining two couples heard about the study and volunteered to participate. To recruit the clinic couples, the therapists described the study and research assistants then contacted the couples that were interested in participation. Data were collected in different periods of time over one and a half year period. The 28 couple cases in the Wampler study involved 11 therapists (one to six cases each).

Selection Process

Selecting the cases. There were certain criteria formulated in order to select the specific cases used in the study. The criteria for choosing the cases used were modality, number of sessions, and sound quality. Each case consisted of at least one of the following combination of modalities: couple/family, couple/individual, or couple/family/individual. For the purpose of the study, all combinations were eliminated except for the couple/individual constellation. In order to be included in this study, there had to be both couple and individual sessions. In addition, to ensure an ample number of sessions to be sampled from, any case that had fewer than six taped sessions was not used in the study. The rationale for the chosen number of sessions is due to the suggested number of sessions used in a sample in the Experiencing Scale Training Manual (Klein et al.,1969).

There are a few variables in the study that we wished we could have used in the selection criteria, however because of the number of available cases that fit the criteria, that was not possible. The number of therapists involved in each case is a moderating variable

that can affect the results of the study. Again, however, because of the limited sample size, the number of therapists in each case was a factor that could not be controlled for. The gender of the client was an additional factor that was hard to control. Instead of focusing on one gender, we choose to include both genders for the enrichment of the study. The gender and the experience level of the therapist were other variables that needed to be controlled for. Unfortunately, because of the limited availability, that could not be done. Overall, after eliminating the cases that did not fit the specified criteria, 14 out of 30 cases in the Wampler sample were chosen for the study.

Sample description. The sample for this study includes a clinic population of 14 heterosexual couples, in marital distress, simultaneously attending conjoint and individual therapy sessions. Of the 14 couples, six cases had both partners represented in conjoint and individual sessions, only the husband was represented in four cases, and only the wife was represented in four cases. Therefore there are actually 20 participants in the study with emotional experiencing data. All of the couples were receiving therapy for relationship problems at the Texas Tech Marriage and Family Therapy clinic. The majority of couples were married (n =13) and one couple had currently separated. The length of the relationship ranged from one to 33 years and 11 of the couples had children. The mean age for males was 36 (SD = 11, Range = 22-56) and 32 for females (SD =10, Range = 17-53). Twenty-five people out of the 14 couples were European-American. The education level for the males ranged from some high school or less (n = 7) to some college (n = 4), with only three having college degrees. Most of the females (n = 11) had some college, with one having a college degree and two having a high school degree or less. Most of the participants were employed

either full-time or part-time (n = 12), some were students (n = 7), others were either unemployed or full-time homemakers (n = 6) and three participants did not specify employment status.

As stated earlier, a majority of the couples were distressed. The relational distress was indicated by the mean score on the Dyadic Adjustment Scale (Spanier, 1976). For males the mean score was 86 (SD = 21, Range = 43-123). For females the mean score was 76 (SD = 11, Range = 35-102). Five of the 14 cases were served by one therapist and nine of the 14 cases were served by two to three different therapists.

Selecting the sessions. The number of therapy sessions for the 14 cases ranged from six to forty-eight sessions per case ($\underline{M}$ = 25). Criteria were formulated to select the sessions used in the study. The criteria included the sound quality of the session, the spacing between sessions, and the point in time in therapy. The sound quality of the videotape had to be audible, clear, and loud enough to be transferred to an audiocassette tape. Ideally it is important to sample from at least two time periods in therapy, however because of the limited sample size in the study, the time frame in therapy was held constant. Sampling of the tapes included two sessions in the middle or working phase of therapy. Initial or termination sessions are often different in character from other sessions, so these were not selected.

The spacing of sessions was another criterion used in the selection process. There are two sessions for each of the 20 individuals in the study, one individual session and one conjoint session with the partner. The sessions had to be no more than two sessions apart from each other, in order to avoid sampling from different points in therapy. If the wife and

husband were both target clients, then the couple session sampled had to be different for both partners. In order to control the therapist factor as much as possible, in the cases where more than one therapist was involved, sessions where the therapist switched were not selected as viable for the study. In addition, in one case, there were two pairs of individual and conjoint sessions available for the same couple case. Each pair was with a different therapist. To increase the sample size, data for two sets of individual and couple sessions were included for this couple. It would have been ideal to have the same number of conjoint and individual sessions to sample from per case, but due to the limited availability of sessions that fit the criteria that was not possible.

Using the criteria formulated for the selection process, 44 sessions were used in the study. Twenty-two sessions had a male as the target client, and 22 sessions had a female as the target client. Therefore eleven sessions focused on the male in individual session and the other eleven focused on the same male in conjoint session. Eleven sessions focused on the female in individual session, and 11 sessions focused on the same female client in conjoint session.

Selecting the segments. Two undergraduate research assistants were used in selecting the segments. The undergraduates were blind to the hypotheses or the purpose of the study. In order to have a more representative sample, three segments per session were chosen. Training consisted of learning the criteria for the selection of segments, and preparing the segments for the coding process. Training lasted for two weeks, for six hours a week. At each training session, the undergraduates selected segments, using the criteria, from practice

tapes not used in the study. The criteria used in the selection process included sound quality, the amount of time the target client is speaking in session, and the length of the segment.

