

Bonus Chapter 2

Empirically Informing Integrative Systemic Therapy (IST)

The core of this book and perspective, the Integrative Systemic Therapy (IST) Blueprint, is a clinical-experimental process for decision making in therapy. Consisting of four components—hypothesizing, planning, conversing and reading feedback—the blueprint is the process by which hypotheses about the relational and problem-solving tasks of therapy are generated, tested and progressively refined until clients solve their presenting problems. The Blueprint provides the practical basis for integrating strategies from various models of therapy and the logical basis for empirically informed problem solving. IST is empirically informed as scientific findings are incorporated into hypothesizing and planning, when plans incorporate interventions from empirically-supported models, and/or when empirical feedback is provided by clients and incorporated into decision making. This chapter focuses on the last option and details the clinical use of a measurement and feedback system that was developed in concert with IST.

The Empirical Transformation of Psychotherapy

Over the last 25 years, an empirical transformation has been slowly gaining strength as it rolls across the field of psychotherapy. The imperative at the core of this transformation is that psychotherapy needs to be driven or informed by some kind of scientific data. This fundamental shift in what is expected of therapy impacts two dimensions. The first is policy. Scientific evidence has become an essential hallmark of psychotherapeutic policy—how practice should be done. Increasingly, third party payers, professional organizations and boards of directors of mental health organizations are insisting that the treatments their therapists provide must be empirically supported or informed. The second level is practice—how practice is done. At this level, therapists are increasingly following treatment protocols or manuals that specify what

should be done when with particular types of clients. Alternatively, or complementarily, therapists are using data they collect from patients at the beginning of therapy and/or during its course to inform assessment and/or clinical decision making.

This transformation started primarily within individual therapy but quickly spread into couple and family therapy. It began with behavioral and cognitive behavioral treatment models in each of the three modalities, but has progressively encompassed other models, including emotionally focused, psychodynamic, multisystemic and functional therapies. There have been two primary strategies for bringing science into treatment.

Empirically Supported Treatments

Empirically supported treatments (ESTs) are treatments that have been manualized and tested in some form of randomized clinical trial. In the randomized clinical trial, the EST has been shown to be more effective for treating some specific disorder than a “no-treatment” or waiting-list control condition (the lowest criterion for empirical support), better than a “treatment-as-usual” condition (a moderate criterion) or as effective as or better than another empirically supported treatment (the highest criterion). Typically, effectiveness (or efficacy) is evaluated in regard to pre–post changes on specified outcome measures and/or the effect sizes of the changes. ESTs are politically important in the legitimization of psychotherapy in general as well as the validation of specific psychotherapies. Coupled with adherence ratings that measure actual therapist “adherence” to the manualized treatment protocol, ESTs are also useful in training therapists to be “competent” providers of particular models of psychotherapy. However, there are a host of problems with ESTs once they leave the laboratory or original context in which they were developed.

First, when ESTs are tested by researchers and clinicians who have not developed them or in community settings, their success or effectiveness rates usually deteriorate. Second, experienced therapists outside of academic contexts do not like to follow manualized procedures once they become proficient in their use. Third, the randomized clinical trials in which ESTs are tested typically do not measure client progress. Fourth, the manualized treatments do not permit significant deviation in response to the inevitable vicissitudes of the clinical process. Manualized treatments intentionally constrain therapists and preclude or minimize their capacity to use their intuition and/or improvise in response to client behaviors. Lastly, ESTs are developed to address particular disorders with particular types of clients who just have that disorder (and no other) at a level that meets certain diagnostic criteria. In actual practice, most clients have multiple problems at different levels of severity (e.g. depression and marital conflict; familial cut-off and anxiety; alcohol dependence and obsessive-compulsive disorder, etc.). To state the obvious, clients in the real world, as opposed to most research settings, do not come so neatly and distinctly disordered.

ESTs are based on group or nomothetic data. In essence, they say, “with this type of client with this type of problem, this is the prescribed course of therapy.” They do not give the therapist idiographic or longitudinal data. Therapists need specific information about the specific case they are treating at the beginning of therapy as well as over the course of therapy, in order to assess how the case is responding to the therapist’s interventions. This last point is particularly relevant in regard to IST’s view of assessment and intervention as two coextensive processes, guided by the blueprint, that span the course of therapy. ESTs do not penetrate to that level of specificity at the beginning or over the course of therapy.

Empirically Informed Psychotherapy

An alternative or complement to ESTs in the empirical revolution, empirically informed therapies (EIPs), avoid the abovementioned problems with ESTs, yet bring science and data fully into the psychotherapeutic process. Whereas ESTs are therapist-focused, primarily addressing and evaluating the extent to which the therapist competently performs the prescribed behaviors, EIPs are client-focused (Lambert, Hansen, & Finch, 2001; Lutz, 2002), targeting client behavior (and progress) over the course of therapy. EIPs integrate the historical distinction between process and outcome research (Greenberg & Pinsof, 1986), focusing on the “process of outcome.”

The hallmark of empirically informed psychotherapies is that they use a measurement and feedback system (MFS) to measure client behavior over the course of therapy and then provide data about these client behaviors to therapists and other clinical stakeholders (including the clients themselves). By definition, an MFS is quantitative—it measures some aspect of client behavior or experience and feeds back some numerical indicator about that behavior or experience. MFSs can differ in a variety of ways (Pinsof, Tilden, & Goldsmith, 2015), including, but not limited to: a) their frequency of measurement over the course of therapy; b) the extent to which they involve an empirical assessment of a client system; c) their technological sophistication (paper/pencil, online, etc.); d) their interpersonal focus (individual, dyad, family, multiple-systems, etc.); e) the extent to which they integrate the empirical feedback into the clinical process (used only by therapist, shared with clients, used as a clinical tool, etc.); f) their dimensionality (multiple versus singular); and g) their globality versus molecularity.

In contrast to ESTs, EIPs do not attempt to constrain or control therapist behavior. The therapist and clients can use the feedback to inform their clinical decision making and planning

any way they see fit. As such, EIPs respect the improvisational and idiographic nature of therapy. Additionally, when the experience of each client in the therapy is measured, EIPs give the client's experience a structured and explicit voice in their therapy. Furthermore, using MFS data with clients facilitates collaborative assessment, planning and progress evaluation. This makes clients investigative partners in their own therapy and contributes to the formation and maintenance of the therapeutic alliance. EIPs bring science into therapy to facilitate accountability, adaptability and responsiveness. Lastly, research consistently demonstrates that using an MFS with virtually any treatment (including ESTs) significantly improves outcomes. In other words, feedback improves effectiveness (Shimokawa, Lambert, & Smart, 2010; Pinsof, Tilden, & Goldsmith, 2016).

