Journal of Marital and Family Therapy
July 2004, Vol. 30, No. 3, 319–333

ENACTING RELATIONSHIPS IN MARRIAGE AND FAMILY THERAPY: A CONCEPTUAL AND OPERATIONAL DEFINITION OF AN ENACTMENT

Sean D. Davis
Virginia Polytechnic Institute and State University

Mark H. Butler
Brigham Young University

Enactments are a potential common clinical process factor contributing to positive outcomes in many relational therapies. Enactments provide therapists a medium for mediating relationships through simultaneous experiential intervention and change at multiple levels of relationships—including specific relationship disagreements and problems, interaction process surrounding these issues, and underlying emotions and attachment issues confounded with those problems. We propose a model of enactments in marriage and family therapy consisting of three components—initiation operations, intervention operations, and evaluation operations. We offer a conceptual framework to help clinicians know when and to what purpose to use this model of enactments. We provide an operational description of each component of an enactment, exemplifying them using a hypothetical clinical vignette. Directions for future research are suggested.

Although reviews of psychotherapy outcome literature consistently show that psychotherapy is effective, studies investigating the comparative efficacy of different psychotherapy models have consistently found few if any differences between models (Lambert, 2004). This has led researchers to hypothesize that "different therapies embody *common factors* [italics added] that are curative, though not emphasized by the theory of change central to any one school" (Asay & Lambert, 1999, p. 29).

Although research investigating *common factors* of psychotherapy is well established, empirical research investigating common factors in marriage and family therapy (MFT) is almost nonexistent. A review of the literature revealed only one empirical inquiry into common factors in MFT (Butler & Bird, 2000), one survey of therapists' opinions regarding common factors of MFT (Blow & Sprenkle, 2001), two theoretical articles (Sprenkle, Blow, & Dickey, 1999), one debate (Sexton & Ridley 2004; Sexton, Ridley, & Kleiner, 2004; Sprenkle & Blow, 2004*a*, 2004*b*), and one professional conference presentation (Wampler, 1997) outlining common factors.

Empirical research investigating common dynamics of distressed couples may be useful in discovering common factors across MFT models (Carrère & Gottman, 1999; Driver, Tabares, Shapiro, Nahm, & Gottman, 2003; Sexton & Alexander, 2004). Reasonable inferences based on such research may begin to fill in the gaps in MFT common factors research. Together, each of these sources offers evidence suggesting the common utility of enactments, a proposed common factor of change across many models of MFT.

Enactments have traditionally been defined as "an interaction stimulated in structural family therapy in order to observe and then change transactions which make up family structure" (Nichols, 1984, p. 584). A broader definition sustains the potential use of enactments independent of any particular clinical model: Enactments are defined as "therapist behaviors [that] stimulate and guide couple interaction as opposed to

Sean D. Davis, MS, Marriage and Family Therapy Program, Virginia Polytechnic Institute and State University; Mark H. Butler, PhD, Marriage and Family Therapy Department, Brigham Young University.

Correspondence concerning this article should be addressed to Sean Davis, Marriage and Family Therapy Program, Department of Human Development, Virginia Polytechnic Institute and State University, 366 Wallace Hall, Blacksburg, Virginia, 24061. E-mail: seandavis@byu.edu

channeling interaction through the therapist" (Butler, 1996, pp. 27–28). This inclusive definition recognizes that enactments can be a common element of most MFT models and are used for a variety of purposes within these models.

The dynamic utilization of relationships to bring about change is a characteristic unique to MFT, both conceptually and operationally. Given that "in [MFT], the client is the relationship" (Johnson, 1996, pp. 17–18), the relationship (rather than the individuals within the relationship) should be the focus of therapy. A primary operation in MFT is relational mediation and coaching. We propose that this occurs best in the context of therapist-coached couple interaction via enactments. Enactments both use the relationship as an agent or mechanism of change as well as directly facilitating change within relationships.

Our clinical observation suggests that although problems themselves can be problematic for couples and families, more often it is the interaction process that is the primary source of distress and trouble in relationships. What brings couples and families to therapy is not "the problem" but the ways in which couple interaction gets hung up and stuck and partners hurt each other when they try to resolve the problem. Enactments—unique to MFT and relational therapies—provide an excellent vehicle for intervening at the level of interaction process.