As stated before, the sound quality of the segment, had to clear and audible enough for it to be heard. In order to be a chosen segment, the target client, either the husband or wife, had to be talking for at least half the time of the entire length of the segment. If the segment was two minutes in length, the target client had to be speaking consecutively for at least sixty seconds. This enabled the rater to receive enough information to code the level of experiencing. To determine the ideal unit length the guidelines in the Experiencing Scale Training Manual (Klein, et al., 1969) were followed. The Experiencing Scale Training Manual (Klein et al., 1969) suggested in general that segments of five to eight minutes provide enough material to identify high levels of experiencing without becoming unmanageably complex or tedious. However, during training, I began to notice the raters became tired when segments reached a length of five minutes or more and did not rate as effectively. In order to maintain substantial amount of information, but remedy the fatigue, the unit length chosen for this study had to be at least two minutes, but no more than five minutes in length. According to the training manual (Klein et al., 1969) sampling of certain time periods may have more precision and offer better control of the time factor in small samples.

The amount of time watched for each session is a variable that may affect the results. It would be ideal to rate the level of experiencing for the entire session, however; mandating that the raters watch the entire tape could cause fatigue and habituation within the observer. Therefore, for each session three segments were chosen. In order to avoid mixing times in

sessions, the counter time was held constant for each 50-minute session. The first segment was pulled from between the 12^{th}-15^{th} minute time block, the second segment from between the 25^{th}-28^{th} minute, and the third segment between the 37^{th}-40^{th} minute. If the criteria were not met at the particular counter time, then the undergraduate was instructed to adjust the time block either one-minute prior or one minute after the designated time block.

Using the selection criteria, this study chose 132 segments to be recorded for rating (i.e., 44 sessions with three segments each). Of the 132 segments, 33 segments were husbands in individual sessions, 33 were husbands in conjoint sessions, 33 were wives in individual sessions, and 33 segments were wives in conjoint sessions.

Preparing segments for rating. The next step of training process involved preparing the chosen segments for the rating process. To ensure confidentiality of the clients, the original therapy tapes were copied onto an audiocassette tape. The transposition of original data onto cassette tape also ensured that the raters would not be affected by moderating variables such as therapist and client expressions and movements. There were ten cassette tapes used in the study. To enhance the independence of the rating for each segment, each segment was randomly given a unique number and randomly recorded on one of the ten tapes. This ensured that the raters would not be affected by previous segments of the target client. For example, if the rater coded one segment very high or low, he or she may be inclined to code the next segment high or low as well. Therefore, this was prevented by randomly recording the segments on different tapes. As much as possible, this also enhanced the blindness of the raters as to what type of session (i.e., conjoint versus individual) and the particular case the segments were chosen from.

Each undergraduate was given step-by-step instructions on the recording process. Once a particular segment was chosen, the undergraduate attached the tape recorder to the television, and made sure the microphone was plugged into the tape recorder. After the equipment was assembled, the undergraduate found the unique number for the specific segment chosen. For example, for case xxxx, the target session for an individual husband session, the segment number is one, and the unique number is fourteen. Once the unique number was retrieved the undergraduates spoke into a microphone and recorded the unique number on the cassette tape and then the actual segment was recorded onto one of the ten tapes. After each segment a different cassette tape was chosen to record another segment, and then rotated out. After the segment was recorded, the undergraduate replayed the segment to check for sound quality. Once the segment was properly recorded, the undergraduates were instructed to write down the unique number and what tape number it was recorded onto.

Measure

Experiencing Scale. The Patient Experiencing Scale (Klein et al., 1969) consists of a seven-point ordinal scale used to describe the level of emotional experiencing and involvement in therapy. It can be obtained by contacting the Bureau of Audio-Visual Instruction at the University of Wisconscin. The scale uses an observational rather than a self- report strategy. In addition to individual therapy, the scale can be applied to group therapy, couple therapy, and other interactional formats. The scale includes two scores, modal and peak, which both range from one to seven. The modal rating is the rating that

characterizes the overall scale level of the segment. The peak rating is the rating given to the highest Experiencing Scale level reached in the segment. A low rating on the scale portrays superficial and impersonal involvement in session. Middle rating on the scale is illustrated by inwardly elaborated descriptions of feelings, and at the highest levels of the scale new feelings and experiences are explored, which leads to problem solving and greater self-awareness. According to Klein et al. (1986):

> The descriptions of the stages in general progress from impersonal (1) or superficial (2) through externalized references to feelings (3), to direct inner referents (4), to questioning unclear referents (5), to focusing with step resolution (6) and finally coming to the point where focusing becomes easy and provides the connections for inner discourse. (p.22)

The Experiencing Scale originated from Gendlin's experiential (1969) and Roger's client centered theories (1951) to capture the quality of the client's personal involvement in therapy (Klein et al., 1986). As a result of a series of therapy process and outcome studies the scale was developed as a measure that related to client outcome. The scale itself attempts to measure the way these levels of experiencing appear and are referred to in client speech during therapy sessions. It has been demonstrated to be a highly reliable measure of client involvement or experiencing in therapy. Klein et al. (1986) report high inter-rater reliabilities for over 15 studies despite variations in therapist orientation and client problems. The reliabilities ranged from .76 to .93 for modal ratings and .61 to .93 for peak ratings. No variations due to segment length or data form were apparent (Klein et al., 1986). Reliabilities were highest after training without apparent differences between professionals and nonprofessional raters. The lowest reliabilities reported were for brief units from an

experiential study, where subjects were asked to code standardized prerecorded "therapist statements" and "client statements" (Klein et al., 1986).

