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The University of Georgia

Doctoral Portfolio

George Bowden Templeton
Department of Child and Family
Development

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Publications

I. **Articles published in peer reviewed journals**

Templeton, G. B., Bush, K. R., Lash, S. Robinson, V., & Gale, J. (under review). *Adolescent socialization in rural Appalachia: The perspectives of teens, parents and significant adults*. Journal of Adolescent Research.

Tambling-Blyskal, R., Johnson, L. N., Templeton, G. B., & Santilli Melton, M. (under review). *Using web-based technology to facilitate client engagement*. American Journal of Family Therapy.

II. **Edited book chapter (While this publication does not meet portfolio requirements, it seems to fit here better than in other areas of the portfolio.)**

Templeton, G. B., Anderson, S. R., & Burwell, S. R. (in press). A handout for families confronting HIV and AIDS. In Linville, D. & Hertlein, K. M. (Eds.), *The therapist's notebook for family healthcare: Homework, handouts, and activities for individual's, couples, and families coping with illness, loss, and disability*. Haworth Press.

Presentations

I. **First authored presentations of national/international academic/professional organizations.**

Templeton, G. B., Johnson, L. J., Tambling, R. R., & Santilli, M. (2005, October). *Using web-based technology to facilitate client engagement*. Poster presented at the meeting of the American Association for Marriage and Family Therapy, Kansas City, MO.

Templeton, G. B. (2005, June). *The next generation of challenges facing families with HIV infected parents*. Poster presented to the National HIV Conference, Atlanta, GA.

*Gale, J. E., Templeton, G. B., Anderson, S., Childs, N. & Slater, L. (2005, June). *Examining our practices or power, race, and gender through discourse analysis in supervision*. A two hour workshop presented to the joint annual meeting of the International Family Therapy Academy and the American Family Therapy Academy, Washington, DC.

*Gale, J. E., Templeton, G. B., Slater, L, Anderson, S. R., & Childs, N. (2004, September). *Naked truths in supervision: Discourse analysis reveals all*. Workshop presented at the meeting of the American Association for Marriage and Family Therapy, Atlanta, GA.

*Gale, J. E., Anderson, S. R., Templeton, G. B., Childs, N., & Slater, L. (2004, January). *Using conversation and discourse analysis for self-supervision*. Workshop presented at QUIG: The Conference for Interdisciplinary Qualitative Studies, Athens, GA.

*Presenters shared equal responsibility for the research and presentation of the research (see letter documenting this fact following checklists for each article.)

II. **Additional presentations at national/international academic/professional organizations.**

Anderson, S.R., Templeton, G.B., Johnson, L.N., Childs, N.M. & Peterson, F.R. (2006, October). *Enactments and connection in couple therapy: A process study*. Poster presented at the annual meeting of the American Association for Marriage and Family Therapy, Austin, TX.

Silva, L., Templeton, G. B., Tambling-Blyskal, R., & Johnson, L. N. (2006, October). *The use of phone calls and web-based scheduling to enhance*

client engagement. Poster presented at the annual meeting of the American Association for Marriage and Family Therapy, Austin, TX.

Burwell, S. R., Brewer, A. L., & Templeton, G. B. (2006, July). *Using Photovoice as a method to explore the experiences of spouses of younger women with breast cancer*. Poster presented at the annual meeting of the American Family Therapy Academy, Chicago, IL.

Childs, N. Anderson, S., Templeton, B., Slater, T. & Johnson, L. (2003, October). *Finding common ground in clinical practice and research: A process research review*. Poster presented at the meeting of the American Association for Marriage and Family Therapy, Long Beach, CA.

III. **Additional presentations at state/regional academic/professional organizations.**

Bush, K. R., Peterson, G. W., Templeton, G. B. (2006, March). *A qualitative examination of adolescent socialization in rural Appalachia: The perspectives of teens, parents and significant adults*. Paper presented to The Appalachian Studies Association: Twenty-Ninth Annual Appalachian Studies Conference, Dayton, OH.

Teaching and Outreach

I. **Full responsibility for one class at the University of Georgia.**

CHFD 3920 (Issues in Family Systems) Fall 2005.

II. **Full responsibility for a second class at the University of Georgia.**

CHFD 3920 (Issues in Family Systems) Spring 2006.

III. **Full responsibility for teaching three courses at Mercer University School of Medicine, Marriage and Family Therapy Program.**

MFST 600 (Introduction to Family Studies) Spring 2006

MFST 640 (Family Treatment of Addiction) Summer 2006

MFST 675 (Family Research Methods) Fall 2006

Leadership and/or Citizenship

I. **Maintaining membership in a professional society beginning from the first year in the program.**

Membership verification is provided by a letter from the American Association for Marriage and Family Therapy (AAMFT).

II. **Participation in leadership and/or professional activities.**

Reviewing proposals for presentations or publications

Abstract reviewer for AAMFT 2005 Conference.

Service on departmental, university, outreach, or professional organization committees.

Student Faculty Liason 2005

MFT Faculty Search Committee 2005

Membership on professional or service organization boards.

Student/Associate Representative to GAMFT Board of Directors 2001-2005

Volunteer work at state, multistate, or national conferences.

Volunteer for AAMFT Annual Conference 2002 and 2003

Volunteer for GAMFT Annual Spring Conference 2000-2005

Volunteer for National HIV Conference 2005

Appointment or election for committee involvement in state, multistate, or national organizations.

Professional Development Task Force, GAMFT Board of Directors 2003-2005

Spring Conference Planning Committee, GAMFT Board of Directors 2002-2005

Significant involvement in the Graduate Student Organization.

Treasurer of the CFD GSO 2004-2005

Significant involvement in the planning and implementation of Quint State.

Chair, Quint State Planning Committee 2004-2005

Other Professional Accomplishments

I. **Honors and awards for scholarship, teaching, and outreach.**

Invited Attendee (2002, 2004). American Association for Marriage and Family Therapy Annual Leadership Conference.

Inductee of Gamma Sigma Delta Honor Society (2004). The University of Georgia, Athens, GA.

II. **Evaluation by students being trained in clinical, laboratory, field, or teaching hospital activities.**

Have provided supervision to over 28 Master's level students at Mercer University through 5 semesters of teaching clinical practicum.

II. **Guest lectures.**

Templeton, G. B. (2005, February). *Mate selection*. The University of Georgia, Issues in Family Systems Class.

Templeton, G. B. (2005, January). *Community resources available to families*. The University of Georgia, Introduction to Lifespan Development Class.

Templeton, G. B. (2004, November). *Family adjustment to divorce*. The University of Georgia, Issues in Family Systems Class.

Templeton, G. B. (2004, November). *ADHD from a family perspective*. The University of Georgia, Advanced Human Development Class.

Templeton, G. B. (2004, November). *Childhood adjustment to divorce*. The University of Georgia, Issues in Family Systems Class.

Templeton, G. B. (2004, September). *The role of marriage and family therapists in the community*. The University of Georgia, Introduction to Lifespan Development Class.

Anderson, S. R. & Templeton, G. B. (2004, June). *Working with families in therapy*. The University of Georgia, Advanced Human Development Class.

Templeton, G. B. (2004, April). *Professional development: Factors to consider when deciding to attend graduate school*. University of Georgia, Professional Development/Community Activities Class.

Templeton, G. B. (2004, April). *The impact of ADHD on family relationships*.
The University of Georgia, Advanced Human Development Class.

Templeton, G. B. (2004, March). *What is marriage and family therapy?* The
University of Georgia, Introduction to Lifespan Development Class.

Running head: WEB-BASED TECHNOLOGY

Using Web-Based Technology to Facilitate Client Engagement

Rachel B. Tambling, Lee N. Johnson, and G. Bowden Templeton

University of Georgia

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Auburn University

Rachel B. Tambling, Lee N. Johnson, and G. Bowden Templeton, Department of Child and Family Development, University of Georgia; Michele Santilli Melton, Department of Human Development and Family Studies, Auburn University.

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Abstract

To meet the needs of clients, clinics must offer responsive, organized intake procedures. Clients who receive rapid intervention when they request therapy services are more likely to attend, and benefit from, therapy. The present study examined the effects of implementing of a web-based scheduling program on treatment delays and first session attendance. Results indicated that the use of a web-based scheduling system significantly reduced the number of days clients waited for a first appointment and increased the number of kept appointments. Clients provided with an immediate response to their request for treatment successfully terminated from therapy after fewer sessions.

Using Web-Based Technology to Facilitate Client Engagement

A great deal of clinical research has sought to determine when, and for what reasons, clients fail to attend first sessions of therapy. This research has delineated several factors associated with clients' failure to appear for an initial appointment. Clients who fail to attend first appointments or who cancel first appointments typically wait longer to begin treatment after their initial contact with a clinic (Benjamin-Bauman, Reiss, & Bailey, 1984; Kourany, Garber, & Tornusciolo, 1990). Treatment delays before the first session are directly related to client attendance at first therapy sessions with greater delays resulting in a decreased likelihood of first session attendance (Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Festinger, Lamb, Marlowe, & Kirby, 2002). Alternatively, clients who experience a short wait time between the phone call requesting services and the first scheduled session are more likely than their counterparts to attend first therapy sessions (Festinger, Lamb, Marlowe, & Kirby, 2002). Thus, the length of time between the clients' initial contact with a clinic and the scheduling of a first therapy session is closely related to client attendance at the first session. Several authors suggest that there is a critical period for intervention with a client during the first week after clients call to schedule an appointment (Festinger, et al., 1995; Festinger, et al., 2002; Kourany, Garber, & Tornusciolo, 1990). Further, studies suggest that a treatment delay of one week or less result in the lowest levels of missed first appointments (Benjamin-Bauman, 1984; Festinger, et al., 2002).

In addition to the actual length of time between the initial contact and the first session, client perceptions of wait time influence appointment failure rates. Research indicated that clients perceive wait time independently of actual wait and these perceptions impact attendance (Festinger, Lamb, Kirby, & Marlowe, 1996; Lacy, Paulman, Reuter, & Lovejoy, 2004). In one study, having been offered an immediate appointment significantly increased first session

attendance regardless of client's actual scheduled appointment time or length of wait (Festinger, Lamb, Kirby, & Marlowe, 1996). This result was confirmed in a qualitative study that reported that clients seemed to have a perception about the length of wait that was appropriate for their case and clients' inability to get an appointment within their desired time frame decreased the likelihood of first session attendance (Lacy, Paulman, Reuter, & Lovejoy, 2004). It is clear that first appointments are kept with greater frequency when clients experience a rapid response to their help-seeking contact, with sessions scheduled as closely to the first contact as possible.

Treatment Delay and Attrition

Time elapsed between the initial phone call and the scheduled appointment is not only associated with attendance failures, but also with treatment attrition. Clients who express urgency when seeking therapy are more detrimentally impacted by treatment delay, perhaps because such clients are experiencing acute crisis. Clients seeking urgent help are likely to perceive counselors as unavailable, are less likely to think their needs were met by the clinic/counselor, and are more likely to terminate therapy prematurely when they experience lengthy treatment delays (Obetz, Farber, & Rosenstein, 1997). Long waiting periods negatively affect clients, resulting in treatment attrition.

Some authors have suggested an explanation for the relationship between treatment delay and attrition. Crisis events, those events that may prompt an individual to seek therapy, are opportunities for growth (Hill, 1949). Stressful events produce a state of disequilibrium during which time individuals work to realign resources and recover from stress. It is during this period of reorganization that individuals can develop new problem solving skills and better coping strategies (McCubbin, et al., 1980; Tschann, Johnston, & Wallerstein, 1989). Improvements in functioning or access to resources at the time of the crisis can help individuals positively recover

from crisis events. Therapy or involvement with a helping professional during a stressful event can be a valuable resource for individuals experiencing a crisis. As well, counselors may find crisis times present an opportunity for successful treatment. At times of crisis, individuals are often more amenable to therapeutic intervention (Woolley, 1990). Therapy can make contributions to growth and adaptation following a crisis. It is also possible that intervening during a stressful period can improve attendance and shorten treatment duration.

It is clear that quick intervention during crisis situations is essential to engaging clients in therapeutic services. Scheduling clients shortly after the clients' first phone call is crucial to increasing first session attendance, reducing client attrition from therapy, providing clients a resource at crucial periods in their lives, and potentially shortening treatment. The relationship between length of wait for a scheduled first therapy session, first session attendance, attrition, and length of treatment will be addressed by answering the following research questions:

1. Does scheduling a client's first session during their initial phone call significantly decrease the number of days between the initial phone call and first therapy session?
2. Does wait time between the initial phone call and first therapy appointment predict first session attendance?
3. How does scheduling a client's first session during their initial phone call influence the number of therapy sessions attended?

Methods

Participants

Data from this study came from one university-based marriage and family therapy clinic in the Southeastern United States. The sample for this study was ($N = 136$) cases of individual, couple, or family therapy initiated during the time period of March 2003 to December 2004. For

this study, the units of analysis were therapy cases, not the therapy participants. This study had a waiver for informed consent, so no demographic information was available from the cases used for analysis; only variables important to this study were collected. The clinic's clientele are predominantly Caucasian (85%; African American, 1%; Hispanic, 1%), educated at a high school or college level, and report incomes ranging from less than \$5,000 annually, to more than \$40,000, with an equal distribution across income groups. Clients at the clinic range in age from three to seventy; the mean age for male clients is 30.48 and the mean age for female clients is 29.69.

Procedures

Participants presented to the clinic for individual, couple, or family therapy services. There were no criteria for inclusion in the present study other than having contacted the clinic to obtain therapy services. Clinic staff implemented the use of Corporate Time[®], now operating under the trademark of Oracle Calendar[®] ("Oracle Calendar", 2006), a web-based calendar system that allows for instant online scheduling of clients and conveys scheduling information via email to clinicians. Using this program, clinic staff and therapists were able to make, change, and confirm appointments via the Internet. This study utilized existing clinic data representing the one year period prior to the implementation of the system and a nine month period after implementation of the calendar system. Data were matched on number of cases, rather than time period, to assure that the analysis represented roughly equivalent groups.

Participants phoned the clinic to complete a telephone intake prior to receiving therapy services. During the intake, clinic staff obtained contact information and assigned the client to a therapist. Cases were divided into two groups: cases whose initial phone call to the clinic fell in the time period before the implementation of the system, the therapist-based scheduling group (n

= 68), and cases whose initial phone call to the clinic occurred in the time period after the implementation of the system, the web-based scheduling group (n = 68). The cases whose initial phone call fell in the one year period before the implementation of the system (March, 2003 – March, 2004) were assigned to a clinician and the clinician was responsible for contacting the client to schedule a first session. During the nine month period after the implementation of the system (April, 2004 – December, 2004), clients scheduled a first session with clinic staff during the initial phone call.

Results

Treatment Delay

A *t* test was conducted to evaluate the hypothesis that cases in the web-based scheduling group waited fewer days between their initial phone call and first appointment than cases in the therapist-based scheduling group. The test was significant, $t(87) = 2.92, p < .01$, two tailed. Results indicated that individuals in the web-based group waited fewer days ($M = 7.02, SD = 8.45$) than individuals in the therapist-based scheduling group ($M = 12.55, SD = 9.41$). The η^2 index indicated a moderate effect size for scheduling group, $\eta^2 = .06$.

First Session Attendance

A one-sample Chi-square test was conducted to compare expected and observed frequencies of therapy attendance by group. This test was conducted to assess whether individuals in the therapist-based scheduling and web-based scheduling groups were more likely than chance to attend their first session of therapy. The results of the test for the web-based group were significant, $\chi^2(1, N=68) = 15.06, p < .001$, indicating that 50 (74%) of the 68 clients attended their first session of therapy. The proportion of clients who appeared for their first appointment was greater than was expected by chance for the web-based scheduling group. For

the therapist-based scheduling group, the results of the test were not significant, $\chi^2(1, N=68) = 1.47, p = .225$, indicating that clients in this group were no more likely to attend their first therapy session than what would be expected by chance. These results suggest that web-based scheduling resulted in an increased likelihood of attendance at first therapy sessions.