The reliance of many MFTs on enactments as a common dimension of treatment process is evidenced by the diversity of clinical models that utilize enactments to address the experiences of distressed couples. Greenberg and Johnson's (1988; Johnson 1996) emotionally focused therapy (EFT) utilizes enactments as a means for emotional expression. The therapist urges couples to express their primary emotions to each other in the context of an enactment with the intent that the expression of primary emotions will lead to new interactional styles. Marital enrichment approaches such as Relationship Enhancement (Guerney, Brock, & Coufal, 1986) use enactments in training. In behavioral marital therapy, enactments are called behavioral rehearsals, and they are used extensively to help couples practice new skills, such as listening or speaking nondefensively (Jacobson & Margolin, 1979). Communications-oriented approaches (e.g., Anderson & Goolishian, 1988; Miller, Nunnally, & Wackman, 1976) also encourage dialogue between couples and couple interaction in the basic form of an enactment. One could also surmise narrative therapists' potential use of enactments, as couples or families together *re-story* their relationships and their problems toward resolution. Thus, even where not currently conceived as part of a particular treatment model, enactments may in fact be a reasonable process for intended outcomes.

Perhaps therapists are most familiar, however, with the use of enactments in structural therapy (Aponte & VanDeusen, 1991; Minuchin & Fishman, 1981; Simon, 1995). Enactments in structural therapy focus primarily on redirection of the structure of family interactions and on enactments for clinical assessment purposes. Couple dialogue is also encouraged as a component of solution-focused therapy (O'Hanlon & Weiner-Davis, 1989), although a complete model and use of enactments is not endorsed. Altogether, though, established clinical models suggest the use of enactments for: (a) Facilitating communication skills; (b) redirecting relationship process or patterns; (c) restructuring relationships; (d) facilitating attachment-oriented emotional disclosure, sharing, and experience; and (e) assessment (Butler & Gardner, 2003). With some limitations, the model of enactments we are proposing, in combination with the developmental model offered by Butler and Gardner (2003) has the potential to be adapted to use within most models of MFT, whether or not the models specifically incorporate enactments. We consider enactments to be nearly universally *accessible* within the protocols of relationship therapies.

Despite the potential utility of enactments, there is some indication that therapists may not have an adequate conceptual or operational understanding of enactments (Nichols & Fellenberg, 2000). The few published articles providing an operational definition of enactments (Allen-Eckert, Fong, Nichols, Watson, & Liddle, 2002; Nichols & Fellenberg, 2000) do so primarily from a structural family therapy perspective, despite the fact that many other models of MFT utilize enactments. In addition, we only found one article providing a theoretical conceptualization for enactments capable of being applied independent of any particular clinical model (Butler & Gardner, 2003). We will use much of the theoretical framework presented in the Butler and Gardner (2003) article to guide the operational model presented in this article. Theoretical conceptualization of enactments is necessary to generate a purposeful, focused, and coherent model of its several components and their objectives. If enactments were not embedded within a larger

theoretical conceptualization, clinicians would not know when or why they could use an enactment. An operational model of enactments, such as that provided in this article, is necessary to know how to use enactments once a clinician has decided when and why they could use them. The purpose of this article is: (a) To provide a conceptual understanding of enactments that will allow therapists to know when and to what purpose to use our model of enactments; and (b) to draw operational conclusions from our conceptual model, borrowing from and expanding on clinical operations in previous operational models of enactments (Allen-Eckert et al., 2002; Nichols & Fellenberg, 2000).

Inasmuch as we are suggesting the possible candidacy of enactments for eventual empirical validation as a clinical process dimension commonly associated with positive outcomes across diverse relational therapies, we are proposing a generalist model for enactment operations not tied to any particular model or purpose (e.g., assessment, restructuring). This said, we note that, although we consider enactments to be a common factor, we allow that there may be other methods of achieving outcomes similar to those empowered by directly enacting relationships in MFT. Ultimately, research will determine the comparative effectiveness and efficiency of couple/family-centered clinical process (enactments) versus therapist-centered clinical process in the achievement of relationship outcomes. Further, our model does not preclude the use of other enactment forms and operations particular to certain clinical models.

The theoretical inspiration for our model is Bowen's (Kerr & Bowen, 1988) ideas about emotional processes—particularly reactivity—in distressed relationships, and the successful mediation of those conditions (discussed later). However, since our use of Bowenian theory is limited to his ideas about emotional processes, we believe that therapists utilizing many diverse models of MFT can adapt our model of enactments to their practice. Further, although we believe that our model of enactments can be fitted to general couple/family practice, we note its particular harmony with the emotional and attachment focus and goals of EFT (Greenberg & Johnson, 1988; Johnson, 1996.) In addition, although enactment principles, component processes, and objectives are the same across marriage or family therapy, there are important structural adjustments to be made when applying enactments in families. These considerations are, however, beyond the scope of our present purpose.