The Experiencing Scale Training Manual (Klein et al., 1969) summarizes the initial validity of the scale. The most powerful and consistent findings of early studies cited in the manual (Klein et al, 1969) are that successful therapy patients start, continue, and end therapy at higher levels of experiencing or process than do less successful clients. In order to further assess the validity of the Experiencing Scale, Klein et al. (1986) reviewed research literature using the Experiencing Scale since publication of the training manual (Klein et al, 1969). The overall findings show that experiential involvement and shifts are factors in successful outcome in session and that the scale is more a measure of reflective or self-observational style than expressiveness. "Thus the original view of experiencing as a process variable and of the scale as a reflection of this essential quality of self- involvement and participation in therapy still holds" (Klein et al., 1986, p.53). The Experiencing Scale continues to be used and more recent studies also provide evidence for validity. Recent studies show that experiencing is associated with self-exploration, insight, and successful outcome in therapy (Alden, 1987; Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Johnson & Greenberg, 1988; Watson & Greenberg, 1996, Wiser & Arnow, 2001). The Experiencing Scale is a solid measure in assessing client involvement that has been used in the past and still being used.

Rating Process

Selection of raters. The selection of the raters followed the recommended criteria of the Experiencing Scale Training Manual (Klein et al., 1969). Because the Experiencing Scale is an assessment of verbal expression, it is necessary that the raters possess good language skills, in order to grasp the concepts of the scale and apply it to the client's statements. Due to the content of the material, the raters also have to be able to treat the material with discretion and confidentiality. The rater's attitude should be responsible, mature, interested and respectful, not voyeuristic, curious, or self- involved. Each rater was extensively interviewed for verbal skills, dependability, discretion, maturity, and research experience. During the interview, each rater was informed of the requirements the work hours of the project, that their participation was for class credit and that they would each receive a grade according to the criteria set for the class. Out of eight potential raters, four raters were chosen for the study. The population of raters did not include therapists, clients, or researchers on this project. The four raters used in the study were recruited from undergraduates enrolled in courses in the department of Human Development and Family Studies at Texas Tech University and had no prior experience or training in the mental health field. This ensured that psychological sophistication and theoretical knowledge would not be a confounding variable in the study. The raters were blind to the hypotheses, outcome, and other important information of the study.

Training of raters. Each rater was trained extensively according to the training manual instructions. Each rater was instructed to read and understand the code of ethics in the manual (Klein et al., 1969) before training began. The training program was divided into

nine 2- hour group sessions. The first training session was an orientation session that involved reading and understanding each stage description of the Experiencing Scale. Each rater was instructed to give an example of a verbal expression at each stage to ensure they understood the descriptions at each stage. The next eight sessions involved reading some portions of a manuscript provided in the training manual, listening to each individual segment, and practicing the rating technique. The raters were instructed to only rate the level of the experiencing on the basis of what the speaker says, and to ignore other variables such as tone of voice, other speakers, timing, inferred meaning of context, and their own personal feelings. As they listened to the segments, the raters kept a running rating of the speaker's verbalizations, and listened to crucial peak moments of change in the segment. The rating process included both a modal and a peak rating for each segment. A modal rating is the rating that characterizes the overall scale level of the segment. The peak rating is the rating given to the highest Experiencing Scale level reached in the segment. After selecting the peak and mode rating, each rater had to discuss their individual rating and justifications for the score. This was followed by a comparison with the expert's ratings and justifications within the manual.

The actual manuscripts from the manual (Klein et al., 1969) were used during the first four training sessions; this enabled raters to familiarize themselves with the scale and the rating process. In the last four sessions, the raters scored the segments from the audio taped examples from the manual without the manuscripts in order to heighten their listening skills. When there was disagreement during training, the segment was replayed, and discussed until there was an understanding of the basis of the experts' rating and

justification. The training acquainted the raters with behaviors targeted for this study, and inter-rater agreement was monitored before the actual research coding began. After training, raters individually scored a practice tape from the manual that consisted of ten segments. This was to ensure that the reliabilities were high enough to begin the rating process. Reliability was calculated by the percentage agreement of the scores that matched exactly or were within one point of the correct score in the manual. The reliabilities that matched exactly with the manual ranged from 40% to 80% for the modal rating and 40% to 70% for the peak rating. The reliabilities compared to the training manual for the practice segments within one point ranged from 80% to 100% for the modal rating and 90% for the peak rating. The inter-rater agreement within one point among the raters themselves ranged from 60% to 100% for the modal rating and 80% to 100% for the peak rating.

Rating Procedures. The segments used in the study were transposed onto ten cassette tapes. The raters used the rating sheet created in the training manual, to score the modal and peak ratings of each segment. The raters listened to the tapes in isolation at the designated observation room so as to not to be influenced by other raters. In addition, they were instructed to listen to the tapes at least three times before rating the segment. This ensured that the rater heard all of the needed information to score the segment confidently. The raters were not allowed to rate segments in more than two hour blocks with a 10 to 15 minute break between the hours. This reduced fatigue and the tediousness of the project. The monitoring of the rater's weekly time sheets strictly enforced this rule. For seven weeks, the raters scored approximately 20 segments per week according to the rating schedule. A schedule was formulated in order to calculate weekly inter-rater reliabilities. If

the reliabilities were below 70% agreement or there was great discrepancy among scores for certain segments, the raters met as a group and came to a consensus rating for each of the segments. This process also allowed continual training on the coding process.

