Evaluating the Immediate Impact and Short-Term Therapeutic Effects of the “Internalized-Other” Interviewing with Couples

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Western Michigan University

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EVALUATING THE IMMEDIATE IMPACT AND SHORT-TERM THERAPEUTIC EFFECTS OF THE "INTERNALIZED-OTHER" INTERVIEWING WITH COUPLES

by

Shai M. Brosh

A Dissertation Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Doctor of Philosophy Department of Psychology Dr. Galen Alessi, Advisor

Western Michigan University Kalamazoo, Michigan August 2007
The present study examined empirically the immediate and short-term therapeutic effects of the internalized-other interview (Tomm, 1996) with couples during a single session and compared it with the standard method of interviewing couples (i.e., treatment as usual). Thirty-two married couples ($N = 64$ participants) were randomly assigned into one of two conditions (internalized-other versus standard interviewing). Couples attended an initial interview session and two follow-ups (one and four-weeks respectively). Self-reported measures of session impact were taken immediately after the session, while self-reported measures of marital satisfaction, intimacy, closeness and empathy were taken at baseline (before the session) and during follow-up sessions one and two (one and four weeks post-baseline respectively).

Data suggested that both interviewing conditions yielded a positive therapeutic impact on couples following the session. No statistical significant differences were detected between the two groups or between the two genders. However, among some of the session impact measures, a gender x experimental condition interaction was found. Specifically, males in the standard interviewing condition reported higher satisfaction and greater session helpfulness than males in the internalized-other interviewing condition.
Conversely, females in the internalized-other interviewing condition reported higher satisfaction and greater session helpfulness than females in the standard interviewing condition.

Additionally, data showed that both treatment conditions resulted in statistically significant short-term therapeutic effects (i.e., improvement from pre-session baseline to one and four-week follow-up sessions) with respect to marital satisfaction, intimacy, closeness and empathy. Possible interpretations of these results and the identification of areas for further investigation are discussed.
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INTRODUCTION

Therapeutic Conversations

Solution-Focused Interviewing

The idea that interpersonal conversations can be used as a therapeutic tool is shared by many psychotherapy approaches. For example, the solution-focused brief-therapy approach (de Shazer, 1985, 1988, 1991) holds the view that the client’s “reality” is socially constructed by the use of language. This post-modern psychotherapy approach makes use of conversations to construct changes in the client’s belief system. Ultimately, these belief system changes may lead the client to take new actions toward a solution to his or her presenting problem (Hoyt & Berg, 1998). The underlying assumption held by the solution-focused therapist is that by changing the “viewing,” clients can change their “doing.” Through asking a series of unique, constructive questions (e.g., “miracle”, “exception”, “coping”, and “scaling”), the solution-focused therapist directs the client’s attention to his or her capabilities, resources and strengths. These unique questions are designed to evoke self-fulfilling images of the future, and they set the stage for an expected positive change from the client’s perspective. For instance, a depressed client is asked to talk about the times she was able to get out of bed, go to work, contact her family and friends and feel good about herself, rather than focusing on the times she was unhappy and debilitated. By exploring the times when the problem did not appear to have a strong influence, the client can find clues to what she can do differently in order to
expand these “exceptions” in the future. As a result, hope is instilled and the client is empowered to take new actions toward solving the problem.

Narrative Interviewing

Another approach that utilizes conversations as a means to facilitate change is narrative psychotherapy (White & Epston, 1990). Proponents of this approach hold the view that people’s sense of reality and meaning is generated and maintained by narratives (stories) they tell about themselves. These narratives, which form the core of one’s identity, can be self-defeating, negative and oppressive, and they can lead to the objectification of the person (White, 1988). The narrative therapist examines these maladaptive stories with the client and helps him or her to replace them with alternative empowering stories.

The process of deconstructing old narratives and replacing them with new stories is accomplished through a unique method of conversations called “externalizing conversations.” In this method of discourse, the therapist helps to separate the client from his or her symptom. By doing that, the therapist frees the client from thinking of himself or herself as pathological (Nichols & Schwartz, 2001). In externalizing conversations, the therapist talks as if the problem is a separate entity from the individual. The therapist asks the client a series of questions, thematically called “relative influence,” that portray the problem as an unwelcome invader which oppresses him or her (e.g., How does “jealousy” affect the relationship between you and your wife?; When did “shame” tell you to stop living your life?; How did you let “Anorexia” convince you that starvation is the only way to feel good about yourself?). The aim of externalization is to
help the client detach himself or herself from the oppressive narrative and to consider new possibilities. For example, in a widely cited case study (White, 1984) of a child who suffered from Encopresis, a DSM-IV (1994) diagnosis that refers to repeated passage of feces into inappropriate places, the therapist (Michael White) used the name “Sneaky Poo” to refer to Encopresis. Throughout the interview, White talked as if “Sneaky Poo” was a separate entity from the child (referring to it by its name). By doing that, White externalized the problem, separating it from the child, and thus empowered him to fight against it.

Strategic Interviewing

A third approach that uses a variety of specific conversational interventions is strategic family therapy. Therapists who belong to this school of thought developed a number of specific techniques such as “reframing” and “restraining” to promote rapid therapeutic change through conversations. For instance, in “reframing,” the therapist labels the presenting problem as normal and/or changeable, and consequently demystifies it and makes it solvable. As a result, the family may perceive the problem from a different viewpoint, and may attribute new meanings to it. For example, in a case study of a couple who sought therapy for the husband’s depression (Madanes, 1981), the therapist reframed the husband’s depression as irresponsibility. Consequently, the system of interactions around the symptom changed. The husband accepted the fact that his behavior was voluntary, and hence could be voluntarily changed. As a result, the helplessness of his depressive symptoms diminished and he was motivated to take actions to become more responsible toward his wife. Other examples include a therapist who
reframes the Attention Deficit Hyperactive Disorder (ADHD) of a young child as a non-compliance behavioral problem, thus changing the child’s behavioral problem from being internal, biological and stable (ADHD) to being external, environmental, manageable and solvable. Alternatively, a therapist may reframe a young girl’s diagnosis of Pyromania as a problem of safety with matches (Minuchin, 1974), thus freeing the family from the pathologizing and disempowering effects of a psychiatric disorder that requires medical expertise.

**Milan Associates Interviewing**

Finally, a fourth approach that endorses the view that therapeutic changes can be embedded within a linguistic framework is the Milan family therapy approach. In a seminal paper (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980), the authors described three important guiding principles for the therapist who conducts the first interview session with the family. These principles (neutrality, hypothesizing and circularity) all refer to the therapist’s posture, the position he or she adopts, the framework that guides his or her investigative activity and the questions he or she chooses to ask during the family interview. The Milan approach views the process of questioning during the family interview as a vehicle to deliver therapeutic change, and as indistinguishable from the intervention phase. According to the Milan approach, questions are more than an information-gathering tool for the therapist. Instead, questions have a potential power to evoke changes in the family’s perceptions of their problem. The Milan family therapist typically uses distinctive questions (e.g., “triadic questions”, “behavioral effect questions”, “hypothetical questions”) to shift family perceptions, beliefs and behaviors.
away from the dysfunctional cycles of interactions that reinforce the symptom. For example, in “triadic” questions, one family member is asked to comment on the interactional pattern of behaviors of two other family members (e.g., When Dad is nervous, what does mom do?; When Billy misses school, who is more worried, Mom or Dad, and why?; Is this the way Mom and Dad fight at home too?). These types of questions can bring forth new meaning to the family, helping them to develop a new vision about themselves as one unit. Furthermore, “triadic” questions help family members to become better observers of their own systemic interaction process (Tomm, 1984).

By maintaining a stance of curiosity and adopting a holistic (systemic) perspective, the therapist helps the family to find its own resources and to choose a solution out of a plurality of alternatives (Cecchin, 1987). The typical Milan interview is conducted in an unorthodox manner where questions are focused on highlighting differences between family members and then drawing connections that help them in redefining the problem as systemic (Brown, 1997). The therapist’s questions, as Tomm (1985, pp. 34) described, “...trigger family members to ‘release’ new information into their own and each other’s awareness which enables them to develop a new understanding of their own systems of interaction.” Similar to “reframing,” the Milan approach employs an intervention called “positive connotation.” In this intervention, the therapist reframes the family’s problem-maintaining behavior as positive and protective to the system as a whole. For example, a child’s Anorexia may be re-described to the family as a protective behavior that attempts to bring the parents closer to each other (Tomm, 1984).
In summary, the idea that interpersonal conversations play an important role in the therapeutic process of change is shared across different theoretical orientations of psychotherapy. The therapeutic process is fundamentally communicative, and it occurs via the exchange of verbal and non-verbal behaviors between the therapist and the client. Unlike conversations with family members, friends, or colleagues, conversations between a therapist and his or her client are expected to be therapeutic (Adams, 1997). According to Frank and Frank (1991, pp. 48), “words are human beings’ chief tool for analyzing and organizing experience.” Therefore, therapists can utilize words, as well as other means of communication, to help their clients by increasing their sense of mastery or self-efficacy, instilling hope and transforming meanings in their assumptive worlds.

Intervening Interview

Some may argue that the initial interview/session is not different in its essential characteristics from the intervention phase, and hence cannot be separated from it (Beavers, 1985; Talmon, 1990). During this relatively short time, the therapist simultaneously attempts to collect information (assess), formulate hypotheses about the client’s problem(s), establish a therapeutic relationship and facilitate change (intervene) (Berg & de Shazer, 1993; O’Hanlon, 1993; Lipchik & de Shazer, 1986; Minuchin, 1974; Selvini-Palazzoli et al., 1980; Tomm, 1987a, 1987b, 1988).

The first therapeutic encounter has a unique importance compared with subsequent encounters. This is the time when the client forms his or her first impressions about the therapist and the therapeutic process. A number of studies in social psychology have shown that an overall impression is influenced more by the first information that is
perceived by the person than by information that comes later (as known as the “primacy effect”; Luchins, 1957). Moreover, the first session is the time when the therapist sets the tone and expectations for future encounters with the patient.

Howard, Kopta, Krause and Orlinsky (1986) reported that between 29% and 38% of patients show measurable improvements over the course of the first three sessions (traditionally referred to as the assessment phase of therapy). Outcome criteria in their study included both the patients’ ratings of subjective well-being as well as researchers’ ratings of functioning based on clinical charts. Talmon (1990) reported in his study that of all patients who attended a single therapy session, 88% reported either “much improvement” or “improvement” in a follow-up phone interview. These studies, therefore, clearly indicate that therapeutic changes can occur during the early phases of therapy.

Beside the evidence for an early therapeutic gain during the initial session, other studies also showed that in general psychiatric clinics, 20% to 57% of the patients fail to return after the first session (Baekeland & Lundwall, 1975). Rosenbaum, Hoyt, and Talmon (1990) reported that in an outpatient psychiatric unit of a large health maintenance organization (HMO), 30% attended only one session, despite the fact that the clients were entitled to more sessions by their coverage insurance plan. Wolfe (1999) reported that the dropout rate after the first session is even higher in couple than in individual therapy. Finally, other studies indicate that clients seem to decide whether to return to therapy or not after the initial interview (Anderson, Hogg, & Magoon, 1987), and that those who see counseling as less helpful in the first session have less positive attitudes toward returning (Gunzburger, Henggeler, & Watson, 1985). In summary,
Previous data indicate that therapeutic gain is possible at the early stages of psychotherapy and that a significant large number of patients drop therapy after the initial session (either because they achieve their goals or because they are dissatisfied with the therapy).

Tomm (1987a) described the initial interview as composed of a series of continuous interventions, and therefore named the process “interventive interviewing.” Influenced by the Milan team approach (Selvini-Palazzoli et al., 1980), Tomm argued that the process of interviewing alone could trigger therapeutic changes without the need of a distinct intervention phase (Tomm, 1987a). The initial interview, according to Tomm, offers continuous therapeutic opportunities for the therapist to act therapeutically. These unique therapeutic moments are embedded, according to Tomm, in the process of questioning. Tomm presumed that questions, as opposed to statements or direct advice, call for greater client participation, and empower them to take responsibilities, choose their own solutions and ultimately take new actions. Similar to the Milan approach, Tomm argued that well-crafted questions are the core of the therapeutic process.

Questions as Therapeutic Interventions

Although previously considered as information-gathering tools, the therapeutic utility of questions has been acknowledged by various therapy models. Asking questions is one of the chief therapeutic tools therapists can use during their encounters with their clients. One of the unique characteristics of a question is that it constrains the client to answer within a framework of presuppositions set by the question (McGee, Vento, & Bavelas, 2005). For instance, if the question asks about the patient’s resources, strengths
and capabilities, the patient typically accepts the presuppositions of the question (i.e., that he or she possesses strengths and capabilities) and provides the therapist with evidence for this information.

Previous research has shown that the phrasing of questions can affect the perception of reality. For example, Loftus and Palmer (1974) reported that participants who were exposed to the same videotape scene (a car accident), provided different speed estimation, depending on the type of question that was asked (i.e., "How fast were the cars moving when they crashed?" versus "How fast were the cars moving when they hit?" This illustrates how specific words or phrases can embed different presuppositions, and how these presuppositions can affect the individual perception of reality and responses.

McGee (1999) identified 10 sequential steps that demonstrate the modus operandi of questions in psychotherapy: (1) questions invite answers or responses, (2) the client has to understand the question in order to formulate a reply, (3) questions restrict and orient the client to a particular part of his or her experience (the part that the therapist chooses to focus on), (4) the client has to review, in the moment, personal experience in order to respond to the question, (5) the client typically does not comment on the embedded presuppositions of the question, (6) an embedded presupposition can be corrected or modified by the therapist if the client decides to challenge it, (7) once the client has replied to the therapist’s question, the very act of answering the question implicitly implies that he or she accepts the question embedded presuppositions, (8) the client is the “owner” of the answer (i.e., he or she discovers and presents the information to the therapist), (9) after the question is answered, the therapist can pose another follow-
up question, and (10) it is unlikely that the client challenges earlier embedded presuppositions.

Consider the following question taken from an unpublished interview with a schizophrenic patient conducted by Luigi Boscolo (Milan approach) and reported by McGee (1999). After the patient had told Boscolo: “I used to be promiscuous but I’m not any more,” he (Boscolo) asked her the following question: “What made you decide to change, from being promiscuous to not being promiscuous?” Boscolo invited his patient to focus on the positive change in her life. By using the words (“you decide”), Boscolo inserted an embedded presupposition suggesting that the patient is responsible for this positive change and, therefore, should be credited for it. Boscolo could have chosen to focus on the patient’s pathology, but instead, he decided to center the patient’s attention on her strengths. This example illustrates two essential principles, as described earlier by McGee (1999): (a) questions restrict and orient the client to a particular part of his or her experience (in this example, to the client’s strengths), (b) once the client has replied to the therapist’s question, the very act of answering the question implicitly implies that he or she accepts the question embedded presuppositions. In other words, once Boscolo’s client had responded to his question, she had accepted his frame of reference (i.e., that she made a decision to change).

The Functions of Questions during the Therapy Session

Therapist’s Theoretical Orientation

A therapist’s theoretical orientation affects the type of questions asked during the interview session (Walter & Peller, 1992). For example, a psychoanalyst who views
psychopathology as symptoms with underlying causes will tend to ask questions that focus on finding these underlying causes within the client’s inner world. Usually these questions are past oriented, reflecting the idea that uncovering the past is essential to understanding the present. Furthermore, these questions are often relationship focused, presupposing that past relationships, with parents and other significant figures, have had a major effect on the current well-being and functioning of the individual. For example, in the context of couple therapy, a psychoanalyst may ask questions such as: (a) what kind of wife was your mother? Or (b) what was your experience growing up without a father figure?

On the other hand, a therapist who comes from a systemic school of thought (e.g., Milan, structural, strategic) views the presenting problem as maintained by the system/context where it occurs. Rather than looking for historical causes of the problem, this therapist will look for what maintains the problem (i.e., what is the current systemic function of the problem?). Questions asked by this therapist will mostly focus on transactional behavioral patterns among family members, revealing boundaries, coalitions, power structure, and the overall system arrangement. For example: (a) who decides in this family what will be served for dinner? And, (b) who does David go to when he has a problem, Mom or Dad?

Finally, a solution-focused therapist, who believes that the focus of therapy is to construct solutions to presenting problems, will often ask questions that contain very distinct presuppositions (i.e., there are solutions, there are exceptions to the problem, and the client knows what works or does not work for him or her). Questions of this nature, will shift the client’s focus toward constructing solutions and viewing exceptions to the
problem. For example: (a) when was the last time you felt intimate with each other?, and (b) what are the things that you can do in order to show her that you are interested in being close to her?

**Therapist’s Intent**

During the interview session, therapists generally have two main purposes in asking questions (Lipchik & de Shazer, 1986; Tomm, 1988). First, questions are used as a means to get to know the clients well, and to understand their problems, experiences, difficulties, and struggles, as well as their strengths and assets. In other words, questions facilitate understanding on the therapists’ side and help orient them toward the presenting problem. These types of questions function as assessment tools and are frequently used during the initial contact with the client. Examples of assessment or orienting questions of this type include: (a) for how long have you had the problem?, (b) why are you so anxious?, (c) how often do you have these arguments?, and (d) in what situations do you feel unsafe?

Second, therapists ask questions with the intention of triggering therapeutic changes and therefore, influencing the client. Questions can prompt the individual to think and reflect about his or her experiences from an often-unfamiliar standpoint and to explore new possibilities. This process of reflection can evoke significant changes in perceptions, beliefs, attitudes, and behaviors. Examples of these questions include: (a) how would she react if you showed her affection?, (b) what do you want your life to stand for?, (c) do you think that there is a connection between your son’s school refusal behavior and your threat to leave your husband?, (d) what kind of husband do you want
to be?, and (e) if a miracle happens tonight, and your problem were gone, what would you and your wife do differently?

While questions with orienting intent are often (a) past or present oriented, (b) problem or symptom focused, (c) descriptive, (d) close-ended, and (e) information specific, questions with influence intent are often (a) future oriented, (b) open-ended, (c) hypothetical, (d) solution focused, and (e) speculative. It is important to add that these categories of questions (orienting versus influencing) are not mutually exclusive, and can be better conceptualized as two poles of a continuous dimension.

Therapist’s Assumptions

Therapists’ assumptions about the nature of mental health problems will also guide their questioning styles (Tomm, 1988). A therapist adopting a lineal perspective assumes a clear cause-effect linear path by which one individual (A) affects a second individual (B) which in turn affects a third one (C) and so on. As a result, this therapist will attempt to discover the first link in the causal chain and often labels it as the problem that needs to be fixed. A therapist who endorses lineal assumptions will tend to focus on the individual’s symptoms, behaviors, personality traits, attitudes, intelligence, etc. For example, the wife’s unrealistic demands (A) cause the husband’s withdrawal (B). In this scenario, the wife is more likely to be labeled as the problem, and the focus of therapy will be on changing her behaviors (e.g., focusing on reducing her unrealistic expectations). Adopting a lineal perspective in the context of couple therapy can lead to villain-victim distinction and to blame.
However, when adopting a circular perspective, the therapist holds a holistic view where each individual affects and is affected by the other in a recursive process (A affects B, and B affects A in a circular way). The notion of circularity is rooted in Gregory Bateson’s philosophy (Bateson, 1979). Bateson claimed that in contrast to the physical world, which can be comprehended with linear thinking, the social world requires circular causality to be better understood (Sprenkle, 2005). The therapist, who adopts a circular view, supports the notion that the system’s behaviors are determined by its entire structure and the relationship between its elements. Therefore, this therapist looks for a systemic pattern of behavioral sequences and the context where they occur, rather than labeling one component of the system as the cause of the problem. He or she views relationship as the sum of communication between individuals across different levels of communication (verbal, non-verbal, contextual) (Cottone, 1989). In other words, the therapist endorses that the whole is greater than the sum of its parts and that, metaphorically speaking, looking for the forest (i.e., the family as a whole) is more important than looking for the trees (i.e., the identified patient). For example, the husband’s withdrawal leads to concerns and suspicion by his wife who demands to be closer to him, which leads to further withdrawal of the husband who perceives his wife as intrusive, which leads to further demands of the wife to be close to her husband. One implication of this view is that the problem is attributed to a dysfunctional pattern of interactions between the two partners (i.e., demand-withdrawal), and hence does not reside within one or the other. Therapists who hold circular positions emphasize the recursiveness in the interaction between parts of the system. Thus, instead of asking the wife why she is so demanding, a therapist who holds a circular view will ask about what
the husband is doing when his wife asks to be close to him, and what the wife does when the husband withdraws.