CONCEPTUAL AND OPERATIONAL UNDERSTANDING OF ENACTMENTS

The lack of a coherent, theoretically based model and operational understanding of enactments is evidenced in the MFT literature. To date, only two published articles operationalize a successful enactment (Allen-Eckert et al., 2002; Nichols & Fellenberg, 2000). Although these authors succeed in providing detailed enactment instructions from a structural perspective, clinicians that utilize other models are left without published literature to guide their efforts. In the following section we propose an operational model of enactments that can further aid clinicians utilizing other models in deciding when and to what purpose to use enactments. The framework for our model of enactments stems from Bowenian ideas concerning emotional reactivity (Kerr & Bowen, 1988). However, our model diverges from Bowen's in several instances. Those differences and the rationales behind them will be discussed below.

RELATIONSHIP MEDIATION AND COACHING: A THEORETICAL FRAMEWORK FOR CLINICAL OPERATIONS

Bowenian theory presupposes, although it does not completely articulate, the full operational range of our model of enactments better than any other clinical theory, though the use of our model need not be restricted to Bowenian therapists. Bowenian theory articulated a fundamental conceptualization of clinical structure and process in terms of a relationship triangle (Kerr & Bowen, 1988). The distressed, dyadic system (which could consist of two persons or two subsystems) is viewed as compromised or impaired in terms of one or more of three key emotional processes—*relationship* (regard for self, other, and the relationship), *neutrality* (systemic perspective combined with focus on change, not blame), and *responsibility* (individual self-change and relationship problem-solving focus). Where relationship, neutrality, and/or responsibility are impaired in the client system, it is presumed to lead to emotional reactivity.

Therapists may respond to emotional reactivity in the client system by co-opting their anxiety and responsibility, thereby becoming the expert to the couple system and responsible for process and outcome. Couple responsibility is thereby jeopardized. Perhaps this is why a direct, therapist-responsible therapy style has been found to lead to poorer treatment outcome, whereas an indirect, couple-responsible therapy style has been found to lead to more positive treatment outcome (Butler & Bird, 2000; Butler & Wampler, 1999).

Bowen postulated that emotional reactivity would lead to triangulation—the involvement of a third entity in an attempt to relieve dyadic tension. The third party becomes instrumental in mediating dyadic tension. Bowen viewed the therapist as this third party, and his or her presence as a mediator was essential for therapeutic success. The role of the therapist was to contain emotional reactivity and push anxiety back into the dyad, then subsequently to facilitate its resolution within the dyad. As the therapist both manifested and promoted relationship, neutrality, and responsibility, the couple would become emotionally receptive (rather than reactive) once again and able to independently resolve their problems (Butler & Harper, 1994; Kerr & Bowen, 1988).

At this point, our model diverges from Bowen's. We believe that a clinical model that proposes the resolution of dyadic anxiety within the dyad under the watchful eye of a mediating third party presupposes enactments. The role of the therapist in traditional Bowenian theory is that of managing and dampening emotionally reactive relationship elements through therapist buffering. The majority of interaction in traditional Bowenian therapy is channeled through the therapist in an attempt to reduce anxiety. Emotional reactivity in couple dialogue is assumed to diminish as couple anxiety dissipates. In traditional Bowenian therapy, however, a couple is not encouraged to demonstrate this self-reliant interaction under the watchful eye of a therapist. In contrast, enactments allow a couple to enjoy an increase in self-reliant couple dialogue as their internal emotional state is further dampened, likely increasing the probability that interactional change will continue beyond therapy. Gottman and Gottman (1999) concur, and warn that making the therapist "irreplaceable . . . may maximize the couple's relapse once therapy terminates" (p. 310). Johnson and Greenberg (1995) describe a similar, couple self-reliant dialogue, noting that "it is clear when the therapy process is complete, because the couple is able to exit from negative cycles in the session, to sustain emotional engagement, and to be accessible and responsive to each other" (p. 130).