The Systemic Therapy Inventory of Change—STIC

The Systemic Therapy Inventory of Change (STIC) is an MFS that was designed explicitly to fit the pillars and guidelines of Integrative Systemic Therapy (IST). At the time of this writing it is being used clinically at the Family Institute at Northwestern University, at the Momentous Institute in Dallas, and at a consortium of mental health centers in Norway. The Northwestern and Norwegian centers have also been conducting a randomized clinical trial testing whether using the STIC, as an integral practice component, improves outcomes over treatment as usual without the STIC. Of the existing MFSs in the field of psychotherapy, it is the most multisystemic, multidimensional and uses the most sophisticated and modern information technology to collect, measure, feedback and display client change data. The STIC focuses on client system assessment, evaluates progress every session and links the tracking of client change/progress to the assessment of the client system's presenting problems and major constraints.

The STIC and IST

The IST perspective can be used without employing MFSs or by employing MFSs other than the STIC. However, we believe that, consistent with the findings from research on the added benefits of using MFSs, the effectiveness and efficiency of any psychotherapeutic model or perspective will be enhanced with the use of MFSs. That the STIC was explicitly designed to fit IST makes it the ideal, but not the necessary or only MFS that can be used to empirically inform IST practice.

Although to date IST has not undergone a randomized clinical trial and, as such, is not an EST, there is some empirical evidence to support its effectiveness. Knobloch-Fedders, Pinsof, and Haase (2015) conducted a single group outcome analysis of couple therapy using the IST model and found effect sizes that supported the effectiveness of IST. Used in concert with the STIC, IST fully integrates science and empirical data into its practice. As such, IST with the STIC becomes an EIP, using scientific data to inform clinical decision making throughout the course of therapy.

The STIC embodies three components. The first is the STIC Initial, a set of questionnaires that each client in the direct system fills out before the first session. The second is the STIC Intersession, a shorter version of the questionnaires in the Initial plus a brief Integrative Psychotherapy Alliance Questionnaire (Pinsof, Zinbarg, & Knobloch-Fedders, 2008) that each client in the direct system fills out before every session after the first. The third component is the STIC data collection and feedback system that collects and analyzes data and feeds them back to therapists via email and the internet.

The STIC Initial

The STIC Initial consists of a detailed demographic questionnaire and six “system scales.” Integrated with the hypothesizing metaframeworks, the demographic questionnaire helps to locate each client in regard to their culture, developmental stage, life/organization, and gender/sexual contexts. The six “system” questionnaires deal with six systems that typically comprise the “intimate” client system. The Individual Problems and Strengths (IPS) Scale addresses an adult or adolescent client’s perspective on their functioning and well-being. The Family-of-Origin (FOO) Scale addresses each adult client’s recollection of their family-of-origin when they were growing up as well as the status of current relationships with their family-of-origin members. Relationship with Partner (RWP) addresses a partnered client’s perspective on their relationship with their partner. Family-Household (FH) addresses a parent-client’s or an adolescent-client’s experience of their current nuclear family. Child Problems and Strengths (CPS) addresses a parent-client’s perspective on each of their children’s problems and strengths. The last scale, Relationship with Child (RWC) targets each parent-client’s perspective on their relationship with each of their children. The validity of these scales in regard to their capacity to measure the domains they address has been supported empirically (Zinbarg et al., in press).

To ensure that the therapist gets a multisystemic picture of every client’s life, each client (above the age of 12) fills out all demographically appropriate scales regardless of the type of therapy in which they are engaged (individual, couple, family, etc.). Thus, a partnered-father fills out all six scales. An unpartnered 23-year-old woman would fill out IPS and FOO. It takes a partnered-parent about 45 minutes to fill out the STIC Initial.

The STIC Intersession

The STIC Intersession contains briefer versions of each of the STIC System Scales. It also contains three Alliance questionnaires (Individual, Couple and Family Therapy) derived from the Integrative Psychotherapy Alliance Model (Pinsof, 1994; 1995; Pinsof et al., 2008), that address the alliance from a multisystemic perspective. Specifically, it targets three dimensions: (a) *Self-Therapist*—“the alliance between me and the therapist”; (b) *Other-Therapist*—“my perception of the alliance between the therapist and the other key members of the client system (i.e., my partner, the other members of my family and the people who are important to me)”; and (c) *Within*—“the alliance between me and the other key members of the client system (not including the therapist)”.

The STIC Intersession is filled out sometime in the 24 hours before each session by all members of the direct client system (above the age of 12). Each client fills out all demographically appropriate system scales and the alliance scale that fits the type of therapy in which they are engaged. A single adult in individual therapy fills out the Individual Therapy Alliance Scale, whereas an adolescent in family therapy fills out the Family Therapy Alliance Scale. It takes a partnered parent about 6–8 minutes to fill out the Intersession.

The Data Collection and Feedback System

Clients can fill the STIC out at home or in an agency or office setting on a computer, tablet or smart phone. Upon completing the questionnaire, they hit “Send” and their therapist instantly gets an email. Upon opening the email, therapists immediately see the Feedback Report, which tells them at a glance: 1) if any risk (suicide, homicide, abuse) items have been endorsed and their level of endorsement; 2) if any of the three alliance scales have changed significantly since the last session 3) which factors/dimensions on which scales have changed significantly

since the last session; and 4) the status (better, worse or no change) of the Big 6—the six factors that were most problematic to that client at intake. The Feedback Report was designed to give therapists a 90-second overview of the most critical information about their client systems. If they have time to review more details, the Feedback Report also contains bar graphs of the client’s current (that session) status on each factor on each scale. The therapist can also leave the feedback report and go to the case to look at the data from other members of the direct system with both bar graphs and line or change graphs.

Norming the STIC

As part of the developmental process, the STIC was normed and its current factor structure confirmed on a clinical outpatient sample and on a random representative sample of the population of the United States (Pinsof et al., 2015). Norming involved comparing a factor’s (e.g. Open Expression on the Individual Problem and Strengths-IPS Scale) distribution on both samples and statistically determining (Jacobson & Truax, 1991) their point of overlap. That point became the “clinical cut-off”—any score above it was in the Normal Range and any score below was in the Clinical Range.