Tomm’s Questioning Model

Based on the dimensions of the therapist’s intentionality and assumptions, Tomm (1988) identified four fundamental question category types in the context of interviewing: (a) Lineal - Questions with orienting intent and with lineal assumptions (e.g., when do you have difficulties falling asleep?, how often do you feel anxious?), (b) Circular - Questions with orienting intent and with circular assumptions, (e.g., who is more concerned, Mom or Dad?, when Mom is quiet, what does Jason do?), (c) Strategic - Questions with influence intent and with lineal assumptions (e.g., why don’t you show him that you care?, can’t you see that the more you try to control her eating behavior, the more she becomes oppositional?), and (d) Reflexive - Questions with influence intent and with circular assumptions (e.g., suppose your daughter was here, what do you think she would say?, what is a small step you can make to show your wife that you are willing to forgive her?). Of these four category types of questions, Tomm (1987b, 1988) identified reflexive questions as having the greatest potential to facilitate self-healing and generate positive changes among clients during the interview.

Reflexive Questions

Tomm used the term “reflexive questioning” to describe questions a therapist asks to facilitate changes in the client’s belief system and generate new behaviors that can lead to self-healing (Tomm, 1987b). These questions introduce novelty to the system (i.e.,
family, couple), and can create a small alteration in the patterns of interaction that will be amplified later by the system in a positive feedback/deviation-amplifying loop (Penn, 1982). Reflexive questions invite each individual to entertain new possibilities about the future (Penn, 1985), and are based on the assumption that he or she has the resources and skills to solve the presenting problem. Finally, these questions are usually neutral, and imply that the individual or the system has the autonomy to make choices and can evolve freely to find their own solution. Ultimately, reflexive questions have the potential to change the client’s epistemology.

From a theoretical perspective, reflexive questions are verbal stimuli that prompt reflexive activity (in the form of covert thinking) that may lead to change in the individual/couple/family’s pre-existing system of beliefs and meanings, and which is sometimes referred to as a second-order change (Watzlawick, Weakland, & Fisch, 1974). These questions are based on circular assumptions about mental health phenomenon. They invite each individual to reflect upon his or her perceptions and behaviors and to consider taking new actions toward a direction of healing.

In contrast to strategic questions, reflexive questions do not aim to impose a certain solution or to coach the client in a certain direction. In other words, reflexive questions do not have constraining effects and are not confrontational; instead, they liberate the client to evolve and choose freely from a plurality of possibilities. For example, questions such as, "Why don’t you stop being judgmental towards him for the next seven days?" attempts to educate the wife or husband in a specific manner and thus can be categorized as strategic. However, a question such as, "What will she have to do differently in order for you to feel loved?" or “Suppose you will be able to be open and
honest with her. What do you imagine she will feel?" can "open space" that leads the 
individual to reflect upon future possibilities without forcing him or her to take any 
particular action and thus can be referred to as reflexive. Reflexive questions are often 
open-ended, future-oriented, and include conditional verbs (i.e., suppose, imagine, what 
if). The therapist often adopts a neutral, accepting and respectful stance and views 
himself or herself as a facilitator rather than an educator.

From his clinical experience, Tomm (1987b) illustrated how immediate, 
convincing, and powerful the therapeutic effects of reflexive questions can be. Tomm 
described an initial interview with a family (The "Dutch family") where the father was 
accused by his wife and eight children of being violent and harsh in disciplining the older 
boys. The therapist (Tomm’s supervisee) noticed during the interview a strong coalition 
of the mother and her children against the father who became increasingly tense, 
withdrawn and distanced from the rest of the family as the interview progressed. After 
consultation with Tomm, the therapist asked each child the following question: "If 
something were to happen to your mother so that she became seriously ill and had to be 
hospitalized for a long time, or perhaps even die, what would become of the relationship 
between your father and the rest of the children?" This question evoked different types 
of responses from the children that were not previously expressed (e.g., “he would help 
us with school-work”; “he might see another side of us”). The children suddenly were 
able to talk about the positive, warm, nurturing and protective side of their father, and as 
a result, he appeared less tense and felt more included and accepted by his family. By the 
end of the interview, the children protested against the therapist who tried to connote
positively the father’s tyrannical behavior as helping the mother and children to get closer, and claimed instead that their father is very affectionate and helpful.

This case eloquently shows how the use of reflexive questions can evoke significant and immediate changes among family members’ views and beliefs, and how these changes can be subsequently strengthened and amplified within a series of positive feedback loops (i.e., the children think and talk differently about their father – the father appears to feel more included and accepted by his family – he is engaging with his children in a positive way – the mother views him in a more positive light). This one unique hypothetical question redefined the Dutch family’s system of beliefs and meanings (i.e., father was viewed as caring rather than tyrannical) and helped them to construct a hypothetical alternative “reality” that might pave their way to resolving their presenting problem.

The uniqueness of reflexive questions lies in their elegance and appeal. The change they produce is not attributed to the therapist or the intervention. Instead, the family often attributes the change to its own resources and strengths. Hence, these types of questions are empowering, and they strengthen the belief that the family is a strong and capable social unit. Also, as indicated by Tomm (1985; 1987b), the change produced by these questions often seems spontaneous and immediate, which makes them appealing.

Tomm (1987b) and others (Fleuridas, Nelson, & Rosenthal, 1986; Penn, 1982) categorized reflexive questions into several groups based on their intent and semantic structure. For example, “future oriented questions” such as: “How do you envision your life after retirement?” “What will your relationship be like when your son leaves home?”
“What are your expectations of your son?” or “What are you afraid will happen if your wife leaves?” facilitate future-oriented thinking and open up possibilities for individuals who are “stuck” in the present or in the past (metaphorically speaking), or blocked from being able to entertain the possibilities of the future (Tomm, 1987b). Alternatively, “unexpected context-change” questions focus on opening up the possibilities for new meanings and perspectives among individuals who seem to be stagnated and rigid with respect to their perception and interpretation of events (Tomm, 1987b). For example, a father who complains about his son’s misbehavior may be asked questions such as, “When was the last time your son behaved in an appropriate way in that kind of situation?” “What do you like about your son’s behavior?” or “Can you tell me about a time you misbehaved in a similar way as a child?”

Internalized-Other Questions

One subtype of reflexive questioning includes a unique method of interviewing called “internalized-other interviewing.” In this type of interviewing, the therapist invites the client to take the perspective of another person and respond to the therapist’s questions “as if” he or she is that person. In the context of couple therapy, each partner is asked by the therapist to speak as the other partner, using his or her own perceptions and internal images about the other spouse. For example, Jim (the husband) is asked to answer the therapist’s questions as if he were his wife Judy, using the internal images he has formed of her. A therapist may ask Jim, “So tell me Judy, what aspects of Jim attracted you when you first met?” and Jim will respond to the question according to his perceptions of how his wife would answer the same question.
The expected purpose of this unusual interview is to enhance empathy and understanding, increase intimacy and closeness, and to facilitate positive changes, wellness and healing. The therapist invites the husband and wife to reflect about themselves and explore their patterns of interaction by taking the perspective of the other spouse. By taking the perspective of the other, the individual can think through the effects of his or her behaviors on the partner and become aware of the cyclical patterns of their interactions. In addition, each partner can develop a better understanding of the other's experience. Later, the therapist typically gives an opportunity for the other partner to provide feedback and express his or her reactions after listening to their spouse.

By using specific internalized-other questions, the therapist can orient the couple to existing knowledge that is not readily available to them and that may lead them to a more positive and healthy path of thinking about their relationship. For example, when the husband is asked (as his wife) to talk about the things she admires in him, the therapist is shifting his mode of thinking from focusing on her negativity toward him to focusing on her love and respect for him.

From a behavioral-analytic perspective, the internalized-other questions are verbal stimuli that have the potential to become function-altering stimuli. Specifically, the use of the internalized-other questions may transform the stimulus property of each spouse from being a conditioned aversive stimulus (i.e., unloving, argumentative) to being a conditioned reinforcing stimulus (i.e., validating, caring) to the other spouse. When the stimulus function of each partner becomes reinforcing to the other, they (the couple) are more likely to seek each other proximity and to develop greater intimacy and closeness.
The internalized-other interview originated from the clinical work of David Epston (1993), a narrative therapist who often noticed that many couples view psychotherapy as an arena where they can dispute their differences. Epston observed that couples usually have trouble envisioning themselves together as one entity when coming to therapy. Instead, each emphasizes individual needs and wants without considering those of the other. In the context of couple therapy, these stances can be maladaptive and counter-therapeutic, leading to escalation of negativity, demonizing the other and further polarization of the two partners.

Epston (1993) also described typical dynamics evolving in psychotherapy with couples. In these dynamics, both the therapist and his or her clients tend to adopt specific social roles and functions. Three common dynamics identified by Epston were: (a) The juridical, (b) The ecclesiastical/moral, and (c) The politics of reality.

In the juridical dynamic, both spouses engage in tactics of attack/defend, counterattack/counter-defend and credit/discredit similar to the courtroom dynamics where the spouses serve as their own attorneys. The therapist is often assigned the role of a judge who needs to listen, review the claims and evidence, and finally decide who is guilty. This type of dynamic can easily lead to polarization, the disappearance of unity and the emergence of singularity (the couple is not seen as a unit but instead as two separate individuals who fight each other).

In the ecclesiastical/moral dynamic, the couple’s argument is about the morality of the subject of disagreement (and not the legality of it). In other words, each spouse tries to convince the therapist that he or she is innocent while the other is sinful or morally wrong. The therapist often assumes the position of a clergyman who needs to
decide based on morality. Similar to the juridical, the ecclesiastical/moral dynamic can lead to demonizing the partner, amplifying perceptions of core problems, and further polarization.

Lastly, in the politics of reality practice, each spouse assumes that: (a) reality is objective, and (b) he or she has direct access to it. Whenever a disagreement emerges, the spouse may question the abilities of the other spouse to see the world accurately. Often, the spouse adopts the role of a mental health professional and claims that the other spouse possesses a pathology that needs to be treated (e.g., depression, personality disorder, chemical imbalance). In this dynamic, the therapist is requested to adopt the role of a mental health expert who has to decide who the real patient is and who needs to change. Viewing the partner as sick, mentally impaired or irrational leads to further polarization of the couple.

Epston (1993) warned that if therapists assume a passive stance, they could be easily dragged into the position assigned to them by the couple (e.g., judge, clergyman, mental health expert). Furthermore, Epston added that when resisting this assigned role, the couple usually reacts with confusion and anger. Therefore, Epston realized that in order to avoid these unwanted consequences, he needed to reconstruct the typical format of the clinical interview session. For that purpose, he developed a format of questioning, (called “cross-referential questioning”) that allowed him to set a different tone for the session.

Similar to Tomm’s internalized-other questioning style, this format of questioning requires that each partner take the perspective of his or her spouse. Epston noticed that by conducting an interview of this kind, he could successfully prevent the destructive
pattern of negative escalation and polarization among distressed couples. In his clinical work, Epston also noticed that when one partner was asked to speak from the perspective of his or her spouse, the answers provided were not offensive and hence did not invite defensiveness and counter-attack from the other spouse. Attacking the other spouse was rare since it is unlikely that one will attack one’s self (while adopting the position of the other). These types of questions encourage the speaker to reflect in an unusual manner and the listener to show interest and curiosity toward the other. Therapeutically, this questioning paradigm can begin to bring the partners together, breaking the cyclical pattern of negative escalation and polarization.

The internalized-other interviewing of Tomm is an elaboration of Epston’s cross-referential questioning method. Both Tomm’s and Epston’s techniques are topographically and functionally similar, although stemming from somewhat different theoretical views. Epston belongs to the narrative psychotherapy school of thought. His chief therapeutic target includes helping people construct new meaning by changing their maladaptive stories that organize their experience and influence their behavior. Therefore, Epston’s therapeutic style is rich with storytelling and metaphors and is less focused on family cybernetics (i.e., self-defeating patterns of behavior within the family) (Nichols & Schwartz, 2001). Tomm, who is also coming from a post-modernistic frame of reference, is committed to the view that the “mind” is fundamentally social, but also acknowledges the significance of a person’s biological makeup (i.e., nervous system) in setting limits to what the mind can construct coherently (Tomm, 1996). Also, the “self” according to Tomm is not restricted in its existence within the skin-bounded limits of the individual. Instead, the “self” also exists within a community of other people who are
familiar with the individual and who internalized aspects of him or her (spouses, partners, parents, siblings, friends). Tomm called this part of the self in others the "distributed-self," thus making a distinction between the "actual self" which resides within the individual's skin-bounded limits and the "distributed self" which resides within others' skin-bounded limits (Tomm, 1996). In the context of the internalized-other interviewing with couples, the therapist interviews both the "internalized-other" and "distributed self" within each partner, and asks the "actual self" to provide feedback. Tomm views the anticipated potential therapeutic benefits of this method as occurring to both the partner person whom he interviews (specifically, the "distributed self" or the "internalized-other" within this partner) as well as the second partner who is observing the interview (the "actual self"). Finally, Tomm's approach is influenced by systemic theories, thereby, adopting circular and holistic views of mental health phenomena. Tomm recognizes the fact that the experience of the "internalized-other" and the real actual other is never completely the same (Tomm, 1996). There will always be a gap between the experience of the real spouse and the experience of the "internalized-other" within the other spouse. Introducing this gap to the couple invites each partner to distinguish the other's experience as different from his or hers and yet as connected and related (a distinction that has therapeutic merit). Tomm's idea of introducing differences in order to draw connections is derived from Bateson (1972) and is practiced by the Milan approach. For instance, in the Milan approach "mind reading" questions, the therapist asks one family member to speculate on what other family members might have said (Tomm, 1984) (i.e., "If I would ask her the same question that I asked you, how would she respond?"). These types of questions have the potential to influence both the person who answers them and
the other family member/spouse who observes and listens. In summary, both Epston’s and Tomm’s approaches are influenced by post-modernistic philosophies. However, while Epston seems to be mainly focused on helping clients build empowering stories, Tomm seems to be also interested in the cybernetics of the family/couple and in helping family members to take collective new actions in the direction of healing and wellness.

Previous Research on Tomm’s Questioning Model

Up to this point, no empirical published study has been conducted to evaluate directly Tomm’s internalized-other or Epston’s cross-referential interviewing methods. However, two published studies assessed the validity of Tomm’s questioning model (mentioned earlier). Dozier, Hicks, Cornille, and Peterson (1998) evaluated the effects of Tomm’s four categorical questioning styles (lineal, circular, strategic, and reflexive) on the therapeutic alliance between the family and the therapist. In this clinical analogue study, the participants (40 family triads consisting of a mother, father and a high school son) were randomly assigned to one of four experimental conditions in which they were asked to view a 5-minute videotaped family intake scenario that portrayed each of Tomm's four categorical questioning styles. In this intake session, the therapist interviewed a family of three (mother, father and a teenage son) using predominantly lineal, circular, strategic or reflexive questions (depending on the treatment condition). The same therapist and family members (actors) were used across the four treatment conditions. After viewing the 5-minute tape, the participants were asked to identify themselves with their corresponding role and to complete the Family Therapy Alliance Scale (FTAS; Pinsof & Catherall, 1986) and a validity check instrument. The results
showed that the circular and reflexive questioning style elicited significantly higher scores ($p < 0.001$) on the FTAS than either lineal or strategic questioning. More specifically, families who observed a therapist who primarily used circular or reflexive questioning styles during the intake session viewed themselves on average as more allied with him or her than families who observed therapists who used predominantly the lineal or strategic questioning styles. The authors did not find any statistically significant differences between the alliance scores of families who observed a therapist using the circular questioning style versus the alliance scores of families who observed a therapist using the reflexive style. Additionally, no statistically significant differences were found between the alliance scores of families observing a therapist who used a lineal versus a strategic interview style. In summary, data analysis illustrated main effects only for the therapist’s assumptions (circular versus lineal) and not for the therapist’s intent (assessing versus influencing), indicating that families reported feeling more aligned with therapists who ask questions rooted in a circular frame of reference versus therapists who ask questions embedded in a linear thinking style.

Ryan and Carr (2001) replicated and extended the Dozier et al. (1998) study to test Tomm’s hypotheses about the differential effects of questioning styles on therapeutic alliance. They incorporated a repeated measure within group design, in which each participant watched all four interviewing styles (the order of administration was counterbalanced) and evaluated their relationship with the therapist using three different measures of alliance. Similar to Dozier et al. (1998), these results showed that, compared to strategic and lineal questioning styles, circular and reflexive questions led to
statistically significant higher ratings of therapeutic alliance on the three different alliance scales.

Taken together, the results of these studies showed support for Tomm’s hypotheses regarding the potential effects of a therapist’s assumptions (as reflected by the questions asked during the session) on the collaborative therapeutic relationship bond (alliance) with the family. Families gave ratings that are more favorable to therapists who used questions emanating from a circular point of view than those therapists who asked questions derived from a lineal perspective during the interview session. Tomm (1988) suggested that questions asked within the circular assumption framework could bring the client to experience a sense of freedom, acceptance and choice, while questions asked within a lineal agenda could bring the client to feel judged by the therapist and to feel an overall sense of constraint.

It is important to mention that the studies by Dozier et al. (1998), and Ryan and Carr (2001) were analogue studies, and hence entail some methodological shortcomings. Specifically, both studies were not conducted in real clinical settings, with real patients, and therefore their external validity (to other contexts) is questionable. In addition, in order to assess therapeutic alliance, participants in both studies viewed only short excerpts taken during the beginning phase of therapy without seeing an entire session. It would be premature to claim that families favor therapists whose approach is embedded within a circular frame of reference compared to therapists who adopt a lineal perspective after viewing only the first five minutes of the therapy session. One may also argue that the first phase of the therapy session (i.e., joining the family) is essentially different from other phases. Consequently, generalizations from both studies (Dozier et al. (1998); Ryan
& Carr (2001)) should be limited only to the specific conditions outlined in their studies. Replication of these studies in real therapeutic settings, with real patients and across different phases of the interview session, would be important prior to drawing any definitive conclusions about these interview methods.

The Present Study

Thus far, no attempt has been made to evaluate empirically Tomm’s internalized-other interviewing method in any therapeutic context (e.g., family, couple, or individual therapy). Despite this fact, the internalized-other interviewing has been used by other family therapists (Deacon & Davis, 2001), and in other therapeutic contexts, such as with the treatment of abusive males (Nylund & Corsiglia, 1993). In addition, the internalized-other interviewing method has been demonstrated, taught and practiced at influential national conferences such as the American Association of Marital and Family Therapy (AAMFT) (e.g., Tomm, 1996) and other professional workshops.

There also is very limited research that assesses the immediate and short-term effects of specific interventions in different therapeutic circumstances, such as the initial interview with couples. Discovering which therapeutic component leads to which therapeutic outcome can be an elusive task. However, this particular line of research is essential in order to answer questions such as: (a) Does it matter how a therapist begins the initial couple therapy session? (b) What are the potential effects of the therapist’s response modes on the couple? (c) Is it more helpful to focus on the couple’s problems or on the solutions to it during earlier phases of treatment? (d) Do specific techniques (e.g., reframing, restraining, externalizing the problem or paradoxical intervention) and
questioning style (e.g., circular versus lineal) tend to evoke certain types of responses from the couple and have different therapeutic effects? These are all specific questions that can give clinicians guidance on the more general question of whether different ways of conducting therapy sessions with clients are beneficial, harmful or ineffective (Stiles, 1980).

There were primarily two objectives for this study. The first objective was to evaluate the immediate impact of the internalized-other interviewing method on couples during the first session. Impact refers to the session’s immediate effects on each spouse, as reflected both by their evaluations of the session and their mood, measured immediately after the session (Stiles, 1980), as well as their perceptions of the therapist and the level of therapeutic alliance established. Measuring the overall session level impact may offer a bridge between molecular levels of the therapeutic process in couple therapy (i.e., what specific therapist’s actions can become salient, significant and memorable events that may facilitate positive change in the couple), to molar levels of the therapeutic process in couple therapy (i.e., the entire cumulative effects of a series of sessions on the couple) (Mallinckrodt, 1994).