In accordance with Butler and Gardner (2003), the majority of therapist interaction in our model is also channeled through the therapist in the beginning stages of therapy until highly emotionally reactive couples can learn to soothe themselves on their own. Once the therapist and couple decide that the couple can manage their anxiety, our model proposes that relational anxiety be contained within the relational dyad, with the degree of therapist intrusion in a couple enactment negatively related to the couple's ability to manage their emotional reactivity (Butler & Gardner, 2003). The less emotionally reactive the couple becomes, the less the therapist structures the enactment. Thus, Bowenian clinical process theory addresses the containment of reactivity through therapist-channeled interaction and successful mediation through therapist-originated and therapist-promoted emotional processes of relationship, neutrality, and responsibility. Indeed, enactments can be a therapeutic vehicle used to promote relationship, neutrality, and responsibility in the couple system, while still providing the means for appropriate, incremental therapist exit from their relationship as it improves. As the less reactive couple invites the therapist into a relationship triangle, the therapist can redirect their anxieties to be contained and then resolved within their relationship by using an enactment. The therapist can thereby coach the couple to a resolution of their difficulties while promoting couple relationship, neutrality, and responsibility. As relationship, neutrality, and responsibility increase within the dyad through an enactment, the therapist is increasingly able to become a mediator rather than a director of couple process, culminating in the ability for the dyad to sustain healthy interaction on their own (Butler & Gardner, 2003).

Such a model of enactments, linking them to a potentially universal, generic treatment goal of couple interaction self-reliance, invites us to consider the possibility that enactments may be not just a stylistic preference in therapy, but also a significant component of clinical practice and demonstrable progress toward couple self-reliant interaction. Based on such a conceptualization of enactments within the broader process and outcome of MFT practice, we can begin to develop an operational understanding of enactments. The following section provides our proposed profile of a successful enactment.

OPERATIONALIZATION OF ENACTMENTS

Attempting to provide an integrated, common factor perspective on enactments across clinical models, Butler and Gardner (2003) outline five main purposes of enactments: (a) Facilitating communication care and skills; (b) redirecting relationship process or patterns; (c) restructuring relationships; (d) facilitating attachment-oriented emotional disclosure, sharing, and experience; and (e) assessment. Nichols and Fellenberg (2000) divide enactments into three phases: Initiation, facilitation, and closing. In their study, raters used 21 videotaped segments of 18 therapy sessions to determine therapist interventions contributing at each stage to a successful or unsuccessful enactment. To integrate the findings of both Nichols and Fellenberg (2000) and Butler and Gardner (2003), we will use the terms initiation, intervention, and evaluation, respectively, to represent the three stages of an enactment. Following the operationalization of an enactment will be a case vignette illustrating each of the therapist skills discussed below.

It is important to remember that, in their entirety, the skills discussed below represent a highly structured enactment. This level of detail is offered to allow the therapist to be able to match the amount of structure of an enactment with the degree of emotional reactivity present between the partners. Taken in their entirety, the skills discussed below would be appropriate for a stage-1 enactment as discussed by Butler and Gardner (2003). As a couple becomes increasingly independent in their healthy interaction (e.g., stages 2–5; Butler & Gardner, 2003) fewer operations would be utilized. Interested readers are referred to Butler and Gardner (2003) for a more detailed account of matching therapist involvement with couple reactivity.

Initiation Skills

Initiating an enactment consists of introducing the purpose of the enactment and the roles of both the client and therapist (see Table 1). Proper initiation helps the couple to understand the nature of the enactment and criteria for its success (Butler & Gardner, 2003; Nichols & Fellenberg, 2000).

Introducing roles and goals. The therapist must clearly explain the purpose of the enactment. Without the establishment of clear goals during the initiation phase, an enactment is more likely to founder. The therapist needs to rationalize the enactment in terms of the couple's goals in therapy. In addition, the therapist should clearly explain the roles of each partner. The clients should have an understanding of which behaviors will be needed if their goals are to be reached. The therapist also needs to explain the role of the therapist during the enactment. The couple should know what to expect from the therapist in terms of involvement, coaching, and so forth (Nichols & Fellenberg, 2000).

The therapist should explain that he or she will be peripheral to the dialogue, intervening briefly if the couple begins to wander from process likely to help them reach their goals. Therapists should also explain

Table 1
Components of the Initiation Phase of an Enactment.