Norming is not meant to suggest that the STIC or IST seek to classify clients as normal or abnormal. Nor does it suggest that scores in the Clinical Range indicate a particular pathology or nullify client strengths. Rather, the primary purpose of norming was to, at a glance, get a sense of how problematic a particular factor or scale was to the client. The further into the Clinical Range, the more problematic or distressing the factor. For instance, the Big 6 are the six factors furthest into the Clinical Range on the Initial at intake. It is a way to visually see where the “pain” or distress” is for each client. For most clients, a clinical factor moving into the Normal Range signals more than just improvement, but a return to a positive, nonproblematic state. As evident

in Figure B2.1, the Clinical Range on STIC graphs (bar and line/change) is larger than the Normal Range. This reflects the fact that the STIC was designed primarily to measure change or improvement in problems over the course of therapy.

Conjoint Data Display

As shown in Figure B2.1, a unique feature of the STIC data format is that it can display the scores for each client on the factors of each scale side by side. Negative Subscales tap factors on which improvement typically means going down (e.g. IPS Negative Affect), whereas Positive Subscales tap factors on which improvement typically means going up (e.g. RWP Commitment). Figure B2.1 shows the Initial STIC scores for a couple, Tim and Nora, in couple therapy on two STIC Scales—Individual Problems and Strengths (IPS) and Relationship with Partner (RWP). Tim and Nora presented with an emotional and relational crisis—Tim had an affair. Nora felt devastated and it exacerbated her depression, which had started after their son, Trevor was born. The both felt they had lost the spark that brought them together and wanted to see if they could fix their relationship and rekindle their love. They presented problem sequences in which they avoided honest and direct communication with each other. They also avoided conflict until it would explode and drive them further apart.

The couple's profile on IPS shows that Nora, in red, is substantially more troubled individually than Tim, in blue. She is in the Clinical Range on five of the eight factors, whereas Tim is in the Clinical Range on three. Additionally, Nora's clinical factors are far more distressing to her (further into the Clinical Range) than Tim's are to him. From the bar graph, the therapist can discern that Nora's major problems concern knowing what she is feeling (Self Misunderstanding) and being able to express her feelings (Self Expression). She also has

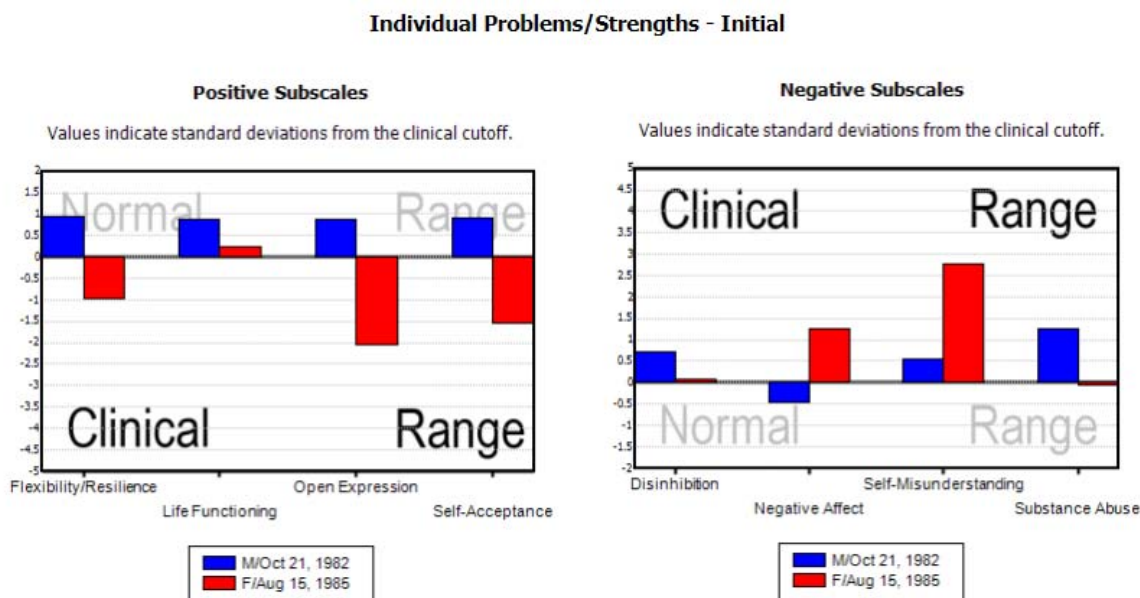


Figure B2.1. Initial STIC scores for Tim and Nora on Individual Problems and Strengths (IPS) and Relationship With Partner (RWP).

difficulty accepting herself (Self-Acceptance) and feels depressed and anxious (Negative Affect). Lastly, she struggles with the daily tasks of life (Life Functioning).

As seen in the Relationship with Partner (RWP) graph, Tim and Nora's couple profile differs from their individual (IPS) profile. On RWP they are more aligned and generally equally troubled by the same things. They are equally dissatisfied with their sexual relationship; trust is a problem for both of them, but more so for Nora; substance abuse is a problem for both of them, but more so for Tim; Nora feels more anger and task inequity (having to do more); and Tim's commitment to their relationship is weaker than Nora's. All of Tim and Nora's factors in the Normal Range can be thought of as strengths.

The STIC as a Clinical Tool

As well as being able to measure, track and evaluate problems and outcomes, the STIC is a clinical tool that can facilitate the empirically informed and collaborative use of the Blueprint.

STIC data are feedback that can be used with clients to empirically inform collaborative hypothesizing, planning, conversing and reading feedback.

Using Scientific Data to Facilitate Collaborative Treatment

The collaborative use of the STIC in treatment is predicated on the IST perspective on scientific data. Consistent with the epistemological foundation of IST, partial and progressive knowing, our knowledge of anything, including scientific data, are always limited and incomplete. In this sense, IST aligns with postmodernism, but then parts company with it by asserting that there is an external reality, which we can know. That knowledge is always partial or limited. However, our knowledge of that reality is progressive. We can know more and more about it. We can get closer to the truth, without ever fully grasping it.

STIC data about a client system give us another perspective or source of information about that system beyond our sensory impressions. The data are not objective (in the sense that no form of human knowledge is objective), but they are more systematic—subject to the rules of scientific discourse about the validity and reliability of knowledge. Combined with our sensory impressions, STIC data provide a fuller, more controlled and interpersonally intelligible understanding of the client system.