Inter-rater agreement

The inter-rater agreement was assessed weekly. The raters coded 20 to 25 segments weekly. For the first week, the inter-rater agreement ranged from 67% to 98% for the modal rating, and from 79% to 93% for the peak rating. For the second week of coding, the inter-rater agreement ranged from 90% to 100% for the modal score and ranged from 76% to 100% for the peak score. For the third week of coding, the agreements were 100% for the modal score and ranged from 88% to 100% for peak score. For the fourth week, the agreement percentages ranged from 91% to 100% for the modal rating and 82% to 100% for the peak rating. For the fifth week, the agreements ranged from 83% to 100% for the modal rating and 71% to 99% for the peak rating. For the last week of coding, the agreement percentages ranged from 75% to 92% for the modal score to 82% to 100% for the peak score (See table 1). The overall percentage agreement was 95% for mode and 94% for peak. The correlation across the four raters over the 132 segments was $F(131,393) = .83$, $p < .001$ for modal scores and peak scores $F(131,393) = .85$, $p < .001$.

Design and Analyses

Essentially, this study is a cross-sectional design, even though for each of the 20 participants, two sessions at different times were included. It is not longitudinal because the

order of the two sessions could not be controlled. Sometimes the couple session was first in time and sometimes the couple session was the later one. Also the session chosen varied widely across cases. The earliest session included was the second session and the latest session included was the 45th session.

The independent variables in the study include the modality or type of session (individual vs. conjoint), the gender of the target client, and the segment (1st, 2nd, 3rd segment in a therapy session). The dependent variables include the level of experiencing which are the modal rating and the peak rating, an ordinal score ranging from one to seven. For each therapy session, there are three peak scores and three modal scores.

Preliminary analyses. As already mentioned, many of the variables that ideally would be controlled or included as independent variables, could not be used because of insufficient sample size. These include phase of therapy, gender of the therapist, experience level of therapist, and order of couple and individual sessions. Although not anticipated, we assessed whether experiencing level is associated with marital satisfaction, education level of the participant, age, and the number of years married. A correlation was computed between experiencing level and the marital satisfaction, age, and the number of years married. A t-test was computed to test for differences between the educational level and the experiencing level of the participant.

Table 1. Inter-Rater Agreement for Coding the 132 Segments.

Raters	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
A-W	Mode: 97%	Mode: 100%	Mode: 100%	Mode: 100%	Mode: 99%	Mode: 92%
	Peak: 97%	Peak: 100%	Peak: 100%	Peak: 100%	Peak: 99%	Peak: 92%
A-J	Mode: 97%	Mode: 90%	Mode: 100%	Mode: 91%	Mode: 99%	Mode: 75%
	Peak: 97%	Peak: 86%	Peak: 88%	Peak: 82%	Peak: 71%	Peak: 82%
A-K	Mode: 100%	Mode: 100%	Mode: 100%	Mode: 100%	Mode: 100%	Mode: 100%
	Peak: 100%	Peak: 95%	Peak: 100%	Peak: 100%	Peak: 99%	Peak: 92%
W-J	Mode: 97%	Mode: 90%	Mode: 100%	Mode: 91%	Mode: 83%	Mode: 82%
	Peak: 97%	Peak: 86%	Peak: 100%	Peak: 100%	Peak: 99%	Peak: 92%
W-K	Mode: 100%	Mode: 100%	Mode: 100%	Mode: 100%	Mode: 99%	Mode: 92%
	Peak: 97%	Peak: 100%	Peak: 100%	Peak: 100%	Peak: 87%	Peak: 100%
K-J	Mode: 97%	Mode: 90%	Mode: 100%	Mode: 91%	Mode: 83%	Mode: 82%
	Peak: 97%	Peak: 76%	Peak: 100%	Peak: 100%	Peak: 79%	Peak: 100%

Hypotheses. It was hypothesized that modal and peak level of experiencing will be higher in individual sessions than in conjoint sessions. It was also hypothesized that the modal and peak experiencing scores would be higher in later segments than earlier segments. And lastly, there would be no significant differences in the modal and peak scores among males and females. The first two hypotheses were analyzed by two separate two (modality) by three (segment) repeated measures analyses of variance with peak and modal levels of experiencing as dependent variables. I expected a main effect on modality with experiencing scores higher in individual sessions than conjoint sessions. I also expected a main effect on segment, with the third segment having a higher modal and peak score than the other two segments. Lastly, I expected no interaction between modality and segment. The third hypothesis, which compares experiencing level by gender, was analyzed using an independent t-test. I expected no differences in peak and modal scores by gender of the client.

CHAPTER IV

RESULTS

Preliminary Analyses

Analyses were conducted to examine whether there were any associations between levels of experiencing and the demographic characteristics of participants. Pearson product-moment correlations were computed between levels of experiencing and marital satisfaction, age, and the number of years married. An independent t-test was computed to look for differences between the educational level and the level of experiencing of the participants. The experiencing level scores were averaged together for each session for these analyses. There was one mean modal score and one mean peak score for each session instead of using three separate scores for each session (early, middle, late segments in session).