Component	Task
Introduce goals/roles	Explain purpose of the enactment Explain the roles of each partner Explain the role of the therapist
Specify topic	Specify the content focus Set expectations for positive communication process Set expectations for attachment-based expression and listening
Establish structure	Arrange the spouses for couple interaction Request first-person language Remove self from couple interaction

the possible use of a proxy-voice perspective, which is discussed in detail later. As discussed earlier, Butler and Gardner's (2003) five stages of enactments suggest that the level of emotional reactivity present in the couple's relationship determines the level of therapist involvement necessary to mediate an enacted relationship successfully. Instructions given to the couple should reflect the therapist's intended level of involvement.

Specifying a topic and presupposing process success. To increase the likelihood of the enactment flowing smoothly, the therapist needs to specify a content focus. The content focus of an enactment is neither random nor haphazard, but rather it should be calibrated to the clients' current level of emotional reactivity and consistent with the overall process and problem focus in therapy. Carefully and collaboratively determining the content focus before the enactment begins may help to ensure that the couple will be able to sustain the enactment of their relationship to the successful conclusion of their current task. Next, the therapist needs to set expectations for positive communication process. The therapist should explain the "how to" of the specific communication skills focused on in the enactment (e.g., I-statements, reflective listening, validating, requesting change positively, etc.), briefly modeling them if necessary. The therapist should also set expectations for attachment-based emotional expression and listening during an enactment.

Because attachment issues may be an important basis for negative interactional cycles, a primary goal of an enactment is to help couples express their attachment-based emotions and to listen and respond to the emotional experience of their partner in a way that ensures emotional "safety" within the relationship (Greenberg & Johnson, 1988). Helping the couple understand how to express their primary emotions and listen to those of their partner, followed by careful coaching during the enactment (discussed later) can help ensure a positive emotional experience for a couple during the forthcoming enactment.

Establishing physical structure. The therapist should be sure to arrange the spouses physically so as to promote couple interaction. The therapist should have the couple turn their chairs to face each other, look each other in the eye, and move closer together if necessary. This helps the couple to focus on dyadic, rather than triadic, interaction, process, and goals (e.g., dyadic resolution rather than triadic alliance, etc.). This helps to avoid interaction process that potentially threatens neutrality and/or responsibility. Requesting first-person language, such as addressing their partner by name, or "I" and "you" rather than "he" or "they" also helps to ensure that the couple emphasizes the enactment of their relationship, not one with the therapist. Inviting the couple to use first names can also lead to an intensification of the emotional experience for both partners, which, if carefully coached, can lead to new, emotionally healing interactional cycles (Greenberg & Johnson, 1988; Johnson, 1996). Emotional and attachment-oriented expressions may be of greater effect when spoke directly to one's partner rather than "through" a third party. Finally, before beginning the enactment, the therapist should remove him or herself from couple interaction by creating either physical or interactional separation, or both (e.g., moving the chair away or looking down and "focusing" on notetaking). As needed to sustain couple interaction, the therapist may remind them that he or she is not "part of their conversation."

Intervention skills

The purpose of the intervention stage of enacted relationships is to give the couple an opportunity to practice communication and interaction skills discussed in the initiation stage, bring the emotional experience of the relationship into the open, work through attachment issues and needs, and resolve problems. During the intervention stage, the therapist is primarily a coach, facilitating and commending positive dialogue and circumventing and redirecting negative exchanges. Through therapist coaching, couples can be led to increasingly self-reliant interaction. Principles and practices for the intervention stage of enactments are described in detail below (see Table 2).

Sustaining positive couple interaction. The therapist must maintain positive couple interaction, keeping the couple engaged with one another once the enactment has begun (Nichols & Fellenberg, 2000). Sustaining couple interaction can be as simple as pointing to the disengaging person partner and saying, "Talk to her, not me." Clues that suggest the clients are disengaging include: (a) Using third person pronouns, (b) turning toward the therapist, or (c) breaking eye contact with their partner. Although the need to sustain interaction is important, the therapist should not interrupt the couple unnecessarily. This can be

Table 2
Components of the Intervention Phase of an Enactment.

Component	Task
Sustain interaction	Maintain positive couple interaction Commend positive interaction Interrupt negative interaction
Coach interaction	Promote positive expression Promote positive attending Assist positive expression and/or attending
Facilitate attachment-based interaction	Promote attachment-based expression Promote attachment-based listening Promote attachment-based responses

difficult, as even productive couple interaction can generate considerable anxiety for both the couple and the therapist. Hence, therapists too may need to rely on their understanding of the purpose and process of successful enactments and relationship mediation to maintain appropriate balance between unproductive extremes of intervention—either unnecessarily micromanaging couple interaction to the point that the emotional and attachment experience cannot occur and couples are frustrated even in their attempts to communicate; or adopting a *laissez faire* stance that allows destructive interaction to undermine relationship, neutrality, and responsibility in the couple. Therapist coaching should not be neglected when indicated, but should be carefully considered and briefly undertaken. Except in earlier stages of therapy with highly emotionally reactive couples (Butler & Gardner, 2003), extended teaching, advice giving, and interpretations should be avoided.