The optimal use of STIC data requires conversation with clients about their data. What do they say that their data reflect and mean? When the therapist receives a client's Feedback Report that signals a statistically significant drop since the last session in a client's Self-Therapist alliance score, the therapist needs to ask the client "what happened" or "what does the score drop mean?" Perhaps the client felt that the therapist misunderstood him in the last session, or that he felt that the therapist did not stop his wife from dumping her anger on him in the last session, or that the therapist seemed distant or preoccupied in the last session. Without the client's input, all

the therapist would know was that there was a statistically significant drop or rupture in the client's alliance with him. In this sense, STIC data are doors that the therapist needs to enter to more fully understand client experience. Together, the client(s) and the therapist cocreate the meaning of the clients' STIC data.

Therapists can tell clients about their STIC data (e.g. "It looks like you are feeling more trusting of your husband this week") or show their clients the actual STIC data. Telling them is more efficient and simpler—it also does not require having a monitor available in the office to show them their data. However, we believe that our clients are ultimately coinvestigators and our partners in the process of helping them transform their problem sequences into solution sequences. In that sense, showing them their data and asking them to help us understand and interpret what they have provided makes that partnership real. It demystifies the therapy and places the therapist and the clients squarely on the same playing field. They see the data we are using and join with us in creating meaning.

Empirically Informed Hypothesizing

Typically, therapists do not share STIC data with clients in the first session, using that session to meet the clients, hear their descriptions of their problems, and begin to understand the key problems sequences. In the second session, Tim and Nora's therapist decided to share their STIC data with them. When they walked in, the therapist had their data (the two graphs in Figure B2.1) on the video monitor in his office. After checking in with them about their reactions to their first meeting and how things had been since, the therapist invited them to join him in looking at their data. Explaining that Tim's data were in blue and Nora's in red, the therapist explained that bar graphs into the Clinical Range reflected areas that were troubling or of concern to them, and that bar graphs in the Normal Range reflected areas of strength for them

individually and/or as a couple. Nora immediately pointed at the Individual Problem and Strengths graph and said:

Nora: Wow, I look like a real wreck.

Therapist: Not necessarily. You may just be more sensitive or aware of what you're feeling and what's going on.

Nora: (Pointing to the big red graph for Self-Misunderstanding) What does Self-Misunderstanding mean—that I don't understand myself?

Therapist: Let me click on it and we can see the questions and your answers. (The therapist clicks on the Self Misunderstanding Bar graph [see Figure B2.2] and Nora's answers pop up).

Self-Misunderstanding Feb 17, 2015			
Client	Client Score	Min. Possible Score	Max. Possible Score
F/Aug 15, 1985	2.77	-0.55	3.88

Question	Answer
I don't understand why I do the things I do.	Very true
It's tough for me to know what I'm feeling.	Somewhat true

Figure B2.2. Nora's responses on STIC Initial IPS Self-Misunderstanding Subscale.

Nora: Yeah, those answers are true for me. I frequently don't know what I'm feeling and I am frequently puzzled about why I get so upset about little things that don't really matter. I see that I am also way into the Clinical

Range on Self-Expression and almost as bad on Self-Acceptance. So, I guess this is telling me that I don't know what I'm feeling, I can't express myself and I don't like who I am.

Therapist: Does that seem right to you?

Nora: Unfortunately, yes.

Therapist: And Tim, your data suggest that you are feeling pretty good about yourself at this time in your life. What is that substance abuse score about?

Tim: As we mentioned last time, sometimes I drink too much and that can lead to problems.

Therapist: I think that is important for us to discuss, but I'd like to come back to it later, because I'd like to focus on your Relationship with Partner scores, which may tell us more about the specific problems that bring you to therapy.

At this point the therapist begins to link the couple's clinical subscales (their clinical profile) on IPS and RWP with each other and Tim and Nora's presenting problems. He is facilitating the coconstruction of Tim and Nora's web of constraints—an empirically informed working model or narrative about the relationships between their problems and the constraints that might be preventing change.

Nora: It's no surprise to see that we are not very happy about our sexual relationship. We've lost that connection since he had the affair.

Therapist: Nora, is that something that you'd like to regain?

Nora: Yes, but I don't think I can work on that until we have taken care of other things.

Therapist: Your STIC data suggest that the main problem areas for you are trust and anger. Are they what you are referring to as what needs to be taken care of first?

Nora: That's right, I feel angry that I have to work full time and still do most of the care-taking for Trevor. Tim does not do his share, he's been preoccupied with this new job and he still wants to hang out with his buddies after work and drink.

Therapist: That helps explain a lot about the anger. Do those things relate to your low trust score?

Nora: Most of that is the affair and his lies. But I don't feel that I can even count on him to be there for me and Trevor. I almost feel like he is my second son, and not such a good one. He comes home pretty drunk from partying with his friends and then he is out of it in the morning.

Therapist: It sounds like feeling so angry, disappointed and distrustful toward Tim makes it difficult to feel like you want to be intimate sexually with him?

Nora: Totally, I don't know if we can ever get our sexual connection back.

Therapist: Tim, where does all of this leave you?

Tim: Pretty discouraged. I don't know that I can ever get out of the doghouse with Nora.

Therapist: Does that relate to your low commitment score?

Tim: Yeah. I not sure we can get over what's gone down. I've stopped the affair, which was not a serious relationship, and I am trying to be home more and

help with Trevor. But Nora seems so hurt and pissed off that I'm not sure she even sees that I'm trying and that I'm sorry for being such a stupid jerk.

Therapist: Is Tim right that it is hard for you to see and appreciate his efforts to be a better husband and coparent?

Nora: Maybe, although I think he thinks he's doing more than he's really doing.

Therapist: If "maybe" is at all true, what do you think prevents you from appreciating his efforts more?

Nora: I just can't trust him. I am scared to believe that he really means it. I think he does not want to go through the hassle of a divorce—and breaking up our family. I don't think he really wants me.

Therapist: Would you be willing to ask him now?

Nora: I'm not sure what you want me to ask him?

Therapist: How about does he really love and want you, or is he just avoiding the hassle and pain of a divorce?

Nora: I don't think he'll really tell me the truth or that I'd believe him.

Therapist: Try it and let's see.

Nora: OK. Do you really love me or do you just not wanna get divorced?

Tim: I love you, but I've been pretty unhappy in our marriage. After Trevor was born, I felt you were depressed and didn't give a shit about me.

Nora: I was depressed (to the therapist). I had postpartum, but I feel better now.

Tim: But how am I supposed to know that? I come home and you seem pissed to see me. It's like I'm child care relief and not much more.