Treatment Length

An independent samples *t* test was conducted to determine whether clients in the web-based or therapist-based scheduling groups differed with regard to number of therapy sessions attended. Levine's test for homogeneity of variances was significant, $F(98)=32.90, p < .001$, so results adjusted for unequal variances were analyzed. The test was significant $t(57.50) = 3.73, p < .001$, indicating that clients in the therapist-based scheduling group attended more sessions of therapy ($M = 6.88$) than did their counterparts in the web-based scheduling group ($M = 3.28$). Further analysis of the data indicated group differences in the data. The therapist-based scheduling group had a wider range in number of sessions (1 – 19 sessions) than the web-based scheduling group (1 – 11 sessions).

Discussion

These results extend the body of research indicating that client wait time is an important predictor of first session attendance (Benjamin-Bauman, Reiss, & Bailey, 1984; Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Festinger, Lamb, Marlowe, & Kirby, 2002; Kourany, Garber, & Tornusciolo, 1990). Findings from this study suggest that immediate scheduling of an appointment shortens the length of time between the initial contact and the first session and increases client attendance at first sessions. It also supports previous research that shows scheduling within one week of requesting services is an important factor in client attendance at first therapy sessions (Benjamin-Bauman, 1984; Festinger, et al., 2002). This study provides

information about a simple way to utilize web-based scheduling programs to decrease client wait time, increase first session attendance, and improve the timing of therapy onset. Results from this study also indicated that clients who received a prompt appointment terminated therapy after fewer sessions than their counterparts. Immediate scheduling offers clients appointments during a time of crisis, a time when clients need services and are most amenable to change.

One possible explanation for the success of the web-based scheduling procedure is that it provides an opportunity for quick intervention on the part of therapists. Quickly intervening during a crisis has many benefits (McCubbin, et al., 1980; Tschann, Johnston, & Wallerstein, 1989). When a potential client first contacts an agency for therapy, the individual is likely experiencing some crisis event or stressful situation. Clients benefit from a responsive intake process that offers help when it is most needed.

An accelerated, web-based appointment process also provides benefits for clinicians and clinics. Therapists enjoy more efficient use of their time, as clients who schedule appointments are more likely to attend. Therapists experience increased control over their time and their schedules through online features allowing therapists to monitor and update their schedules in real time via the Internet. Though clients in the web-based scheduling group attended fewer sessions on average, more clients presented for therapy during that time period. During the therapist-based scheduling period, the clinic had an average of 5.44 new cases per month. During the web-based scheduling period, the clinic had an average of 7.56 new cases per month. This may indicate that, due to rapid scheduling, clinicians were intervening during times of crisis, when clients were most open to change, and clients were obtaining immediate benefits from therapy. This would enable clients to terminate from therapy in a timely fashion and open a space in the therapists' schedules for a new client.

One limitation of this study concerns the potential impact of history effects. This study compared two groups, one before and one after the implementation of the scheduling system. Both of these groups were obtained from the same university-based clinic. Although the findings from this research are helpful, it can not be determined if the effects are the result of an event in the community, or other history threat. Future research could rule out history threats by comparing web-based scheduling between two clinics.

Another limitation was the lack of demographic information available on the participants. While general demographics for the clinic are presented, the information is not detailed enough to determine the generalizability of the findings. Future researchers should work with human subjects boards early in the research process to facilitate data collection while honoring the right of participants to voluntary participation.

The findings of this study support and extend the body of research supporting rapid intervention with therapy clients. Results indicated that clients whose first appointments were scheduled using a web-based system obtained first appointments with shorter treatment delays. Clients who experienced shorter treatment delay were more likely to attend first therapy sessions, increasing therapist productivity. Future research examining similar web-based scheduling methods is warranted to confirm the efficiency and practical viability of such a scheduling method.

References

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December 5, 2005

G. Bowden Templeton
Shayne Anderson
Stephanie R. Burwell, Ph.D.
Child and Family Development
Marriage and Family Therapy
The University of Georgia
112A Dawson Hall
Athens, GA 30602

Dear Mr. Templeton, Mr. Anderson, and Dr. Burwell,
Thank you for submitting your chapter, "Working with gay Couples Facing HIV or AIDS" to the *Therapist's Notebook for Family Healthcare*. Your chapter has been accepted for publication and we think it will make a significant contribution to our book. We ask, however, that you please make the following changes to your chapter:

1. Edit paper for grammar and consistency with APA 5th edition style, including the reference section.
2. Change the title to reflect the use of the worksheet (and maybe more creative).
3. In the instructions section, please provide an overview of the adapted worksheet regarding its contents. Additionally, provide some guidance as to when a therapist might choose to use this worksheet in the course of treatment.
4. In the clinical vignette, please make verb tense consistent throughout.

Please make these changes by **January 15, 2006**. Once you have made these changes, please submit **three (3) hard copies** of the chapter, the **corresponding version of the chapter**, and **short biographies** of each author on a 3.5" floppy disk to: **Dr. Deanna Linville, Center for Family Therapy Clinical Director, Marriage and Family Therapy Program, University of Oregon, Eugene, OR 97403**. The version on disk should be in Microsoft Word format.

Let us know if you have any further questions or concerns. Thank you again for your wonderful addition to our book. We look forward to working with you.

Sincerely,

Deanna Linville, Ph.D., LMFT
Katherine M. Hertlein, Ph.D.

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Adaptation of the Family Systems-Illness Model for HIV or AIDS

Patients and their Partners

G. Bowden Templeton

Shayne R. Anderson

Stephanie R. Burwell

Type of Contribution: Handout

Objective

This handout provides information for therapists dealing with issues that may arise in treating the psychosocial aspects of HIV or AIDS in the context of gay relationships. The handout may be used as a psycho educational tool that can be easily adapted to individual, couple, or family therapy sessions. The handout illustrates the multiple challenges faced by patients and their loved ones as they confront HIV and AIDS and is relevant for all stages of therapy.

Rationale for Use

HIV presents a unique set of challenges to patients, their partners, and health care providers. Stigma, discrimination, isolation, grief, loss, role strain, fear, distrust, and uncertainty are commonly experienced by patients and partners who must adapt to and cope with this disease. In addition, gay couples may not be aware of the unique legalities involved in their interactions with the financial, judicial, and medical systems. Illness

adjustment and coping efforts are further complicated by cultural norms and sexual orientation. For these reasons, it is important for therapists to be informed of the many issues gay couples face as they cope with and manage HIV and AIDS. With this information, clinicians will also be better prepared to actively collaborate with other health care providers.

While patients and their loved ones once considered a diagnosis of HIV or AIDS to be a death sentence, this is no longer the case. With the advent of antiretroviral treatments, patients are now living longer and what was once a terminal disease is now considered a chronic illness. As such, couples face prolonged exposure to a host of psychosocial stressors. The convergence of these factors creates a tremendous need for the development of resources that can be used to educate patients and providers about the issues that may arise across the illness trajectory.

The experiences of patients and their partners will vary at different stages in the life cycle of an illness. One particularly useful way to conceptualize illness and the demands it places on family systems at different stages has been proposed by Rolland's Family Systems-Illness Model (1994; 2003). This model takes into account interactions between the type of illness, the individual, family, and illness life cycles, and the social context. According to this model, illnesses can be categorized along four dimensions (onset, course, outcome, and incapacitation) and transition through specific developmental time phases (crisis, chronic, and terminal). Thus, AIDS is viewed as an illness with a gradual onset, progressive course, fatal outcome, and severe incapacitation. Further, AIDS places different demands on a couple at various phases of the illness.

This typology has important implications for therapists working with gay couples where one partner has AIDS. A diagnosis of AIDS is clearly a crisis that brings with it countless unanswered questions and concerns. Yet, the gradual onset of its associated symptoms may be respite in the midst of crisis because it allows time for couples to address other important and stressful issues that emerge. With medical management of the illness underway, a patient may focus on dealing with the shock and grief associated with diagnosis. The couple may have time to explore the possibility that the diagnosis reveals infidelity and betrayal or a substance abuse problem. It may allow time for the couple to contact extended family and reveal undisclosed lifestyle choices. Each of these represents unique opportunities for therapists to help navigate difficult conversations between partners and among extended family members.

Likewise, the chronic phase of AIDS brings with it extensive exposure to unique stressors that will challenge even the most committed couples. As the initial shock of diagnosis wears off, stigma may begin to take its toll. Patients may be unwilling to get out of their homes and socialize with other people. Patients may be reluctant to attend appointments with their physician for fear of being seen entering an infectious disease clinic. Partners also face the long-term implications of managing the day-to-day tasks of living with a partner who has a chronic illness. Shared household responsibilities may now become one person's burden. Further, a partner may be increasingly anxious about whether or not he has been infected. Concern related to lack of financial support and uncertainty about medical treatments increases. Couples in this phase of the illness need to be flexible and open to change. They also need information and extensive on-going support.

The terminal phase of illness is characterized as a period of mourning and bereavement in which the inevitability of death is apparent. In the terminal phase of illness, the infected patient may find himself in and out of hospitals and dealing with increasing symptom related discomfort. He may experience increased apprehension about the course of the illness and impending death. The partner may find himself giving injections and changing bedpans, while continuing to provide emotional support for his partner. The couple may struggle with the implications of being in a relationship not legally recognized by most states and the reality that a partner is not allowed to participate in treatment planning or even visit the patient in the hospital.

The social context in which HIV and AIDS exist also constitutes a significant stress on the couple. Gay patients whose cultural or religious background scorns homosexuality face additional difficulties in that their family and social network may not be supportive or they may be outcast. At best, if a patient is willing to share his illness narrative with family members, he runs considerable risk that he will lose their support. Issues of poverty and substance use are also significantly related to HIV and AIDS and complicate access to treatment and support services.

Instructions

This handout provides an overview of the issues that gay couples face when one partner is being treated for HIV or AIDS and is adapted from the Family Systems-Illness Model (Rolland, 1994; 2003). The handout is organized by stage of the illness (crisis, chronic, terminal) and details many of the unique and often unexpected issues that a gay couple may anticipate confronting during the course of treatment. Clinicians are

encouraged to have the handout readily available to reference during treatment planning and in subsequent therapy sessions. Some clinicians may choose to share copies of the handout with their clients. By having quick access to this information, clinicians will be better prepared to meet the needs of gay couples at every stage of the illness. In addition, the nature of the organization and content of the handout makes it readily adaptable to individual and family therapy sessions as well.

Brief Clinical Vignette

Joe and Dave were referred for couple's therapy by a local agency serving HIV and AIDS patients and their families. Agency staff was concerned that the stress placed on the relationship as a result of Joe's HIV positive status was more than the couple could manage without additional support and resources. At their first therapy appointment, Joe and Dave described the history of their relationship. They had been committed to each other for more than 20 years and owned a home together. Each shared equally in day-to-day tasks and both had full time jobs. They described themselves as happy and comfortable until Joe's illness changed their lives dramatically.

Over the course of the next few therapy sessions, more details emerged about their relationship and the strain it was experiencing. Joe described feeling depressed and using alcohol as a coping mechanism. Conversations that were once friendly and engaging for the couple now became argumentative and antagonistic. They bickered constantly. In addition to his HIV positive status, Joe also coped with diabetes, encephalopathy, liver disease, and a recent hernia. His medical conditions required significant attention and care and Dave became the primary caregiver.

Dave is Hispanic and worked in a warehouse. He closely guarded his sexual orientation by choosing to share this information with only a few very close friends. Dave was not out to family, primarily due to his cultural belief that men should be strong and provide for the family, certainly not gay. This concern that his family and co-workers would not approve of his lifestyle resulted in Dave spending most of his time alone with Joe. He was isolated and as the stress of caring for his sick partner increased, Dave realized that he needed additional support.

After a three month period in which the couple discontinued treatment, Dave contacted the clinic to say that Joe had died suddenly and that he wanted to resume therapy. Over the course of several months, he reported feelings and difficulties he had experienced with his partner's illness and subsequent death. He described having survivor guilt and talked about feeling torn between the responsibility of caring for his aging parents and his dying partner. He felt like he had no time or energy to care for himself. His thought process became quite negative and resulted in having little capacity to see that the care he provided was substantial.

Dave also expressed a great deal of pain around the injustices he experienced during his partner's illness and death. On several occasions, he had not been allowed to visit Joe in the hospital or participate in treatment decisions. Because Joe and Dave did not have wills or power of attorney, property that they owned jointly was left to Joe's family rather than Dave. As a result Dave found himself in the awkward position of owning his home with his partner's father, a man who did not approve of their lifestyle and relationship.

Suggestions for Follow-up

The issues that couples face in dealing with HIV and AIDS are monumental and can only be addressed over time. This handout can facilitate open communication among partners and family members as they share their experiences with how the illness has impacted their lives.

Contraindications

Therapists must always be sensitive to the emotional states and needs of their clients. Patients and their partners may feel overwhelmed at certain times or by certain material and, therefore, careful attention should be paid to gently timing when and how these topics are brought up in therapy.

Professional Readings and Resources

Campbell, T. (1999). AIDS-related death: A review of how bereaved gay men are affected. *Counseling Psychology Quarterly*, 12(3), 245-252.

Grossman, G. (1996). Psychotherapy with HIV-infected gay men. In P.M. Kato & T. Mann (Eds.), *Handbook of diversity issues in health psychology* (pp. 237-260). New York: Plenum.

Kurdek, L.A. (2005). What do we know about gay and lesbian couples? *Current Direction in Psychological Science*, 14(5), 251-254.

- McDaniel, S.H., Hepworth, J. & Doherty, W.J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York: Basic Books. Particular attention should be paid to Chapter 8 and Chapter 10.
- Oram, D., Bartholomew, K., & Landolt, M.A. (2004). Coping with multiple AIDS-related loss among gay men. *Journal of Gay & Lesbian Social Service, 16*(2), 59-72.
- Rolland, J. S. (1994). *Families, illness, and disability: An integrative treatment model*. New York: Basic Books.
- Rolland, J. S. (2003). Mastering family challenges in serious illness and disability. In F. Walsh (Ed.), *Normal family processes* (3rd ed., pp. 460-489). New York: Guilford Press.
- Springer, C.A. & Lease, S.H. (2000). The impact of multiple AIDS-related bereavement in the gay male population. *Journal of Counseling and Development, 78*, 297-304.

Resources for Clients

- Bartlett, J.G. & Finkbeiner, A.K. (2001). *The guide to living with HIV infection: Developed at John Hopkins AIDS clinic* (5th ed.). Baltimore: John Hopkins University Press.
- Lambda Legal Defense and Education Fund (1998). Life planning: Legal documents and protections for lesbians and gay men. Retrieved November 14, 2005, from <http://www.lambdalegal.org/sections/library/lifeplanning.pdf> .
- Shernoff, M. (Ed.). (1997). *Gay widowers: Life after the death of a partner*. New York: Haworth Press.