Therapists should commend positive interaction and interrupt and correct negative interaction. Through commendations, couple hopefulness regarding their ability to conduct their relationships successfully increases. Commendations should be brief, specific, and process (rather than content) oriented. Conversely, when the couple begins to wander from the goals of the enactment, the therapist needs to interrupt negative interaction and redirect the couple to a healthy interactional process. (Butler & Gardner, 2003; Nichols & Fellenberg, 2000).

When using an enactment, a therapist needs to distinguish between passionate and intense discussion and relationally destructive interaction (Carrère & Gottman, 1999). A therapist may be tempted to allow destructive interaction to escalate, provided that the couple seems to be working towards the goals of therapy. Adopting such a position prioritizes outcome over process in therapy, something interactional research suggests may ultimately undermine both couple process and outcome (Shields, Sprenkle, & Constantine, 1991). When therapists fail to structure enactments with sensitivity to process as well as outcome, the conversation can quickly turn from a productive, therapist-coached dialogue to an escalation of destructive criticism, contempt, negativity, defensiveness and/or hostility, and withdrawal (Driver et al., 2003). It is imperative that therapists maintain their professional position in terms of their authority and responsibility to interrupt destructive interaction.

On occasion, a time-out from the enactment may be called to redirect the couple to healthier process. Reinstating positive interaction often includes a collaborative review and renewal of the couple's relationship goals, followed by evaluation of current interaction in light of those goals, and concluding with review and restoration of interaction more conducive to those goals. On occasion, when one or both partners is stuck, the therapist can briefly model effective communication or use a proxy-voice perspective to

facilitate needed and positive emotional expression, and then turn the interaction back to the couple.

Coaching interaction. Pauses during enactments need not elicit therapist intervention (Nichols & Fellenberg, 2000). If partners seem genuinely stuck, the therapist can assist minimally. Promoting positive expression can be a minimally intrusive form of helping couples to continue their dialogue when stuck. Therapist promotion of positive couple expression includes facilitating standard speaking and meta-communication skills, as well as emotional and attachment-focused expression. The therapist can also promote positive attending, including routine listening skills, empathic listening, and deescalation principles and practices.

When a counterproductive sequence of exchanges persists, or begins to escalate, or the couple is having difficulty implementing the skills outlined in the initiation phase, the therapist should assist positive attending and/or expression. Assisting positive expression and/or attending involves a greater interruption than promoting positive expression and/or attending. A therapist can assist positive attending and/or expression by reframing what was said in a way conducive to being heard or restating what was said in more clear and succinct language.

Assistance can also be offered by means of a proxy-voice perspective in which the therapist slides his or her chair behind either the acting or attending partner and speaks (or listens) on their behalf. The therapists' purpose is to unlock underlying issues and unblock expression. After offering proxy-voice perspective, the therapist physically removes himself or herself from the couple dialogue again. Because the purpose of the proxy-voice intervention is to get the clients "unstuck" by introducing a new, healing dialogue, the therapist should be more concerned about the process of what he or she says than the content. The client should feel free to edit what the therapist says and respond in his or her own words using the process modeled by the therapist. An example of a proxy-voice intervention will be included later in the case vignette section of this article.

Facilitating attachment-based interaction. Successful intimate interaction requires tracking multiple channels of interaction, including content, emotion, and attachment messages. Interaction can bog down or escalate destructively when a couple becomes mired in the content of a discussion, failing to attend to and resolve emotions or neglecting underlying attachment needs that are implicit in the dialogue. Healing in a relationship is often tied as much or more to these latter two channels of communication and relationship as to the content level. As previously mentioned, one of the main purposes of an enactment is to facilitate the couple in expressing and responding to attachment-based emotions (Butler & Gardner, 2003; Greenberg & Johnson, 1988; Johnson, 1996). As this occurs, the couple often experiences each other in a new way and responds in a manner conducive to healing from past relational wounds.