Nora: I feel so tired most of the time, that when you come home I do look at you as child care relief. I also feel guilty after you've been working so hard to cement your position at work that I need you to work at home.

Therapist: I also think you haven't adequately processed the hurt and anger at Tim's affair. He quit the affair and you guys just soldiered on, but I don't think the two of you have healed the wound. To feel and let his love in while you're still so hurt is close to impossible.

Nora: I still wake up with nightmares about him having sex with other women. I can't see their faces, but he is doing with them what he used to do with me and I feel sick, like I want to throw up when I wake up.

Employing a number of hypothesizing metaframeworks, the therapist weaves a web of understanding that leads back to the couple's failure to resolve the trauma of the affair. The web hypothesizes that Nora has swallowed a lot of her feelings about the affair and that they exist, undigested, within her. The nausea she experiences when she wakes up from the infidelity nightmares, reveals Tim and Nora's failure to do the necessary work to heal the wound of the affair (mind metaframework). Additionally, the information about Tim's drinking and going out with his buddies to the detriment of his family suggests a struggle with life stage adaptation (development metaframework) and possibly an addictive process (biology metaframework). That the affair followed Tim's sense of being abandoned by Nora after Trevor was born and she became depressed, suggests constraints relating to the development, mind, and biology metaframeworks.

With the therapist's help, Tim and Nora are beginning to create an empirically informed narrative that draws together relevant hypothesizing metaframeworks, STIC data and client

reports into a coherent picture of what went wrong, when and why. They are beginning to see that Trevor's birth and Nora's postpartum depression broke the somewhat tenuous marital bond they had created. Tim's affair, an "immature" reaction to his feelings of abandonment, ended in Nora's traumatization and the rupture of their relationship. Now they were beginning to formulate a plan to address this problem narrative.

Empirically Informed Treatment Planning

The empirically informed web of understanding that the therapist has woven with Tim and Nora leads into the Planning Metaframeworks. From their data and their descriptions of their behavior, Tim and Nora have behaviorally put their marriage and family back together. But, it is not working. The deeper wounds of the affair, as well as their failure to master the tasks of early marriage and having a child, are preventing them from truly moving on with their lives and marriage.

At this point in the second session the therapist begins to move from hypothesizing to planning, articulating for the couple's consideration a plan for how they might proceed.

Therapist: Nora, I think what your dreams are telling you and us, is that there is a bunch of feelings, thoughts and images that still haunt you from the affair. Also, it sounds to me like you, Nora, feel that Tim has not really grown up and is still stuck back there with his buddies and their partying. Lastly, I don't think that two of you have really gotten over the developmental challenge of integrating a first baby into your life.

Tim: I agree with you about the affair and I may agree with you about me not having grown up, but I don't understand what you mean about integrating Trevor into our lives.

Therapist: What I mean is that the challenge that all couples face when they have their first baby, is how are they going to sustain their marital relationship and not sacrifice it to their new relationship as coparents? It is so easy to lose yourselves in being parents and forget about being a wife and husband to each other.

At this point, the therapist is utilizing strategies from the Meaning/Emotion planning metaframework. He uses psychoeducation to teach the couple about the challenges of maintaining the marital thread in the face of becoming parents. This gives them a cognitive framework to understand and normalize what they have been going through. It also implies the action of attending to and rebuilding their marriage—regaining the marital thread. Below, building on that theme, he explicitly suggests a solution sequence of engaging in an emotional healing process related to the affair. He is assuming, but leaves implicit, the idea that such emotional healing work will also address the developmental constraints that have limited their capacity to move ahead.

Nora: We have definitely lost that marital thread. We are like two sexless parents raising a son. I also think you are right about us not getting over the affair. Tim did stop it and we went forward. But I am still obsessed and feel like I cannot get over it. I hate to be a whiner and go on and on about my problems.

Therapist: I hear that it feels to you like “whining,” but it isn’t. The two of you need to go through a process of coming to terms with the affair—what it means to both of you and how you feel about it. You will never be able to truly rebuild trust if you don’t do this emotional work.

Tim: What do you mean by emotional work? And how long is this gonna take?

Therapist: Tim, if you really do the work, it doesn't take forever. When you don't do the work after an affair, the pain and hurt goes on forever. It just gets buried and lurks underground corroding the foundation of your marriage. I sense from your low Commitment score on the STIC, that you know this.

Tim: Yeah, I know things are not right. We are going through the motions, but we are very distant. I don't like it.

Therapist: Tim, you asked me about what I mean by emotional work. I mean you and Nora talking about the tough stuff, having some courageous and painful conversations about what happened and what it meant to each of you. Nora needs to ask you about anything she wants to know about the affair and you need to answer her honestly, even if you know it is going to hurt her. You need to listen with an open heart to her reaction and not defend or explain yourself—you need to be vulnerable to her and show her how you feel about her pain. And the bad news is that you will have to do that over and over again as she digests and integrates the news. When that's played out, we'll focus on why the affair happened in the first place. What you were seeking. What you needed, but couldn't ask for.

Tim: I think I understand what you mean, but I feel scared. I feel bad enough about what I did and to have to tell it over and over sounds like hell.

Therapist: The good news is that every time you tell it and Nora listens and you listen to what she feels and thinks, that distance between you is diminished and the marital thread grows stronger. Are you up for this?

Tim: Yeah, I want to do whatever it takes.

Therapist: Nora, how about you. Does this sound like a plan for our working together?

Nora: I can't carry this pain around forever and I do believe that Tim wants me and our family. Yeah, let's do it.

The plan that the therapist and Tim and Nora agreed upon is a product of their conversations about their problems and their Initial STIC data. They use both sources to codelineate a plan for their work.

Empirically Informed Conversing

The STIC primarily informs Conversing through the use of three Alliance Scales that are part of the Intersession—The Individual Therapy Alliance Scale, The Couple Therapy Alliance Scale and the Family Therapy Alliance Scale. Each client system only fills out the scale that fits the kind of therapy in which they are participating—individual, couple or family. Tim and Nora filled out the Couple Therapy Alliance Scale.

Data about the three alliance factors within the scale—Self, Other and Within—are collected before every session. Any statistically significant change (for better or worse) in any alliance factor score since the previous session is included at the beginning of the Feedback Report. Therapists are encouraged to discuss any statistically significant deviation with the clients in the upcoming session, particularly any significant decrease or rupture.

IST places great emphasis on the dual concepts of alliance rupture and alliance repair.