As shown in Table 2, the correlations between the four experiencing level scores (individual mode, individual peak, couple mode, couple peak) and number of years married, marital satisfaction, and age were not statistically significant. When computing the t-test for education and experiencing level, education level was grouped into two categories, low and high, with low defined as a high school diploma or less and high defined as some college or higher. The results indicated that there was no statistically significant difference in levels of experiencing by the amount of education. The results of the study are shown in Table 3. Therefore, the demographic variables of marital

satisfaction, age, number of years married, education levels were not considered in further analyses.

It was expected that modal scores would be lower than peak scores. Two paired t-tests were computed to compare modal and peak scores. The first t-test compared the modal score with the peak score in the individual session. The second t-test compared the modal score with the peak score in the couple session. As expected, the individual peak score (M = 3.23, SD = .72) was higher than the individual mode score (M = 2.56, SD = .55), t (22) = -8.67, p = .05. The peak score (M = 2.75, SD = .56) was also higher than the mode score in the couple session (M = 2.23, SD = .34), t (22) = -7.28, p = .05.

Hypotheses

Modality and Sequence. The first two hypotheses were analyzed by computing two separate two (modality) by three (segment) repeated measures analyses of variance, one for peak and one for the modal level of experiencing. The first hypothesis stated that the modal and peak levels of experiencing scores would be higher in individual sessions than in conjoint sessions. The analyses of variance indicated a main effect for modality for both the modal and peak scores. The descriptive statistics are represented in Table 4 and the results of the analyses are represented in Table 5 and Figure 1. In each case, experiencing levels were higher in individual sessions than in couple sessions. Therefore the first hypothesis was supported.

The second hypothesis stated that modal and peak levels of experiencing scores would be higher in later segments than earlier segments within a session. The analysis of

variance tests results indicated there was no main effect for segment for either mode or peak. The descriptive statistics are represented in Table 4 and the results of the analyses are represented in Table 5 and Figure 2.The modal and peak experiencing ratings did not increase across the three segments of the session. Therefore, hypothesis two was not supported. The results also indicated no statistically significant interaction between modality and segment for either mode or peak.

To further explore the significant main effect for modality, follow-up t-tests were calculated separately for males and females. This took into account the lack of complete independence in the data in that six couples were included as 12 of the 22 individuals in the analyses of variance. Results of the separate t-tests are reported in Table 6. Within these subsamples, there were no statistically significant differences by modality for women. For men, peak levels of experiencing were higher in the individual than couple session. There was marginal difference ($p < .07$) for the modal level of experiencing.

Gender. The third hypothesis, which compared experiencing level by gender, was analyzed by an independent t-test. The hypothesis proposed that there would be no differences in peak and modal scores between males and females. Since there were no statistically significant differences by segment, the mean score across the segment was used to analyze the third hypothesis (individual mode, couple mode, individual peak, couple peak). The t-tests were not statistically significant which indicated that there were no differences between males and females in levels of experiencing. The results of the t-tests are reported in Table 7. Therefore, hypothesis three was supported.

Table 2. Correlations Between Demographic Characteristics and Experiencing Level

Characteristics	n	Individual Mode	Individual Peak	Couple Mode	Couple Peak
Number of Yrs. Married	21	-.11	-.04	-.22	-.16
Age	22	-.02	.09	-.19	-.21
Marital Satisfaction	22	.25	.32	-.00	.04

Table 3. Differences in Experiencing Levels by Level of Education

	Education Level					
	Low (n= 6)		High (n= 16)			
Experiencing Levels	M	SD	M	SD	t	df
Individual Mode	2.8	.70	2.5	.48	1.1	21
Individual Peak	3.6	.84	3.1	.64	1.6	21
Couple Mode	2.2	.50	2.2	.28	.01	21
Couple Peak	2.8	.80	2.7	.46	.14	21

Table 4. Descriptive Statistics for Levels of Experiencing by Modality and Segment

	Individual			Couple		
MODE SCORES						
	1	2	3	1	2	3
Mean	2.60	2.57	2.52	2.18	2.28	2.24
Median	2.25	2.25	2.38	2.00	2.25	2.00
Std. Deviation	1.05	.85	.65	.55	.45	.54
Range	1-6	1.75-5	1.8-4	1.25-3.5	1.25-3	1.5-4
Frequency						
1.0-2.4	12	14	11	17	14	17
2.5-4.4	9	7	11	5	8	5
4.5-6.0	1	1	0	0	0	0
PEAK SCORES						
	1	2	3	1	2	3
Mean	3.17	3.31	3.20	2.93	2.67	2.64
Median	3.00	3.00	3.00	2.50	2.50	2.63
Std. Deviation	1.00	1.38	.91	1.18	.57	.70
Range	1.75-6	2-6	2-6	1.75-6	2-4	2-5
Frequency						
1.0-2.4	3	7	4	8	8	8
2.5-4.4	17	11	17	12	14	13
4.5-6.0	2	4	1	2	0	1

Note. Scale goes from 1 to 7. No segments received a score of 7 for either mode or peak scores. (n=132)