As a therapist learns to track the emotional experiences of each partner, he or she can encourage and facilitate each partner in doing the same for themselves and for their partner. The enactment can be interrupted and congruence encouraged when there is incongruence between what is felt and what is expressed. With the speaking partner, the therapist can promote attachment-based expression. A common intervention designed to promote attachment-based expression during an enactment is to use a proxy-voice perspective (previously discussed) to speak the unspoken and promote awareness of underlying emotions and/or attachment needs (Butler & Gardner, 2003).

Another common intervention for softening the often intense emotions present in an enactment is to reframe what one partner said in a way that is conducive to having it heard (Butler & Gardner, 2003). In this case, the therapist may speak from primary emotions or request changes positively, and then turn the interaction back over to the couple. As couples progress, the therapist will merely prompt the partners to do the same (Butler & Gardner, 2003). The therapist can also prompt the client to give voice to hidden emotions or attachment needs.

In addition to promoting attachment-based emotional expression, a therapist needs to promote attachment-based listening in order for the speaking partner to feel emotionally received, secure, and safe enough to continue the healing dialogue. As needed, the therapist can use a proxy-voice perspective to help the attending partner to discern the underlying emotions and attachment needs of the speaking partner. As couples progress, the therapist can prompt partners to "hear the emotion" behind what their partner is saying, and then encourage them to respond to that emotion. When deciding which intervention should be

used, determining the level of emotional reactivity (Butler & Gardner, 2003) and how "stuck" a couple is are often the best guides. In our model, successful enactments require careful therapist tracking, discernment, and discretion, with the goal being progress toward minimizing therapist intrusion and maximizing couple self-reliant interaction (Butler & Gardner, 2003; Nichols & Fellenberg, 2000), which, paradoxically, is facilitated most efficiently by appropriate and timely therapist intervention and coaching.

As the partners in a couple become more aware of one another's emotional experience and their own, they often need to be shown how to respond to each other in a way that allows the attachment-based dialogue to continue. In this case, the therapist needs to promote attachment-based responses. Again, this can be done with either a proxy-voice perspective or less intrusive prompting. In addition, therapists can prompt a partner to offer physical comfort to an emotionally expressive partner, thus possibly increasing the healing effect of the emotional expression.

Evaluation Skills

While Nichols and Fellenberg (2002, p. 148) suggest that the two primary methods for closing an enactment should be to "[describe the] specific nature of [the] problematic dynamic," and "[give] advice or suggestions about how participants should continue to work on their communication or relationship," we disagree. First, given that the goal of an enactment is to coach the couple toward sustaining positive interaction, we presume that a successful enactment is marked by the experience of successful interaction, and that effective coaching will have kept "problematic dynamics" to a minimum. In our view, enactments ought to be an experiential intervention, rather than assessment followed by didactic intervention. Uncoached enactment processes can become destructive—leading both therapists and clients to resist their use—if allowed to simply "reenact" couples' at-home interaction. Except for limited purposes of assessment, occurring exclusively in the first sessions of therapy and explicitly conveyed to the couple as being permitted for the express purpose of assessing interaction, we believe that enactments should be coached to success.

Although this poses significant challenges during the beginning stages of therapy, when couples/families may be highly emotionally reactive (Butler & Gardner, 2003), we believe that an enactment should, nevertheless, not continue until it breaks down. Butler and Gardner (2003) propose a 5-stage model to calibrate the process and structure of enactments and therapist intervention to a couple's presenting interactional conditions. This model allows therapists to coach successful enactments even with highly distressed couples/families.

In addition, a review of a significant body of research literature suggests that direct, didactic interventions such as, "[describing] the nature of the problematic dynamic" or "[giving] advice or suggestions" is associated with more negative treatment outcomes and higher treatment dropout, whereas an indirect, inductive stance is associated with more positive treatment outcome and lower treatment dropout (Butler & Bird, 2000). We propose that using inductive questioning, allowing the couple to analyze their interaction process on their own and draw conclusions from them, may increase ability to both "own" the evaluation and critique of their process and respond to it. Developing and enhancing couples' ability to stand meta to their own interaction and change their behavior based on their evaluation also promotes their ultimate interactional self-reliance. Examples of evaluating an enactment using inductive process will be given in the vignette section.