The second objective of this study was to evaluate the short-term therapeutic effects of the internalized-other interviewing on couples. As mentioned earlier, both Epston and Tomm asserted that the internalized-other interviewing approach has the potential to change the couple’s dynamic of interactions from polarization to closeness (Epston, 1993), and can generate closeness, intimacy, mutual understanding, and empathy between the two partners (Bubenzer et al., 1997; Tomm, 1996). Hence, this study also examined these potential effects for each couple.
This was an exploratory study and the first that attempted to examine the effectiveness of the internalized-other interviewing questions. Consequently, predictions in this study could not be based on previous research findings, and the aims of this study were not to confirm past empirical findings. Instead, study hypotheses were based on Tomm’s and Epston’s suppositions that were directly derived from their theoretical and clinical work. Although study hypotheses were reframed as one-tailed (i.e., it was expected that one condition would be superior over the other), based on the nature of this study, any outcome was possible and could have had scientific merit.

Hypotheses

Hypothesis I

It was hypothesized that couples who were interviewed using the internalized-other interviewing method would show higher levels of empathy, intimacy, closeness and overall marital satisfaction at both follow-up assessments (one-week and four-week) compared to baseline, while it was hypothesized that couples who received the standard interviewing method would not show any improvement at follow-up assessments compared to baseline.

Hypothesis II

It was hypothesized that couples who were interviewed using the internalized-other interviewing method would report higher levels of closeness and connectedness following the session as compared to couples who received the standard interviewing method.
Hypothesis III

It was hypothesized that couples who were interviewed using the internalized-other interviewing method would evaluate the therapeutic qualities of the session and its impact on them more positively following the session than couples who received the standard interviewing method.

Hypothesis IV

It was hypothesized that couples who were interviewed using the internalized-other interviewing method would report a higher level of therapeutic working alliance with the therapist following the session and would evaluate him more favorably than couples who received the standard interviewing method.

Hypothesis V

It was hypothesized that couples who were interviewed using the internalized-other interviewing method would report higher levels of satisfaction following the session than couples who received the standard interviewing method.
METHOD

Participants

Thirty-two married couples participated in this study (N = 64 participants). Participants were recruited from Western Michigan University and the surrounding community. Recruitment methods included flyers posted on campus, class announcements, newspaper advertisements in Kalamazoo and the surrounding towns, and signs posted at local establishments (see Appendix D). The flyers/ads/signs specified that the main investigator was looking for married couples who had some desire to improve their relationship, and that were willing to participate in three sessions in order to evaluate and compare the session impact and the therapeutic effects of two different methods of clinical interviewing. All couples were paid one hundred dollars for their participation in this study (fully attending the three sessions). Couples responding to the advertisements were instructed to call the main investigator to schedule an initial appointment. All potential participants were contacted by the main investigator to conduct a phone-screening interview, to ensure that they met the initial study criteria for participation (see below). If the couple met these criteria, an initial session was scheduled. Prior to this session, the main investigator randomly assigned the couple to either experimental condition A or B, in which participants assigned to condition A received the “standard” (i.e., treatment as usual) clinical interview and participants who were assigned to condition B received the “internalized-other” clinical interview (for a complete description of each of these methods of interviewing, please refer to Appendix G).
In order to qualify for this study, the couple had to meet the following criteria: (a) they were married and living together with their spouse; (b) both husband and wife were eighteen years or older (c) both husband and wife reported some desire to improve their relationship (d) there were no current reported excessive or dangerous levels of physical violence in their relationship and (e) no history of psychotic disorders (e.g., Schizophrenia) for either spouse. Recruitment for this study ended after approximately 10 months, when thirty-two couples had completed the interview and follow-up sessions. All participants and their data were treated in accordance with the “Ethical Principles of Psychologist and Code of Conduct” (American Psychological Association, 1992) and in accordance with the protocol that was approved by WMU Human Subjects Institutional Review Board (see Appendix B).

Therapist

The main investigator, a doctoral student in clinical psychology who held a master’s degree, conducted the initial sessions in both treatment conditions. Prior to the beginning of the study, the therapist had participated in an auto-didactic training program that included listening to and viewing videotapes of Karl Tomm conducting the internalized-other interviewing with a couple, as well as engaging in an extensive reading of his theoretical work. Following training, the therapist participated in regular individual and group meetings that provided supervision and feedback for his on-going work. All therapy sessions were videotaped to ensure treatment integrity.
Setting

The study was conducted at the Department of Psychology of Western Michigan University (a large public Midwestern university). The interview sessions were conducted in a therapy room (11 x 12 feet) containing three chairs, a small round table and a television set. A video camera mounted in the upper corner of the wall facing the table was used to monitor and record the sessions.

Procedure

Session I – The Interview

The main investigator (the main investigator and the therapist will be used interchangeably, and will refer to the same person) met the participants at the Behavioral Pediatrics and Family Studies Lab, located at Western Michigan University, Department of Psychology. Upon their arrival, the main investigator greeted the couple and escorted them to the therapy room where the interview session took place. The main investigator described to the couple the purpose of this study. The participants were informed that the purpose of this study was to evaluate and compare two clinical interviewing methods with couples during the first session. In addition, the participants were told that the study involved participation in one clinical interview session that lasts approximately 180 minutes (this includes the consent process, the clinical interview, as well as the time given to completing the pre and post questionnaires), followed by two follow-up sessions (after one and four-week intervals respectively) that last approximately 30 minutes.
The main investigator proceeded by asking the participants to read the consent form (see Appendix C) and, if in agreement, to sign it. In order to ensure that the participants had read and fully understood the informed consent, the main investigator discussed with them the potential risks and benefits of this study. More specifically, the main investigator informed the participants that during the interview session they would be asked to discuss personal information that might evoke emotional discomfort, such as anxiety, sadness, anger, guilt or shame. The participants also were informed that they could choose not to answer questions, or even withdraw from participation, at any time during the course of the session, without penalty or prejudice.

In addition, participants were told that the interview session would be videotaped, and later would be observed and scored by trained graduate research assistants to ensure treatment integrity. Participants also were told that these tapes would be destroyed following data analysis and the completion of this study (dissertation defense). Moreover, the participants were informed that all information collected from them (questionnaires, demographic data and videotapes) would be kept confidential, and only the main investigator, his advisor and research assistants directly involved in this project would have access to them. In addition, any identifying information (e.g., names, addresses, and phone numbers) were not to be directly associated with the data collected. Instead, the data collected were coded with a serial number and kept locked in a file cabinet. A master list of the participants’ names and corresponding code numbers was kept in a separate locked cabinet and would be destroyed after the completion of this study. As a final point, the main investigator answered any questions the participants raised about the study.
Next, the participants completed, independently and in separate rooms, a series of questionnaires regarding their level of marital satisfaction, level of closeness and intimacy, level of their perspective-taking abilities, and other demographic information. The order of the questionnaires was randomly determined for each individual separately and prior to the session. The main investigator emphasized to both participants the importance of responding honestly to all questionnaire items.

After completing the questionnaires, the initial interview session began. During the interview session, the therapist engaged in conversations with the couple. Similar to a typical intake session, the therapist asked each partner separately a series of questions with respect to multiple domains in their lives, such as their history as individuals and as a couple; how they met; what they like and admire about the other; aspects of their relationship that they value and want to preserve; domains in their relationship that they want to change or improve; and their expectations, dreams and hopes about their future as a couple. In addition, while one partner was engaged in a conversation with the main investigator, the other partner who listened was later given time for comments, reactions, and feedback.

As mentioned before, the type of clinical interview was based on the couple’s randomized experimental condition. Group A received the “standard” clinical interview in which each spouse was asked to talk for himself or herself, while group B received the “internalized-other” clinical interview in which each spouse was asked to talk from the perspective of his or her partner (i.e., the other’s “distributed self”). The format and content of these interviews were similar across the two groups, and the main difference was the perspective taken (speaking as yourself versus speaking as the distributed other).
At the end of the interview, the couple completed, independently and in separate rooms, a series of post-session questionnaires. The order of the questionnaires had been randomly assigned for each individual and pre-determined before the session.

Following the session, the main investigator paid the participants twenty American dollars (ten dollars for each spouse), and informed them that subsequent to this first session, they would be asked to return for a follow-up session that would last approximately thirty minutes and that would entail completing a series of questionnaires similar to the one they already filled before. The therapist scheduled another appointment for the following week.

One-Week Follow-Up

Approximately one-week after the completion of the initial session, the couple returned for the first follow-up session. The main investigator met the couple at the Behavioral Pediatrics and Family Studies Lab, located at the Department of Psychology at Western Michigan University. Participants were seated in separate rooms and completed a partial series of the same questionnaires they completed during the first session (please refer to Table 1 for a description of all the administered questionnaires for this particular session). The order of questionnaires was randomized and pre-determined before the session. Following this, the main investigator thanked the couple for coming to the session, paid them twenty American dollars and scheduled the last appointment.
Four-Week Follow-Up

Approximately four weeks after the completion of the initial session, the couple returned for a second follow-up session. The main investigator met the couple at the Behavioral Pediatrics and Family Studies Lab, located at the Department of Psychology at Western Michigan University. Each participant was seated in a different room and was asked to complete a series of questionnaires they had also completed during the one-week follow-up session. The order of the questionnaires was randomized prior to the session. Following that, the main investigator thanked the couple for their participation, paid them sixty American dollars and gave them a short debriefing about the main purposes of the study. The therapist also asked the couple to provide him with any informal feedback about their experiences throughout the study. Finally, the main investigator gave each couple a referral list of couple’s therapists and outpatient clinics in the Kalamazoo region in case they decide to pursue therapy in the future.

Measures

Marital Adjustment Test

The Marital Adjustment Test (MAT; Locke & Wallace, 1959) measures the overall level of marital quality and satisfaction. The MAT is a rapid assessment instrument that includes series of questions regarding the spouses’ compatibility and their perceptions about their marriage. This instrument is standardized and has a mean of 100 and a standard deviation of 15. Higher scores represent higher marital satisfaction. The MAT proved to have satisfactory internal consistency reliability (median Cronbach alpha
coefficient of .83), test-retest stability (ranging from .82 to .84), and ability to discriminate between satisfied and unsatisfied couples (criterion-related validity) (Freeston & Plechaty, 1997). The MAT was given to each participant three times (i.e., pre-session, one-week, and four-week follow-ups) to detect changes in overall marital adjustment and satisfaction over time. Additionally, pre-session MAT scores were used as a comparison measure to assess whether the participants in the two experimental conditions (A and B) had similar levels of marital satisfaction and adjustment prior to intervention. Had the two experimental groups significantly differed on initial level of marital satisfaction and adjustment, MAT scores would have been used as a covariate in subsequent statistical analysis.

**Dyadic Perspective Taking Scale**

The Dyadic Perspective Taking Scale (Long, 1990) assesses perspective taking and empathy. This instrument consists of two scales. The first scale (Self-Dyadic Perspective-Taking Scale - SDPT), assesses the individual’s ability to see their spouse’s point of view, or take their perspective, and contains 13 items on a 5-point Likert scale (0 = Does not describe me very well; 4 = Does describe me very well) while the second (Other-Dyadic Perspective-Taking Scale - ODPT) assesses the individual’s perceptions about his or her spouse’s perspective taking abilities and contains 20 items on a 5-point Likert type scale (0 = Does not describe my partner very well; 4 = Does describe my partner very well). Higher scores indicate higher levels of the measured characteristic. Both the SDPT and ODPT have been shown to have satisfactory internal consistency (alpha coefficient of .89 and .94, respectively), and were moderately positively correlated.
with other measures of perspective-taking (Long, 1990). The Dyadic Perspective Taking Scale was administered to each participant three times (i.e., pre-session, one-week, and four-week follow-up sessions).

Inclusion of Other in the Self

The Inclusion of Other in the Self Scale (IOS; Aron, Aron & Smollan, 1992) measures the level of closeness and connectedness of a relationship as perceived by the individual. The IOS scale consists of seven pairs of circles labeled “self” and “spouse” that overlap to various degrees, creating a 7-point interval scale. Higher overlaps indicate a higher level of closeness and connectedness in a relationship. Each participant was asked to select the pair that best describes his or her relationship with his or her spouse. The IOS is reported to have satisfactory levels of test-retest and alternate form reliability (.85 and .92, respectively), as well as convergent validity with related instruments and discriminate validity with unrelated measures (Aron et al., 1992). In addition, the IOS proved to be a good predictor of relationship maintenance among couples (Aron et al., 1992). Two forms of the IOS were used in this study. The first refers to the present (i.e., how each spouse views his relationship with the other in the present), while the second refers to the ideal (how each spouse would like his or her relationship with the other to be). The IOS was administered to each participant three times (i.e., post-session, one-week, and four-week follow-up sessions).
Relationship Closeness Inventory

The Relational Closeness Inventory (RCI; Berscheid, Snyder, & Omoto, 1989) measures the level of relationship closeness in behavioral terms. This instrument consists of three sub-scales that intend to tap the properties of frequency, diversity, and strength in the couple’s relationship. Frequency refers to the amount of time the couple spent together and alone over the past week; diversity refers to the number of activities they engaged in with each other over the past week; strength refers to the overall level of influence each has on the other in more global and stable matters (e.g., who manages finance). Raw scores in each of these sub-scales are converted to scaled scores (1-10), where higher scores indicate higher levels of what is measured (i.e., frequency, diversity, strength). Because no dramatic changes over relatively stable relationship matters were expected, only the frequency of contact and diversity of activities sub-scales were administered. The RCI has been reported to have satisfactory test-retest reliability (.82), as well as to have the ability to discriminate successfully between close and non-close relationships (Berscheid et al., 1989). In addition, it has been reported to predict relational stability (i.e., early breakup, late breakup, enduring) (Berscheid et al., 1989). The RCI frequency of contact and diversity of activities sub-scales were administered to each participant three times (i.e., pre-session, one-week, and four-week follow-up sessions).
**Subjective Closeness Index**

The Subjective Closeness Index (SCI; Berscheid et al. 1989) also assesses closeness and the level of connectedness between the two spouses. The purpose of including the SCI in this study was to use it as a pre-session (baseline) measure that shares common variance with the IOS (given after the interview session) which could be used as a covariate that would compensate for any pre-intervention differences between the two experimental conditions. The original SCI includes only two items, which asked respondents to estimate the level of closeness of their relationship compared to other relationships they have in life using a 7-point Likert-type scale, with higher scores indicating greater closeness and connectedness. After consulting with Arthur Aron (personal communication, 2004), who developed the IOS, a new item (developed by the main investigator) was added to the original SCI scale. Hence, the SCI consisted of three, 7-point Likert-type scale items. The SCI has been reported to yield moderate positive correlations with other measures of intimacy, such as the IOS and RCI (Aron et al., 1992). In the present study, it was administered to all participants once at pre-session.

**Miller Social Intimacy Scale**

The Miller Social Intimacy Scale (MSIS; Miller & Lefcourt, 1982) measures the level of intimacy experienced by each spouse. This 17-item 10-point Likert-type scale intends to capture intimacy and closeness in the context of a marriage relationship. Higher scores indicate a higher level of intimacy. Test-retest reliability for the MSIS was reported to range from .84 to .96, and the magnitude of Cronbach alpha coefficient was

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reported to range from .86 to .91 (Miller & Lefcourt, 1982). In addition, the MSIS proved to discriminate between distressed and non-distressed married couples (Miller & Lefcourt, 1982). The MSIS was administered to each participant three times (i.e., pre-session, one-week, and four-week follow up sessions).

**Session Evaluation Questionnaire**

The Session Evaluation Questionnaire (SEQ) was developed by Stiles (1980), and was designed to evaluate the immediate impact of a therapy session. This instrument consists of 24 bipolar adjective scales presented in a 7-point semantic differential format designed to measure: (a) clients’ perceptions and impressions with regard to depth and smoothness of the therapy session, and (b) clients’ overall mood and level of arousal following the session. The SEQ is typically given to clients immediately after the therapy session ends. Factor analysis of the SEQ yielded four factors (Stiles & Snow, 1984). Factor one (depth/value) distinguished sessions described as valuable, full, special, deep, and good from sessions described as worthless, empty, ordinary, shallow, and bad. Factor two (smoothness/ease) distinguished sessions described as smooth, pleasant, easy, and safe from sessions described as rough, unpleasant, difficult, and dangerous. Factor three (positive feelings) distinguished sessions described as happy, pleased, strong, and sharp from sessions described as sad, angry, weak, and dull. Factor four (arousal) distinguished sessions as described as slow, sleepy, and still from sessions described as fast, alert, and active. Therefore, the SEQ yields four subscales scores (Depth, Smoothness, Positivity and Arousal); each is designed to tap different aspects of the therapy experience. Subscale index scores range from 1 to 7, with higher scores
indicating a higher level of the measured characteristic. For example, a high score on the Depth subscale indicates a session that was perceived by the respondent as deep, valuable and meaningful.

Internal consistency of the four dimensions of the SEQ ranged from .78 to .91 (alpha coefficients) as reported by Corcoran and Fischer (1987). Finally, this instrument has been cited by others as one of the most frequently used measure in counseling process research (Mallinckrodt, 1994). In this study, the SEQ was administered to each participant once, following the interview session.

Revised Session Reactions Scale

The Revised Session Reactions Scale (RSRS; Reeker, Elliot, & Ensing, 1996) is a 22-item Likert-type scale instrument that measures the extent by which the therapy session was helpful or hindering. The RSRS consists of three subscales derived from previous research on the reactions of significant therapy events: (a) Task Reactions (10 items) – measures the extent by which the client perceives the session as beneficial in terms of progress toward a therapeutic goal, (b) Relationship Reactions (4 items) – measures the extent by which the client perceives the therapeutic relationship as helpful and (c) Hindering Reactions (8 items) – measures the extent by which the client perceives the therapy session as non-helpful. Task and Relationship Reactions subscales are often combined to form the Helpful Reactions subscale (14 items). All items are rated on a 5-point scale (1 = not at all, 2 = slightly, 3 = somewhat, 4 = pretty much, 5 = very much). Higher scores indicate a higher level of the measured characteristic.
Reeker et al., (1996) reported satisfactory internal reliabilities for all subscales (Hindering Reactions: .83; Task Reactions: .91; Relationship Reactions: .89; Helpful Reactions: .92). The Helpful Reactions subscale has been reported to positively correlate with the Smoothness and Positivity SEQ subscales, while the Hindering Reactions subscale has been reported to negatively correlate with the Positivity and Smoothness SEQ subscales (Reeker et al., 1996). The RSRS was administered once to each participant immediately following the session.

Couple Therapy Alliance Scale

The Couple Therapy Alliance Scale (CTAS; Pinsof & Catherall, 1986) is a self-report measure, consisting of 40 Likert-type items on a 1-7 scale (1 = completely disagree, 7 = completely agree) that assess the clients' perceptions of the therapeutic alliance in the context of couple therapy. Higher scores indicate higher levels of alliance. The CTAS assesses the alliance on three inter-personal levels: (a) self-therapist (e.g., “I trust the therapist”) (b) partner-therapist (e.g., “My partner feels accepted by the therapist”) (c) couple-therapist (e.g., “The therapist is helping my partner and me in our relationship”). The content of all items reflects Bordin’s (1979) definition of the working alliance and includes three categories: (a) tasks – the extent to which the client agrees about the way therapy is being conducted; the extent he or she feels understood by the therapist; and the extent he or she perceives the therapist as helpful; (b) goals – the extent to which the client is in agreement with the therapeutic goals; and (c) bond – refers to the quality of the human relationship between the therapist and the client. An overall alliance score and sub-score for each of the interpersonal dimensions (self-therapist,
partner-therapist, and couple-therapist) and the content categories (task, goals, and bond) are generated by the CTAS. Test-retest reliability for the overall alliance score was reported to range from .79 to .84 (Pinsof & Catherall, 1986), while internal consistency was reported to be .93 (Heatherington & Friedlander, 1990) and .95 (Bourgeois, Sabourin & Wright, 1990). In addition, the overall scale alliance score was found to be positively correlated with client progress and therapy outcome (Catherall, 1985; Bourgeois et al. 1990; Brown & O’Leary, 2000), supporting the predictive validity of the scale. The CTAS was administered to each of the participants once, immediately following the interview (post-session).