Table 5. Analysis of Variance Table for Modal and Peak Scores

MODAL SCORES

Within Subjects

	df	MSS	F	p	Eta squared
Modality	1,21	3.58	6.01	.02	.22
Segment	2,42	.02	.07	.94	.03
Modality/Segment	2,42	.07	.13	.88	.01
PEAK SCORES					
Modality	1,21	7.52	6.31	.02	.23
Segment	2,42	.17	.20	.82	.01
Modality/Segment	2,42	.49	.58	.57	.03

Table 6. Differences in Experiencing Levels by Modality and Segment for Males and Females

	Modality						
	Individual		Couple				
Experiencing Level	M	SD	M	SD	t	p	df
Mode							
Males	2.72	.57	2.23	.43	2.02	.07	9
Females	2.49	.55	2.26	.28	1.51	.17	9
Peak							
Males	3.47	.75	2.63	.67	2.40	.04	9
Females	3.06	.74	2.84	.49	1.11	.29	9

Note. The couple for which two sessions were entered, only one set of data was used.

Table 7. Differences in Experiencing Levels by Gender

	Gender					
	Males (n = 11)		Females (n = 11)			
Experiencing Level	M	SD	M	SD	t	df
Individual Mode	2.7	.59	2.4	.53	.80	10
Individual Peak	3.4	.73	3.0	.70	1.2	10
Couple Mode	2.2	.41	2.3	.26	-.31	10
Couple Peak	2.6	.64	2.9	.47	-.88	10