Adaptation of the Family Systems-Illness Model for HIV or AIDS Patients and their Partners

Stage	Patient	Partner
Crisis	<ul style="list-style-type: none"> • Diagnosis: Explore initial feelings of shock and grief related to diagnosis. • Disclosure: Diagnosis may necessitate disclosing to family and friends otherwise unknown lifestyle choices. Explore who to tell, when, and how. Role play the disclosure process. • Stigma: Process feelings related to stigma. Educate that family, friends, and neighbors may shun the patient and partner. Explore ways in which stigma may impact their lives on a day-to-day basis and develop plans for managing those situations. Work to heal these relationships. • Fear of contagion: Educate family and friends about the transmission process and related medical issues. • Loss of social support: Work to establish or extend networks of social support. Provide referrals to services that are supportive and designed to meet specific needs. • Legal and financial issues: Patients may not be aware of the implications of being in a same sex relationship as it relates to living together agreements, powers of attorney, wills, living wills, revocable trusts, and funeral arrangements. Explore needs and provide appropriate referrals. 	<ul style="list-style-type: none"> • Diagnosis: Explore initial feelings of shock and grief related to the patient’s diagnosis. • Inadequate information: Partner may not have adequate information about the illness leading to fear & uncertainty. Provide information and referrals for partners. Collaborate with healthcare professionals. • Betrayal: Partner may feel angry or confused if the illness is a result of an affair or drug use. Facilitate conversations between the partners to heal differences. • Fear of infection: Provide referral for testing and facilitate discussions to work through the possibility of infection. • Support system: Partner may not be “out” and thus lack the support system of family and friends to process the diagnosis. Facilitate discussions about coming out and expanding the support system. • Dealing with issues related to obtaining medical information from health care professionals: Assist partners in planning for legal issues early in the illness as this may serve to prevent or minimize frustration. Encourage and make referrals to attorneys who are knowledgeable of medical, legal, and financial issues as they relate to same sex couples.

Chronic	<ul style="list-style-type: none"> • Coping with emotions: Allow for expression and normalization of feelings related to sadness, loss, confusion, loneliness, and suicidal ideation. • Exposure to trauma and fear: Address feelings related to recurring illness episodes and the impending loss of hopes and dreams. • Physical decline: Patient's physical abilities diminish and activities of daily living become much more challenging. Explore feelings related to being a burden on those providing care. Assist in finding new ways to make meaningful contributions to family life. • Normalcy in daily routine: May experience the loss of a sense of predictability and control in their lives. • Isolation: Patients may spend increasing amounts of time in isolation. Assist in finding ways to engage in social interaction. Provide appropriate referral to support groups. • Sexuality: Explore new and safe opportunities for sexual expression. • Guilt related to infecting others: Explore feelings of fears and guilt related to the possibility of having infected others. Challenge irrational fears and develop strategies to work with rational fears. 	<ul style="list-style-type: none"> • Social support: Explore sources of support available to the partner. Assist in developing plans that ensure continued social interaction and leisure activities. • Role shifts and strain: Explore feelings related to changes in roles assumed in the relationship. Partners may find themselves providing more and more care to the patient, creating instability and imbalance. • Social rejection/isolation: Partner may fear social rejection, loss of a job and/or housing as a result of being associated with a person with HIV or AIDS. They may decide to conceal the illness from family and friends. • Caregiver fatigue and burnout: Explore feelings of being overwhelmed and burned out by the responsibilities of providing day-to-day care for the ill partner. Consider home health or other services to alleviate caregiver burden. • Lack of financial and emotional support: Explore stress related to inadequate financial and emotional support. • Sexual relationship: Partner may experience a loss over a lack of sexual involvement with their partner. • Fear of HIV or AIDS testing: Partners may be reluctant to be tested for fear of learning that they are seropositive. Be prepared to make appropriate referrals for testing when the partner is ready.
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Terminal	<ul style="list-style-type: none"> • Coming to terms with the inevitability of death: Assist patients in processing feelings related to impending death. Facilitate contact with a religious or spiritual leader. Explore patient's beliefs about homosexuality as they relate to death. • Fear of what lies ahead: Explore beliefs about life after death. Educate about end of life and dying. Collaborate with palliative care providers. • Symptomology: Patients may experience an exacerbation of illness related symptoms resulting in numerous hospitalizations or utilize hospice care. 	<ul style="list-style-type: none"> • Caregiving responsibilities change: Partners may provide intensive, front line medical care including keeping track of medications, giving injections, inserting catheters, or cleaning wounds. • Feelings of loss and grief: Explore feelings associated with the impending loss of the patient. • Feelings of helplessness: Ensure that partners are in contact with appropriate support networks charged with caring for the caregiver. • Treatment decisions: Partners may find themselves limited by legal issues in the role they can play in making treatment decisions. Explore and actively pursue legal means through which partners can be involved. Provide appropriate referrals. • Estate planning: Partners may experience frustration with the legal challenges associated with executing the will of a patient in a same sex couple.
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March 31, 2005

Dear G. Bowden Templeton:

Congratulations! Your proposal for a poster presentation has been accepted for the 2005 AAMFT Annual Conference to be held at the Crown Center in Kansas City, MO on October 20 – 23, 2005. The title of your presentation is: *Using Web-Based Technology to Facilitate Client Engagement*.

POSTER PRESENTERS MUST BE PRESENT FOR THE POSTER SESSION. The poster session is scheduled for **Friday, October 21, 2005 at 4:30 PM - 6:00 PM**. During that time, be prepared to discuss your poster with conference participants. Poster presentations are of completed research, if the data collections and analysis for your presentation is not completed at this time, please contact the AAMFT immediately. Please read the enclosed Instruction Sheet for further information regarding the setup of your poster.

Please look over the attached “Presenter Contract and Poster Information Sheet” to verify the accepted format of the session and presenter information. This sheet must be signed and faxed to 703-253-0509 before we can print your name in the conference brochure. Please fax this document back to the AAMFT **NO LATER THAN April 5, 2005**. If you do not have access to a fax machine, please call or email Dawn Berry, Educational Program Administrator, at 703-253-0481 or dberry@aamft.org to make other arrangements.

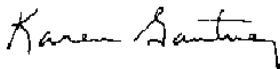
Conference participants who attend the Poster Session will receive 1.5 hours of continuing education credit. Therefore, it is critical that presenters be present to interact with the participants for the entire time period. If you are unable to be there at that time, notify us *immediately* by calling Dawn Berry, Educational Program Administrator, at 703-253-0481.

To enhance the experience for participants, I encourage you to prepare a handout with the highlights of your presentation. Include your name and where you can be contacted for further discussion.

This year we are also planning to have a virtual poster session on the AAMFT website. Here we will be posting all of the posters online for conference attendees and others who may want to view the posters before or after the conference. In order to achieve this goal, we will need your poster emailed to us in Powerpoint or Word format by August 1, 2005. We will contact you with more information about this in the future.

I would like to invite you to a dessert reception for the conference presenters in Kansas City on Thursday evening, October 20th at 8:30pm. I will inform you of the room locations in future correspondence, and it will also be printed in the on-site conference materials. Again, congratulations on being selected to present at the conference. See you in Kansas City!

Sincerely,



Karen Gautney, M.S.
Deputy Executive Director

Office Use Only:

Abstract ID: 162

POSTER SESSION CONTRACT

RETURN BY April 5, 2005

AAMFT FAX NUMBER (703)-253-0509

Instructions: Please review and sign the contract listed below. It is your responsibility to consult your co-presenters for updates. Make any corrections directly on this sheet.

Poster Information

Accepted Format: Poster Session

Presentation Date and Time: Friday, October 21, 2005 at 4:30 PM - 6:00 PM

Title: Using Web-Based Technology to Facilitate Client Engagement

Presenters: Please review carefully spelling errors. All presenters listed are expected to be present during your presentation. If, for any reason, a presenter is unable to attend, please contact AAMFT immediately.

G. Bowden Templeton
Michele Santilli

Lee N. Johnson

Rachel R. Tambling

I (we) agree:

1. the data collection and analysis for this poster is complete.
2. to receive all conference correspondence and accept responsibility for conveying conference-related information to co-presenters.
3. to obtain appropriate release(s) of copyrighted materials (including video slips, slides, cartoons and photographs) that will be used as part of this presentation.
4. that informed consent has been obtained from all research participants.
5. to present in Kansas City, MO during the hour and date assigned to this presentation at the 2005 AAMFT Annual Conference and to conduct this presentation according to the conditions listed above.
6. that all presenters will register for the conference and pay all conference fees.
7. that all research presented has followed established ethical guidelines and has obtained necessary IRB approval prior to being conducted.

Signature of Lead Presenter: _____

Date: _____

Name (printed): _____

THE AAMFT POSTER SESSION INFORMATION:

Objective of the Poster Sessions:

The purpose of the poster session is to provide an opportunity for conference attendees to become acquainted with the latest information on research, program successes and practice innovations. You may choose to present your information in graphic, tabular, or chart form so as to interest the 1,500+ attendees.

An effective poster session is a highlighted synopsis of your work enabling the viewer to move quickly through your presentation. Resist the temptation to reproduce full pages of typed material. Viewers will be intrigued by crisp phrases and brief lists.

Set-Up/ Tear-Down:

Posters will be highlighted at the AAMFT Poster Session. Your poster must be set-up between 8:00am and 2:00pm on Friday, October 21, 2005. Plan to bring plenty of push pins or thumbtacks (about 50) to place your materials on the board. You may **NOT** use tape or adhesive on the boards.

Display Format and Design:

Each display is allocated a space **4 ft by 4 ft**. As a rule of thumb, six to eight individual panels are recommended for your poster. Each panel should be on heavyweight paper or lightweight cardboard so they are easy to mount to the tack board.

The poster presentation is primarily a visual one. Make maximum use of figures, graphs, diagrams and flow charts on your display panels. The major components of an effective poster presentation include:

- One panel for a brief statement of the problem.
- One panel for a brief description of the methods used.
- Three to four to show graphs of figures depicting the results.
- One panel presenting the conclusions and/or recommendations.

Tips for Preparing and Presenting Your Poster:

- Each individual panel in the display must be clearly numbered in the upper left hand corner so that viewers can quickly determine the sequence to follow.
- Be sure connection of ideas and progression of thought is clear from one panel of the poster to another.
- Use a minimum of text. Use lists or phrases instead of complete sentences when possible. Usually the total length of text for a poster presentation should not exceed 25 lines.
- A printed strip at least four inches high showing the title of the presentation and the names of the author(s) or presenter(s) should be prepared to be attached to the top of your display. Lettering for headers, such as title, should be at least 1" high and subtitles should be at least 1/2" high. Use dark block letters if possible.
REGULAR TYPEWRITER SIZE TYPE IS TOO SMALL. Viewers will be standing from three to six feet away from the poster and lettering must be legible and visible from that distance.
- Use of color adds emphasis. Beginning with a brightly colored background and adding contrasting letters, graphs and charts is effective. Keep illustrative material bold and simple.

Handouts:

Due to popular demand, we are asking poster presenters to prepare handouts to go along with your poster. The handout can contain a synopsis of the material presented, report additional data that would not fit on the poster, give relevant readings, etc. There will be a table at each poster to hold the handouts. Since we have not done this before, we can only estimate the demand for the handouts, we suggest you bring 100. If the demand is greater, you can refer participant to the AAMFT website to the virtual poster presentation. Please hold the handouts and put them out during the Poster Session. If you have any left over, you can leave them for participants that visit the posters later in the conference.

Using Web-Based Technology to Facilitate Client Engagement

G. Bowden Templeton

Lee N. Johnson

Rachel Tambling Blyskal

Department of Child and Family Development

The University of Georgia

Michele Santilli Melton

Department of Human Development and Family Studies

Auburn University

Purpose

- ◆ To evaluate the impact of a web-based appointment scheduling system designed to reduce the “wait time” clients experience between their initial phone call and first therapy appointment.

Relevant Literature

- ◆ Accelerated intakes have been shown to increase initial attendance in outpatient substance abuse treatment (Festinger, Lamb, Kirby, & Marlowe, 1996).
- ◆ Longer wait intervals between referral and initial appointment are significantly associated with nonattendance (Bender & Koshy, 1991; Festinger, Lamb, Marlowe, & Kirby, 2002; Hamilton, Round, & Sharp, 2002).
- ◆ A wait period of more than eight days for an appointment reduced the chances of initial attendance from 71% to 48% for substance abusing clients (Wanberg & Jones, 1973).

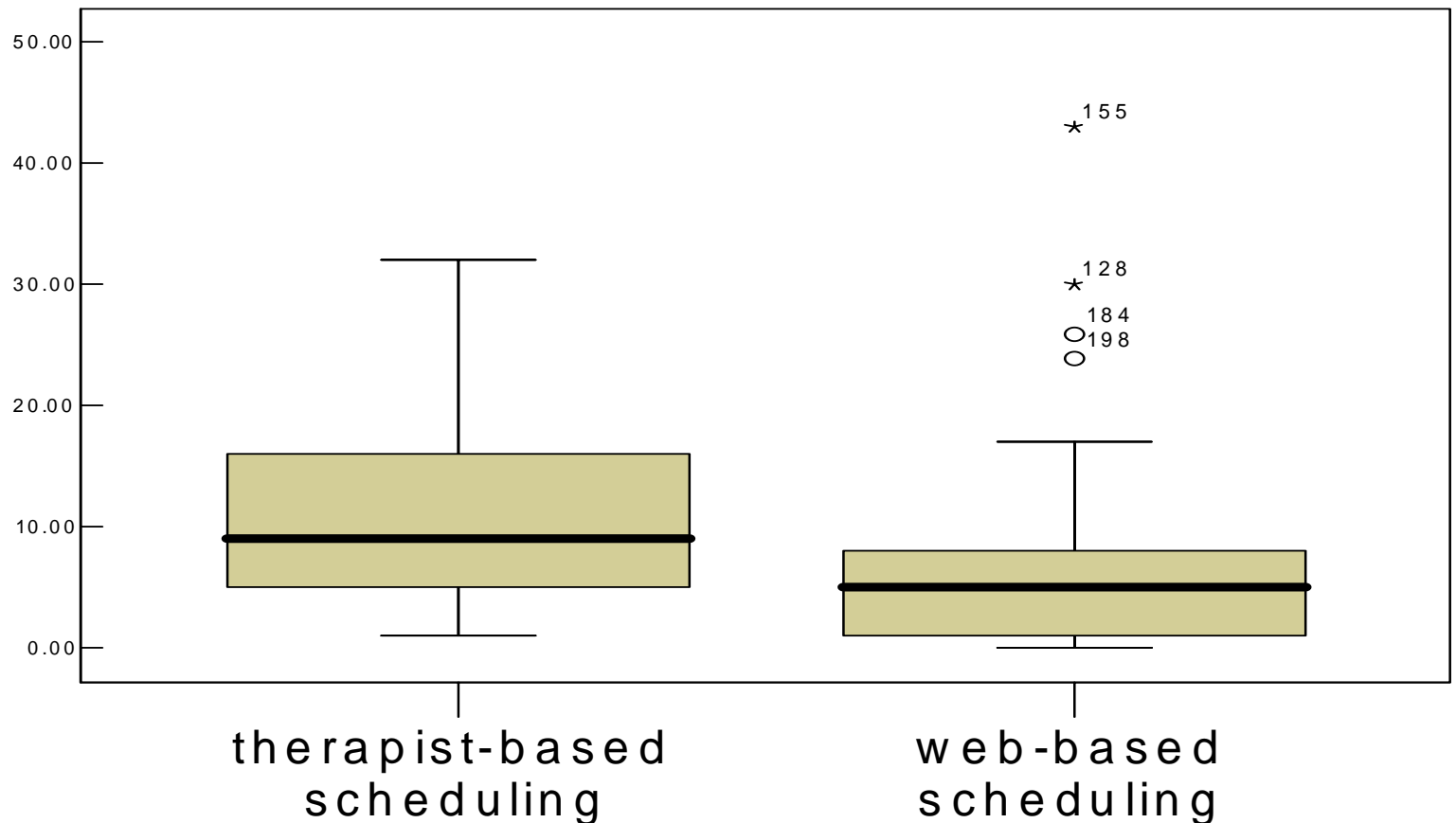
Research Questions

- ◆ Does scheduling a client's first session during their initial phone call through the use of a web-based calendar significantly decrease the number of days between the initial phone call and first therapy session?
- ◆ Does scheduling first therapy sessions using a web-based calendar system increase the likelihood that clients will attend therapy?