Counselor Rating Form – Short Version

The Counselor Rating Form-Short Version (CRF-S; Corrigan & Schmidt, 1983) is a self-report measure, which asks the client to rate his or her perceptions regarding the therapist’s expertness, attractiveness, and trustworthiness. The client is asked to rate the extent to which the therapist demonstrated 12 different characteristics (e.g., friendly, prepared, sincere) using a 7-point Likert scale (1 = Not very; 7 = very). The CRF-S consists of three subscales (Expertness, Attractiveness, and Trustworthiness); each contains four adjectives associated with its construct. The range of scoring for each subscale is 4-28, with higher scores indicating that the therapist demonstrated very much of the characteristic. Corrigan and Schmidt (1983) reported split-half reliability for the three subscales for both outpatients and undergraduate student populations ranging from .82 to .94. Construct validity of the CRF-S was confirmed by factor analysis (Corrigan & Schmidt, 1983) and was also reported by Wilson and Yager (1990). Previous studies
with the CRF-S demonstrated a positive relationship between perceptions of therapist source characteristics and client satisfaction (McNeill, May, & Lee 1987). Finally, the CRF-S has been cited as one of the top three most frequently used measures in research published in the Journal of Counseling Psychology and the Journal of Consulting and Clinical Psychology between 1978 and 1992 (Hill, Nutt & Jackson, 1994). The CRF-S was administered to each of the participants once, at the end of the interview (post-session).

**Social Validity – Client’s Satisfaction Questionnaire**

The Social validity-Client’s satisfaction questionnaire, developed by the main investigator, assessed the overall quality and impact of the interview session using 14 items formulated on a 7-point Likert-type scale (1 = strongly disagree, 7 = strongly agree). Specifically, the questionnaire items assesses whether the interview session facilitated more closeness, understanding, empathy and greater appreciation between the two spouses. Moreover, it assessed the overall worth and significance of the session. Higher scores indicate greater client’s satisfaction. The social validity instrument was administered to each of the participants once, at the end of the interview (post-session).

**Treatment Integrity**

Two independent research assistants (advanced doctoral students in clinical psychology) viewed 10 randomly selected tapes (approximately 33% of all tapes) and evaluated treatment adherence by completing a checklist developed by the main investigator for the purpose of this study (see Appendix H). The checklist was devised to
determine the extent to which the therapist implemented the treatment as prescribed by the treatment manual (session script) and avoided the use of any interventions that were not part of the treatment manual (e.g., assigning home-work, exploring irrational thinking, making interpretations, teaching new skills, giving directives). Prior to scoring the tapes, all research assistants received four hours of supervised training which included didactic information on the internalized-other interviewing method, as well as detailed instructions on how to use the scoring checklist form. Additionally, both research assistants viewed an instructional tape in which Karl Tomm conducted a similar interview session with a couple at a conference of the American Association of Marital and Family Therapy (Tomm, 1996).

Research assistants scored the tapes by recording the occurrence or non-occurrence of each checklist item. Treatment adherence was assessed by the percentage occurrence of session events. This index was calculated by dividing the total number of session events marked by the rater as “fully occurred” by the total number of session events prescribed by the session script, and multiplying it by a 100. For example, if the rater marked 40 events as “fully occurred” and 4 events as either “partially occurred” or “not occurred,” percentage occurrence index will be $(40/44) \times 100 = 90.9\%$. A session event was defined as the therapist’s response modes as prescribed by the session script (e.g., the semantic content of questions asked by the therapist during the interview). An additional index was calculated for session events not prescribed by the session script (e.g., advice giving, skills building). Inter-raters reliabilities were calculated by using a point-by-point agreement ratio. The point-by-point agreement ratio was calculated by the

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total number of agreements of the observers divided by the number of agreements plus disagreement and multiplied by 100 to form a percentage.

Statistical Analysis and Research Design

Measures of central tendency (i.e., means), distribution of scores (i.e., standard deviations), and inter-correlations for all dependent measures were included in this study. Frequencies and percentages were used to describe nominal level data. Additionally, two different statistical designs were implemented to analyze the data. First, a repeated measures multivariate analysis of variance (MANOVA) was conducted in order to evaluate short-term therapeutic gains. This analysis was selected over running separate ANOVAs in order to maximize the chance of detecting treatment effects by combining several measures that share common variance into a single variable. Second, depending on the circumstances, a between-subjects analysis of variance (ANOVA), between-subjects analysis of covariance (ANCOVA) or between-subjects MANOVA were performed in order to compare the immediate session impact of each treatment condition on couples. The decision to carry out several analyses rather than combining all post-session measures into a single variable and executing between-subjects MANOVA was based on the intricate structure of some of the measures (i.e., some measures consist of various sub-scales) and the possible difficulties in interpreting the results by carrying out such analysis.
Short-Term Therapeutic Effects

A 3 (pre-session baseline vs. follow-up 1 vs. follow-up 2) x 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) repeated measures MANOVA was carried out to analyze short-term therapeutic effects across time with respect to measures of closeness, intimacy, empathy, and overall marital satisfaction. These measures included the MAT, IOS, MSIS, RCI, SDPT and ODPT.

Session Immediate Impact

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) between-subjects ANCOVA was performed to analyze group and gender differences on level of closeness and intimacy scores (measured by the IOS), with the SCI baseline scores as a covariate and IOS post-session scores as the dependent measure.

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) between-subjects MANOVA was performed to analyze group and gender differences with respect to session impact (measured by the SEQ and RSRS.)

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) between-subjects (ANOVA) was performed to analyze group and gender differences on level of therapeutic working alliance (measured by the CTAS).

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. female) between-subjects MANOVA was performed to analyze group and gender differences with respect to participants’ evaluations of the therapist (measured by the CRF-S therapist’s expertness, attractiveness, and trustworthiness subscales.)
A 2 (internalized-other vs. standard interviewing) × 2 (males vs. females) between-subjects ANOVA was performed to analyze group and gender differences on level of participants’ satisfaction (measured by the SVQ).

Table 1 (Appendix A) provides a summary list of all measures given across study phases. All of the instruments under the heading "post-session" (with the exception of the IOS) were given to each participant only once and all assessed participant’s session impact. On the other hand, all instruments given at pre-session baseline and one-week and four-week follow-up sessions measured short-term therapeutic gain.
RESULTS

Demographic Information

Thirty-two married couples participated in this study ($N = 64$ participants). One couple ($n = 2$) dropped after their initial session, and the remaining couples fully completed the study. Participants ranged in age from 19 to 75, with an average age of 41.67 ($SD = 16.64$). The average length of marriage in this sample of participants was 14.6 years ($Min = .25$, $Max = 54$, $SD = 16.29$). Fifty-one participants (79.7%) reported that this was their first marriage, and 19 participants (29.7%) reported that they had been in couple therapy with their current spouse before.

18.7% of sample participants reported individual annual incomes of less than $10,000, 46.9% reported incomes between $10,000 and $30,000, and 32.9% reported incomes higher than $30,000. Only 3 participants (4.7%) reported having less than a high-school education, 10 participants (15.6%) reported finishing high-school, 16 participants (25%) reported having some college education, 13 participants (20.3%) reported finishing college, while 8 participants (12.5%) reported earning a Master’s degree.

The majority of sample participants were Caucasian ($n = 57$, 89.1%). Others consisted of African American ($n = 3$, 4.5%), Native American ($n = 1$, 1.5%) and other ($n = 2$, 3%). The majority of participants ($n = 41$, 64.1%) endorsed having a religious affiliation, with Catholicism the most prevalent ($n = 9$, 14.1%).

A series of chi-square tests were conducted in order to determine whether the distribution of demographic characteristics described above was similar in both
experimental conditions. Results showed no statistical significant differences between the two experimental conditions across all demographic variables taken. Tables 2-6 (Appendix A) provide complete information on sample demographic data, as well as the chi-square test results.

Initial Level of Marital Happiness and Satisfaction

Marital happiness and satisfaction were assessed by the Marital Adjustment Test (MAT). The average baseline (pre-session) MAT score for this sample of participants was 110.49 (SD = 21.26), ranging from 40 to 150. Among the internalized-other interview group participants, the average baseline MAT score was 111.95 (SD = 19.61), while among the standard interview group participants, the average baseline MAT score was 109.2 (SD = 23.01). Only 19 participants of this entire sample (29.69%) had a baseline MAT score that was below 100, which suggests that overall, this sample of couples was not clinically distressed. An independent samples t-test was conducted in order to determine whether there were pre-session statistically significant differences between the two experimental conditions on baseline MAT scores. Results showed no statistically significant difference between the two groups, $t(62) = -0.548, p = .586$.

Descriptive Statistics and Inter-Correlations among Dependent Variables

Table 7 depicts means and standard deviations for all dependent variables given at baseline and across the two experimental conditions (standard and internalized-other interviewing). A series of independent samples t-tests were conducted in order to determine whether there were any pre-treatment statistically significant differences
between the two experimental conditions across these measures. Results showed no statistically significant differences between the two groups across all dependent variables administered prior to the intervention (see Tables 7 and 8 in Appendix A). Because there were no statistically significant differences between the two groups across all measures prior to the intervention (as would be expected by random assignment), comparisons between the two conditions were conducted without concern for selection bias.

Table 9 depicts a correlation matrix for all dependent variables that measured short-term therapeutic effects. These variables measured similar constructs such as intimacy, closeness, empathy and marital satisfaction. Not surprisingly, the data indicated that most instruments correlated with each other at a medium to high level. Exceptionally high positive correlations were observed between the MAT and SCI ($r = .767, N = 64, p < .001$), IOS and SCI ($r = .732, N = 64, p < .001$), and MSIS and MAT ($r = .717, N = 64, p < .001$).

Table 10 depicts the correlation matrix for all dependent variables given at post-session that measured immediate session impact. These instruments measured different aspects of session impact, such as therapeutic alliance, session depth and session smoothness, and participants’ perceptions of the therapist. There was a range from low to high correlations among these instruments. Higher positive correlations were observed between the SVQ and RSRS ($r = .711, N = 64, p < .001$), SVQ and SEQ (Depth subscale) ($r = .706, N = 64, p < .001$), and SEQ (Depth sub-scale) and SEQ (Positivity sub-scale) ($r = .614, N = 64, p < .001$).
Treatment Integrity

Session adherence was measured by the percentage occurrence of session events as prescribed by the session script (see Appendix H). This index was calculated by dividing all session events the rater marked as “fully occurred” by the total number of session events (occurred + non-occurred), then multiplying it by one hundred. Results indicate that the mean percentage occurrence of session events was 93.37% (Min = 85.2%, Max = 97.72).

Additionally, session adherence was assessed by the percentage occurrence of session events not prescribed by the session script (e.g., therapist gives direct advice, therapist teaches certain skills, therapist assigns homework, etc.). This index was calculated by dividing all session events not prescribed by the session script that the rater marked as “fully occurred” by the total number of session events not prescribed by session script (occurred + non-occurred). Results indicate that the mean percentage occurrence of session events not prescribed by the session script was 0%.

Finally, the point-by-point agreement ratio for inter-raters reliability was calculated by dividing the number of session events where both observers agreed had occurred or not occurred by the total number of session events (agreement and disagreement) and multiplying it by 100 to form a percentage. Results show that the mean point-by-point agreement ratio across the 10 sessions was 95.04% (Min = 86.67%, Max = 100%).

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Inferential Statistics

Short-Term Therapeutic Effects

Hypothesis 1 predicted that the interview style would yield differential short-term therapeutic effects on couples. Specifically, it was hypothesized that couples who had received the internalized-other interview would show higher levels of marital satisfaction, intimacy, empathy, and closeness at one-week and four-week follow-up sessions than at baseline. The researcher did not expect to observe any improvement among couples in the second experimental condition (standard interviewing method). A 3 (baseline vs. one-week follow-up vs. four-week follow-up) x 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) repeated measures MANOVA was conducted in order to determine short-term therapeutic effects. All dependent measures that were administered to participants three times (i.e., baseline, one-week follow-up, and four-week follow-up) were included in this analysis. This included the MAT, MSIS, SDPT, ODPT, RCI and IOS. Tables 14-15 (Appendix A) depict means and standard deviations for each of the dependent measures across time and experimental condition.

Results showed a significant main effect for time, Wilks’ $\Lambda = .571$, $F(12, 45) = 2.82$, $p = .006$, $R^2 = .429$. Univariate ANOVAs indicated significant time effects for MAT, $F(2, 122) = 7.37$, $p = .001$, MSIS, $F(2, 122) = 3.54$, $p = .032$, SDPT, $F(2, 122) = 5.53$, $p = .005$, and ODPT, $F(2, 122) = 7.04$, $p = .001$. Post-hoc comparisons showed that the MAT mean score at four-week follow-up ($M = 116.66$, $SD = 18.14$) was significantly higher than at pre-session baseline ($M = 110.34$, $SD = 21.36$), $p = .005$; that the MSIS mean score at four-week follow-up ($M = 149.41$, $SD = 12.62$) was significantly
higher than at pre-session baseline ($M = 146.06, SD = 15.79), p = .046; that the SDPT mean score at four-week follow-up ($M = 35.37, SD = 6.69$) was significantly higher than at pre-session baseline ($M = 33.12, SD = 7.13$), $p = .007$; and that the ODPT mean score at four-week follow-up ($M = 51.52, SD = 12.67$) was significantly higher than at baseline ($M = 47.28, SD = 14.24$), $p = .003$.

Results showed no statistically significant main effect for experimental condition, Wilks’ $\Lambda = .967, F (6, 51) = .288, p = .940$. Thus, contrary to the study hypotheses, no statistically significant differences were found between the two experimental conditions. In addition, results approached significance for the gender main effect, Wilks’ $\Lambda = .798, F (6, 51) = 2.148, p = .064$ (no further analyses were conducted). Finally, none of the possible interactions (i.e., experimental condition x gender; time x experimental condition; time x gender; and time x experimental condition x gender) were found to be statistically significant.

Figure 1 and Table 11 (Appendix A) depict changes of scores of marital satisfaction, intimacy, empathy and closeness in combined groups ($N = 64$) over time. It can be seen that for those variables which showed a statistically significant change over time (i.e., MAT, MSIS, SDPT and ODPT), there is a gradual increase in the overall mean score from pre-session baseline to one-week follow-up and from one-week follow-up to the four-week follow-up. This trend can be observed across the two experimental conditions (see Figures 2 and 3, and Tables 14 and 15).
Figure 1. Changes of Dependent Measures Mean Scores across Time for Combined Groups (N = 64).

Note. MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking; ODPT = Other-Dyadic Perspective Taking; RCI = Relationship Closeness Inventory; IOS = Inclusion of Other in the Self.

Figure 2. Changes of Dependent Measures Mean Scores across Time for Standard Interview Group (n = 32).

Note. MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking; ODPT = Other-Dyadic Perspective Taking; RCI = Relationship Closeness Inventory; IOS = Inclusion of Other in the Self.
Figure 3. Changes of Dependent Measures Mean Scores across Time for Internalized-Other Interview Group (n = 32).

Note. MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking; ODPT = Other-Dyadic Perspective Taking; RCI = Relationship Closeness Inventory; IOS = Inclusion of Other in the Self.

Because the sample of participants in the present study was not clinically distressed (i.e., their initial mean MAT score was almost one SD above the population mean), a separate descriptive analyses of the data for participants whose MAT score was below and above 100 was conducted.

For the sample of participants whose MAT scores were below 100 at baseline (n = 18; not 19 as reported earlier, because one participant had dropped) there was a significant and gradual positive increase in MAT, MSIS and ODPT scores from pre-session baseline to the one-week follow-up and from the one-week follow up to the four-week follow-up. Particularly striking is the change of their mean MAT score from 84.11 (pre-session baseline) to 102.83 (one-week follow-up), a 22% increase; and the change in their mean MSIS score from 36.44 (pre-session baseline) to 44.44 (four-week follow-up), a 22% increase (See Table 12, Appendix A).
On the other hand, for the sample of participants whose MAT scores were above 100 at baseline ($n = 42$) there was a minimal positive increase across all measures (i.e., MAT, MSIS, SDPT, ODPT) from baseline to one and four-week follow-up sessions (See Table 13, Appendix A).

**Immediate Impact of Session**

Hypotheses II-V predicted that interview types would significantly differ from each other on the degree of immediate session impact. It was expected that the internalized-other interviewing condition would yield a greater positive impact on couples than the standard interview. To test these hypotheses, several analyses were performed across different dependent variables, each attempting to tap different aspects of session impact.

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) ANCOVA was conducted to determine whether there were post-session differences between the two experimental conditions with respect to the level of closeness rated by each spouse immediately following the session, as measured by the IOS. Pre-session SCI was a covariate to compensate for any pre-intervention differences between the two experimental conditions.

Results indicated that the mean IOS score in the internalized-other interviewing group ($M = 5.81$, $SD = 1.23$) was higher than the mean IOS score in the standard interviewing group ($M = 5.61$, $SD = 1.44$). However, this difference was not statistically significant ($F (1, 59) = .016, p = .920$). Moreover, the main effects for gender was not significant ($F (1, 59) = .001, p = .980$). Results however indicated a gender x
experimental condition interaction that approached a statistically significant difference \( (F(1, 59) = 3.158, p = .081)\). Whereas the female average IOS score was higher in the internalized-other interview condition \( (M = 5.87, SD = 1.09) \) than on the standard interviewing condition \( (M = 5.34, SD = 1.60) \), the male average IOS score on the standard interviewing condition \( (M = 5.87, SD = 1.26) \) was higher than on the internalized-other interviewing condition \( (M = 5.75, SD = 1.39) \) (see Figure 4). In other words, while wives exposed to the internalized-other interviewing condition reported after the session feeling closer to their husbands than did wives exposed to the standard interviewing condition, husbands exposed to the internalized-other interviewing condition reported feeling less close to their wives than husbands who were exposed to the standard interviewing condition.

\[\text{Figure 4. Mean IOS Score at Post-Session across Experimental Condition and Gender (N = 64).}\]

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) MANOVA was performed to detect any statistically significant differences between the two experimental conditions, as well as between genders, on session impact as measured.
by the SEQ. As mentioned earlier, the SEQ is composed of four different sub-scales (i.e., Depth, Smoothness, Positivity, and Arousal); each taps a different aspect of session impact.

Figure 5 depicts the results across the two experimental conditions. Results failed to detect a main effect for interview type, Wilks' $\Lambda = .980$, $(F(4, 57) = .287, p = .885)$. In other words, contrary to study hypotheses, no statistically significant differences between the two experimental conditions were found. However, results showed a statistically significant difference for gender, Wilks’ $\Lambda = .835$, $(F(4, 57) = 2.813, p = .034)$. Post-hoc tests for gender differences revealed a statistically significant difference on the Arousal subscale $(F(1, 60) = 4.884, p = .031)$. Males reported significantly higher arousal score ($M = 4.85, SD = 1.14$) than females ($M = 4.23, SD = 1.07$). Finally, the gender x experimental condition interaction effect was not significant, Wilks’ $\Lambda = .973$, $(F(4, 57) = .390, p = .815)$.

![Figure 5. Mean SEQ Sub-Scales Scores across Experimental Conditions (N = 64).](image-url)
Results of the present study were also compared with the outcome of previous studies, where the SEQ was used to assess session impact. Specifically, the objective was to determine whether session impact, as reported by participants in this study and across the two experimental conditions, was more or less similar to the effects of other psychotherapy sessions of different theoretical approaches conducted by different therapists. For that purpose, results of the current study were compared with the outcome reported in previous studies conducted by Stiles, Shapiro and Firth-Cozens (1988) and Reynolds, Stiles, Barkham, Shapiro et al., (1996), who used the SEQ to assess session impact of various therapeutic orientations.

Figures 6, 7 and 8 clearly indicate that the mean index scores of the Depth, Smoothness and Positivity subscales were higher in both treatment conditions of this study (i.e., standard and internalized-other interviewing conditions) than in other treatment modalities tested in various studies (e.g., Psychodynamic, Cognitive Behavioral Therapy). The implications of these results will be elaborated in the Discussion section to follow.