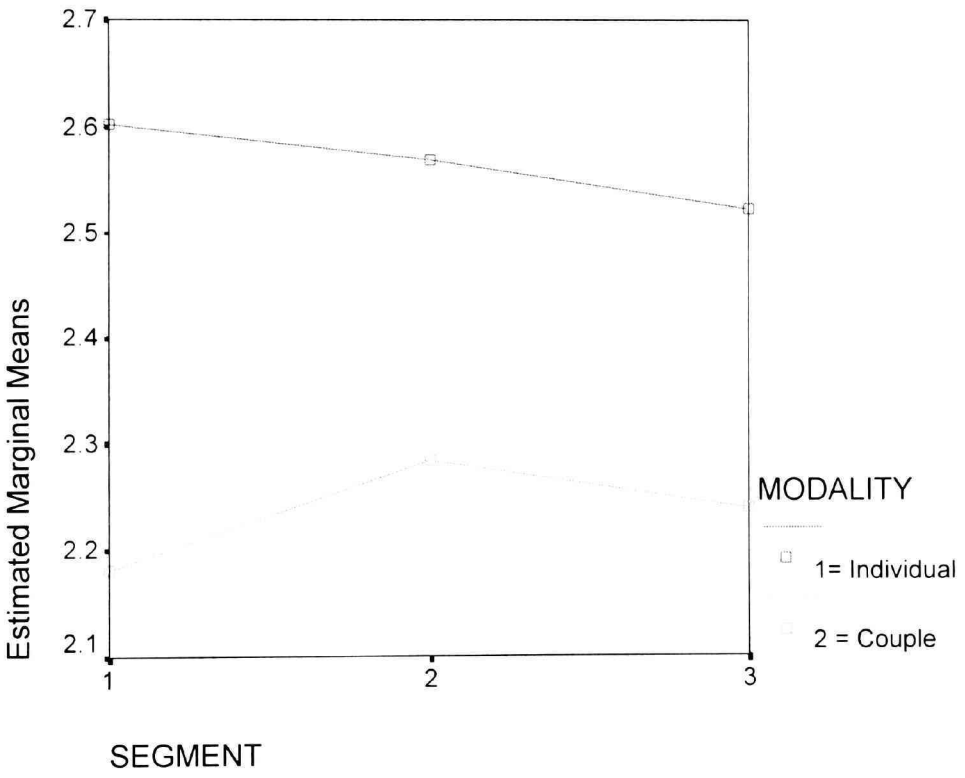

Figure 1. Modal Level of Experiencing by Modality and Segment

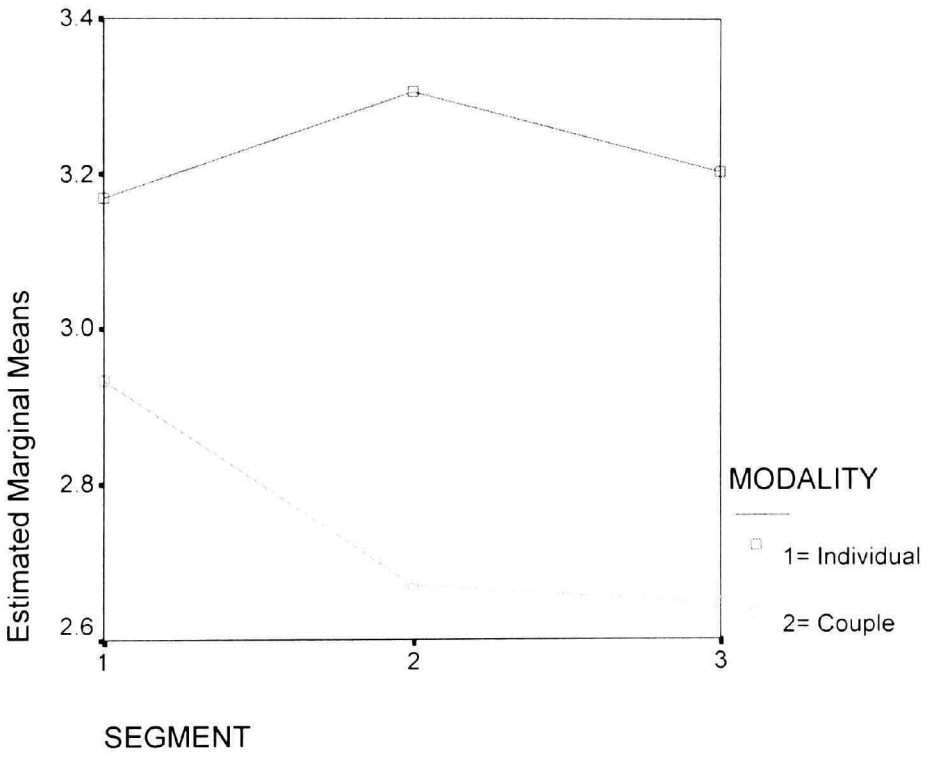

Figure 2. Peak Level of Experiencing by Modality and Segment

CHAPTER V

DISCUSSION

General Information About The Level of Experiencing

The purpose of this study was to examine the levels of emotional experiencing in the same clients in individual and conjoint couple sessions. The levels of emotional experiencing were measured using the Patient Experiencing Scale (Klein, Matheiu, Gendlin, & Kiesler, 1969). The participants in the study were drawn from a clinic data set in the marriage and family therapy clinic at Texas Tech University. The sample included 14 couples of whom 20 participants were involved in the study, 10 men, and 10 women. One couple had a sufficient number of sessions, that they were included twice. For six couples, data were included for both partners. The lack of independence in the data is problematic, but data of this type are very difficult to obtain. It was felt that the uniqueness of the data set justified the mixed nature of the sample. Both sample size and the lack of independence of data should be kept in mind when interpreting the findings.

With regards to the level of experiencing in general, I found that, as expected, the peak scores were higher than the modal scores for both individual and couple sessions. However, overall the experiencing levels in this sample were lower than in other studies that examined emotional experiencing with individual psychotherapy and with couples. In this study the mean modal score was 2.5 for the individual sessions and 2.2 for the couple sessions. The mean peak score was 3.2 for the individual sessions and 2.7 for the couple sessions. In other studies the mean modal and peak scores ranged from 2.3 to 3.2

for modal scores and 4.0 to 4.6 for peak scores (Chenne, 1973; Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Johnson & Greenberg, 1988; Watson & Greenberg, 1996). Not only are the scores relatively low, there is also less variation among the scores. In this study there was not one score rated a seven. Only two of the 132 segments had modal scores of 4.5 or higher, and only ten of the 132 segments had peak scores of 4.5 or higher.

One explanation for the relatively low experiencing levels could be the phase of therapy from which the segments were pulled. A majority of the segments were pulled from the middle phase in therapy. Levels of emotional experiencing may have been higher in later or earlier stages of therapy. Another explanation could be that some of the therapists in the study might not have facilitated higher levels of emotional experiencing from their clients. In addition to these explanations, the setting of the therapy sessions may have been a factor in the low levels of experiencing. The therapy clinic is a training clinic, where there are videocameras, one-way mirrors, and supervised sessions. This environment may not have been as comfortable for clients, as in a normal therapy setting. However, it is suggested that by the middle phase of therapy, that clients are more comfortable with the therapeutic setting in the clinic. The different theoretical orientations of the therapists, where some orientations emphasize emotion, and others do not, may be another factor of the low level of experiencing. These possible factors suggest future research examine the factors that elicit higher levels of emotional experiencing.

There is strong evidence to believe that the coding of experiencing level in this study was reliable and accurate. A high level of inter-rater agreement among the coders,

and the high amount of percentage agreement of the coders with the Experiencing Scale Training Manual (Klein et al., 1969) was achieved. The training and coding procedures outlined in the manual were followed closely. The transcripts and taped provided for training were used and the coders in this study had high agreement with the standard ratings of the training tapes. In addition to the accuracy and reliability of the raters, the number of raters is also an added benefit to the study. Each one of the four raters coded all of the 132 segments. Great care was also used to ensure that the raters were focusing on the level of experiencing instead of extraneous factors such as opinions about the partners, the therapist, or the therapy session. This was done by rerecording the segments in random order to reduce the cues.

Segment

As stated earlier, I hypothesized that the level of experiencing would increase across segment, where the latest segment coded in the therapy session (segment three) would have higher levels of experiencing than segment one or two. However, the results indicated that this was not the case. There was no increase of experiencing across the segments and no main effect for segment for either mode or peak. An examination of Figures 1 and 2 suggest some interesting changes in experiencing level over the course of the session, but they were not statistically significant. The lack of statistical significance may have resulted from the lack of statistical power in the analysis of variance, because of the small sample size. Another explanation for this finding could be the phase of therapy from which the segments were pulled. A majority of the segments were pulled

from the middle phase in therapy. In the middle phase of therapy, clients may be comfortable enough to have jumped into session in the first or second segment with higher levels of experiencing. Perhaps an effect of segment would be seen more clearly in early sessions of therapy. In order to find a definite explanation, future research is needed to ascertain when in therapy levels of emotional experiencing are the highest. It is surprising that no research has been conducted to look at either the changes in the level of experiencing in different phases of therapy or changes within a therapy session.