Procedures

- ◆ Clinic staff implemented the use of Corporate Time, a web-based calendar system that allows for instant online scheduling of clients in a university-based family therapy clinic.
- ◆ Utilized existing clinic data representing the period 9 months prior and 9 months after implementation of the calendar system.
- ◆ Divided clients into two groups:
 - Clients scheduled 9 months before the implementation of a web-based calendar system (n = 49).
 - Clients scheduled 9 months after the implementation of a web-based calendar system (n = 68).
- ◆ Computed *t*-test to explore the mean difference in “wait time” before and after implementation of the web based calendar system.
- ◆ Conducted binary logistic regression using scheduling method to predict attendance in therapy.

Results: "Wait Time": Days to First Appointment



Results: “Wait Time”: Days to First Appointment

◆ Client “wait time” was significantly less with the web-based system than with the therapist-based system $t(73) = 2.29, p < .05$, two tailed.

Method	<i>M</i>	<i>SD</i>
Therapist-based	11.67	9.26
Web-based	6.79	8.59

Results: The Impact of Scheduling Method on Attendance

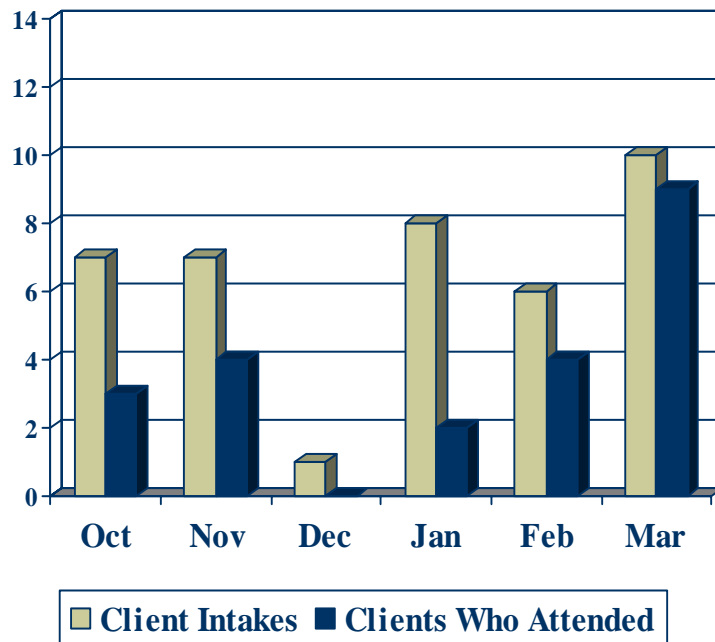
Binary logistic regression analyses were conducted to determine whether or not scheduling method predicted attendance in therapy.

Despite an insignificant result likely due to sample size, the results were in the expected direction with the odds of attendance for clients scheduled using the web-based system being 40% higher than clients scheduled with the therapist-based system.

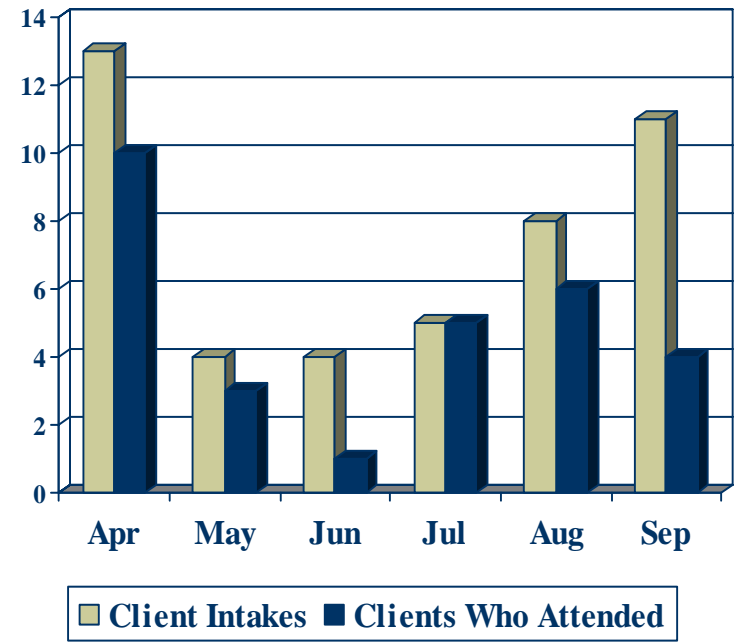
	Therapist-based Scheduling (n=49)		Web-based Scheduling (n=68)	
	n	%	n	%
Attend	28	57.14	47	69.12
Not Attend	21	42.86	21	30.88

Results: Client Intakes and Clients Who Attended

Therapist-Based Scheduling



Web-Based Scheduling



Discussion and Limitations

◆ Limitations

- No comparison group
- Insufficient power to detect impact of “wait time” on attendance in therapy.
- Does not include an entire calendar year.

◆ Discussion

- Clients benefit from a responsive intake process by receiving help when it is most needed.
- Therapists enjoy more efficient use of their time.
- The clinic is experiencing an increase in revenue as a result of increased client attendance which allows for greater financial self-sufficiency during a period of increased budgetary strain.

Future Research

- ◆ Study will include a phone call to remind new clients of their first scheduled appointment.
- ◆ Are there differences based on the type of case?
- ◆ Comparison to a clinic that uses another method of instant scheduling such as as secretary.

The Next Generation of Challenges Facing Families with HIV Infected Parents
G. B. Templeton
University of Georgia

Background: Researchers have documented risk and protective factors in children's adaptation to parental HIV illness. However, while this research contributes to our understanding of affected families, over the past decade, advances in the medical treatment of patients with HIV infection have necessitated a reexamination of the challenges these families face. Stigma, for example, may now be a source of long-lasting stress which may have a detrimental impact on family members. New stressors such as this suggest the need for ongoing investigations into the mechanisms through which families and children adapt to parental HIV illness. The goal of this study is to provide a review of the relevant literature and identify areas for further research that addresses the changing needs of families facing HIV illness.

Methods: In exploring the extant literature on how parental HIV illness impacts children, on-line periodical abstracts were extensively reviewed from the PsycINFO and Medline databases. Multiple combinations of keywords were used including parental HIV, children, parental illness, adolescent coping, adolescent development, HIV, AIDS, family coping, and family illness.


Results: Over 15 empirical articles that suggest the pathways through which children cope with and adapt to parental HIV illness were identified. The models proposed in these studies include factors such as social support, individual coping strategies, the parent-child relationship, parental emotional distress, illness severity, the marital relationship, and parenting behaviors. However, these studies fail to take into account current changes in the medical treatment of HIV infected patients.

Conclusions: Models being used to understand children's adaptation to parental HIV fail to take into account the increasingly successful treatment of HIV. This new state of affairs necessitates that researchers consider the effect from issues such as a parent's ongoing need for medical treatment, strained family relationships, enduring exposure to stigma, or prolonged contact with a preoccupied parent. Models that consider these dynamics and their impact on the family must be developed.

Objective One: Participants will identify three factors currently used to explain children's adjustment to parental HIV illness.

Objective Two: Participants will identify three new challenges facing families with HIV infected parents.

Objective Three: Participants will identify three new areas of research needed to take into account the increasingly successful medical treatment of HIV.



The Next Generation of Challenges Facing Families of HIV Infected Parents

G. Bowden Templeton

Department of Child and Family Development

University of Georgia

2005 National HIV Prevention Conference, Atlanta, GA



Background

- 15,570 HIV-infected parents dying annually (Liebowitz, Schuster, Bhattacharya, & Rotheram-Borus, 2000)
- 72,000 – 125,000 children and adolescents orphaned (American Association for World Health, 1997)



Background

- HIV and AIDS are family illness processes
 - Intergenerational transmission
 - For every infected person there are untold affected family members
- Focus of care and intervention has been primarily on the infected person



Background

- In the case of parental HIV/AIDS, children and other family members are often neglected because they are not perceived to be in immediate need
- Advances in the medical treatment of patients with HIV infection have resulted in greater control of symptoms, greater latency to infection, and prolonged length of life



Purpose

- To review the literature with regard to child and family adaptation to parental HIV and AIDS
- To document new challenges faced by families confronting parental HIV and AIDS
- To make recommendations for clinical intervention and future research



Methods

- On-line periodical abstracts extensively reviewed from the PsychINFO and Medline databases
- Multiple combinations of keywords:
 - Parental HIV
 - Parental illness
 - Children
 - Adolescent coping
 - HIV
 - AIDS
 - Family coping
 - Family illness
 - Adolescent development



Results

- Over fifteen empirical articles discuss the factors which influence families' adaptation to parental HIV/AIDS



Factors that Influence Family Adaptation to HIV/AIDS

- Illness characteristics
 - Degree of incapacitation
 - Length of time since diagnosis
 - Symptom severity
 - Illness demands
- Individual characteristics
 - Age and gender
 - Child and parent coping style
 - Parental emotional distress
 - Depression and anxiety



Factors that Influence Family Adaptation to HIV/AIDS

- Family/relational factors
 - Marital relationship
 - Nature of parent-child relationship
 - Family functioning
 - Conflict
 - Family coping
 - Adaptability and cohesion
- Community factors
 - Socio-demographics
 - Social support
 - Stigma



Prolonged Exposure to HIV/AIDS Related Stressors

- Family members of persons with HIV and AIDS cope with
 - threat of the loss of a parent/lover/spouse
 - decreased parental availability
 - increased household responsibilities
 - changes in schedules and routines
 - depletion of already stressed financial resources
 - stigma



Gaps in Literature

- Studies are cross sectional and fail to account for successful advances in medical treatment
- Studies fail to consider the implications of long term exposure to stressors/stigma



Conclusions

- HIV/AIDS patients and their families are facing a new generation of challenges brought about by improvements in medical treatment
- This necessitates a reexamination of the psychosocial issues being faced by HIV/AIDS affected families



Clinical Recommendations

- Hear the illness story from **each** family member
- Facilitate family communication as there is strength when families discuss the unspoken
 - This aligns families against stigma, promotes empathy and encourages a willingness to access testing and treatment
- Facilitate egalitarian distribution of care giving and household tasks



Clinical Recommendations

- Help families maintain age appropriate rules and behaviors
- Explore issues of meaning and faith
- Deal with long term issues, not just immediate planning
- Work with the ENTIRE family whenever and wherever appropriate...and it almost always is!!!
- Use clinical moments to talk with the ENTIRE family about sex and prevention



Research Recommendations

- How does living with uncertainty influence adaptation to parental HIV/AIDS
- Develop models which evaluate how long term exposure to stress/stigma mediates child and family outcomes with HIV/AIDS
- Develop and evaluate family based prevention programs
 - Families can be sources of support and empathy to confront stigma, thus enhancing the potential for accessing testing and treatment



Research Recommendations

- Evaluate the impact of parental HIV/AIDS on children's achievement of age appropriate developmental tasks
- Evaluate the impact that a parent's ongoing need for medical treatments and lack of physical/emotional availability has on the family
 - Might either of these findings influence how we develop prevention programs aimed at children and adolescents?



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Examining our practices of power, race and gender through discourse analysis in supervision

Abstract

A group of four students and one faculty at a MFT doctoral program experimented with a new methodology for clinical supervision. Using discursive research approaches (conversation analysis, discourse analysis and narrative analysis) we critically examined and discussed exemplars of our own clinical practices. Employing individual reflections and group discussion, this approach led each person to a deeper and richer understanding of his/her clinical skills. While the analytical focus was on micro-practices occurring in-session, each person found applications to macro issues of clinical practice and theory development. Additionally, this approach brought out dynamic self-of-therapist issues and revealed many unnoticed, but influential practices.

The procedure we followed included each person selecting a 10-minute segment from one of his/her own sessions, transcribing it, doing preliminary analysis, and then presenting the tape and transcripts to the group. The video and transcripts provided an exceptionally strong evidence base for discussion. While labor and time intensive, the rewards were very rich. This pedagogical approach has brought in discussions ranging from issues of therapist's power, use of pronouns, body language, use of pauses, turn-taking, issues of gender, issues of race, development of clinical theory, narrative theory, and self-of-therapist issues. Our workshop will present the methods and procedures of using this approach. We will present examples of the transcripts and analysis. Guidelines for using this approach for supervision will be shared.

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Date: Wed, 9 Feb 2005 11:19:38 -0500

From: "Jerry Gale" <jgale@fcs.uga.edu> [Add To Address Book](#) | [This is Spam](#)

Subject: Fw: AFTA-IFTA 2005 / Acceptance Letter

To: <shaynea@uga.edu>, "nicole childs" <whasaboutit@aol.com>, "Latrina Slater" <latrinaslater@msn.com>, "Bowden Templeton" <BOWDENT@uga.edu>

we are in!!!

----- Original Message -----

From: [Scientific AFTA-IFTA 2005](#)

To: jgale@fcs.uga.edu

Sent: Wednesday, February 09, 2005 10:54 AM

Subject: AFTA-IFTA 2005 / Acceptance Letter

Dear Jerry Gale,

We are pleased to inform you that your abstract entitled **"Examining Our Practices of Power, Race and Gender through Discourse Analysis in Supervision"** has been accepted for the AFTA-IFTA 2005 International Conference on Family Therapy to be held on June 22-25 in Washington, DC, United States. We are honored to extend an invitation to you and your colleagues to attend the conference.

We have received an overwhelmingly large number of abstract submissions. It is our desire to give many people an opportunity to share their work and consequently, because of considerations of space, we have sometimes had to put presentations in other categories than the one applied for.

You have been accepted into the category of "**45-minute Workshop**", and you will be informed of the exact date and time of your presentation in the near future. Please be advised that we are not able to provide any funds for travel, registration, or accommodations for your attendance at this conference.

We look forward to your participation and believe this conference holds promise for new connections, intellectually and personally, that can help us meet the needs of families in a changing world.

A comprehensive guide about the program, registration, abstract submission, and housing and travel can be viewed on the Internet at www.afta-ifta2005.org.

Should you or the embassy/consulate need more information, please contact the Conference Secretariat at (+90 212) 299 9980 (voice), (+1 202) 318 0217 (fax), or via email at secretariat@afta-ifta2005.org.

Sincerely,

Jane Ariel

Conference Co-Chair, AFTA

Chana Winer

Conference Co-Chair, IFTA

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Examining Our Practices of Power, Race, and Gender through Discourse Analysis in Supervision

Jerry Gale, G. Bowden Templeton, Shayne R. Anderson, Nicole M. Childs, and LaTrina M. Slater¹
Department of Child and Family Development, Marriage and Family Therapy Program, The University of Georgia
AFTA-IFTA International Conference on Family Therapy, June 22-25, 2005, Washington, D.C.

I. THE RESEARCH QUESTION

The question of relevance is *how*. How does each micro-detail of interaction contribute to the construction and maintenance of the context in which the talk occurs? Examples of research questions include:

- How a solution focused therapist achieves solution talk in therapy (Gale & Newfield, 1992)
- How supervisors and supervisees deal with disagreement (Ratliff, 1992)
- How families decide on hospitalization of members with psychological problems (Holstein, 1988)
- How blame accounts are used in marital therapy (Buttney, 1990)
- How clients in a family therapy session construct family patterns (Stamp, 1991)
- How doctors engage with patients with psychotic illness during a routine consultation (McCabe, Heath, Burns, & Priebe, 2000)

The data in CA are naturally occurring interactions drawn from purposeful samples. These interactions are represented through video or audio tape recordings that are transcribed for further analysis. ten Have (1999) suggests that the recording is the actual data and that transcripts are an aid through which we can view the data in more detail. The data may also be derived from examples of similar interactions such as initiating a phone call such as to 911. In CA, the data may be quite brief or quite extensive as in Gale (1991) which details an entire solution focused therapy session.