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) ANOVA was conducted to detect any group and/or gender differences on the level of session impact measured by the RSRS. Results indicated that there were no statistically significant differences between the internalized-other ($M = 48.94, SD = 10.17$) and the standard interview ($M = 48.53, SD = 11.45$) conditions on the mean Helpful Reactions RSRS index score, $F(1, 60) = .022, p = .882$. Additionally, results indicated that there was no statistically significant difference for gender, $F(1, 60) = .243, p = .624$. 

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Figure 6. Comparison of Mean Depth Scale Score across Different Treatment Modalities.


Figure 7. Comparison of Mean Smoothness Scale Score across Different Treatment Modalities.

Figure 8. Comparison of Mean Positivity Scale Score across Different Treatment Modalities.


Although results indicated that there were no statistically significant difference for gender x experimental condition interaction, $F(1, 60) = .950, p = .334$, data showed that males who were exposed to the standard interviewing condition ($M = 49.19, SD = 11.23$) reported higher level of positive session impact than males who were exposed to the internalized-other interviewing condition ($M = 46.94, SD = 10.86$), while females who were exposed to the internalized-other interviewing condition ($M = 50.94, SD = 9.33$) reported higher level of positive session impact than females who were exposed to the standard interviewing condition ($M = 47.87, SD = 12.00$) (see Figure 9).
The RSRS includes a single item that assesses the overall helpfulness of the session. In order to determine whether group or gender differences existed on the overall helpfulness of the session rating, an ANOVA was performed. Results showed that there were no statistically significant differences between the internalized-other interviewing condition ($M = 7.31, SD = 1.12$) and the standard interviewing condition ($M = 7.25, SD = 1.08$), $F(1, 60) = 0.056, p = .814$ or between the two genders, $F(1, 60) = 0.056, p = .814$. However, results indicated that there was a statistically significant experimental condition x gender interaction effect, $F(1, 60) = 6.747, p = .012$. Female participants in the internalized-other condition rated the overall session as more helpful ($M = 7.62, SD = .72$) than females in the standard interviewing condition ($M = 6.87, SD = 1.2$). However, male participants in the standard interviewing condition rated the overall session as more helpful ($M = 7.62, SD = .81$) than males in the internalized-other condition ($M = 7.00, SD = 1.37$). This suggests that wives viewed the internalized-other interview as more effective and helpful than the standard interviewing, while husbands viewed the standard interviewing as less helpful.
interviewing as more helpful and effective than the internalized-other interviewing (See Figure 10).

![Graph showing the mean RSRS Overall Session Helpfulness Index Score across Experimental Condition and Gender (N = 64).](image)

**Figure 10.** RSRS Overall Session Helpfulness Mean Score across Experimental Condition and Gender (N = 64).

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) ANOVA was conducted to detect any statistically significant differences between the two experimental conditions, as well as between genders, on the level of therapeutic working alliance measured by the CTAS. Results indicate that there were no statistically significant differences between the internalized-other interviewing condition ($M = 6.00$, $SD = .62$) and the standard interviewing condition ($M = 5.97$, $SD = .70$), $F(1, 60) = .055$, $p = .815$, or between the two genders, $F(1, 60) = .781$, $p = .380$.

Although results indicated that there were no statistically significant differences for gender x experimental condition interaction, $F(1, 60) = 2.414$, $p = .126$, data showed that males who were exposed to the standard interviewing condition ($M = 6.02$, $SD = .52$) reported a higher level of working alliance with the therapist than males who were exposed to the internalized-other interviewing condition ($M = 5.81$, $SD = .62$), while
females who were exposed to the internalized-other interviewing condition ($M = 6.21, SD = .57$) reported a higher level of working alliance with the therapist than females who were exposed to the standard interviewing condition ($M = 5.91, SD = .87$) (see Figure 11).

![Figure 11. CTAS Mean Total Index Score across Experimental Condition and Gender ($N = 64$).](image)

A 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) MANOVA was conducted to detect any statistically significant main effects for experimental condition and gender on participants' perceptions of therapist's qualities as measured by the CRF-S. There were no statistically significant differences for either experimental condition (Wilks' $\Lambda = .930, F (3, 58) = 1.464, p = .234$), gender (Wilks' $\Lambda = .949, F (3, 58) = 1.038, p = .383$), or experimental condition x gender interaction (Wilks' $\Lambda = .971, F (3, 58) = .587, p = .626$).

Furthermore, results in this study contrasted with those reported by Corrigan and Schmidt (1983), who had asked college students to view filmed excerpts of three therapists (Albert Ellis, Carl Rogers and Fritz Perls) and to rate their impressions of the
therapists using the CRF-S (see Figure 12). The comparison indicates that the mean therapist's index rating scores across CRF-S three sub-scales (i.e., Attractiveness, Expertness, and Trustworthiness) were higher for the therapist conducting both the internalized-other and standard interview conditions in this study, compared to the therapists mentioned above. Interpretation of these results will be further elaborated in the Discussion section.

Figure 12. Attractiveness, Expertness, and Trustworthiness Mean Scale Scores across Different Therapists and Therapy Approaches.

Note. SI = Standard Interviewing condition; IOI = Internalized-Other Interviewing condition; Ellis (RET) = Albert Ellis conducting Rational Emotive Therapy; Perls (Gestalt) = Fritz Perls conducting Gestalt Therapy; Rogers (Client centered) = Carl Rogers conducting Client Centered Therapy. Data are taken from Corrigan & Schmidt (1983).

Finally, a 2 (internalized-other vs. standard interviewing) x 2 (males vs. females) ANOVA was conducted to detect any statistically significant main effects for experimental condition and gender, on participants' level of satisfaction measured by the social validity questionnaire. Results indicated no statistically significant differences between the internalized-other interviewing condition ($M = 103.47$, $SD = 13.14$) and the
standard interviewing condition \( (M = 102.25, SD = 15.78) \), \( F(1, 59) = .146, p = .704 \), or between the two genders, \( F(1, 59) = .245, p = .622 \).

Nonetheless, a statistically significant experimental condition x gender interaction was found, \( F(1, 59) = 4.554, p = .037 \). Males in the standard interviewing condition reported a significantly higher level of satisfaction \( (M = 105.19, SD = 12.15) \) than males in the internalized-other interviewing condition \( (M = 98.91, SD = 15.45) \). Conversely, females in the internalized-other condition reported a significantly higher level of satisfaction \( (M = 108.33, SD = 8.07) \) than females in the standard interviewing condition \((M = 99.31, SD = 18.6)\). This suggests that wives viewed the internalized-other interviewing as more appealing and beneficial than the standard interviewing, whereas husbands rated the internalized-other interviewing as less appealing and less helpful than the standard interviewing condition (results are illustrated in Figure 13).

![Figure 13](image)

Figure 13. Social Validity Mean Scale Score across Experimental Condition and Gender \((N = 64)\).
DISCUSSION

Macro versus Micro Outcomes

The aim of this study was to evaluate empirically the immediate impact and short-term therapeutic effects of the internalized-other interview with couples. The effectiveness of psychotherapy can be examined across different levels. In a macro-level of analysis (sometimes called an outcome research or efficacy study), the researcher examines the cumulated effects of all therapeutic encounters on the client, comparing the client's levels of functioning and well-being before and after the treatment. This pre-post comparison helps the researcher to determine whether therapy was successful or not. On the other hand, in a micro-level of analysis (sometimes referred to as process research) the researcher explores how psychotherapy works (i.e., what is happening during the session that leads to a therapeutic change). In this type of analysis, the experimenter assesses the moment-to-moment effects of the therapists' actions (i.e., the questions they ask; the comments they make; the posture they adopt; their inter-personal styles) on their clients during the therapy session.

This study forms a bridge between the micro and macro levels of a psychotherapy analysis. Rather than evaluating the cumulated outcome of a therapeutic model across a number of sessions, or the specific consequences of a single therapist's utterance, this study focused on determining the intermediate and short-term therapeutic effects of a single therapy session. Therefore, the center of attention in this study was the evaluation of a very specific technique (i.e., the internalized-other interview), which was utilized in
a specific temporal context (i.e., the first interview session) and with a specific population (i.e., married couples).

Therapeutic change is typically a continuing process which takes place during the actual encounter with the therapist, as well as outside the therapy room and between sessions. According to Greenberg and Newman (1996), the overall client improvement (i.e., macro-outcome) consists of a series of micro-outcomes; each is a building block for the bigger and long-lasting therapeutic change. Orlinsky and Howard (1986, pp. 366-367) also stated that the "macro-outcome is the net result of an extended series of incremental short-term changes." Thus, micro-outcomes are small but significant steps, indicating a progress in the client’s level of functioning and psychological well-being. Under optimal conditions, micro-outcomes should cumulate over the course of therapy and consolidate into a more stable and significant change in the client’s behaviors and attitude (Orlinsky & Howard, 1986).

The present study examined the effects of one specific potential micro-outcome intervention, the internalized-other interview, with couples during the first session. As Orlinsky and Howard (1986) suggested, researchers should shift some of their focus from macro-outcome to micro-outcomes. Studying micro-outcomes can link specific events occurring in the therapy session to specific changes that occur in the client’s life. It can help clinicians/researchers “connect the dots” and achieve greater understanding of how small changes combine into a global, meaningful and stable transformation in the client’s life.

The internalized-other interview is an exclusive method of interviewing that can be implemented in a variety of therapy formats (i.e., individual, couple, and/or family)
and with different client populations. Although this method stems from distinct theoretical views (Epston, 1993; Tomm, 1996), it can be easily incorporated into other therapeutic approaches (e.g., Internal Family System; Deacon & Davis, 2001) and used by clinicians who consider themselves eclectic, integrating into their therapy those techniques that have the potential to facilitate healing and positive change. Hence, data obtained in this study would be useful to therapists who are considering adopting this method of interviewing in their work with couples, as well as to trainers and trainees in the field of couple therapy.

In examining the effectiveness of the internalized-other interview, data were evaluated across two dimensions: (a) the immediate (i.e., post-session) impact of the interview on each spouse, and (b) the short-term therapeutic effects of the interview on each spouse. Session immediate impact was assessed by a variety of instruments (i.e., SEQ, RSRS, CRF-S, CTAS, and SVQ) that measured the participants' impressions and reactions to the session, and their evaluations of the therapist and the level of established therapeutic working alliance. On the other hand, short-term therapeutic effects were measured by a selection of self-reported measures (i.e., MSIS, RCI, SDPT, ODPT, and MAT) that focused on assessing specific psychological constructs (i.e., intimacy, empathy and marital satisfaction) that were hypothesized to change as a result of this intervention. One instrument (the IOS) was used to assess both post-session immediate change, as well as short-term therapeutic effects.

Although the study hypotheses were defined as one-tailed (i.e., it was expected that the internalized-other interview would yield stronger session impact and short-term therapeutic effects than the “treatment as usual” condition), the exploratory nature of this
study implied that every outcome would be potential and acceptable. Because this is the first empirical study evaluating the internalized-other interview, its aim was to assess whether this method of interviewing is, in general, therapeutic, non-therapeutic or counter-therapeutic, and not necessarily, if it is superior to the “treatment as usual.”

Short-Term Therapeutic Effects

A statistically significant time-effect was found, in which participants in both groups showed improvement across measures of marital satisfaction, intimacy and empathy from pre-session baseline to one and four-week follow-up sessions. Results indicate that participants across the two experimental conditions showed a gradual improvement in their marital satisfaction (as measured by their MAT scores), level of intimacy (as measured by their MSIS scores), and level of empathy (as measured by their SDPT and ODPT scores) from baseline to one-week follow-up and from one-week follow-up to four-week follow-up. There were no statistically significant differences between the two interview conditions or between the two genders. In addition, there were no statistically significant interactions.

Considering the fact that the sample of couples in this study was not clinically distressed, and that their initial mean MAT scores at pre-session baseline was almost one standard deviation above the normative mean (in both conditions), one might expect a regression toward the mean for these scores during the one and four-week follow-up sessions. In other words, treatment effect was operating against the regression toward the mean expected trend, hence being even more difficult to be detected. A second related problem to the pre-session baseline high scores of marital satisfaction is the “ceiling
effect.” The ceiling effect refers an effect whereby data cannot take on a value higher than some theoretical "ceiling." The fact that both interview conditions yielded statistically significant positive results across the domains of marital satisfaction, intimacy and empathy, and despite the expected regression to the mean and possible ceiling effect, is quite remarkable. These short-term therapeutic changes indicate that both interview conditions have the potential to establish a significant micro-outcome and a positive therapeutic momentum.

A separate analysis for participants whose initial pre-intervention baseline MAT scores were below 100 versus participants whose initial MAT scores were above 100 (100 is a typical cut-off score on the MAT that discriminates distressed from non-distressed couples) revealed that the 18 participants whose initial MAT scores were below 100 improved greatly over time across all four measures (i.e., MAT, MSIS, SDPT and ODPT.) For example, their mean MAT score increased from 84.11 at baseline to 102.83 at follow up 2, an increase of approximately one standard deviation, which is considered an impressive effect size. On the other hand, participants whose initial MAT score was above 100 at baseline showed, as expected, only minimal improvement from baseline to follow-up one and two sessions across the same measures.

Two instruments that failed to show changes over time were the RCI and IOS (both measure intimacy). The RCI is a self-reported instrument that measures the levels of intimacy between the husband and wife by asking them to report their frequency of contact (i.e., how much time they had spent together over the past week), as well as their diversity of activities (i.e., the number of different activities they had engaged in together as a couple during the past week). Thus, the RCI directly assesses behavioral changes
that may possibly indicate closeness and intimacy. One explanation for the lack of change in RCI scores from baseline to one and a four-week follow-up session is that behavioral change may require more time than attitudinal change. In other words, an exposure to one therapy session may be insufficient to bring meaningful behavioral changes in such a short time interval. In addition, there might have been other factors that interfered with a behavioral change, such as a demanding work schedule of one or the two spouses, parenting duties and other family responsibilities. In other words, it is possible to speculate that although some couples might have had a greater desire to spend more time with each other as a result of the intervention, they were not able to do that due to life demands. Finally, the therapist did not prescribe any behavioral change during the session (explicitly or implicitly); hence, it was naive to expect that the couples would initiate these changes by themselves. Couple’s therapists who are coming from a behavioral change approach typically give directives to couples in order to facilitate behavioral change. For example, in “caring days” (Stuart, 1980), a common intervention in couple therapy, the therapist directly asks each spouse to engage in behaviors that show care toward the other. However, in the present study, and across the two treatment conditions, the therapist refrained from giving directives or prescribing behavioral change.

The IOS scale, a measure of perceived closeness and intimacy, also failed to show any changes over time. One explanation for the lack of changes in the IOS scale mean scores across time is that it may not be an ideal measure to detect subtle changes in the perceptions of closeness and interconnectedness among married couples. Maybe this scale is more suitable to detect changes in the feeling of intimacy and closeness among
other populations. For example, Aron et al., (1997) have shown that the IOS is a useful tool to detect immediate changes in feelings of closeness among strangers who were asked to engage in self-disclosure and relationship building tasks. It is possible that among married couples, who share a relatively long history of behavioral exchange, subtle changes in subjective feelings of closeness will be less probable to be detected by the IOS scale.

Additionally, because the IOS is a single-item scale, it is likely that the participants remembered their previous ratings. This, in fact, could have influenced their subsequent ratings during follow-up sessions. Another possible reason for the lack of change in the IOS scale mean scores over time is a ceiling effect as a result of the exceptionally high post-session IOS mean scale score (i.e., $M = 5.71$ for the entire sample, on a 1-7 scale in which higher scores indicate higher intimacy). For comparison, in another study conducted by Aron et al., (1992), participants were asked to rate their closest, deepest, most involved, and most intimate relationship using the IOS scale. The mean IOS scale in that sample was 4.65. Because the IOS scale was administered at post-session and not during baseline pre-intervention, it is unclear whether the high IOS mean score at post-session was a direct result of the intervention, or a reflection of a pre-intervention high level of closeness and connectedness among the participants in this study. Thereby, unlike other measures that were used to assess short-term therapeutic change (i.e., MAT, MSIS, RCI, SDPT and ODPT), the IOS was administered to all participants following, rather than before, the session. Because IOS scores could have increased from baseline (i.e., pre-intervention) to post-session, it is plausible to assume that if the IOS would have been administered before the intervention, and then compared
with the one and four-week follow-up scores, a statistically significant difference would have been detected.

Session Impact

Contrary to study hypotheses, there were no differential effects between the two interview styles on session impact. Results showed that both treatment conditions yielded strong immediate positive impact on couples. Specifically, participants across the two conditions reported overall positive impressions about the therapeutic utility and helpfulness of these interview sessions. Additionally, participants across the two conditions favorably rated the therapist and generally reported that they had established high levels of a therapeutic working alliance with him.

Unfortunately, the empirical literature on the evaluation of the initial couple therapy session-impact is very limited. Therefore, when examining the results of the current study with respect to the session impact, there were no available established standards to compare and contrast with. Nevertheless, the results of this study clearly indicate that the participants in both treatment conditions perceived the interview sessions to be extremely therapeutic, potent, beneficial, and meaningful. For example, in both the internalized-other and the standard interview conditions the participants perceived the session as deep, valuable and special, as reflected by their high scores on the SEQ Depth subscale. As illustrated earlier in the Results section (see Figure 6), the mean SEQ Depth subscale scores in both treatment conditions were higher in comparison to ratings of a variety of other psychotherapy sessions as reported in the literature.
Additionally, participants in both groups perceived the session to be smooth, calm, pleasant and comfortable, as indicated by their high mean scores on the SEQ Smoothness subscale. The results therefore indicate that, overall, both interview modalities were perceived as non-threatening and non-confrontational. The SEQ Smoothness subscale mean scores, in both treatment conditions, were higher in comparison to ratings of other psychotherapy sessions in the study of session impact (See Figure 7). One way to interpret the high scores of session smoothness is that in both therapeutic conditions the questions asked by the therapist were non-confrontational and respectful. An alternative interpretation is that because the sample of participants in this study was not considered clinically distressed, the topics of discussion chosen by the couples during their interview sessions were, for the most part, neutral in their emotional tone. Hence, the session was perceived by them as easy, comfortable and pleasant.

Furthermore, the participants in both the internalized-other and the standard interview groups rated their mood to be positive following the session, as indicated by their high SEQ Positivity subscale scores. This suggests that, in general, participants felt confident and happy following the session. The mean scores on the SEQ Positivity subscale in both experimental conditions were higher in comparison to ratings of a variety of other psychotherapy sessions as reported in the literature (see Figure 8).

Similar to the SEQ, results on the RSRS showed that participants in both groups gave higher ratings for the effectiveness of the interview session. Again, no differential effects between the two experimental conditions were detected.

In sum, the results on session impact indicated that participants in both treatment conditions perceived the session as beneficial and therapeutic. The results are in
contradiction to the stated hypothesis that participants in the standard interviewing group (who had to talk about their marital problems from their own perspective) would perceive the interview session as more polarizing and less helpful, whereas participants in the internalized-other interview group would perceive the session as more unifying and therapeutic.

A plausible explanation for the lack of differential therapeutic effects between the two conditions on session impact is that the sample of participants in this study did not meet the criterion of being clinically distressed. Thereby, escalation and polarization of the two spouses were less likely to occur. In addition, the participants in this study were aware that they would participate in one session and that this single session would not be a substitute for a comprehensive couple therapy. Therefore, it might be the case that the majority of the participants chose not to disclose and/or discuss thorny and challenging aspects of their relationship, knowing that this therapy would only consist of a single session. Consequently, the topics that were discussed during the interview did not have the potential to create a dynamic of polarization and hostility, as predicted by Epston (1993). It is possible that with a sample of clinically distressed couples who participate in a longer-term couple therapy, results could have been different.

Therapeutic Working Alliance

Another outcome measure examined in this study was the established level of therapeutic working alliance between the therapist and the couple. Some argued that the therapeutic working alliance is particularly imperative during the early phase of therapy (Kokotovic & Tracey, 1990). Various studies have shown that a poor early working
alliance could predict premature termination (e.g., Piper, Ogrodniczuk, Joyce, et al., 1999). Others reported moderate positive association between working alliance and therapy outcome in individual therapy (Horvath & Symonds, 1991) and in couple therapy (Brown & O'Leary, 2000).