Modality

As hypothesized, the results indicated that both mode and peak scores were higher in individual sessions than couple sessions. It was consistent across all of the segments. According to the study by Chenne (1973), when peak levels of experiencing are considered, the individual is more facilitated by the therapist than the spouse. Therefore, the focus on the individual client and the therapeutic alliance between the therapist and client in individual session may have facilitated higher levels of experiencing than in couple session. This finding does raise serious questions concerning the modality of therapy sessions. As past research has stated, emotional experiencing is a crucial and necessary element of the therapeutic process and, without emotional experiencing therapeutic change is less likely for clients in session (Alden, 1987; Asay & Lambert, 1999; Chenne, 1973; Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Johnson & Greenberg, 1988; Mahrer, Lawson, Stalikas, & Schacter, 1990; Watson & Greenberg, 1996).

Although the findings were clear, caution must be exercised because of the small sample size and the lack of independence in the data. In order to lessen the problem of some couples being included in the data set, follow-up t-tests were conducted separately for males and females. Although males had a higher level of experiencing in individual than in couple sessions, this was not true for females. It could be speculated that the level of experiencing for males may be more affected by modality than females. However, with the small sample size with only 10 males and 10 females, the generalizability of these findings is limited.

Gender

As expected, the results indicated no difference between males and females in levels of emotional experiencing. However, there should be caution in interpreting this finding because the levels of emotional experiencing were lower than in other studies that examined emotional experiencing (Chenne, 1973; Fitzpatrick, Peternelli, Stalikas, & Iwakabe, 1999; Johnson & Greenberg, 1988; Watson & Greenberg, 1996). Further research needs to be conducted to be confident of these results.

Limitations of the Study

After thoroughly thinking through the steps of this study a few limitations came to mind, as well as several aspects that may affect the internal and external validity of the project. Threats to internal validity include instrumentation and observation bias. In regards to instrumentation, the raters could have become more astute in rating the targeted segments

later in the study, than when initial coding began. Hopefully, intensive training and calibration of the instrument prior to rating minimized this threat in the study. This may have reduced differences between initial observations and observations that occurred later in the study. Observational bias is another threat to the internal validity. The type of observer chosen for the project may have controlled for this. As stated earlier, raters were blind to important information about the study. They were also unaware of the aims of this project, nor were they able to infer accurately the goals of the project after data collection had been completed.

The limited sample size is a threat to the external validity. The original Wampler sample, from which this sample was selected, was not a representative sample. This inhibits the generalizablity of results to an outside population. The homogeneity of the sample is another aspect that affects the generalizability of the results. A majority of the sample population consisted of Anglo-American, Protestant couples from the University- based clinic. For future research, the taped sessions should include a variety of clients. The population should be diverse in race, sexual orientation, age, and socioeconomic status.

One of the biggest problems is lack of independence of the data. The unit of analysis is the individual even though six couples were included. In addition, one couple was included twice. Hopefully the importance of the study question and the difficulty of finding relevant data justify the violation of the statistical assumption of the independence.

Another possible threat to the external validity of the study is the age of the instrument. The Experiencing Scale (Klein et al., 1969) was introduced in 1969 and is still being used today; however, because the instrument is thirty years old, the validity of the

instrument could be in question. In addition the cultural validity of the instrument may be a possible limitation of the study. The Experiencing Scale (Klein et al., 1969) was created and tested on people with psychiatric symptoms in a limited geographic location. The ordinal range of the scale (1-7) may also be a possible limitation, in the fact that the range may be too narrow to assess all of the possible levels of emotional experiencing.

As discussed earlier, another limitation of this study is the training setting of the university-based clinic and the inability to control for the gender of the therapist, therapist experience, phase of the therapy, and order of couple and individual sessions. In addition, a there was no way of being confident that all of the therapists were practicing therapy from a systemic perspective, which could have affected the results of the study.

Clinical Applications

The results of this study suggest some clinical applications. These findings indicate that therapists may need to focus more on the individual emotional experiencing in couple sessions, instead of just relational issues. This could also mean that the marriage and family therapy field may need to focus more on the importance of the systemic individual session and realize the benefit of combining modalities when working with clients. Research evidence and Emotionally Focused Therapy suggests that higher levels of experiencing are possible in couple sessions (Alden, 1987; Chenne, 1973; Johnson, 1996; Johnson & Greenberg, 1988). Another clinical application that should be considered is the facilitation of emotional experiencing by the spouse. The Chenne (1973) study found that the therapist facilitated higher peak levels of experiencing than the spouse. However, it

could be more powerful for the client and the relationship, if the spouse could learn to facilitate higher levels of experiencing.

As stated earlier, therapists may need to focus more heavily on the emotional experiencing of the client, regardless of modality. Past literature has stated that it is not necessarily the type of therapy, but what the therapist brings to the session (Asay & Lambert, 1999). Further research needs to be conducted to examine what therapist characteristics are necessary to elicit high levels of emotional experiencing. This could be an essential element not only in training better therapists, but also in higher rates of successful therapy.

In addition to clinical applications, this study also raises some important questions about emotion and systemic theory. How well does emotional experiencing apply to systemic theory? How important is emotion in couple sessions, dealing with relational issues? Could it be possible, that a client may be experiencing emotionally in session, and may not verbalize their emotions? Does emotion have to be stated verbally to ensure therapeutic progress and change in session? Further research is necessary to embark on answering these important questions.

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