II. RECOMMENDATIONS FOR TRANSCRIPTION

- Use quality recording equipment
 - Video has advantages in that you can see facial expressions, gestures, and eye contact
 - Audio equipment should be of the highest quality possible as clarity of sound is necessary.
- Record an audio tape from the video (direct feed from audio out on video player to audio in on audio recorder)
- Do it yourself...there is no substitute for time invested
- Immerse yourself in the data...this helps you recognize patterns and categories
- Listen to the recordings with colleagues...they will notice things that you didn't thus contributing to the transcription and analysis
- Use a transcription machine...it eases the process...
 - Talk is slowed down such that good typists can type as they listen
 - Slowed down talk allows for better hearing allowing the researcher to distinguish overlapped talk and clarify hard to hear sounds
 - The tape machine backtracks automatically
 - When a foot pedal is included, hands are free to type rather than move back and forth between the keyboard and transcription machine

III. ANALYSIS

A. RECOMMENDED STRATEGIES

- Schegloff (as cited by ten Have, 1999, p. 104) describes a strategy for initial readings of a transcript
 - Read the transcript carefully looking for illustrations of turn-taking: how turns, pauses, and overlaps are constructed; note any instances of turn taking that stand out, particularly any disturbances in the fluency of turn taking.
 - Next read the transcript for sequences in the transcript: for example, adjacency pairs and how they are resolved.
 - Finally, note any repairs in the interaction.
- Pomerantz and Fehr (1997) suggest a five step analytic process:
 - Decide on a sequence to investigate
 - Describe the actions in the sequence
 - Consider how the speaker's packaging of actions, including their selection of reference terms, provides a certain understanding of the action performed and the matters talked about. How does this influence the options that are available for the respondent?

¹ All authors share equal contributions in the preparation of this presentation.

- Think about how the timing and taking of turns creates certain understandings of these actions and the matters being talked about
- Think about how the manner in which these actions were achieved implicates identities, roles, and relationships for the participants
- If a researcher is interested in investigating the features of institutional talk, Heritage (1997, p. 164) proposes six places to probe for the institutional nature of interaction.
 - Turn-taking
 - The overall structural organization of the interaction
 - Sequence organization
 - Turn design
 - The words that are used in interaction
 - Epistemological and other forms of asymmetry
- ten Have (1999) proposes an additional analytic strategy:
 - Read through the transcript looking for organization in the interaction
 - turn-taking organization
 - sequence organization
 - repair organization
 - organization of turn construction and design
 - Consider what are the practices relevant to these organizational features
 - Present “remarks” or “codes and observation” as “analytic descriptions” either on the transcript or in separate columns.
 - Begin to formulate some general observations, statements, or rules about what is being seen.

B. PATTERNS OF TALK IN INTERACTION (GALE, 1993; GALE, 1996)

- A **transition relevance place (TRP)** represents an opportunity in a conversation when a transition from one speaker to another is possible. TRP’s may be accomplished in several different ways: Current speaker selects the next speaker either verbally or non-verbally or the listener selects him/herself as the next speaker. When there is no preselection or self-selection, then the speaker may choose to continue.
Things to consider when examining TRP’s:
 - How does the therapist/client get his/her turn?
 - How do the various speakers compete for a turn?
 - How are interruptions avoided or elicited?
 - How are narrative accounts collaboratively constructed through the negotiation of turns?
 - How are gender differences displayed through turn-taking sequences?
 - How are power issues displayed through turn-taking sequences?
 - How are narrative themes constructed and managed through turn preference and domination?
- **Adjacency pairs** are sequentially paired actions in that the action of the first part of the sequence requires a reciprocal second action (such as a summons and response, question and answer, invitation and response). Adjacency pairs are two turns for which the first creates the expectation of a particular type of second.
Things to consider when examining adjacency pairs:
 - How are questions posed/constructed?
 - Who responds to questions?
 - How are questions not answered or avoided?
 - What assumptions are embedded within a question or response?
 - What do the question/response situations imply about the relationship between participants?
 - What questions are not asked?
 - What accomplishment or goal is the first paired part attempting to achieve?
- **Presequences** are used to check out a situation for committing to an action. They are used to feel out the participants to see if they are receptive to dealing directly with the material. They may be used to determine which story is pursued when there are several possibilities. They are like tentative actions.
Things to consider when examining presequences:
 - How does the therapist set up requests for descriptions, accounts, and tasks?
 - How do clients set up issues or requests of other participants?
 - How are issues avoided?
 - How does the therapist avoid getting a negative response (denial or refusal)?
 - How are particular speakers selected to respond?
 - What assumptions are embedded in presequenced statements that may contribute to a particular narrative?

- How are minimal cues (verbal and non-verbal) conveyed that express support or rejection of a presequence?
 - **Formulations** provide a summary of what another participant has said. While the formulation is restating the gist of what another participant has said it also may focus ensuing conversation on an element thought to be of importance. Things to consider when examining formulations:
 - Who does the formulation?
 - How is the formulation constructed?
 - What assumptions or suppositions does the formulation imply?
 - What changes from previous talk are introduced or deleted into a formulation?
 - How are formulations used to change topics or maneuver the narrative?
 - When are formulations presented in the narrative?
 - How are issues of power demonstrated through formulations?
 - **Accounts** are the explanations people have for their actions (often unusual or unexpected types of behavior). Accounts may include excuses, justifications, apologies, or requests. Things to consider when examining accounts:
 - What type of account is being employed (justification, excuse, apology, etc.)?
 - How is the account being used accomplish a particular function?
 - Where is the account placed in the sequence of activities, and what implications does this placement have?
 - How are accounts used by participants to avoid or accept responsibility?
 - How are accounts used with assigning and carrying out tasks?
 - How are accounts used to revise history?
 - How do other participants accept or reject the speaker's account?
 - **Repairs** are moves to correct what people think is a mistake or a misunderstanding. Things to consider when examining repairs:
 - How do participants recognize the need for repair?
 - How are repairs initiated and who initiates them?
 - How do the participants know that the repair has been effective?
-

IV. STRATEGIES OF TRUSTWORTHINESS

- Credibility through prolonged engagement and persistent observation.
 - Repeated listening to and/or observing the tape
 - Continually refining the transcript
 - Sharing the tape and transcript with colleagues to refine the transcript and discuss themes
 - Maintaining an audit journal
 - Find negative case examples or deviant examples
 - Instances in which the speakers depart from the typical patterns they have established
 - Show how speakers orient to this change in the conversation
 - Use of repeated examples to support claims regarding patterns and themes
 - Provide examples of text for readers so that they can develop their own conclusions as well as a sense of the trustworthiness of the data and analysis
 - Provide detailed description of the procedures used by the researcher
 - Provide complete transcripts, video, and/or audio tape for review/replication by others
-

V. STRENGTHS AND WEAKNESSES

- Focus on interaction - how participants achieve and demonstrate meaning
- Excellent tool for evaluating how language creates social identity and relationships
- Empirically rigorous
 - Studies appearing in British Medical Journal, Journal of Marriage and the Family, Family Process...journals that traditionally you expect to find quantitative articles
- Potentially limited in that the researcher's perspective is the instrument through which data is filtered thus inviting bias and limited outlook
- Transcripts can only offer a limited illustration of interaction and cannot capture the complexities of actual talk – restricted database
- Reductionistic – by focusing on minutia you ignore social and political issues such as power and inequality

- Edwards and Potter (1992) counter that issues of power and culture are inherent in the actual talk and thus can be accounted for in the talk
- You must know the cultural context of the interaction as the same interaction may produce different results in different cultures

VI. USEFUL SKILLS

- Self-reflective stance
- Openness and willingness to challenge dominant but unseen discourse
- Lots of patience
- Commitment in terms of time and energy
- Viewing the text with fresh eyes and ears...looking at the data through your own eyes and experiences while remaining open to other possibilities
- Being mindful not to attribute motive and meaning beyond what speakers actually present
- Being able to synthesize multiple dynamics (e.g. themes, categories, patterns) and put them together in a meaningful way

VII. TIME COMMITMENT

- CA is extremely time intensive
 - Transcription is an ongoing process of refining the representation of spoken word in text
 - Depends on the level of transcription you want to achieve
 - Analysis
 - For even a ten minute segment of tape, we have spent approximately 20 hours analyzing our transcripts
 - Reporting
- And worth every minute of it

VIII. RESOURCES

WEBSITES

- <http://www.sscnet.ucla.edu/soc/faculty/schegloff/>: Schegloff's (one of the colleagues of Sacks at UC Berkeley) website. It contains links to all of his published works as well as audio clips for each article.
- <http://www.sscnet.ucla.edu/soc/faculty/schegloff/TranscriptionProject/index.html> : This is a great link to the transcription symbols for conversation analysis produced by Schegloff. It provides a tutorial of how each symbol is used with textual and audio examples.
- <http://www2.fmg.uva.nl/emca/> : *Ethno/CA News* Paul ten Have's website with great resources on CA. Called by many the most comprehensive source of information about CA.
- <http://www-staff.lboro.ac.uk/~ssca1/intro1.htm> : This is a link to an introductory tutorial on conversation analysis. It provides audio and video clips of a transaction and has a step-by-step tutorial on working through the transcription and analysis process.
- <http://www-staff.lboro.ac.uk/~ssca1/links.htm> : Page provides useful links to Conversation Analysis sites on the web.

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Examining Our Practices of Power, Race, and Gender through Discourse Analysis in Supervision

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Clinical Consultations

Friday, June 24

2:00 – 3:30 PM

Chair: *Celia Falicov (USA)*

(Please feel free to sit in on discussions to stimulate your own thinking even if you do not present a case)

Senior clinician Celia Falicov will consult by applying her MECA (multidimensional, ecosystemic, comparative approach) to articulate cultural issues and social justice thinking to the presenting concerns and the potential avenues for change. Please email her at cfalicov@ucsd.edu if you would like to present a case for consultation.

Research Consultations

Friday, June 24

2:00 – 3:30 PM

Chairs: *Beatrice Wood and Victoria Mitrani (USA)*

Members of AFTA's Research Committee will collaborate with participants in the session to provide peer consultations to individuals at any stage of the research process. If you would like to obtain consultation on a particular project, or would like to discuss more general research issues, please e-mail Beatrice (Betsy) Wood at: bwood@buffalo.edu. Please feel free to join us for the discussion even if you are not requesting a research consultation.

45 Minute Workshops

Friday, June 24

2:45 – 3:30 PM

14. Aging Family Relationships: Resiliency and Vulnerability to Elder Abuse Across Ethnic Groups

Jonathan Appel, Dohlee Kim-Appel (USA)

With the explosion of an aging population, the topic of elderly abuse warrants great attention. Participants will explore strengths and limitations of a systems approach for working conjointly with aging families. Through interaction, participants will receive information to identify high-risk families across ethnic backgrounds, assess the current protection laws, and explore intervention, education and prevention strategies, family configurations, and service utilization. This workshop will be a mix of didactic lecture, interactive discussion, case processing, and use of handouts.

16. Examining our Practices of Power, Race and Gender through Discourse Analysis in Supervision

Jerry Gale, Bowden Templeton, LaTrina Slater, Shayne Anderson, Nicole Childs (USA)

Four students and one faculty member at a MFT doctoral program experimented with a new methodology for clinical supervision. Using discourse and narrative analysis we critically examined exemplars of our clinical practices. Each person analyzed a 10-minute segment from one of his/her own sessions and presented the tape and transcripts for group discussion. Discussion topics included issues of therapist's power, verbal and non-verbal communication, issues of gender, issues of race, development of clinical theory, narrative theory, and self-of-therapist issues. This approach brought out dynamic self-of-therapist issues and revealed many unnoticed, but influential practices. Guidelines for using this approach for supervision will be shared.

AAMFT abstract 2004

Naked Truths in supervision: Discourse analysis reveals all

A group of four students and one faculty at a MFT doctoral program have been experimenting with a new methodology for clinical supervision. Through the use of discursive research approaches (conversation analysis, discourse analysis and narrative analysis) we are critically examining and discussing exemplars of our own clinical practices. This approach combines individual activities with group activities, and has led to a deeper and richer understanding of our clinical skills. While the analytical focus is on micro-practices that occur in session, each person is finding application to macro issues of clinical practice and theory development. Additionally, this approach has brought out dynamic self-of-therapist issues and revealed many unnoticed, but influential practices. Also, the group discussions have led to a stronger group connection.

The procedure we followed is that each person selected a 10-minute segment from their own session, transcribed it, did preliminary analysis, and then presented the tape and transcripts to the group. The video and transcripts provide an exceptionally strong evidence base for discussion. While labor intensive, we are spending over 10 hours per person, the rewards are very rich. This pedagogical approach has brought in discussions ranging from issues of therapist's power, use of pronouns, body language, use of pauses, turn-taking, issues of gender, issues of race, development of clinical theory, and self-of-therapist issues. We have found that even a 10-minute segment can expose all of these dynamic issues. Our discussions have also had the added benefit of creating closer interpersonal connections as well as improving our clinical skills.

Our workshop will present the methods and procedures of using this approach. We will present videotaped examples of our discussions, as well as examples of the transcripts and analysis. Guidelines for using this approach for supervision will be shared

This workshop will introduce the methods and procedures of a new approach for supervision using discursive analysis, in which brief segments of a therapist's session are analyzed at the microprocess level. We will present how supervision incorporating these details reveal unnoticed practices and provides new insight into macro-level issues such as self-of-therapist, gender, race and power.

Objectives

1. Participants will be introduced to how discursive approaches (conversation analysis, discourse analysis, narrative analysis) for examining therapy can provide a pedagogical tool for clinical supervision.
2. Participants will be taught step by step procedures for using these discursive approaches.
3. Participants will learn how examining the micro processes inherent in talk can reveal taken for granted and unseen practices that shape macro issues (gender, race, power, etc.).
4. Participants will learn how the shared activity of each person revealing unseen practices and exposing their clinical skills can benefit the group supervision process.

First, (30 minutes), this presentation will present how discursive research approaches can be applied to supervision and training. We will present the differences between conversation analysis, discourse analysis and narrative analysis and how these research approaches can be used as pedagogical tools for supervision. Handouts and transcripts will be provided to illustrate the step-by-step procedures of this application. Second (50 minutes), case examples will be presented using videotapes, audiotapes, and transcripts.

These examples will illustrate how discursive analysis of micro-level process, yields evidence-based data that provides insight into macro-level issues of power, gender and race. Third (30 minutes), we will illustrate how the use of this method in a group process allows for a richer experience of supervision, facilitates the discussion of sensitive topics, and increases group cohesion. Videotapes of group dynamics will be shown. We will also present how this method facilitates the self-of-the-therapist process in that the “naked truth” of whom you are and what you do in the therapy room is evident in this micro-level analysis. Fourth (10 minutes), to conclude this presentation, we will entertain questions, suggestions, and concerns about the use of discursive analysis for supervision in marriage and family therapy.

All of the presenters are either students or faculty in a doctoral MFT program, and all five people have presented at previous AAMFT conferences as well as at other conferences. The five presenters represent diversity in terms of gender, race, religion and SES. One of the presenters is an approved supervisor (for over 14 years) and the other presenters all have between 500 and 1000 hours of client contact. One of the presenters has published extensively on this topic and has presented workshops and institutes at previous AAMFT conferences as well as at AFTA and NCFR. Evaluations for previous AAMFT presentations by the five presenters have all been very positive. In January 2004, all of the presenters will be presenting a variation of this proposal at an international conference on qualitative research.