Theoretically, an alliance rupture is any client-experienced break or decrease in the quality of an alliance factor. The client may feel less allied with the therapist—Self alliance factor; the client may perceive that their partner's alliance with the therapist has deteriorated—Other alliance factor; or the client may feel that their alliance with their partner has deteriorated—Within

alliance factor. Alliance ruptures usually occur over a one to two session interval. The STIC feedback system empirically defines a rupture as any statistically significant deterioration in any client's alliance score that occurs between any two sessions.

Studying complete cases with the STIC in couple therapy, Goldsmith (2012) found that alliance ruptures: a) occurred in over fifty percent of all complete couple therapies; b) that the frequency of ruptures did not differ across the first, second and third periods (defined statistically based on the number of sessions in each case) of therapy; c) that the frequency of ruptures did not differ across the three alliance factors—Self, Other and Within. Goldsmith (2012) also examined links between alliance ruptures, repairs and outcome. They found that cases that ruptured and repaired had better outcomes than cases that never ruptured and cases that ruptured and were not repaired. They also found that cases in the third period of therapy that ruptured tended to terminate soon after the rupture, suggesting that unrepaired ruptures were associated with proximal if not immediate termination. These findings have many clinical implications: a) ruptures are very common, if not normal; b) ruptures can occur anytime over the course of therapy; c) ruptures can and do occur in all three factors; 4) ruptures, if repaired, are associated with better outcomes.

The STIC appears to be an effective mechanism for identifying ruptures, alerting therapists to their occurrence, and identifying repairs. Repairing a rupture, from an empirical (STIC) perspective, requires that the client's alliance score return at least to its prerule level. Clinically, the process of repair in IST involves several steps. Specifically, the therapist needs: a) to identify that the rupture has occurred; b) empathically and nondefensively explore the client's experience of the rupture; c) if the rupture occurs on the Within factor, the therapist needs to facilitate an empathic conversation between the reporting client and their relevant other; d) the

therapist needs to apologize for their part in the rupture experience or facilitate an apology between the offending “other” and the reporting client; and lastly, e) make plans with the relevant clients to minimize the likelihood of similar ruptures occurring in the future. The following vignette with Tim and Nora exemplifies this process.

The therapist received the alliance warning shown in Figure B2.3 after Tim and Nora’s ninth session. It was the first alliance deterioration notice he had received with them. Since the second session, Tim and Nora had been following the plan: talking and listening to each other in regard to the affair; starting to have other difficult conversations with conflict potential; Tim stepping up as a coparent and acting less like an emerging adult; etc. The alliance warning indicated significant drops in Tim’s Self and Other dimensions. This meant that Tim was experiencing a deterioration in his alliance with the therapist (Self) and in his perception of Nora’s alliance with the therapist. The therapist saw this feedback report just before beginning his session with Tim and Nora. Since the data were from Tim (Nora’s data did not indicate any alliance change) the therapist decided, after checking in with the couple, to address Tim.

Alliance

Subscale	Change	Graph All Sessions
 Self/Group	Worse	
 Other	Worse	

Figure B2.3. Tim and Nora’s Alliance Change Warning for Session 10.

Therapist: How are things going with both of you since the last session?

Nora: It was a tough week. I felt kind of discouraged.

Therapist: Nora, what were you feeling discouraged about?

Nora: I am not sure. I am not sure if Tim really wants to be in this therapy with me. I don't think he likes me criticizing him and telling him about how much he hurt me.

Therapist: Nora, why don't you check that out with him?

Nora: Tim, I feel like I'm losing you and you're disengaging from the therapy.

Tim: Nora, you're not losing me. I love you and want to fix the damage I've caused.

Therapist: Tim, can I ask you a question?

Tim: Sure.

Therapist: I was looking at your STIC data just before you both walked in and it suggested to me that your feelings about the therapy and possibly even about me, might have changed since last week. Does that make any sense to you?

Tim: Well I did feel kind of irritated after the last session.

Therapist: Can you tell me about it?

Tim: After we left, Nora crashed. She was crying and saying that she was a terrible person because she couldn't forgive me and therapy wasn't helping her.

Therapist: And how did that effect your feelings about the therapy?

Tim: I'm just not sure we are getting anywhere.

Therapist: And maybe that I am not doing enough or not doing the right things?

Tim: I feel like we are just going around in circles in a swamp of pain.

Therapist: And maybe you feel like I should be leading both of you out of that swamp, rather than just circling around within it.

Tim: But you are the expert and we should just trust what you are doing.

Therapist: But having expertise does not mean that I always do what is right or best for my clients and you and Nora may be trying to say to me, with your STIC data, that we need to do something different. Nora, what do you think about that?

Nora: I don't know what something different might look like. But I don't think I am getting better.

Therapist: We have been very focused on the trauma of the affair. Maybe we should give that work a break and focus on something else—like the vulnerabilities in your marriage that led up to the affair. Specifically, I was thinking about your difficulties having necessary and difficult conversations with each other. Like Tim, your difficulty, after your son was born, asking for Nora's attention and love. It seems to me that the work we have been doing may make it harder for you to feel like you can ask Nora for anything for yourself.

Tim: That's true. I am still in the doghouse. Perhaps it's time for me to come out.

Therapist: Nora, how would you feel about heading in that direction?

Nora: It might be a relief not to focus so much on me and my pain. I don't know how generous I feel toward Tim these days, but we could give it a try.

Therapist: My hunch is what Tim wants would also be good for you. He wants you.

This therapy vignette, as well as demonstrating the process of rupture repair, also illuminates a collaborative replanning conversation between the therapist and the clients that was stimulated by STIC alliance data. Our clinical experience as well as Lambert's research (Lambert et al., 2003), suggests that therapists may not be very good at detecting ruptures unless clients bring them up directly. In that sense, the use of an empirical feedback system like the STIC extends therapists' sensitivity and awareness of potentially important changes in the alliance.