In terms of therapeutic alliance as measured by the CTAS, results in this study indicate that in both experimental conditions, the participants reported higher ratings of alliance with the therapist. The high CTAS mean scale scores for the internalized-other interview condition ($M = 6.00$) and the standard interview condition ($M = 5.97$), (on a 1-7 scale where higher scores indicate greater alliance), indicate that the participants perceived the establishment of a strong working alliance with the therapist following the session.

The results obtained in the present study were compared with the outcome of other experiments studying alliance within the context of couple therapy. For example, Heatherington and Friedlander (1990) reported that among couples who had received 8-12 weeks of couple therapy at an outpatient clinic specializing in family therapy in a large north-east general hospital, the mean CTAS score for the total sample ($N = 32$) was 5.64. Unlike the present study, Heatherington and Friedlander had asked their participants to complete the CTAS in the third to the sixth session. It is assumed that the therapeutic working alliance would be even stronger in the third session than the first because couples who did not form a good working alliance had likely dropped out from therapy, hence contributing to a higher mean alliance score for the entire sample. Thus, the results of the current study unequivocally show that the therapeutic working alliance ratings were relatively very high in both treatment conditions.
There can be numerous reasons for the higher levels of therapeutic working alliance ratings by the participants in this study. First, higher alliance scores can be an accurate reflection of a very good therapeutic bond that was established between the therapist and the couple during the initial session. The fact that therapeutic working alliance scores were similar across the two experimental conditions can be explained by the therapist's non-specific characteristics, such as, warmth and empathy. Second, high alliance scores can be a sign of reluctance from couples to report anything negative about their therapeutic experience. Specifically, although the participants were asked to respond to the questionnaire items in a genuine and honest manner, they might have avoided negative evaluations of their alliance with the therapist because they knew that they were going to meet with him again during follow-up sessions. Third, in the early phase of therapy, therapists generally tend to be more validating and less confrontational. These may explain the relatively higher ratings of therapeutic working alliance in this study and in others (e.g., Mamodhoussen, Wright, Tremblay, & Poitras-Wright, 2005). Replication of this study with different therapists can give a better indication whether the positive therapeutic working alliance ratings are related to the intervention or to the therapist's characteristics.

Therapist's Characteristics

An additional post-session outcome measure that was examined in this study was the participants' evaluations of the therapist's characteristics. Specifically, the participants were asked to evaluate the therapist's characteristics along three dimensions (i.e., attractiveness, expertness, and trustworthiness) using the CRF-S scale. Results
indicate that across the two experimental conditions the therapist received high ratings on each of these dimensions (please refer to Figure 12 on the Results section). No statistically significant differences were found between the two experimental conditions or between husbands and wives.

The results obtained in the present study were compared to other studies in which the CRF-S had been used to evaluate the therapist/counselor characteristics. This comparison showed that the therapist's ratings in this study and in both experimental conditions were higher than ratings of other therapists who practice different therapeutic approaches across the three dimensions (i.e., attractiveness, expertness, and trustworthiness) (see Figure 12).

There are various ways one can interpret these results. First, it is possible that the participants in both experimental conditions perceived the therapist as warm, friendly, competent and trustworthy. Luborsky et al. (1986) showed that the differences in outcomes among therapists were more impressive than the differential in outcome among treatments. In other words, variations in treatment outcome had more to do with the therapist than with the type of intervention. Others (i.e., Strupp & Hadley, 1979) have also claimed that nonspecific factors in psychotherapy (i.e., therapist's personal characteristics) have greater impact on therapy outcome than specific factors (i.e., intervention type). This indeed may explain why the results in this study failed to detect any differential effects between the two experimental conditions across different outcome measures.

However, the unusual exceptionally high rating may also indicate that the participants in this study avoided negative evaluation of the therapist. One can speculate
various reasons for the participants' potential avoidance of rating the therapist negatively. First, the participants knew that they would have to come again for a second and third follow-up sessions, and might have had concerns about negatively evaluating the therapist whom they would have to meet again.

Second, the participants might have acted according to what psychologists call "social desirability," providing higher ratings in order to impress or satisfy the main investigator/therapist. The social desirability phenomenon could have been intensified because the participants were paid for their participation. However, according to the Cognitive Dissonance Theory (Festinger & Carlsmith, 1959), participants who receive a large reward for their participation in a boring task will likely experience weaker dissonance than participants who receive a smaller reward, and therefore, will more likely report their actual attitudes about the task. In other words, since participants in this study were well rewarded for their time and effort, it is unlikely that they would have experienced dissonance (i.e., effort justification); therefore, their ratings of the therapist's trustworthiness, friendliness and expertness may have reflected their accurate opinions.

In sum, although the social desirability phenomenon can explain the exceptionally high positive ratings of the therapist, it is unclear whether other opposing factors, such as the potential weak cognitive dissonance, took place too. Replication of this study, in which the therapist refrains from taking an active part in the evaluative process, can minimize the social desirability possible effects.
Gender x Experimental Condition Interaction among Post-Session Measures

Results showed that among some of the post-session measures (i.e., RSRS, and SVQ), a statistically significant gender x experimental condition interaction was detected. Among other post-session measures (i.e., IOS, and CTAS) a similar tendency was observed; however, results did not reach a statistically significant difference. The gender x experimental condition interaction indicates that male participants who were exposed to the standard interview condition evaluated the session as more helpful than male participants who were exposed to the internalized-other interview condition. Conversely, female participants who were exposed to the internalized-other interviewing condition rated its effectiveness higher than female participants who were exposed to the standard interview condition.

Likewise, males who received the standard interview gave greater alliance ratings to the therapist than males who received the internalized-other interview. In contrast, females who received the internalized-other interview gave higher alliance ratings to the therapist than females who received the standard interview condition.

Lastly, males who were exposed to the standard interview condition reported greater closeness to their wives following the interview session than males who were exposed to the internalized-other interview condition. On the other hand, females who received the internalized-other interview reported feeling closer to their spouses following the interview session than females receiving the standard interview condition.

From these results, it can be concluded that, in general, males responded more positively to the standard interview condition, while females responded more positively to the internalized-other interview condition. The results may indicate that there is an
actual gender difference in the preference for interview type. The internalized-other interview requires the individual to take the perspective of the other, and this task may be perceived by males as a threat or a challenge, whereas for females, it can be perceived as an important therapeutic piece. It also might have been the case that taking the perspective of the other may be an easier task for females than for males.

For example, two instruments that had been used in this experiment to measure empathy and perspective taking include the SDPT and ODPT. Both questionnaires examine the level of empathy and understanding between the two spouses. While the SDPT asks each participant to evaluate his or her abilities to take the perspective of the other spouse, the ODPT asks each participant to evaluate his or her spouse’s abilities to take his or her perspective. In other words, the SDPT asks the participants how well they believe they can take the perspective of the other, and the ODPT asks the participants about what they believe is their spouse’s ability to take their perspective. Results in this study showed that the pre-session baseline mean SDPT score was higher for females ($M = 35.55, SD = 8.23$) than for males ($M = 31.29, SD = 5.92$), $t(62) = -2.374, p = .021$. This gender difference indicates that females perceived themselves to have greater capacity to be empathic with their spouses than males did.

In addition, the pre-session baseline mean ODPT score was higher for males ($M = 48.41, SD = 11.83$) than for females ($M = 46.65, SD = 17.04$), indicating that males perceived their female spouses as having greater capacity to understand them than did females’ perception about their males spouses’ abilities.

In summary, baseline scores on measures of empathy indicate that men see themselves less capable of taking the perspective of their wives’ than their wives abilities.
to take theirs. Taken together, baseline data can explain why the internalized-other interview might have been perceived as more intimidating and challenging for males than for females. Finally, the gender x experimental condition interaction may indicate that there are fundamental differences between males and females in terms of therapeutic style preferences. Males may prefer a “straight-forward,” non-challenging therapeutic style, while females may be more willing to engage in unique and non-conventional therapy. Tomm (1996) stated that while conducting the internalized-other interview men sometimes tend to act more rigidly than women do, occasionally refusing the invitation to be playful and take the perspective of their wives.

Limitations, Special Considerations and Future Directions

The internalized-other interview is a special method of interviewing that can be implemented in individual, couple, and/or family therapy contexts. In the present study, the focus was to determine the impact of the internalized-other interview with couples during the initial therapy session. Nevertheless, this method can theoretically be applied during any phase of therapy, not necessarily during the initial session. The decision to evaluate the therapeutic effects of the internalized-other interview during the first session was based on three main reasons. First, this would create uniformity among all couples who participate in this study (within each treatment condition and between the two groups). In other words, in order to reduce threats to internal validity, all couples received the intervention (either the internalized-other or the standard interview) during the same treatment phase (i.e., initial session). Therefore, the results were likely to reflect the actual effects of these specific interventions on the couples rather than the
cumulated effects of previous therapy interventions. Second, this study was based on a demonstration of the internalized-other interview by Tomm at a national conference of the American Association of Marital and Family Therapy (Tomm, 1996). In this demonstration, the therapist (Tomm) had conducted the internalized-other interview during the initial session. Following Tomm's demonstration as a model to be assessed, it was decided to conduct the interview during the initial session. Third, both Tomm (1996) and Epston (1993) stated that this method of interviewing could be useful during the initial therapy contact. Epston (1993) argued that this method of interviewing might be effective in preventing the couple from entering a dysfunctional pattern of mutual accusations, attack-counterattack, and polarization.

In the present study, the therapeutic effects of the internalized-other interview with couples were compared with those of a standard interview, which was defined as "treatment as usual." There was no "real" control group in the present study (i.e., waiting-list/no treatment control group). Several factors prevented the inclusion of a waiting-list control group in this study. First, one of the chief goals of this study was to assess the immediate post-session impact of the internalized-other interview. Thus, in order to respond to most post-session impact measures, the couples were required to be exposed to a certain therapeutic intervention. In other words, these instruments asked each participant to evaluate the quality and impact of the session. Therefore, participants who would not have experienced a therapy intervention (i.e., waiting-list control group) could not have responded to these self-reported measures; hence, comparison between the control and the treatment group would not be possible. Second, others (Baucom, Hahlweg, & Kuschel, 2003) had questioned the necessity of waiting-list control groups in
marital therapy outcome research. Baucom et al., (2003) showed that across 17 controlled studies comparing Behavioral Couple Therapy (BCT) and waiting-list control groups, on average, distressed couples who were placed on waiting lists made no improvement during the waiting period. Third, the difficulties in recruiting couples for a study of this nature hampered the possibility of adding another treatment condition (i.e., waiting-list control group) to the other existing two.

The results of this study should be cautiously interpreted and its external validity should be limited. The sample of participants in this study consisted of heterosexual married couples, selected from a small, Midwestern community. All couples volunteered to participate in this study and none of them was a referral for a couple interventions per se. Most couples in this study did not meet the criteria of being clinically distressed. In other words, these couples did not manifest significant relationship problems. It is unclear whether distressed couples would have responded differently to the internalized-other interview or to the standard interview conditions. Thus, the results of this study can be generalized only to the population of non-distressed married couples. Replicating this study with a sample of clinically distressed couples can further explore whether there is a qualitative difference between these two populations, which may lead to quantitative differences in the ways they respond to these interview styles.

Second, in the present study there was only a single therapist who conducted all interview sessions across the two experimental conditions. Replication of this study with different therapists will be useful to distinguish treatment effects from therapist effects. Moreover, it can be helpful to show whether the therapist's gender influences the impressions of husbands and wives about the session differently.
Third, the sample size in this study was relatively small ($N = 32$ couples). It is possible that with a larger sample size results with respect to short-term therapeutic effects would have been more robust. Moreover, it is probable that with a larger sample size, quantitative differences between the two interviewing styles would have been detected.

Fourth, as mentioned above, this was the first study that attempted to evaluate the internalized-other method of interviewing with couples. Typically, when evaluating the efficacy of an intervention for the first time, it is common to compare it head-to-head with a no-treatment control group. In the present study, the impact of the internalized-other interview was compared with the standard method of interviewing couples. Consequently, it was more difficult to show the advantages of using the internalized-other interviewing technique.

Fifth, this study utilized a between-subjects methodology design. Couples who participate in this study were randomized to either the internalized-other or the standard interview conditions. The results of this study showed that both treatment conditions were highly effective. It is possible to assume that with the implementation of a within-subject methodological design, where each couple is exposed to both therapy interventions, results could have detected a significant quantitative difference between these two methods of interviewing. Using a within-subject methodology would allow each couple to have a frame of reference for comparison. It would have oriented the couples to provide their preference to one method or the other. Nevertheless, applying such methodology can be very complicated. For example, each couple would have to be
exposed to the initial interview twice; consequently, sequential effects could have contaminated the results.

Finally, the present study utilized a quantitative paradigm in assessing the efficacy of the internalized-other interview with couples. While this method of analysis is legitimate, it has its own shortcomings. Specifically, the quantitative paradigm may reduce subjective and a rich psychological phenomenon into numbers. A qualitative approach, on the other hand, uses words rather than numbers to describe the psychological experience (Silverstein, Auerbach, & Levant, 2006). Instead of using standardized tests, qualitative data gathering methods include open-ended interviews and field observations. Consequently, qualitative methods of investigation can tap the subjective and idiosyncratic experience of the individual. Because the internalized-other interviewing was hypothesized to evoke empathy, interconnectedness, intimacy and closeness (all psychological phenomena that have a strong subjective component), a qualitative method of analysis might have better captured subtle changes in these subjective experiences.
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communication: Vol. 1. The order of presentation in persuasion (pp. 62-75).
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APPENDIX A

Tables
Table 1

Summary of Instruments Given Across Study Phases

<table>
<thead>
<tr>
<th>Phase</th>
<th>Screening</th>
<th>Baseline</th>
<th>Post-Session</th>
<th>Follow-Up 1</th>
<th>Follow-Up 2</th>
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</thead>
<tbody>
<tr>
<td>CTS</td>
<td>MAT</td>
<td>IOS</td>
<td>MAT</td>
<td>MAT</td>
<td></td>
</tr>
<tr>
<td>MSIS</td>
<td>CTAS</td>
<td>MSIS</td>
<td>MSIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDPT</td>
<td>SEQ</td>
<td>SDPT</td>
<td>SDPT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODPT</td>
<td>RSRS</td>
<td>ODPT</td>
<td>ODPT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCI</td>
<td>CRF-S</td>
<td>RCI</td>
<td>RCI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCI</td>
<td>SVQ</td>
<td>IOS</td>
<td>IOS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. CTS = Conflict Tactics Scale; MAT = Marital Adjustment Scale; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale; RCI = Relationship Closeness Inventory; SCI = Subjective Closeness Index; IOS = Inclusion of Other in the Self (present and ideal); CTAS = Couple Therapy Alliance Scale; SEQ = Session Evaluation Questionnaire; RSRS = Revised Session Reaction Scale; CRF-S = Counselor Rating Form Short-Version; SVQ = Social Validity Questionnaire.
Table 2

*Level of Education for Sample of Participants*

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Finished high school or equivalent</td>
<td>10</td>
<td>15.6</td>
</tr>
<tr>
<td>Some college</td>
<td>16</td>
<td>25.0</td>
</tr>
<tr>
<td>Two years of college</td>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td>Associate of Arts Degree</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Finished college (BA/BS degree)</td>
<td>13</td>
<td>20.3</td>
</tr>
<tr>
<td>Some graduate education</td>
<td>4</td>
<td>6.3</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>8</td>
<td>12.5</td>
</tr>
<tr>
<td><strong>Total (N)</strong></td>
<td><strong>64</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 3

*Ethnic or Racial Group Membership for Sample of Participants*

<table>
<thead>
<tr>
<th>Ethnicity or Group</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian or Euro-American</td>
<td>57</td>
<td>89.5</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>African American</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Total (N)</td>
<td>64</td>
<td>100.0</td>
</tr>
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</table>
Table 4

*Individual Annual Income for Sample of Participants*

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<thead>
<tr>
<th>Income Range</th>
<th>Frequency</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>12</td>
<td>18.7</td>
</tr>
<tr>
<td>Between $10,000 and $20,000</td>
<td>14</td>
<td>21.9</td>
</tr>
<tr>
<td>Between $20,000 and $30,000</td>
<td>16</td>
<td>25.0</td>
</tr>
<tr>
<td>Between $30,000 and $40,000</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>Between $40,000 and $50,000</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Between $50,000 and $60,000</td>
<td>6</td>
<td>9.4</td>
</tr>
<tr>
<td>Between $60,000 and $70,000</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Between $70,000 and $80,000</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Total (N)</td>
<td>64</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 5

Religious Affiliations for Sample of Participants

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baptist</td>
<td>5</td>
<td>7.8</td>
</tr>
<tr>
<td>Catholic</td>
<td>9</td>
<td>14.1</td>
</tr>
<tr>
<td>Methodist</td>
<td>3</td>
<td>4.7</td>
</tr>
<tr>
<td>Protestants</td>
<td>5</td>
<td>7.8</td>
</tr>
<tr>
<td>Other forms of Christianity</td>
<td>19</td>
<td>29.7</td>
</tr>
<tr>
<td>None</td>
<td>7</td>
<td>10.9</td>
</tr>
<tr>
<td>Missing data</td>
<td>16</td>
<td>25.0</td>
</tr>
<tr>
<td>Total (N)</td>
<td>64</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 6

Chi-Square Tests Results for Demographic Data across the Two Experimental Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>( \chi^2 )</th>
<th>df</th>
<th>( p )</th>
<th>( N )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of education</td>
<td>9.16</td>
<td>7</td>
<td>.242</td>
<td>64</td>
</tr>
<tr>
<td>Ethnic or racial group membership</td>
<td>4.00</td>
<td>4</td>
<td>.406</td>
<td>63</td>
</tr>
<tr>
<td>Personal annual income</td>
<td>5.19</td>
<td>7</td>
<td>.637</td>
<td>63</td>
</tr>
<tr>
<td>Is it your first marriage?</td>
<td>.10</td>
<td>1</td>
<td>.756</td>
<td>64</td>
</tr>
<tr>
<td>Have you been to couple therapy before?</td>
<td>1.87</td>
<td>1</td>
<td>.171</td>
<td>64</td>
</tr>
<tr>
<td>Are you seeing a therapist individually?</td>
<td>1.07</td>
<td>1</td>
<td>.302</td>
<td>64</td>
</tr>
</tbody>
</table>

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Table 7

Means and Standard Deviations for Dependent Measures at Baseline (Pre-Intervention)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Standard Interviewing (n = 32)</th>
<th>Internalized-other Interviewing (n = 32)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>MAT</td>
<td>109.02</td>
<td>23.01</td>
</tr>
<tr>
<td>SCI</td>
<td>18.23</td>
<td>4.33</td>
</tr>
<tr>
<td>RCI (Frequency)</td>
<td>6.19</td>
<td>1.77</td>
</tr>
<tr>
<td>RCI (Diversity)</td>
<td>5.97</td>
<td>1.15</td>
</tr>
<tr>
<td>RCI (Total)</td>
<td>12.16</td>
<td>2.27</td>
</tr>
<tr>
<td>MSIS</td>
<td>145.84</td>
<td>19.46</td>
</tr>
<tr>
<td>SDPT</td>
<td>32.88</td>
<td>8.25</td>
</tr>
<tr>
<td>ODPT</td>
<td>46.09</td>
<td>15.94</td>
</tr>
</tbody>
</table>

Note. MAT = Marital Adjustment Test; SCI = Subjective Closeness Index; RCI = Relationship Closeness Inventory; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale.
Table 8

*T-Tests for Equality of Means across the Two Experimental Conditions at Baseline (Pre-Intervention)*

<table>
<thead>
<tr>
<th>Mean Groups Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT</td>
<td>-2.93</td>
<td>-.55</td>
<td>62</td>
</tr>
<tr>
<td>SCI</td>
<td>-.52</td>
<td>-.61</td>
<td>62</td>
</tr>
<tr>
<td>RCI (Total)</td>
<td>-.44</td>
<td>-.84</td>
<td>62</td>
</tr>
<tr>
<td>MSIS</td>
<td>-.28</td>
<td>-.07</td>
<td>62</td>
</tr>
<tr>
<td>SDPT</td>
<td>-1.07</td>
<td>-.57</td>
<td>62</td>
</tr>
<tr>
<td>ODPT</td>
<td>-2.80</td>
<td>-.75</td>
<td>62</td>
</tr>
</tbody>
</table>

*Note.* MAT = Marital Adjustment Test; SCI = Subjective Closeness Index; RCI = Relationship Closeness Inventory; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale. 