Naked Truths in Supervision: Discourse Analysis Reveals All

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62nd AAMFT Annual Conference, September 10, 2004, Atlanta Georgia

I. THE RESEARCH QUESTION

The question of relevance is *how*. How does each micro-detail of interaction contribute to the construction and maintenance of the context in which the talk occurs? Examples of research questions include:

- How a solution focused therapist achieves solution talk in therapy (Gale & Newfield, 1992)
- How supervisors and supervisees deal with disagreement (Ratliff, 1992)
- How families decide on hospitalization of members with psychological problems (Holstein, 1988)
- How blame accounts are used in marital therapy (Buttney, 1990)
- How clients in a family therapy session construct family patterns (Stamp, 1991)
- How doctors engage with patients with psychotic illness during a routine consultation (McCabe, Heath, Burns, & Priebe, 2000)

The data in CA are naturally occurring interactions drawn from purposeful samples. These interactions are represented through video or audio tape recordings that are transcribed for further analysis. ten Have (1999) suggests that the recording is the actual data and that transcripts are an aid through which we can view the data in more detail. The data may also be derived from examples of similar interactions such as initiating a phone call such as to 911. In CA, the data may be quite brief or quite extensive as in Gale (1991) which details an entire solution focused therapy session.

II. RECOMMENDATIONS FOR TRANSCRIPTION

- Use quality recording equipment
 - Video has advantages in that you can see facial expressions, gestures, and eye contact
 - Audio equipment should be of the highest quality possible as clarity of sound is necessary.
- Record an audio tape from the video (direct feed from audio out on video player to audio in on audio recorder)
- Do it yourself...there is no substitute for time invested
- Immerse yourself in the data...this helps you recognize patterns and categories
- Listen to the recordings with colleagues...they will notice things that you didn't thus contributing to the transcription and analysis
- Use a transcription machine...it eases the process...
 - Talk is slowed down such that good typists can type as they listen
 - Slowed down talk allows for better hearing allowing the researcher to distinguish overlapped talk and clarify hard to hear sounds
 - The tape machine backtracks automatically
 - When a foot pedal is included, hands are free to type rather than move back and forth between the keyboard and transcription machine

III. ANALYSIS

A. RECOMMENDED STRATEGIES

- Schegloff (as cited by ten Have, 1999, p. 104) describes a strategy for initial readings of a transcript
 - Read the transcript carefully looking for illustrations of turn-taking: how turns, pauses, and overlaps are constructed; note any instances of turn taking that stand out, particularly any disturbances in the fluency of turn taking.
 - Next read the transcript for sequences in the transcript: for example, adjacency pairs and how they are resolved.
 - Finally, note any repairs in the interaction.
- Pomerantz and Fehr (1997) suggest a five step analytic process:
 - Decide on a sequence to investigate
 - Describe the actions in the sequence
 - Consider how the speaker's packaging of actions, including their selection of reference terms, provides a certain understanding of the action performed and the matters talked about. How does this influence the options that are available for the respondent?
 - Think about how the timing and taking of turns creates certain understandings of these actions and the matters being talked about

¹ All authors share equal contributions in the preparation of this presentation.

- Think about how the manner in which these actions were achieved implicates identities, roles, and relationships for the participants
- If a researcher is interested in investigating the features of institutional talk, Heritage (1997, p. 164) proposes six places to probe for the institutional nature of interaction.
 - Turn-taking
 - The overall structural organization of the interaction
 - Sequence organization
 - Turn design
 - The words that are used in interaction
 - Epistemological and other forms of asymmetry
- ten Have (1999) proposes an additional analytic strategy:
 - Read through the transcript looking for organization in the interaction
 - turn-taking organization
 - sequence organization
 - repair organization
 - organization of turn construction and design
 - Consider what are the practices relevant to these organizational features
 - Present “remarks” or “codes and observation” as “analytic descriptions” either on the transcript or in separate columns.
 - Begin to formulate some general observations, statements, or rules about what is being seen.

B. PATTERNS OF TALK IN INTERACTION (GALE, 1993; GALE, 1996)

- A **transition relevance place (TRP)** represents an opportunity in a conversation when a transition from one speaker to another is possible. TRP’s may be accomplished in several different ways: Current speaker selects the next speaker either verbally or non-verbally or the listener selects him/herself as the next speaker. When there is no preselection or self-selection, then the speaker may choose to continue.
Things to consider when examining TRP’s:
 - How does the therapist/client get his/her turn?
 - How do the various speakers compete for a turn?
 - How are interruptions avoided or elicited?
 - How are narrative accounts collaboratively constructed through the negotiation of turns?
 - How are gender differences displayed through turn-taking sequences?
 - How are power issues displayed through turn-taking sequences?
 - How are narrative themes constructed and managed through turn preference and domination?
- **Adjacency pairs** are sequentially paired actions in that the action of the first part of the sequence requires a reciprocal second action (such as a summons and response, question and answer, invitation and response). Adjacency pairs are two turns for which the first creates the expectation of a particular type of second.
Things to consider when examining adjacency pairs:
 - How are questions posed/constructed?
 - Who responds to questions?
 - How are questions not answered or avoided?
 - What assumptions are embedded within a question or response?
 - What do the question/response situations imply about the relationship between participants?
 - What questions are not asked?
 - What accomplishment or goal is the first paired part attempting to achieve?
- **Presequences** are used to check out a situation for committing to an action. They are used to feel out the participants to see if they are receptive to dealing directly with the material. They may be used to determine which story is pursued when there are several possibilities. They are like tentative actions.
Things to consider when examining presequences:
 - How does the therapist set up requests for descriptions, accounts, and tasks?
 - How do clients set up issues or requests of other participants?
 - How are issues avoided?
 - How does the therapist avoid getting a negative response (denial or refusal)?
 - How are particular speakers selected to respond?
 - What assumptions are embedded in presequenced statements that may contribute to a particular narrative?
 - How are minimal cues (verbal and non-verbal) conveyed that express support or rejection of a presequence?

- **Formulations** provide a summary of what another participant has said. While the formulation is restating the gist of what another participant has said it also may focus ensuing conversation on an element thought to be of importance. Things to consider when examining formulations:
 - Who does the formulation?
 - How is the formulation constructed?
 - What assumptions or suppositions does the formulation imply?
 - What changes from previous talk are introduced or deleted into a formulation?
 - How are formulations used to change topics or maneuver the narrative?
 - When are formulations presented in the narrative?
 - How are issues of power demonstrated through formulations?

- **Accounts** are the explanations people have for their actions (often unusual or unexpected types of behavior). Accounts may include excuses, justifications, apologies, or requests. Things to consider when examining accounts:
 - What type of account is being employed (justification, excuse, apology, etc.)?
 - How is the account being used accomplish a particular function?
 - Where is the account placed in the sequence of activities, and what implications does this placement have?
 - How are accounts used by participants to avoid or accept responsibility?
 - How are accounts used with assigning and carrying out tasks?
 - How are accounts used to revise history?
 - How do other participants accept or reject the speaker's account?

- **Repairs** are moves to correct what people think is a mistake or a misunderstanding. Things to consider when examining repairs:
 - How do participants recognize the need for repair?
 - How are repairs initiated and who initiates them?
 - How do the participants know that the repair has been effective?

IV. STRATEGIES OF TRUSTWORTHINESS

- Credibility through prolonged engagement and persistent observation.
- Repeated listening to and/or observing the tape
- Continually refining the transcript
- Sharing the tape and transcript with colleagues to refine the transcript and discuss themes
- Maintaining an audit journal
- Find negative case examples or deviant examples
 - Instances in which the speakers depart from the typical patterns they have established
 - Show how speakers orient to this change in the conversation
- Use of repeated examples to support claims regarding patterns and themes
- Provide examples of text for readers so that they can develop their own conclusions as well as a sense of the trustworthiness of the data and analysis
- Provide detailed description of the procedures used by the researcher
- Provide complete transcripts, video, and/or audio tape for review/replication by others

V. STRENGTHS AND WEAKNESSES

- Focus on interaction - how participants achieve and demonstrate meaning
- Excellent tool for evaluating how language creates social identity and relationships
- Empirically rigorous
 - Studies appearing in British Medical Journal, Journal of Marriage and the Family, Family Process...journals that traditionally you expect to find quantitative articles
- Potentially limited in that the researcher's perspective is the instrument through which data is filtered thus inviting bias and limited outlook
- Transcripts can only offer a limited illustration of interaction and cannot capture the complexities of actual talk – restricted database
- Reductionistic – by focusing on minutia you ignore social and political issues such as power and inequality
 - Edwards and Potter (1992) counter that issues of power and culture are inherent in the actual talk and thus can be accounted for in the talk

- You must know the cultural context of the interaction as the same interaction may produce different results in different cultures

VI. USEFUL SKILLS

- Self-reflective stance
- Openness and willingness to challenge dominant but unseen discourse
- Lots of patience
- Commitment in terms of time and energy
- Viewing the text with fresh eyes and ears...looking at the data through your own eyes and experiences while remaining open to other possibilities
- Being mindful not to attribute motive and meaning beyond what speakers actually present
- Being able to synthesize multiple dynamics (e.g. themes, categories, patterns) and put them together in a meaningful way

VII. TIME COMMITMENT

- CA is extremely time intensive
 - Transcription is an ongoing process of refining the representation of spoken word in text
 - Depends on the level of transcription you want to achieve
 - Analysis
 - For even a ten minute segment of tape, we have spent approximately 20 hours analyzing our transcripts
 - Reporting
- And worth every minute of it

VIII. RESOURCES

WEBSITES

- <http://www.sscnet.ucla.edu/soc/faculty/schegloff/>: Schegloff's (one of the colleagues of Sacks at UC Berkeley) website. It contains links to all of his published works as well as audio clips for each article.
- <http://www.sscnet.ucla.edu/soc/faculty/schegloff/TranscriptionProject/index.html> : This is a great link to the transcription symbols for conversation analysis produced by Schegloff. It provides a tutorial of how each symbol is used with textual and audio examples.
- <http://www2.fmg.uva.nl/emca/> : *Ethno/CA News* Paul ten Have's website with great resources on CA. Called by many the most comprehensive source of information about CA.
- <http://www-staff.lboro.ac.uk/~ssca1/intro1.htm> : This is a link to an introductory tutorial on conversation analysis. It provides audio and video clips of a transaction and has a step-by-step tutorial on working through the transcription and analysis process.
- <http://www-staff.lboro.ac.uk/~ssca1/links.htm> : Page provides useful links to Conversation Analysis sites on the web.

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Naked Truths in Supervision: Discourse Analysis Reveals All

Jerry Gale, G. Bowden Templeton, La Trina M. Slater, Shayne R. Anderson, Nicole M. Childs
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 62nd AAMFT Annual Conference, September 10, 2004, Atlanta Georgia
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Naked Truths in Supervision: Discourse Analysis Reveals All

Jerry Gale, G. Bowden Templeton, La Trina M. Slater, Shayne R. Anderson, Nicole M. Childs¹
Department of Child and Family Development, The University of Georgia
62nd AAMFT Annual Conference, September 10, 2004, Atlanta Georgia

- I. Introduction
 - A. History of project
 - B. Discursive analysis (Conversation analysis, discourse analysis and narrative analysis)
- II. The basics of creating a transcript
- III. Procedures and analysis
 - A. Case selection
 - B. Case description
 - C. Processes of analysis
 - D. Themes of analysis
 - E. What each of us learned from the analysis and discussions
- IV. What we learned as a group, and ideas for and about supervision
- V. Guidelines and conclusions
- VI. Questions and discussion

Guidelines for doing discourse analysis of your own therapy

- Collaborative relationship prior to beginning the project
- Consider the goals you want to achieve, and level of intimacy which you want to strive towards
- A willingness to discuss issues of power and trust (maintaining a posture of curiosity, tentativeness, openness, and speak in order to listen)
- Basic skill set/knowledge of the process: what we present and then some good references.
- A basic respect for yourself as a therapist and for those in the group. Remember that what looks smooth to the unaided eye looks jagged and rough under a microscope. Just because we have the rough edges doesn't mean that we're not good therapists. I think that each one of us knew that Jerry and each other thought we were competent therapists prior to this process beginning.
- Application in other settings
 - Almost everything we've said can transition easily into private practice. The beauty of this to me is that the requirement that we be colleagues makes this ideal for doing supervision with your peers.
 - Consent from clients
 - Time commitment as a group not that great (1 hr or so as a group could be part of normal case review time)

¹ All authors share equal contributions in the preparation of this presentation.

TRANSCRIPT NOTATIONS

- Arrows in the margin point to the lines of transcript relevant to the point being made in the text.
- () Empty parentheses indicate talk too obscure to transcribe. Words or letters inside parentheses indicate the transcriber's best estimate of what is being said.
- hhh The letter 'h' is used to indicate hearable aspiration, its length roughly proportional to the number of 'h's. If preceded by a dot, the aspiration is an in-breath.
- [Left side brackets indicate where overlapping talk begins.
-] Right side brackets indicate where overlapping talk ends, or marks alignments within a continuing stream of overlapping talk.
- CAPITAL Words in capitals are uttered louder than the surrounding talk
- Talk appearing within degree signs is lower in volume relative to surrounding talk.
- >< Talk appearing within 'greater than' and 'less than' signs is noticeable faster than the surrounding talk.
- ((looks)) Word in double parentheses indicates transcriber's comments.
- (.08) Numbers in parentheses indicate periods of silence, in tenths of a second. A dot inside parentheses indicates a pause that is less than 0.2 seconds.
- ::: Colons indicate a lengthening of the sound just preceding them, proportional to the number of colons.
- becau- A hyphen indicates an abrupt cut-off or self-interruption of the sound in progress indicate by the preceding letter(s) (the example here represents the word because).
- He says Underlining indicates stress or emphasis.
- dr[^]ink A 'hat' or circumflex accent symbol indicates a marked raised pitch.
- = Equal signs (ordinary at the end of one line and d the start of an ensuing one) indicate a 'latched' relationship-no silence at all between them.

Title:

Enactments and Connection in Couple Therapy: A Process Study

Abstract:

In couple therapy, little is known about the interventions and mechanisms through which change occurs. One intervention that is common in many models of couple therapy is the enactment. This study examined the in-session impact of enactments on emotional connection using a single-case ABCBC design to study one 55 minute therapy session for 12 heterosexual couples during the middle stage of therapy. After a baseline period of five minutes, each couple was exposed to the intervention (enactment) and control (therapist anchored interaction) during alternating periods of 12 minutes within the session. For this study, an enactment was defined as interaction occurring primarily between partners, with the therapist actively coaching their interaction. Alternatively, therapist-anchored interaction was defined as conversation between each partner and the therapist, with the therapist actively encouraging clients to talk to them. Across both conditions, couples engaged in a discussion of a recent disagreement while the therapist blocked negativity and blaming, encouraged each partner to examine his/her role in the disagreement, and facilitated vulnerability.

Immediately after the session, couples reviewed the videotape and rated their level of emotional connection using the Perception Analyzer. The Perception Analyzer linked each partner's rating of connection to the corresponding moment in the therapy session. This allowed for a moment-by-moment account of the emotional connection experienced by each partner. Finally, couples were interviewed about their experience of each condition.

Mean comparisons of the two conditions indicated that the link between enactments and emotional connection varied by level of relational distress. Couples with greater distress reported higher ratings of connection to their partner when the therapist anchored the conversation. In contrast, couples reporting lower levels of distress rated their connection higher during the enactment. These results suggest that the use of enactments should be moderated by the relational distress being experienced by a partner.

Abstract Summary:

Little is known about the mechanisms through which change occurs in couple therapy. One common intervention across models is the enactment. Using a single case ABCBC design this study examined the in-session impact of enactments on emotional connection for 12 heterosexual couples. Results indicated that the link between emotional connection and enactments varied by level of relational distress.

Objectives:

1. Participants will understand the link between enactments and emotional connection.

2. Participants will understand the conditions under which a therapist should use enactments or therapist-anchored communication.
3. Participants will see how technology can be used to enhance our understanding of relational processes.