Empirically Informed Feedback

Feedback has many sources and media. STIC data, particularly Intersession STIC data, constitute a systematic and reliable source of feedback about clients' progress in therapy. It is designed to tell therapists and clients whether the clients are changing and whether that change is just a statistically significant improvement in problem(s), or also a return to what is considered normal and healthy functioning. The graphs in Figure B2.4 reflect Tim and Nora's progress after 12 sessions. The therapist had these two graphs up on his computer when Tim and Nora entered

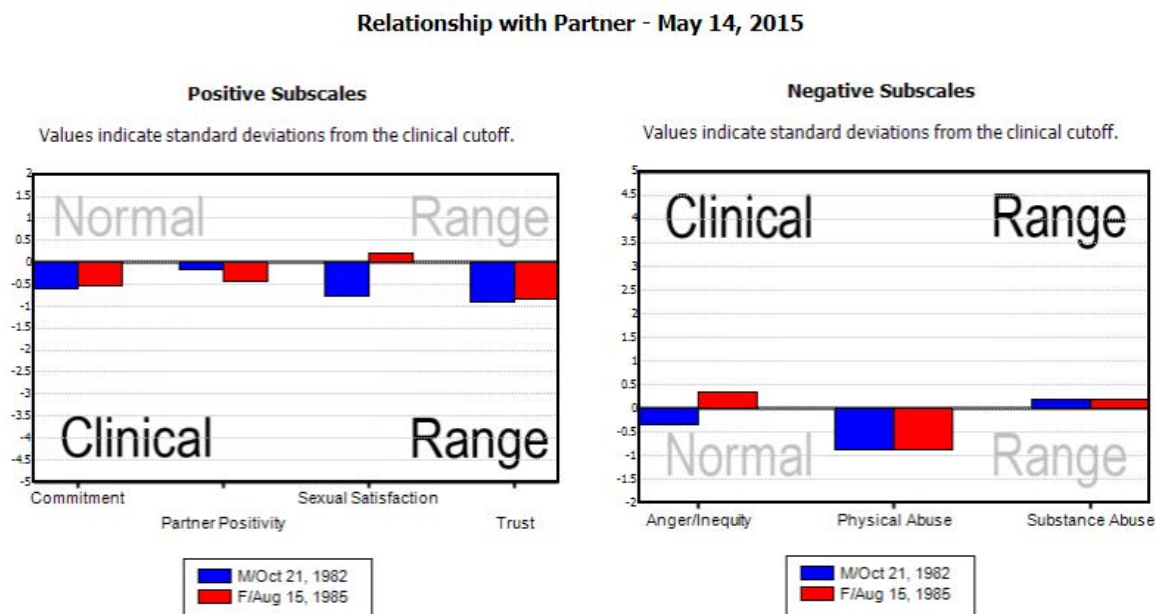


Figure B2.4. Tim and Nora's twelfth session bar graphs.

the office. As she entered the office, Nora walked by his computer and stopped to look at the graphs. She invited Tim to come over and look at them with her.

Nora: Take a look at this. It looks better than before. What do you think?

Tim: I agree, but it looks to me like you aren't doing so well. Lots of stuff still in the Clinical Range.

Nora: I guess I'm still screwed up. So what's new?

Therapist: Tim I'm struck by your response and Nora's response to it. Do you have any idea what I'm getting at?

Tim: You mean that she went negative on herself right away?

Therapist: Yes, I mean that, but I was also getting at what you said before Nora went negative. Do you remember what you said after she invited you to look at the graphs and said that "things look better."

Tim: I'm not sure what I said.

Nora: You said, "I wasn't doing so well."

Tim: Did I really?

Nora: Yeah, and you even added "lots of stuff in the Clinical Range."

Tim: Oops. I guess I played out our negative sequence. I went negative after you said we were making some progress and instead of calling me out on it you jumped on my bandwagon and went even more negative on yourself.

Therapist: Wow. Tim, you really nailed what happened. What prevented you from joining Nora's positive take on your progress, particularly the progress that your couple data reflect?

Tim: I don't really know for sure. We have made progress and things are definitely better. But I feel like things are "less bad," not really good.

Therapist: In looking at your couple data—things are definitely less negative, but you are still in the Clinical Range, a little bit, on all of the positive subscales, particularly Trust, Sex and Commitment. The two of you have stabilized your relationship, but you are now faced with rebuilding it—recreating the things that brought you together in the first place. Nora, I'm interested in your thoughts about this?

Nora: I think both of you are right. Things are better and I don't feel so devastated and distrustful. But we are still not really feeling good with each other—best friends and that kind of stuff.

Therapist: Tim, what do you think Nora means by "that kind of stuff."

Tim: She means really feeling close. Making love, talking about ourselves, having a good time together.

Therapist: Is Tim right? Is that what you meant?

Nora: Yes, mostly. But I go negative so quickly. It is hard for me to feel good about myself, no less our relationship. I wonder if I should go into individual therapy?

Therapist: Why do you say that?

Nora: How else can I learn to feel ok about myself—to believe in me and then in us?

Therapist: I am struggling with what you are saying Nora. On the one hand, you could pursue individual therapy to work out your negative feelings about yourself.

However, I wonder if you and Tim worked on building up the good things in your marriage, whether that might not only make you feel better about you and him, but also about yourself?

Nora: How do we do that?

Therapist: Tim, I don't mean to dodge Nora's question, but I'd like to hear your thoughts about how the two of you might do that.

Tim: Maybe, if I can be out of the doghouse, she could begin to trust me and open herself to loving me again. I want her to open herself to me.

Nora: Tim, I want to do that, but I am still scared. I don't think I could tolerate another deception and betrayal. It would break me.

Tim: I know that. I thought you didn't care what I did now that you had a son. I felt like you didn't need me or really want me.

Therapist: How was that for you, Tim?

Tim: I felt abandoned and alone. Cut off from her love. (he stops talking and gets tears in his eyes). *All three sit silently while Tim struggles with his tears.*

Nora: I didn't realize that you felt that way. I am so sorry. If only we could have talked this way then.

In this vignette, the therapist facilitates the couple's awareness of the problem sequence in which Nora invites Tim to see their progress, he focuses on her moderately improved, but still clinical individual issues, and she moves into self-pathologizing. With the therapist's support, Tim and Nora identify the sequence. The therapist then focuses on what prevents Tim from supporting her positive take on their therapy. Tim then articulates his sense that they have staunched the bleeding and stabilized their relationship, but have not rebuilt their love. The

therapist facilitates Tim's exploration of his feelings of loss and his desire to be desired. Nora responds with empathy and hope—"we are communicating now the way we should have then."

This vignette illustrates the postmodern and improvisational use of empirical feedback to assess progress and replan the therapy. The therapist avoids overpathologizing Nora and implies that her negative-self feelings may be ameliorated by Tim and Nora rebuilding the positive aspects of their marriage. The emergent plan is for them to focus on building up the positive, loving and "best friend" components of their relationship. In other words, reading the feedback leads to rehypothesizing and preplanning the therapy.