* N = 64.
Table 9

*Inter-Correlations among Dependent Measures Given at Pre-Session Baseline* \(^a\)

<table>
<thead>
<tr>
<th></th>
<th>MAT</th>
<th>SCI</th>
<th>RCI</th>
<th>MSIS</th>
<th>SDPT</th>
<th>ODPT</th>
<th>IOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT</td>
<td>-----</td>
<td>.767**</td>
<td>.314*</td>
<td>.717**</td>
<td>.492**</td>
<td>.492**</td>
<td>.668**</td>
</tr>
<tr>
<td>SCI</td>
<td>.767**</td>
<td>-----</td>
<td>.352**</td>
<td>.695**</td>
<td>.442**</td>
<td>.638**</td>
<td>.732**</td>
</tr>
<tr>
<td>RCI</td>
<td>.314*</td>
<td>.352**</td>
<td>-----</td>
<td>.310*</td>
<td>.281*</td>
<td>.140</td>
<td>.443**</td>
</tr>
<tr>
<td>MSIS</td>
<td>.717**</td>
<td>.695**</td>
<td>.310*</td>
<td>-----</td>
<td>.611**</td>
<td>.362**</td>
<td>.474**</td>
</tr>
<tr>
<td>SDPT</td>
<td>.492**</td>
<td>.442**</td>
<td>.281*</td>
<td>.611**</td>
<td>-----</td>
<td>.416**</td>
<td>.297*</td>
</tr>
<tr>
<td>ODPT</td>
<td>.492**</td>
<td>.638**</td>
<td>.140</td>
<td>.362**</td>
<td>.416**</td>
<td>-----</td>
<td>.551**</td>
</tr>
<tr>
<td>IOS</td>
<td>.668**</td>
<td>.732**</td>
<td>.443**</td>
<td>.474**</td>
<td>.297*</td>
<td>.551**</td>
<td>-----</td>
</tr>
</tbody>
</table>

*Note.* MAT = Marital Adjustment Test; SCI = Subjective Closeness Index; RCI = Relationship Closeness Inventory; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale; IOS = Inclusion of Other in the Self.

** - Correlation is significant at a 0.01 level (2-tailed).

* - Correlation is significant at a 0.05 level (2-tailed).

\(^a\) - All measures except the IOS were given at pre-session baseline.

\(N = 64.\)
Table 10

**Inter-Correlations among Dependent Measures Given at Post-Session**

<table>
<thead>
<tr>
<th></th>
<th>RSRS</th>
<th>CTAS</th>
<th>CRF</th>
<th>SEQd</th>
<th>SEQs</th>
<th>SEQP</th>
<th>SEQa</th>
<th>SVQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSRS</td>
<td>-----</td>
<td>.425**</td>
<td>.062</td>
<td>.585**</td>
<td>.013</td>
<td>.404**</td>
<td>.323**</td>
<td>.711**</td>
</tr>
<tr>
<td>CTAS</td>
<td>.425**</td>
<td>-----</td>
<td>.270*</td>
<td>.519**</td>
<td>.372**</td>
<td>.519**</td>
<td>.263*</td>
<td>.529**</td>
</tr>
<tr>
<td>CRF-S</td>
<td>.062</td>
<td>.270*</td>
<td>-----</td>
<td>.189</td>
<td>.161</td>
<td>.226</td>
<td>.008</td>
<td>.117</td>
</tr>
<tr>
<td>SEQ (D)</td>
<td>.585**</td>
<td>.519**</td>
<td>.189</td>
<td>-----</td>
<td>.175</td>
<td>.614**</td>
<td>.453**</td>
<td>.706**</td>
</tr>
<tr>
<td>SEQ (S)</td>
<td>.013</td>
<td>.372**</td>
<td>.161</td>
<td>.175</td>
<td>-----</td>
<td>.461**</td>
<td>.310*</td>
<td>.234</td>
</tr>
<tr>
<td>SEQ (P)</td>
<td>.404**</td>
<td>.519</td>
<td>.226</td>
<td>.614**</td>
<td>.461**</td>
<td>-----</td>
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<td>.602**</td>
</tr>
<tr>
<td>SEQ (A)</td>
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<td>.263*</td>
<td>.008</td>
<td>.453**</td>
<td>.310*</td>
<td>.558**</td>
<td>-----</td>
<td>.389**</td>
</tr>
<tr>
<td>SVQ</td>
<td>.711**</td>
<td>.529**</td>
<td>.117</td>
<td>.706**</td>
<td>.234</td>
<td>.602**</td>
<td>.389*</td>
<td>-----</td>
</tr>
</tbody>
</table>

*Note.* RSRS = Revised Session Reactions Scale (Helpful Reactions subscale); CTAS = Couple Therapy Alliance Scale (Total score); CRF = Counselor Rating Form Short-Version (Total score); SEQ (D) = Session Evaluation Questionnaire Depth subscale score; SEQ (S) = Session Evaluation Questionnaire Smoothness subscale score; SEQ (P) = Session Evaluation Questionnaire Positivity subscale score; SEQ (A) = Session Evaluation Questionnaire Arousal subscale score; SVQ = Social Validity Questionnaire.

** - Correlation is significant at 0.01 level (2-tailed).

* - Correlation is significant at 0.05 level (2-tailed).

*N = 64.*
Table 11

Means and Standard Deviations for Measures of Marital Satisfaction, Intimacy, Empathy and Closeness across Time for Combined Groups

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline M</th>
<th>Baseline SD</th>
<th>Follow-up 1 M</th>
<th>Follow-up 1 SD</th>
<th>Follow-up 2 M</th>
<th>Follow-up 2 SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MATa</td>
<td>110.34</td>
<td>21.36</td>
<td>114.01</td>
<td>19.94</td>
<td>116.66</td>
<td>18.14</td>
</tr>
<tr>
<td>MSISa</td>
<td>146.06</td>
<td>15.79</td>
<td>147.72</td>
<td>15.19</td>
<td>149.41</td>
<td>12.62</td>
</tr>
<tr>
<td>SDPTa</td>
<td>33.12</td>
<td>7.13</td>
<td>34.60</td>
<td>7.26</td>
<td>35.37</td>
<td>6.69</td>
</tr>
<tr>
<td>ODPTa</td>
<td>47.28</td>
<td>14.24</td>
<td>50.09</td>
<td>13.88</td>
<td>51.52</td>
<td>12.67</td>
</tr>
<tr>
<td>RCI</td>
<td>12.33</td>
<td>2.07</td>
<td>12.27</td>
<td>2.45</td>
<td>12.50</td>
<td>2.39</td>
</tr>
<tr>
<td>IOS</td>
<td>5.71</td>
<td>1.36</td>
<td>5.87</td>
<td>1.24</td>
<td>5.78</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Note. MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale; RCI = Relationship Closeness Inventory; IOS = Inclusion of Other in the Self.

*Time effect is significant for (Baseline – Follow-up 2) differences, (p < .05).*
Table 12

*Means and Standard Deviations for Measures of Marital Satisfaction, Intimacy, Empathy and Closeness across Time for Participants with Initial MAT Score < 100*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Follow-up 1</th>
<th>Follow-up 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>MAT</td>
<td>84.11</td>
<td>14.97</td>
<td>94.58</td>
</tr>
<tr>
<td>MSIS</td>
<td>133.00</td>
<td>18.05</td>
<td>135.22</td>
</tr>
<tr>
<td>SDPT</td>
<td>28.91</td>
<td>7.43</td>
<td>28.67</td>
</tr>
<tr>
<td>ODPT</td>
<td>36.44</td>
<td>16.01</td>
<td>41.00</td>
</tr>
</tbody>
</table>

*Note.* MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale.
Table 13

Means and Standard Deviations for Measures of Marital Satisfaction, Intimacy, Empathy and Closeness across Time for Participants with Initial MAT Score > 100

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Follow-up 1</th>
<th>Follow-up 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>MAT</td>
<td>121.58</td>
<td>12.06</td>
<td>122.34</td>
</tr>
<tr>
<td>MSIS</td>
<td>151.67</td>
<td>10.41</td>
<td>153.08</td>
</tr>
<tr>
<td>SDPT</td>
<td>34.94</td>
<td>6.35</td>
<td>37.14</td>
</tr>
<tr>
<td>ODPT</td>
<td>51.93</td>
<td>10.57</td>
<td>53.99</td>
</tr>
</tbody>
</table>

Note. MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking; ODPT = Other-Dyadic Perspective Taking Scale.
Table 14

*Means and Standard Deviations for Measures of Marital Satisfaction, Intimacy, Empathy and Closeness across Time in Standard Interviewing Condition*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Follow-up 1</th>
<th>Follow-up 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>MAT</td>
<td>109.79</td>
<td>23.54</td>
<td>115.52</td>
</tr>
<tr>
<td>MSIS</td>
<td>146.87</td>
<td>19.36</td>
<td>148.20</td>
</tr>
<tr>
<td>SDPT</td>
<td>33.11</td>
<td>8.43</td>
<td>35.22</td>
</tr>
<tr>
<td>ODPT</td>
<td>46.08</td>
<td>12.04</td>
<td>49.05</td>
</tr>
<tr>
<td>RCI</td>
<td>12.10</td>
<td>2.34</td>
<td>12.50</td>
</tr>
<tr>
<td>IOS</td>
<td>5.62</td>
<td>1.48</td>
<td>5.80</td>
</tr>
</tbody>
</table>

*Note.* MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale; RCI = Relationship Closeness Inventory; IOS = Inclusion of Other in the Self.
Table 15

*Means and Standard Deviations for Measures of Marital Satisfaction, Intimacy, Empathy and Closeness across Time in Internalized-Other Interviewing Condition*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline M</th>
<th>Baseline SD</th>
<th>Follow-up 1 M</th>
<th>Follow-up 1 SD</th>
<th>Follow-up 2 M</th>
<th>Follow-up 2 SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAT</td>
<td>110.88</td>
<td>19.80</td>
<td>112.51</td>
<td>18.12</td>
<td>116.88</td>
<td>14.35</td>
</tr>
<tr>
<td>MSIS</td>
<td>145.27</td>
<td>10.94</td>
<td>147.25</td>
<td>12.83</td>
<td>147.95</td>
<td>9.99</td>
</tr>
<tr>
<td>SDPT</td>
<td>33.15</td>
<td>5.84</td>
<td>33.98</td>
<td>6.70</td>
<td>35.00</td>
<td>6.04</td>
</tr>
<tr>
<td>ODPT</td>
<td>48.48</td>
<td>12.47</td>
<td>51.13</td>
<td>11.89</td>
<td>51.87</td>
<td>11.37</td>
</tr>
<tr>
<td>RCI</td>
<td>12.57</td>
<td>1.77</td>
<td>12.03</td>
<td>2.72</td>
<td>12.57</td>
<td>2.25</td>
</tr>
<tr>
<td>IOS</td>
<td>5.80</td>
<td>1.24</td>
<td>5.93</td>
<td>1.08</td>
<td>5.63</td>
<td>1.22</td>
</tr>
</tbody>
</table>

*Note.* MAT = Marital Adjustment Test; MSIS = Miller Social Intimacy Scale; SDPT = Self-Dyadic Perspective Taking Scale; ODPT = Other-Dyadic Perspective Taking Scale; RCI = Relationship Closeness Inventory; IOS = Inclusion of Other in the Self.
Table 16

Means and Standard Deviations for Dependent Measures at Post-Session *a*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Standard Interviewing (n = 32)</th>
<th>Internalized-other Interviewing (n = 32)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>IOS1</td>
<td>5.61</td>
<td>1.44</td>
</tr>
<tr>
<td>IOS2</td>
<td>6.50</td>
<td>.84</td>
</tr>
<tr>
<td>SEQ (D)</td>
<td>5.53</td>
<td>1.05</td>
</tr>
<tr>
<td>SEQ (S)</td>
<td>5.82</td>
<td>.89</td>
</tr>
<tr>
<td>SEQ (P)</td>
<td>6.02</td>
<td>.97</td>
</tr>
<tr>
<td>SEQ (A)</td>
<td>4.49</td>
<td>1.27</td>
</tr>
<tr>
<td>CTAS</td>
<td>5.97</td>
<td>.70</td>
</tr>
<tr>
<td>CRF-S (A)</td>
<td>26.34</td>
<td>2.98</td>
</tr>
<tr>
<td>CRF-S (E)</td>
<td>24.91</td>
<td>3.25</td>
</tr>
<tr>
<td>CRF-S (T)</td>
<td>25.87</td>
<td>2.90</td>
</tr>
<tr>
<td>SVQ</td>
<td>102.25</td>
<td>15.78</td>
</tr>
<tr>
<td>RSRS</td>
<td>48.53</td>
<td>11.45</td>
</tr>
<tr>
<td>RSRS (O)</td>
<td>7.25</td>
<td>1.08</td>
</tr>
</tbody>
</table>

Note. IOS1 = Inclusion of Other in the Self (present); IOS2 = Inclusion of Other in the Self (ideal); SEQ (D) = Session Evaluation Questionnaire, Depth scale; SEQ (S) = Session Evaluation Questionnaire, Smoothness scale; SEQ (P) = Session Evaluation Questionnaire, Positivity scale; SEQ (A) = Session Evaluation Questionnaire, Arousal scale; CTAS = Couple Therapy Alliance Scale; CRF-S (A) = Counselor Rating Form

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Table 16 Continued

(short-version), Attractiveness scale; CRF-S (E) = Counselor Rating Form (short-version), Expertness scale; CRF-S (T) = Counselor Rating Form (short-version).

Trustworthiness scale; SVQ = Social Validity Questionnaire; RSRS = Revised Session Reactions Scale (Helpful Eactions scale); RSRS (O) = Revised Session Reactions Scale (overall session helpfulness).

a - All mean differences were not statistically significant.
APPENDIX B

Human Subjects Institutional Review Board Approval
This letter will serve as confirmation that your research project entitled "Evaluating the Immediate and Short-term Therapeutic Impact of the Internalized-Other Interviewing with Couples" has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 18, 2006
APPENDIX C
Informed Consent Document
I have been invited to participate in a research project entitled “evaluating the immediate and short-term therapeutic impact of the internalized-other interviewing with couples.” This is a doctoral dissertation of Shai Brosh. This research is intended to compare the immediate and short-term therapeutic effects of two different methods of interviewing with couples during the initial session. These two methods of interviewing are only one component out of many other alternatives available in marital therapy. This study will only focus on the therapeutic effects of these methods of interviewing in the context of the initial session. Therefore, this study by itself will not provide a complete and comprehensive course of couple’s therapy. There are other alternatives for couple’s therapy, and the main investigator will provide me with a referral list of couple’s therapists in the surrounding area. Approximately 30 couples (60 participants) will participate in this study.

I will be asked to attend one session lasting 180 minutes, followed by another session (to be scheduled within one week after the first session) lasting 30 minutes, followed by a third session (to be scheduled approximately four weeks after the first session) lasting 30 minutes with the main investigator at Western Michigan University, Department of Psychology – Behavioral Pediatric Lab. During the first session, I will first be asked to complete two screening questionnaires to ensure that I meet the research criteria. Following that, I will be asked to complete a series of questionnaires regarding my level of marital satisfaction, level of closeness and intimacy with my spouse, level of perspective-taking with my spouse, and other demographic information. Following that, I will be asked to engage in a clinical interview conducted by the main investigator. This clinical interview is similar to an intake session, and it entails a conversation between me, the main investigator, and my spouse about aspects of our marriage and our relationship.
During the second and third follow-up sessions, I will be asked to complete a series of the same questionnaires I filled out during the first session.

The first session will be videotaped, observed, and scored later by 3 trained graduate students (Sarah Ver-Lee, Amanda Harris, and Nishi Samaraweera) for treatment integrity purposes (scoring the main investigator’s clinical skills and ensuring that he conducted the interview as written in the protocol). All data (tapes, questionnaires) will be kept confidential and in a locked room. Only the main investigator, the principal investigator, and the research assistants involved in this study will have access to these data. The tapes will be destroyed at the completion of this study (after final dissertation defense). The questionnaires will be kept for at least three years after the completion of this study (final dissertation defense).

As in all research, there may be unforeseen risks to the participants. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to me except as otherwise stated in this consent form. Similar to an ordinary couple’s psychotherapy session, the interview may include questions pertaining to intimate aspects of my relationship and my life. A potential risk of my participation in this project is that I may experience distress and discomfort by some of the questions asked during the interview and during the conversation that I would have with my spouse. Additionally, there is always a risk that the clinical interview may be counter-therapeutic and harmful to my relationship with my spouse. I may terminate the session at any time. In addition, I may choose to not answer any question or not engage in any task without penalty or prejudice. The main investigator will terminate the session if I exhibit severe signs of anxiety. In this case, the main investigator will be prepared to provide short-term counseling, and will make a referral if I need further counseling. I will be responsible for the cost of therapy if I choose to pursue it.

Additional information about the study will be available to me after I complete the third session.
I will receive 50 dollars for participating and completing this study (fully attending sessions 1-3). 10 dollars will be given to me at the end of the first session (upon the completion of the session), 10 dollars will be given to me at the end of the second session (one-week follow-up), and 30 dollars will be given to me at the end of the third session (four-week follow-up). My spouse will receive the same amount of money for his or her participation. Thus, together, my spouse and I can receive up to a hundred dollars for participating in this study. No money will be given to me if either my spouse or I do not meet the research criteria, and hence, are unable to participate in this study. No money will be given to me if either my spouse or I choose to terminate any particular session. If either my spouse or I choose to terminate any particular session, I will not be able to attend the following sessions, and will be excluded from the study. If the main investigator chooses to terminate any particular session, for any other reason than the one mention above, I will only be paid for that particular session, and I will be excluded from the study.

Additionally, if I and my spouse complete the study and choose to seek marital counseling/therapy, we will be given the opportunity to receive the first 5 sessions at the WMU Psychology Clinic free of charge. Alternatively, we will have the opportunity to receive a free “communication skills” training at the WMU Psychology Clinic. There are other alternatives for couple’s therapy, and the main investigator will provide me with a referral list of other couple’s therapists/counselors in the surrounding area.

All the information collected from me (questionnaires, tapes) is confidential. That means that my name will not appear on any papers on which information is recorded. The forms will all be coded. The main investigator will also keep a separate master list with names of participants and their corresponding code numbers. Once the data are collected and analyzed, the master list will be destroyed. All other forms will be retained in a locked file for at least three years after the completion of this study. There will be few exceptions to confidentiality: a) if my spouse or I disclose information indicating child abuse (either by us or by others), b) if my spouse or I disclose our intents to harm ourselves, and c) if my spouse or I disclose our intents to harm each other or...
other people. In these cases, the main investigator is obligated by law to break the confidentiality and report the information to the appropriate authorities (e.g., police, child protective services).

Participation in this study is voluntary, and I may refuse to participate or withdraw at any time without penalty or prejudice. If I have questions or concerns about this study, I may contact Shai Brosh at 387-4456 or Galen Alessi, PhD, at 387-4470. I may also contact the chair of the Human Subject Institutional Review Board at 269-387-8293 or the vice president for research at 269-387-8298 if questions or problems arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Participants should not sign this document if the corner does not show stamped date and signature. Do not participate in this study if the stamped date is older than one year.

My signature below indicates: (1) that I have read the entire document, and understand its content, (2) that I agree to participate in this study, and (3) that I am over the age of 18.

__________________________________________    ________________
Signature                                      Date

____________________________________________
Print Name

__________________________________________    ________________
Consent Obtained By                           Date
APPENDIX D

Recruitment Advertisement
Want to improve your relationship?

Married Couples are Needed!

Western Michigan University – Psychology Department is conducting a study to evaluate the therapeutic effects of two methods of clinical interviewing during the initial session with couples. You may be eligible to participate in this study if you and your spouse meet the following criteria:

- Are both 18 years-old or older
- Are legally married
- Live together
- Have a desire to improve your relationship
- Are not currently being seen by a couple's therapist
- Do not suffer from any form of psychotic disorder
- Do not experience any form of physical violence and abuse in your marital relationship

The study involves participation in one clinical interview session that lasts approximately 180 minutes, and two follow-up sessions, at one-week and four-week intervals that will each last approximately 30 minutes.