Presenter Experience:

All presenters have experience conducting family therapy process research. Previous work by the authors has been published in JMFT, Contemporary Family Therapy, American Journal of Family Therapy as well as other scholarly publications. Each of the authors is an experienced presenter. Combined the authors have over 50 presentations at AAMFT and other national and state conferences.

Key Concepts:

CP (Couples)

RE (Resesarch)

May 9, 2006

Abstract ID# 171

Member ID#: 98411
Shayne R. Anderson
E-mail: shaynea@uga.edu

Dear Mr. Anderson:

Congratulations! Your proposal for a poster presentation has been accepted for the 2006 AAMFT Annual Conference to be held at the Austin Convention Center in Austin, Texas on October 19 - 22. The title of your presentation is: *Enactments and Connection in Couple Therapy: A Process Study*.

POSTER PRESENTERS MUST BE PRESENT FOR THE POSTER SESSION. The poster session is scheduled for **Friday, October 20, 2006 at 4:30 PM - 6:00 PM**. During that time, be prepared to discuss your poster with conference participants. Poster presentations are of **COMPLETED RESEARCH**. If the data collections and analysis for your presentation is not completed at this time, please contact the AAMFT immediately. Please read the enclosed Instruction Sheet for further information regarding the setup of your poster.

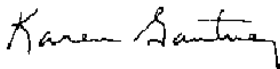
Please look over the attached "Presenter Contract and Poster Information Sheet" to verify the accepted format of the session and presenter information. This sheet must be signed and either faxed to 703-253-0509 or scanned and e-mailed to dberry@aamft.org before we can print your name in the conference brochure. Please send this document back to the AAMFT **NO LATER THAN MONDAY, MAY 15**. If you do not have access to a fax machine or scanner, please call or email Dawn Berry, Educational Program Administrator, at 703-253-0481 or dberry@aamft.org to make other arrangements.

Conference participants who attend the Poster Session will receive 1.5 hours of continuing education credit. Therefore, it is critical that presenters be present to interact with the participants for the entire time period. If you are unable to be there at that time, notify us *immediately* by calling Dawn Berry, Educational Program Administrator, at 703-253-0481.

To enhance the experience for participants, I encourage you to prepare a handout with the highlights of your presentation. Include your name and where you can be contacted for further discussion.

I would like to invite you to a dessert reception for the conference presenters in Austin on Thursday evening, October 19 at 9:00pm. I will inform you of the room locations in future correspondence, and it will also be printed in the on-site conference materials. Again, congratulations on being selected to present at the conference. See you in Austin!

Sincerely,



Karen Gautney, M.S.
Deputy Executive Director

Office Use Only:
Abstract ID: 171/ 028

POSTER SESSION CONTRACT

RETURN BY MONDAY, MAY 15 AAMFT FAX NUMBER (703)-253-0509
E-MAIL SCANNED DOCUMENTS TO DBERRY@AAMFT.ORG

Instructions: Please review and sign the contract listed below. It is your responsibility to consult your co-presenters for updates. Make any corrections directly on this sheet.

Poster Information

Accepted Format: Poster Session

Presentation Date and Time: Friday, October 20, 2006 at 4:30 PM - 6:00 PM

Title: Enactments and Connection in Couple Therapy: A Process Study

Presenters: Please review carefully for spelling errors. All presenters listed are expected to be present during your presentation. If, for any reason, a presenter is unable to attend, please contact AAMFT immediately.

Shayne R. Anderson
Susan A. Nauss

G. Bowden Templeton
F. Ryan Peterson

Lee N. Johnson

I (we) agree:

1. the **data collection and analysis for this poster is complete**. If the lead presenter is a student member, this form must be signed by your professor verifying that this is completed research.

Professor Signature

2. to receive all conference correspondence and accept responsibility for conveying conference-related information to co-presenters.
3. to obtain appropriate release(s) of copyrighted materials (including video slips, slides, cartoons and photographs) that will be used as part of this presentation.
4. that informed consent has been obtained from all research participants.
5. to present in Austin, Texas during the hour and date assigned to this presentation at the 2006 AAMFT Annual Conference and to conduct this presentation according to the conditions listed above.
6. that all presenters will register for the conference and pay all conference fees.
7. that all research presented has followed established ethical guidelines and has obtained necessary IRB approval prior to being conducted.

Signature of Lead Presenter: _____

Date: _____

Name (printed): _____

THE AAMFT POSTER SESSION INFORMATION:

Objective of the Poster Sessions:

The purpose of the poster session is to provide an opportunity for conference attendees to become acquainted with the latest information on research, program successes and practice innovations. You may choose to present your information in graphic, tabular, or chart form so as to interest the 1,500+ attendees.

An effective poster session is a highlighted synopsis of your work enabling the viewer to move quickly through your presentation. Resist the temptation to reproduce full pages of typed material. Viewers will be intrigued by crisp phrases and brief lists.

Set-Up:

Posters will be highlighted at the AAMFT Poster Session. Your poster must be set-up between 8:00am and 2:00pm on Friday, October 20. Plan to bring plenty of push pins or thumbtacks (about 50) to place your materials on the board. You may **NOT** use tape or adhesive on the boards.

Display Format and Design:

Each display is allocated a space **4 ft by 4 ft**. As a rule of thumb, six to eight individual panels are recommended for your poster. Each panel should be on heavyweight paper or lightweight cardboard so they are easy to mount to the tack board.

The poster presentation is primarily a visual one. Make maximum use of figures, graphs, diagrams and flow charts on your display panels. The major components of an effective poster presentation include:

- One panel for a brief statement of the problem.
- One panel for a brief description of the methods used.
- Three to four to show graphs of figures depicting the results.
- One panel presenting the conclusions and/or recommendations.

Tips for Preparing and Presenting Your Poster:

- Each individual panel in the display must be clearly numbered in the upper left hand corner so that viewers can quickly determine the sequence to follow.
- Be sure connection of ideas and progression of thought is clear from one panel of the poster to another.
- Use a minimum of text. Use lists or phrases instead of complete sentences when possible. Usually the total length of text for a poster presentation should not exceed 25 lines.
- A printed strip at least four inches high showing the title of the presentation and the names of the author(s) or presenter(s) should be prepared to be attached to the top of your display. Lettering for headers, such as title, should be at least 1" high and subtitles should be at least 1/2" high. Use dark block letters if possible. **REGULAR TYPEWRITER SIZE TYPE IS TOO SMALL.** Viewers will be standing from three to six feet away from the poster and lettering must be legible and visible from that distance.
- Use of color adds emphasis. Beginning with a brightly colored background and adding contrasting letters, graphs and charts is effective. Keep illustrative material bold and simple.

Handouts:

Due to popular demand, we are asking poster presenters to prepare handouts to go along with your poster. The handout can contain a synopsis of the material presented, report additional data that would not fit on the poster, give relevant readings, etc. There will be a table at each poster to hold the handouts. Since we have not done this before, we can only estimate the demand for the handouts, we suggest you bring 100. If the demand is greater, you can refer participant to the AAMFT website to the virtual poster presentation. Please hold the handouts and put them out during the Poster Session. If you have any left over, you can leave them for participants that visit the posters later in the conference.

Enactments and Connection in Couple Therapy: A Process Study

Shayne R. Anderson, M.S.

G. Bowden Templeton, M.F.T.

Lee N. Johnson, Ph.D.

Nicole M. Childs, M.S.

F. Ryan Peterson, M.S.

Department of Child and Family Development

The University of Georgia

Special thanks to Nedra Owens and Megan Goodwin for their
invaluable help with data collection and analysis.

Purpose

- ◆ To investigate the impact of enactments on emotional closeness using a single-case ABCBC design by addressing the following question...
 - Do partner's levels of emotional closeness change as a result of how talk is occurring in therapy (enactment versus therapist anchored interaction)?

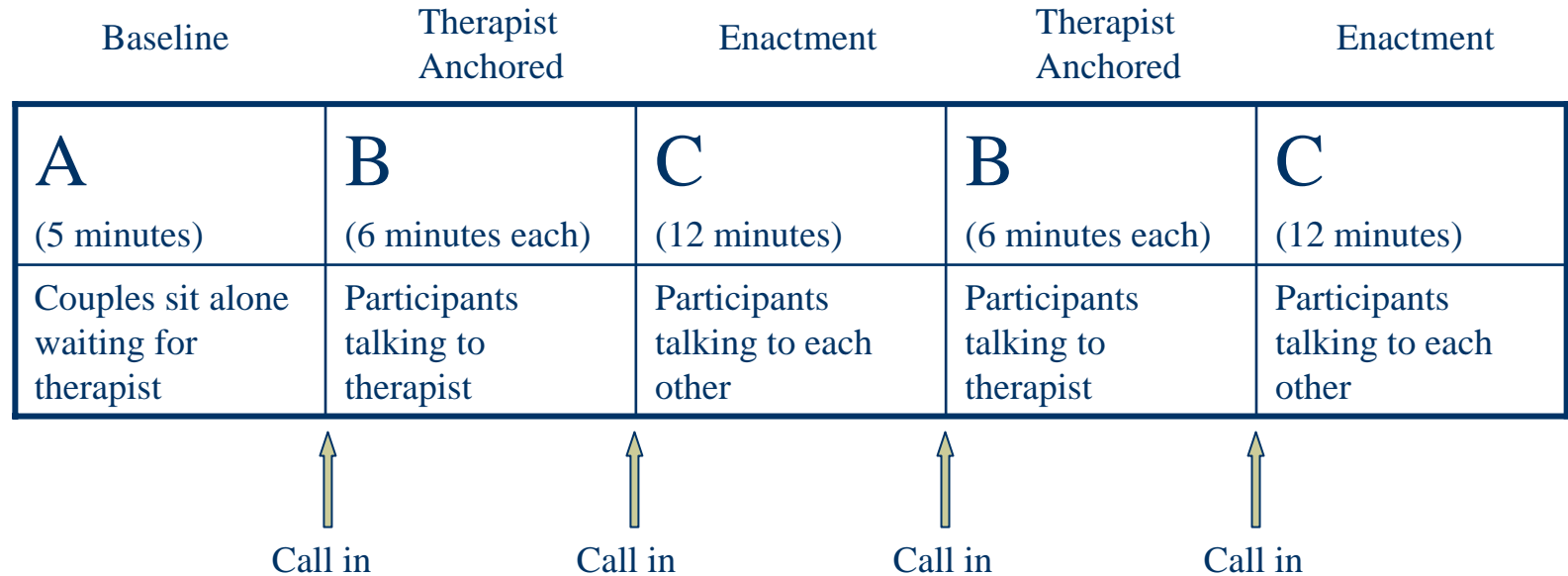
Relevant Literature

- ◆ Enactments are an important component of numerous MFT models including Structural Family Therapy, Emotionally Focused Therapy, Behavioral Marital Therapy, Integrative Couples Therapy, Narrative Therapy, and others.
- ◆ Butler and Gardner (2003) have described a developmental model for enactments as important interventions in addressing varying levels of couple reactivity and volatility.
- ◆ Anderson, Butler, and Seedall (2006) have demonstrated the importance of enactments in enhancing softening in marital therapy.

Sample

- ◆ 4 heterosexual couples.
- ◆ Mean age = 44.75 years, range = 28 – 77.
- ◆ Mean length of marriage = 29.5 months, range = 2 – 48.
- ◆ All middle class Caucasian.
- ◆ Revised Dyadic Adjustment Scale scores < 47.

Research Design



Single-Case ABCBC Design

Procedures

- ◆ One 55 minute structured therapy session during mid stages of therapy (4th through 8th sessions).
- ◆ Two conditions
 - Therapist anchored – interaction between each partner and the therapist, with the therapist actively encouraging clients to talk to them.
 - Enactment – interaction occurring primarily between the partners, with the therapist actively coaching the interaction.

Procedures

- ◆ Therapists were encouraged to
 - facilitate client focus on self rather than on other.
 - block defensiveness and hostility (discourage hard disclosures).
 - facilitate soft disclosures (getting past content to process, accessing primary emotions).

Procedures

- ◆ Immediately following the session, couples reviewed the videotape, continuously and independently rating their perceived level of emotional closeness on a scale of 0 to 100 (not close at all to very close) using a Perception Analyzer.
- ◆ The Perception Analyzer linked each partner's ratings to the corresponding moment in the session allowing for a moment-by-moment account of the emotional connection experienced by each partner.

DO ENACTMENTS PROMOTE INCREASED CLOSENESS?

		Couple 1		Couple 2		Couple 3		Couple 4	
		H	W	H	W	H	W	H	W
TA	X (SD)	81.5 (21.3)	80.0 (13.8)	40.7 (26.3)	41.3 (18.7)	90 (0.0)	77.7 (14.8)	87.5 (4.6)	72.7 (2.5)
EN	X (SD)	61.2 (33.0)	90.8 (9.4)	60.2 (28.3)	49.4 (16.5)	86.3 (5.8)	75.6 (20.9)	94.8 (2.4)	90.2 (4.6)
X diff		-20.3	10.8	19.5	8.1	-3.7	-2.1	7.3	17.5
T (df)		20.5* (2763)	-25.4* (2639)	-19.4* (2942)	-12.5* (2929)	24.3* (1438)	3.1* (2585)	-36.2* (934)	-89.4* (1164)
N		EN: 1604	TA: 1516	EN: 1430	TA: 1430	EN: 1439	TA: 1450	EN: 736	TA: 637

* P < .00

¹: TA = Therapist Anchored Communication

²: EN = Enactment

Mean Difference in Closeness

Enactment mean – Therapist Anchored mean

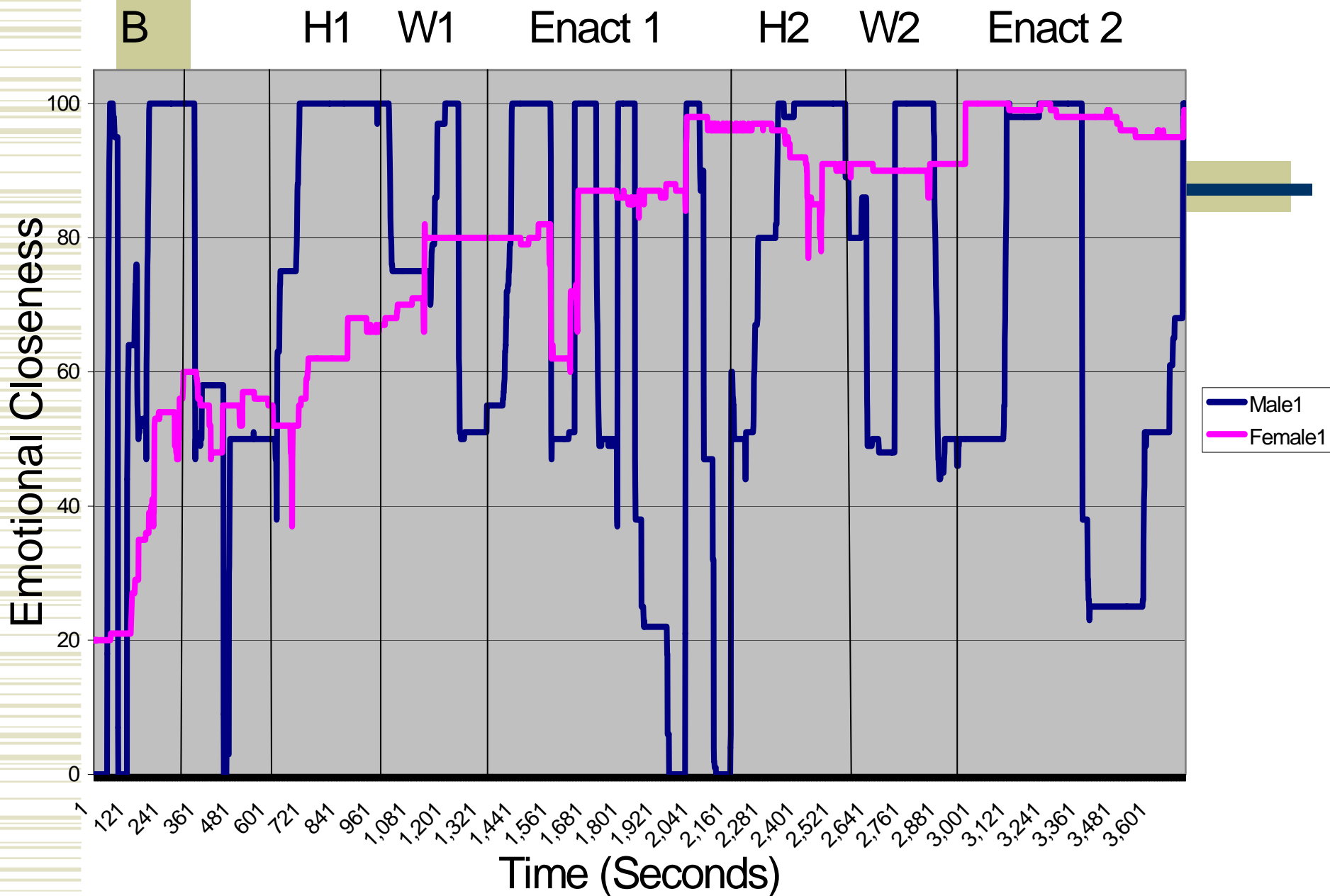
Couple				
	1	2	3	4
Husband	-20.3*	19.5*	-3.7*	7.3*
Wife	10.8*	8.1*	-2.1*	17.5*

* p < .001

Mean Differences

- ◆ Mean of emotional closeness was generally higher for participants during enactments compared to therapist anchored conversation.
- ◆ Assumption of independence was violated so visual inspection of data can help better understand the data.