STIC data inform, but do not dominate the process. The process got launched with Nora and Tim's initial responses to seeing the STIC data. The therapist's focus shifted away from the data to the sequence of interactions between Tim and Nora. The data were the jumping off point—the stimulus to the interaction. Subsequently, the data are woven back into the conversation to highlight that their problems have improved, but there is still substantial progress to be made in moving into the positive (or "normal") range, particularly with the positive subscales on RWP (Trust, Commitment, Positivity and Sexual Satisfaction). That Nora is still in the clinical range on many of the individual (IPS) subscales is integrated into the planning process with the hypothesis that she might feel better about herself if their relationship becomes more positive, and that might be the next best place to start.

Empirically Informed Termination

The goal of IST, simply put, is resolution of the presenting problems. That being said, the decision about when to stop therapy is complex and multidetermined. STIC data can be a useful component of that decision-making process. Ideally, from a pure STIC perspective, therapy should end when all of the subscales that were in the clinical range have gone into the normal

range. A reduced variation on the same theme is that the Big 6 have gone into the normal range. However, termination usually occurs when some combination of the key scales (particularly the Big 6) have improved significantly and/or gone into the normal range, an outcome typically associated with sufficient resolution of the presenting problems and their associated constraints.

Since the IST perspective views therapy as a series of problem centered episodes that occur over the lifetime of a family or client system, termination occurs when the presenting problems are sufficiently resolved. Sufficient resolution is a consensual decision between the key clients and the therapist, in which the key clients feel that the problems for which they sought help are sufficiently resolved—changed and/or accepted. Sometimes episodes conclude for other reasons—therapist initiates termination due to lack of progress over a significant period, clients quit because of an alliance rupture, therapist leaves agency, clients move, etc. However, within IST, sufficient resolution is the ideal criterion for a planned and consensual termination.

In regard to Tim and Nora, STIC data played a meaningful role in their termination process. Figure B2.5 presents the Feedback report on the Big 6 for their penultimate session. In regard to significant change since the previous session, Nora's IPS Life Functioning went into the Normal range. In regard to change in the Big Six since they started therapy, Tim's IPS

Reliable Change since Previous Session

Systems

Client	Subscale	Change (Clinical Status)	Graph All Sessions
F/Aug 15, 1985	Life Functioning - IPS	Better (Normal)	

Alliance

There was no reliable change since previous session.

Reliable Change since First Session

Initial Subscales furthest into the Clinical Range (Big 6)

Subscales furthest into the clinical range at the initial (from most to least severe).

Client	Subscale	Change (Clinical Status)	Graph All Sessions
F/Aug 15, 1985	Self-Misunderstanding - IPS	No reliable change (Clinical)	
F/Aug 15, 1985	Sexual Satisfaction - RVP	Better (Clinical)	
M/Oct 21, 1982	Sexual Satisfaction - RVP	Better (Clinical)	
F/Aug 15, 1985	Open Expression - IPS	No reliable change (Clinical)	
M/Oct 21, 1982	Substance Abuse - RVP	No reliable change (Clinical)	
M/Oct 21, 1982	Substance Abuse - IPS	Better (Normal)	

Figure B2.5. Big 6 feedback report data for Tim and Nora's penultimate session.

Substance Abuse went into the Normal range. Both Tim and Nora's RWP Sexual Satisfaction scores improved significantly, but were still slightly into the Clinical range. Thus, there was statistically significant improvement on four subscales (including Life Functioning) and no significant change on three (from the Big Six).

At this session, Tim and Nora mentioned that they were thinking about "taking a breather" from couple therapy. They felt things were better and that they were on an upward curve. Nora also said that, although things were better in the marriage, she felt like she wanted to pursue some individual therapy for herself because she still had trouble letting herself know and express her feelings, particularly if she judged those feelings to be negative. She said that she felt more trusting of Tim and that the affair was feeling like something in their past that was "behind them now." The therapist suggested that they take a look at their STIC data to get another perspective on their progress.

Therapist: (Pointing to the Life Functioning change) Nora, it looks like you're feeling better, more able to take care of things.

Nora: Yes, I feel like I'm coming back to myself a little bit.

Therapist: That's great. But as you were saying, Self-misunderstanding and Open Expression are still not where you would want them to be.

Nora: That's right. It is still hard for me to hold my ground and speak my truth.

Therapist: Tim, what's your reaction to what Nora is saying? Do you agree with her?

Tim: Somewhat. But it sure feels to me like she is speaking up more. She is also more loving and affectionate.

Therapist: How is that for you?

Tim: It's wonderful. I feel we are more connected.

Therapist: What about Nora doing more work on herself so her inside can catch up with her outside?

Nora: That's a good way to put it. I know I appear more assertive and all, but I still feel unsure of myself and in a fog about what I'm really feeling.

Tim: It's ok with me if she wants to work on that by herself. I'm just afraid that she will come out of the fog and realize she does not want me.

Nora: Tim, don't be ridiculous. Have more confidence in us and me.

Tim: I will try.

Therapist: I think you guys will be fine and I feel confident that Nora is not going to wake up and kick you out. You've both done good work here and need to trust it. And you know, if things head south, you can come back and see me. Just stay connected and if you lose the thread, stop, grab the other person and talk from the heart, even if it's scary.

The session ended with Tim and Nora scheduling a last session for two weeks later. They came in for that session and said they were ready to proceed on their own for now. They even recounted a sequence where Nora expressed some irritation with Tim, he listened and did not defend or withdraw, and she ended up hugging him. They ended the session by both hugging the therapist and thanking him. As they walked out the door, Nora turned around and said "See you. Bye for now."

Empirically Informed Improvisation

The essence of empirically informed therapy is that scientific data become part of the fabric of therapy. They are interwoven in such a way as to clarify, facilitate and evaluate the therapy, without dominating or excluding intuition and mutual creativity. Learning to use an

empirical feedback system like the STIC is like learning to play a musical instrument in a jazz band. It takes time and practice, and requires that therapists bring their creativity, intuition and intelligence to the disciplined and improvisational art of therapy.

Summary

This chapter illustrated how empirical data could be clinically woven into the IST blueprint and the process of therapy. The case of Tim and Nora was used to show how empirical data could be used to open “doors” and facilitate collaboration. As well as demonstrating the use of empirical data to inform hypothesizing, planning, conversing and reading feedback, this chapter showed how STIC data can be used to detect alliance ruptures and repairs. Although the chapter focused on STIC data, potentially other measures and feedback systems could be used with IST as well. The critical point is that IST is committed to the integration of empirical data (from whatever valid and reliable source) into its essence and as such, is an empirically informed psychotherapeutic perspective.

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