Each couple will be paid up to $100 total for their participation.

All data and information collected will strictly remain confidential. This study was approved by the Western Michigan University Human Subject Review Board.

If you are interested to hear more information please contact Shai Brosh at 269-387-4456 or at shai_brosh@yahoo.com
APPENDIX E
Phone Interview Script
Phone Interview Script

A. **Main Investigator:** Hi, may I speak with Mr. or Mrs. _______ (assuming returning a call)?

B. **Main Investigator:** Hello, My name is Shai Brosh. I am a doctoral student in the Clinical Psychology Program at Western Michigan University, and I am responding to your call. I am wondering if it is a good time for you and your spouse to hear some basic information about my study on married couples, and, if interested, to schedule an initial appointment. Is this a good time for us to talk? Is your spouse home? (If potential participant says yes to both questions, proceed; if he or she says no, ask when you could call back).

C. **Main Investigator:** As I said before, I am a graduate student in the Psychology Department at Western Michigan University who is working in collaboration with Dr. Galen Alessi on a doctoral dissertation research project. Let me give you a brief overview of this study and then we will see if you have any questions and would be possibly interested in participating. Our project is designed to determine the therapeutic effects of two different clinical interviewing styles with couples. We are interested in knowing whether there are more therapeutic and effective ways to conduct the first session with couples. For this purpose, we are going to compare two different methods of interviewing styles in the context of the initial session with couples. Interviewing style is only one component of couple therapy, and our research will attempt to focus exclusively on that part. Participants in this study will be asked to attend three sessions. In the first session, participants will be invited to go over the consent document and learn more about the study. After this step, if both spouses consent to participate, the main investigator will administer two short screening questionnaires in order to ensure that they both meet the research criteria for participation, which are outlined in the flyer you already saw. If one spouse or both do not meet research criteria, the main investigator will terminate the session and will offer them a list of referral sources in the community. If both spouses meet the research criteria, they will proceed by filling out a series of
questionnaires, and by engaging in a clinical interview session with a therapist. The clinical interview is similar to an intake session, and it entails a conversation between the therapist and the participants (couple) about their relationship. The first session will last approximately three hours. The second and the third sessions (one-week and four-week follow-up sessions respectively) will entail filling out similar questionnaires, and will each last approximately 30 minutes. All sessions will be conducted at Western Michigan University, Psychology Department. Each couple will receive up to 100 dollars for their participation and the completion of this study (attending three sessions). All the information about the participants and about this phone conversation will remain confidential.

D. Main Investigator: Does this sound like a research project that you might want to learn more about and possibly participate? If potential participant says no, Main Investigator: Go to termination step.

E. If potential participant says yes, Main Investigator: Do you have any questions so far? (If the potential participant has questions, then the main investigator will respond to them).

F. Main Investigator: Can I speak with your spouse about the study? If yes, proceed; if no, ask when it will be the best time to call back and talk with the spouse (if participant refuses to let the main investigator speak with his/her spouse, go to termination step).

G. Main Investigator: Hello, My name is Shai Brosh. I am a doctoral student in the Clinical Psychology Program at Western Michigan University. I am calling about the study on married couples. I already spoke to your husband/wife and now I want to give you some important information about the study. Do you have a few minutes? (If yes, proceed; if no, ask when you could call back).

H. Main Investigator will repeat sections C, D and E.
I. **Main Investigator:** (to any of the spouses): Would you and your spouse be interested in setting an appointment for the first session? If potential participant says no, go to termination step. If potential participant says yes, go to the next step.

J. **Main Investigator:** The next thing we need to do is to schedule an appointment. What will be the best time for you to come? (Main investigator will schedule an appointment based on the couple’s availability).

K. **Main Investigator:** The study is being conducted at Western Michigan University, Department of Psychology. I would be happy to send you directions if you would like me to do so. Is it OK to send you directions and an appointment confirmation via email? (Verify email address).

Do you have any other questions about this study? I will see you at_______. Take care.

**Termination step**

**Main Investigator:** Thank you for your time and interest. Feel free to call me back or to call my faculty supervisor, Dr. Galen Alessi at (269-387-4470) if you have any additional questions.

Thanks again for your time and interest in my study.
APPENDIX F
Criteria for Participation
Initial Criteria for Participation

The following criteria have to be met in order for the couple to be eligible to participate in this study:

• Participants must be 18 or older.
• Participants must be in a legal marital relationship at the present.
• Participants must live with their spouse at the present.
• Both spouses must report some desire to improve their relationship.
• Both spouses must consent to participate in this study.
• The couple is currently not being seen by a couples’ therapist.
• Participants have not had any form of psychotic disorder (e.g., Schizophrenia) in the past or present.
• The couple has not experienced any form of physical violence in their relationship.
APPENDIX G

Interviews Script
Main Investigator: I appreciate your willingness to participate in this study and be here today. The session you are about to experience simulates the initial session/interview with couples. In the next 60-70 minutes, I am going to ask each of you a series of questions with regard to some aspects of yourselves as individuals and as a couple, so I can get to know you better and understand where you are coming from. As I mentioned before, if you feel uncomfortable answering any of these questions, you have the full right to pass. Please use the word “pass” or “skip” as a signal for me that you do not want to answer the question. Do you have any questions so far? (The main investigator will respond to any question).

Main Investigator: Today, I would like to get to know you by exploring how much each of you is in touch with the experience of the other. I believe that as we live with people and get to know them, we internalize some aspects about them and build an internal picture of who they are. I would like to explore these internalized impressions you created about your spouse, and then compare it with the experience of your spouse.

Main Investigator: I am going to ask each of you a series of questions. I want you to speak from your experience about the other’s experience. In other words, I would like you to answer these questions as your spouse (speaking from his/her perspective). For example (Main investigator turns to one spouse): John, I would like to interview your spouse Mary within you. I would like you to answer my questions as “Mary” while Mary
is listening. And (Main therapist turns to the other spouse) Mary, I would like to interview “John” within you while John is listening.

**Main Investigator:** This interview is unique, and at first, you may experience some difficulties or awkwardness in switching roles and speaking as your spouse. If I notice that, I will redirect you. Do you have any questions before we begin? (Main investigator will answer any questions).

**Main Investigator:** Who wants to start first? (Wait for response). For the purpose of this script, let us assume that Mary would start first.

**Main Investigator:** (To Mary) I am going to talk to you as if you were actually John. I will even call you John for that purpose. What I would like you to do is to speak from your experience of John’s experience. In other words, from the inside picture you have about him. I would like you to speak from what you feel is going on deep inside John.

(To John) And while she is answering, John, I would like you to listen.

**Main Investigator:** (To Mary) So tell me “John,” where are you from originally?

**Main Investigator:** (To Mary) “John,” can you tell me a little bit about your family?

**Main Investigator:** (To Mary) What do you do for a living “John”?

**Main Investigator:** (To Mary) Can you tell me a little bit about your hobbies aside from work? What are the things you like to do in your free time, “John”?
**Main Investigator:** (To Mary) Let me ask you, “John,” how you felt about coming to this interview today.

**Main Investigator:** (To Mary) “John,” I am interested to know what are the things that drew you to Mary. What are the things you were attracted to when you first met?

**Main Investigator:** (To Mary) “John,” what qualities do you appreciate most/like most about Mary?

**Main Investigator:** (To Mary) “John,” can you tell me what you value the most about your relationship with Mary that is important for you and that you want to honor and preserve?

**Main Investigator:** (To Mary) “John,” are there some aspects of the relationship with Mary that trouble you right now and that you would like to change? Or, “John,” if things could change in your relationship with Mary, what would you hope that could be?

**Main Investigator:** (To Mary) “John,” to what degree is Mary able to experience your difficulties and struggles, and to understand what you are going through?

**Main Investigator:** (To Mary) If it takes 100 steps for a full realization of what you are going through, “John,” how many steps do you think Mary has taken? What could she do to take a few more steps forward?
**Main Investigator:** (To Mary) Do you have the sense of how Mary can help you grow as a person, so you can feel better about yourself and about your life, “John”?

**Main Investigator:** (To Mary) “John,” what kind of restorative actions can you take in order to make this relationship better?

**Main Investigator:** (To Mary) Are there any other questions it will be useful for me to ask you “John”?

**Main Investigator:** (To Mary) I would like to switch back, and ask you to speak as yourself, Mary. I would like to ask you how much your “internalized John” matches the real John. In other words, how accurate you think you were? Alternatively, what percentage of your answers do you think John would agree with?

**Main Investigator:** (To Mary) Are there any questions I asked you that were difficult?

**Main Investigator:** (To Mary) Are there any questions I asked you that you want to hear him answering?

**Main Investigator:** (To John) And how accurate do you believe Mary was? Alternatively, what percentage of her answers would you agree with?
Main Investigator: (To John) Are you surprised by her accuracy/inaccuracy? Was there anything she said that you were surprised she understood or misunderstood?

Main Investigator: (To John) What are the main things Mary missed about you?

Main Investigator: (To John) Now, I would like to ask you a few questions. As I said before, I am going to talk to you as if you were actually Mary. I will even call you Mary for that purpose. What I would like you to do is to speak from your experience of Mary’s experience. In other words, from the inside picture you have about her. I would like you to speak from what you feel is going on deep inside Mary. (To Mary) And while he is answering, Mary, I would like you to listen.

The main investigator will repeat the same series of questions as before.

At the end, the main investigator will thank the couple for participating and answer any questions that may be raised.
Standard Interviewing Script

*Main Investigator:* I appreciate your willingness to participate in this study and be here today. This session you are about to experience simulates the initial interview with couples. In the next 60-70 minutes, I am going to ask each of you a series of questions with regard to some aspects of yourselves as individuals and as a couple. As I mentioned before, if you feel uncomfortable answering any of these questions, you have the full right to pass. Please use the word “pass” or “skip” as a signal for me that you do not want to answer the question. Do you have any questions so far? (The main investigator will respond to any question).

*Main Investigator:* Today, I would like to get to know you as individuals and as a couple. I am going to ask each of you a series of questions that will help me to understand you better. I am going to interview each of you separately, and while one of you is interviewed, the other will listen.

*Main Investigator:* Who wants to start first? (Wait for response). For the purpose of this script, let us assume that Mary would start first.

*Main Investigator:* (To Mary) So tell me Mary, where are you from originally?

*Main Investigator:* (To Mary) Can you tell me a little bit about your family?

*Main Investigator:* (To Mary) What do you do for a living?

*Main Investigator:* (To Mary) Can you tell me a little bit about your hobbies aside from work. What are the things you like to do in your free time, Mary?
Main Investigator: (To Mary) Let me ask you, Mary, how did you feel about coming to this interview today?

Main Investigator: (To Mary) I am interested to know what were the things that drew you to John. What are the things you were attracted to when you first met?

Main Investigator: (To Mary) What qualities do you appreciate most/like most about John?

Main Investigator: (To Mary) Can you tell me what you value the most about your relationship with John that is important for you and that you want to honor and preserve?

Main Investigator: (To Mary) Are there some aspects of the relationship with John that trouble you right now and that you would like to change? Or, if things could change in your relationship with John, what would you hope that could be?

Main Investigator: (To Mary) To what degree is John able to experience your difficulties and struggles, and to understand what you are going through?

Main Investigator: (To Mary) If it takes 100 steps for a full realization of what you are going through, how many steps do you think John has taken? What could he do to take a few more steps forward?
Main Investigator: (To Mary) Do you have the sense of how John can help you grow as a person and to feel good about yourself and about your life?

Main Investigator: (To Mary) What kind of restorative actions can you take in order to make this relationship better?

Main Investigator: (To Mary) Are there any other questions it will be useful for me to ask you?

Main Investigator: (To John) Now, I would like to ask you a few questions. (The main investigator will repeat the same series of questions as before).

At the end, the main investigator will thank the couple and answer any questions.
Evaluator’s Name:_____________________ Date:_____________________
Couple Number____________________________

Experimental condition: (please circle one)       A    B

A = Standard interview
B = Internalized other interview (IOI)

**Treatment Integrity Form**

**Instructions:** Your task is to carefully view the tape (only the clinical interview part), and answer the following questions below. The main purpose of this treatment adherence form is to assess whether the main investigator followed the session script (attached to this form). Please make sure you are using the appropriate session script (condition A or B) when reviewing the taped session. The questions are arranged according to the natural chronological order of the session. However, in some sessions (only a few) the order of the questions does not correspond 100% to the order as it appears on this form. Please answer each question immediately after you view and/or hear the relevant part on the tape. This will require from you to stop/pause the tape multiple times during the assessment.

Please answer the following questions using the scale below:

Fully       Partially       No       I could not hear

<..........................................................>
1. Did the main investigator provide an introduction to the couple before the actual interview began (briefly explain to them what will happen; orient them to the session)?

   Fully   Partially   No   I could not hear

2. Did the main investigator explain to the couple the nature of the interview (internalized other or standard interview)?

   Fully   Partially   No   I could not hear

3. Did the main investigator make it clear that the participants can choose not to answer any question if they feel uncomfortable?

   Fully   Partially   No   I could not hear

4. Did the main investigator offer time to ask questions about the procedure?

   Fully   Partially   No   I could not hear

5. Did the main investigator let the couple decide who would start first?

   Fully   Partially   No   I could not hear

Did the main investigator ask the first interviewee (as himself/herself or as his/her internalized other, depending on the experimental condition) the following questions?

6. Can you tell me a little bit about yourself? Or, Where are you from originally? Or, Can you tell me a little bit about yourself and your family of origin?

   Fully   Partially   No   I could not hear

7. What do you do for a living?

   Fully   Partially   No   I could not hear
8. Aside from working, can you tell me more about your hobbies and the things you like
to do in your free time?

   Fully    Partially    No    I could not hear

9. How did you feel before coming to this session/interview today?

   Fully    Partially    No    I could not hear

10. What drew you to your spouse when you first met? Or, What attracted you to your
    spouse when you first met/dated him or her?

    Fully    Partially    No    I could not hear

11. What are the qualities about your spouse (as a person) that you mostly appreciate or
    value?

    Fully    Partially    No    I could not hear

12. What are some aspects of your relationship with him or her that you mostly
    like/value/appreciate and that you want to preserve/maintain?

    Fully    Partially    No    I could not hear

13. Are there some aspects of the relationship with X that trouble you right now and
    that you would like to change? Or, are there any aspects of your relationship with X
    that you want to improve/change/work on?

    Fully    Partially    No    I could not hear

14. To what degree do you believe X is able to experience your difficulties and
    struggles, and understand what are you going through or where you are coming
    from?

    Fully    Partially    No    I could not hear
15. If it takes 100 steps for a full realization of what you are going through, how many steps do you think X has taken? Or, If I would use a visual scale that runs from 0-100, where 0 means that your spouse is completely disconnected from your experience, and 100 means that he or she can fully understand where you are coming from, where would you locate him or her?

Fully Partially No I could not hear

16. What can X do to help you grow as a person or be the person you want to be?

Fully Partially No I could not hear

17. What are the things you can do in order to help this relationship grow? Or, what actions can you take to make this relationship a better one?

Fully Partially No I could not hear

18. Are there any other questions that I have not asked you, and that will be useful for me to ask, in order to understand you and your relationship with your spouse better?

Fully Partially No I could not hear

The following questions pertain only to the “Internalized Other Interview” (experimental condition B):

Did the main investigator ask the first interviewee the following questions?

19. I would like to ask you how much your “internalized X” matches the real X. In other words, how accurate do you think you were (percentage wise)?

Fully Partially No I could not hear
20. Are there any questions I asked you that were difficult/more difficult than others?

  Fully  Partially  No  I could not hear

21. Are there any questions I asked you that you want to hear him/her answering? Or, do you want to get some feedback from him or her?

  Fully  Partially  No  I could not hear

Did the main investigator ask the other spouse (listener) the following questions?

22. How accurate do you believe X was?

  Fully  Partially  No  I could not hear

23. Are you surprised by his/her accuracy/inaccuracy?

  Fully  Partially  No  I could not hear

24. What are the main things X missed about you?

  Fully  Partially  No  I could not hear

Did the main investigator ask the second interviewee (as himself/herself or as his/her internalized other, depending on the experimental condition) the following questions?

25. Can you tell me a little bit about yourself? Or, Where are you from originally? Or, Can you tell me a little bit about yourself and your family of origin?

  Fully  Partially  No  I could not hear

26. What do you do for a living?

  Fully  Partially  No  I could not hear

27. Aside from working, can you tell me more about your hobbies and the things you like to do in your free time?

  Fully  Partially  No  I could not hear
28. How did you feel before coming to this session/interview today?
   Fully    Partially    No    I could not hear

29. What drew you to your spouse when you first met? Or, What attracted you to your spouse when you first met/dated him or her?
   Fully    Partially    No    I could not hear

30. What are the qualities about your spouse (as a person) that you mostly appreciate or value?
   Fully    Partially    No    I could not hear

31. What are some aspects of your relationship with him or her that you mostly like/value/appreciate and that you want to preserve/maintain?
   Fully    Partially    No    I could not hear

32. Are there some aspects of the relationship with X that trouble you right now and that you would like to change? Or, are there any aspects of your relationship with X that you want to improve/change/work on?
   Fully    Partially    No    I could not hear

33. To what degree do you believe X is able to experience your difficulties and struggles, and understand what you are going through or where you are coming from?
   Fully    Partially    No    I could not hear

34. If it takes 100 steps for a full realization of what you are going through, how many steps do you think X has taken? Or, If I would use a visual scale that runs from 0-100, where 0 means that your spouse is completely disconnected from your
experience, and 100 means that he or she can fully understand where you are coming from, where would you locate him or her?

**Fully** **Partially** **No** **I could not hear**

35. What can X do to help you grow as a person or be the person you want to be?

**Fully** **Partially** **No** **I could not hear**

36. What are the things you can do in order to help this relationship grow? Or, what actions can you take to make this relationship a better one?

**Fully** **Partially** **No** **I could not hear**

37. Are there any other questions that I have not asked you, and that will be useful for me to ask, in order to understand you and your relationship with your spouse better?

**Fully** **Partially** **No** **I could not hear**

The following questions pertain only to the “Internalized Other Interview” (experimental condition B):

Did the main investigator ask the first interviewee the following questions?

38. I would like to ask you how much your “internalized X” matches the real X. In other words, how accurate do you think you were (percentage wise)?

**Fully** **Partially** **No** **I could not hear**

39. Are there any questions I asked you that were difficult/more difficult than others?

**Fully** **Partially** **No** **I could not hear**
40. Are there any questions I asked you that you want to hear him/her answering? Or, do you want to get some feedback from him or her?

Fully  Partially  No  I could not hear

Did the main investigator ask the other spouse (listener) the following questions?

41. How accurate do you believe X was?

Fully  Partially  No  I could not hear

42. Are you surprised by his/her accuracy/inaccuracy?

Fully  Partially  No  I could not hear

43. What are the main things X missed about you?

Fully  Partially  No  I could not hear

**General Questions**

1. Was the therapist consistently assuring that the perspective taken is in accordance with the experimental condition (self versus internalized other)?

   a) Fully (more than 80% of time)  b) Moderately (50-80% of time)

   c) Slightly (less than 50% of time)  d) Not at all

2. The therapist gave explicit advice or direct suggestions to the couple.

   Not at all  somewhat  very much  extremely

3. The therapist suggested specific activities or tasks (homework) for the couple to attempt outside the session.

   Not at all  somewhat  very much  extremely
4. The therapist taught the couple specific techniques for coping with symptoms

Not at all  somewhat  very much  extremely

5. The therapist explicitly suggested that the couple practice behavior(s) learned in therapy between sessions.

Not at all  somewhat  very much  extremely

6. The therapist interacted with the patient in a teacher-like (didactic) manner.

Not at all  somewhat  very much  extremely

7. The therapist provided the couple/individuals with information and facts about his or her symptoms, disorder, or treatment.

Not at all  somewhat  very much  extremely

8. The therapist focused discussion on the client's irrational or illogical belief system.

Not at all  somewhat  very much  extremely

9. The therapist focused discussion on the relationship between the therapist and the client or couple.

Not at all  somewhat  very much  extremely

10. How long did the session last (in minutes)?

11. Do you have any other comments?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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