Couple 1



Couple 2

Base

W1

H1

Enact 1

W2

H2

Enact 2

Emotional Closeness

100

80

60

40

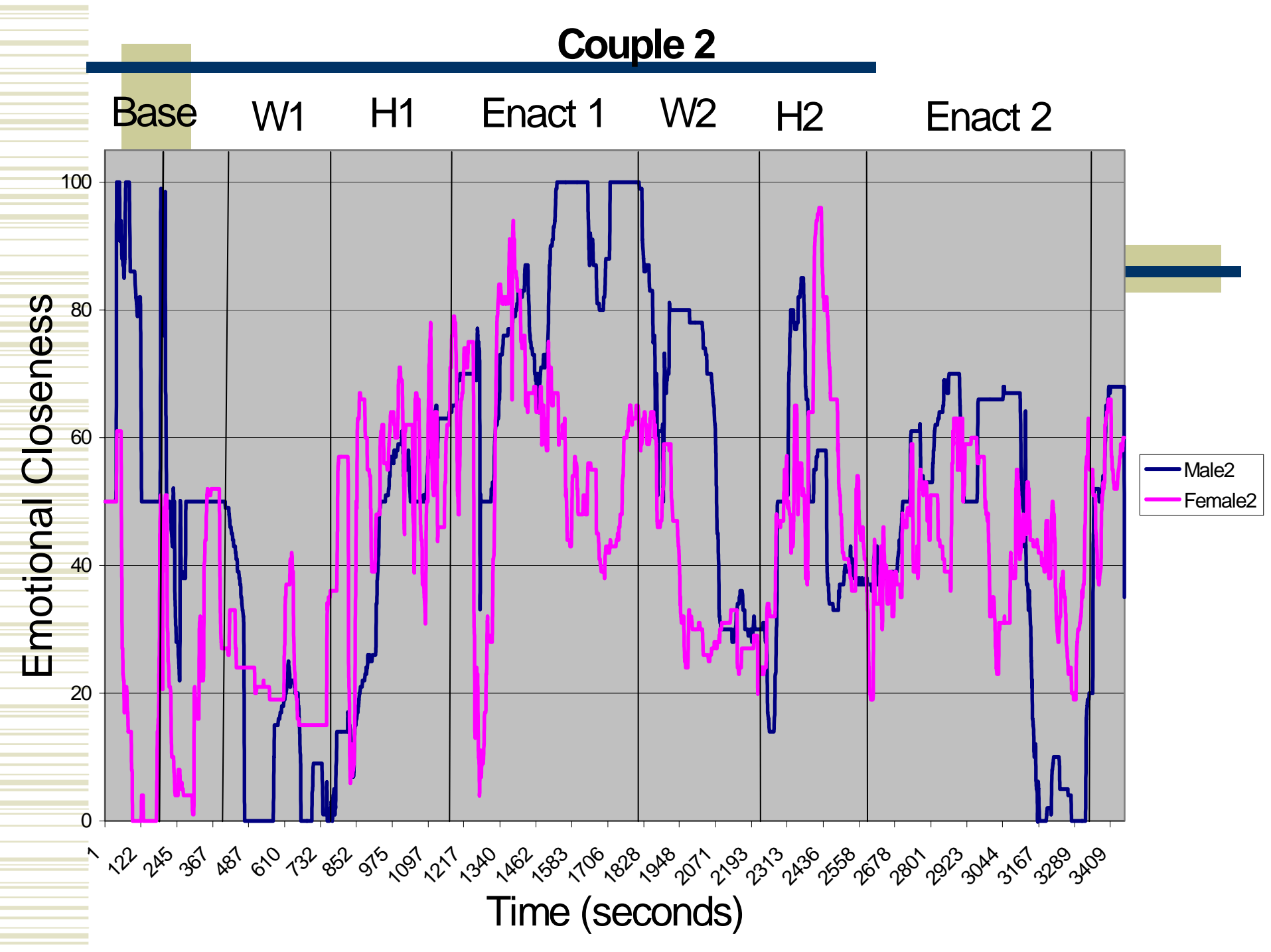
20

0

1 122 245 367 487 610 732 852 975 1097 1217 1340 1462 1583 1706 1828 1948 2071 2193 2313 2436 2558 2678 2801 2923 3044 3167 3289 3409

Time (seconds)

Male2
Female2



Couple 3

B

H1

W1

Enact 1

H2

W2

Enact 2

Emotional Closeness

100

80

60

40

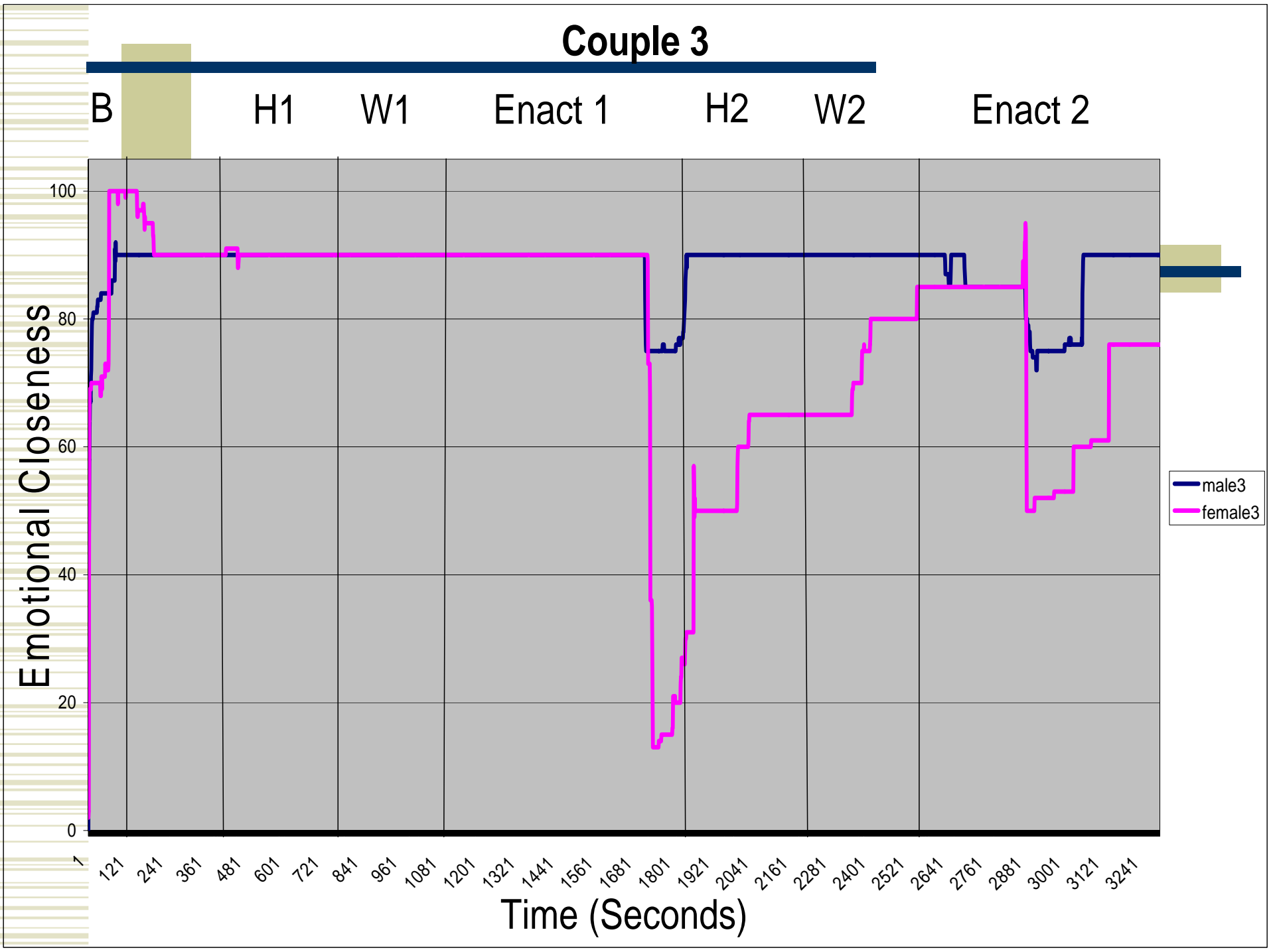
20

0

male3
female3

1 121 241 361 481 601 721 841 961 1081 1201 1321 1441 1561 1681 1801 1921 2041 2161 2281 2401 2521 2641 2761 2881 3001 3121 3241

Time (Seconds)



Couple 4

H2

W2

Enact 2

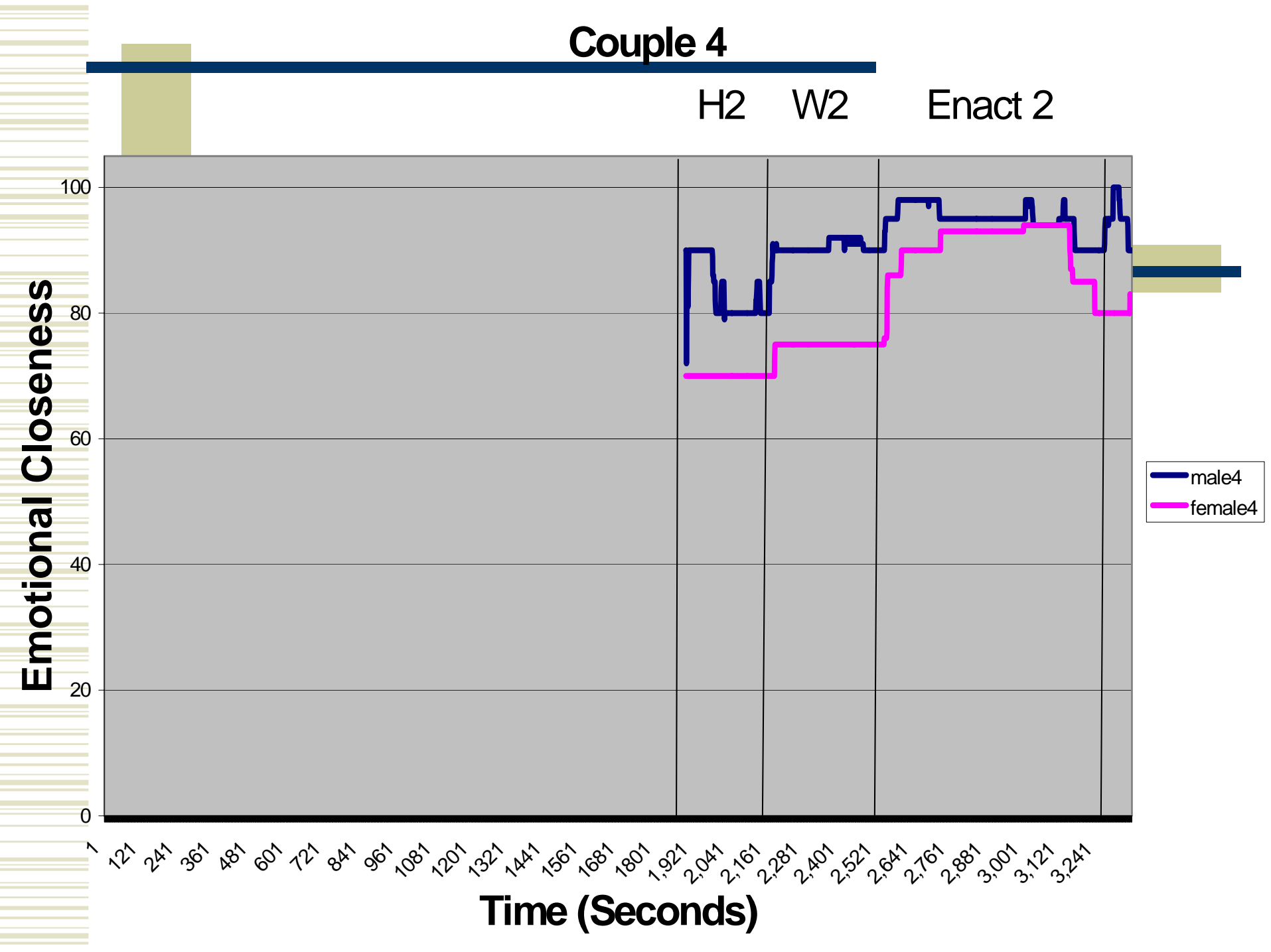
Emotional Closeness

100
80
60
40
20
0

male4
female4

1 121 241 361 481 601 721 841 961 1081 1201 1321 1441 1561 1681 1801 1,921 2,041 2,161 2,281 2,401 2,521 2,641 2,761 2,881 3,001 3,121 3,241

Time (Seconds)



Summary of Visual Inspection

- ◆ Gains during enactments rely upon gains during therapist anchored conversations, suggesting the importance of alternating between the two modalities during the 4th to 8th session. This would support EFT's model of processing within individual and then between partners as well as Butler's stage model of using enactments.
- ◆ As therapists work with one partner the other partner's feeling of closeness can be altered as well. Both the enactment and therapist anchored portions were given precise directions on what each partner was to do during each phase. Butler and others have discussed the importance of prepping couples for enactments. What this may suggest is that when they are prepped well and reminded of what they are to do therapist anchored conversations (what Butler refers to as stage 1 and 2 enactments) can be beneficial for both the speaking and listening partner.

Summary of Visual Inspection

- ◆ Couples with greater relational distress (RDAS mean of couples 1 & 2 = 36.75; couples 3 & 4 = 47.75) have increased variability in closeness. They are more reactive. In post-session interviews couples 1 and 2 made particular mention of the importance of the structure of the session, suggesting that it provided a structured, safe mechanism to get the husbands emotionally involved.
- ◆ Couples are most reactive when interacting together (baseline & enactment). Therapists need to be particularly attuned to blocking negativity during enactments. Therapists in this sample were trained to immediately block and redirect negativity. It is important to note that decreases in negativity were quickly turned and post-session interviews with these couples have indicated that these sessions have been extremely helpful.