Both the couple and therapist will usually sense when the stated purpose of a particular enactment has been fulfilled. At that point, evaluating and processing the enactment is the critical, final stage of an enactment, although it is often inappropriately neglected or truncated. During evaluating and processing, the dialogue is still channeled through the couple. The purpose of evaluating and processing is to allow the couple to be introspective and to evaluate their interaction in light of their relationship goals. As they do this, they can recognize what each did to make the interaction a success and what pulled them away from their goals. Subsequently, they can establish mutual change goals and commitments. Although not every skill will be used each time an enactment is closed, we believe the following skills are necessary to the successful closing of an enactment (see Table 3):

Recalling goals. To close an enactment effectively, a therapist should first review enactment goals with

Table 3
Components of the Evaluation Phase of an Enactment.

Component	Task
Recall goals	Invite/review enactment goals Invite/review enactment roles Invite/recall overall therapy goals
Assess/evaluate	Invite clients to notice what went well Invite clients to commend each other for successes Invite clients to note where change is needed
Inviting commitments	Invite process commitments Invite content commitments Invite attachment-based commitments

the couple. In addition, the therapist should review enactment roles, inviting the couple to remember their individual roles in the process used to reach the goals. Once the couple remembers the goals of the enactment and their own role in achieving that goal, the therapist can help the couple recall overall therapy goals. This enables the couple to see how the enactment fits into their larger goals for therapy. Viewing their present interaction in light of their overall therapy goals can increase desire to persevere in their change work, even when difficult.

Assessing and evaluating. Once the couple has recalled their goals in therapy and the enactment, as well as their specific roles in meeting those goals, the therapist should first invite the couple to notice what went well. The therapist should facilitate the couple in reviewing each partner's positive contributions. Once the couple has highlighted what went well, the therapist can invite the couple to commend each other for successes. Partner's commendations of each other should be preferred to therapist commendations. Having partners express gratitude to the other can further encourage and solidify positive changes. Once the couple has commended each other, the therapist can invite the couple to notice where change is needed. The couple can discuss what was particularly difficult about the interaction and what each of them did that made it difficult to communicate effectively.

Inviting commitments. Once the couple has commended each other for the positive changes and noticed where improvement can still be made, the therapist invites each member of the couple to make commitments to his or her partner to ensure and extend improvements in their relationship. Inviting process commitments is particularly important. The couple should commit to the relationship, neutrality, and responsibility behaviors and attitudes that were present in the enactment that facilitated healthy process. In addition, the therapist can invite content commitments. Couples are often anxious to have specific problems resolved in therapy. Enactments provide couples this opportunity through their dialogue. Evaluating the enactment provides further opportunity to make commitments to each other that can aid in the resolution of the content of their problem. Any progress made toward the resolution of the specific problem being discussed can be highlighted and the couple can commit to make whatever changes necessary to implement the content goals they discussed in the enactment.

The therapist can also invite emotion and attachment-based commitments. The couple can commit to attachment-based process such as expressing their primary (rather than secondary) emotions in future interactions and attending to the emotions and attachment needs underlying what their partner is saying.

FACILITATING AN OPERATIONAL UNDERSTANDING: A CASE VIGNETTE

Now that an operational definition of a successful enactment has been outlined, a case vignette will be provided to facilitate an understanding of the various components of an enactment. The couple in the vignette, Spencer and Lotta, have been married for 12 years and have two young children. Since the birth of their last child, Spencer has been spending more and more time at work. Lotta has begun to resent this, as she spends the day at home with the children and is feeling increasingly alienated from the support and love of her husband. The couple has been in therapy for six sessions. They have made considerable progress in attachment-based expression and basic communication skills. Their relationship follows a pursue–withdraw pattern, with Spencer's withdrawing to work exacerbating Lotta's pursuing, and vice versa. The specific enactment skill will be italicized. In addition, to provide examples of each skill in the space allotted, the level of therapist intrusion into the enactment is higher than it would be in a real session, with the possible exception of highly emotionally reactive couples. See Butler and Gardner (2003) for suggestions about matching couple emotional reactivity with therapist intrusion in the couple process.

Initiation Phase

Therapist: You have both mentioned that you would like to better understand each other's emotional experience in your marriage. By the end of our session today, I hope that you will each understand more of what it is like to be in your partner's shoes (*explains purpose of the enactment*). To do that, I want you to slide your chairs closer to each other, turning so you are facing each other. When talking to each other, please look each other in the eye (*arranges spouses for couple interaction*). Spencer, I would like you to discuss what it feels like when you come home from work and Lotta gets mad at you right away. Lotta, please share the feelings you are experiencing when Spencer comes home from a long absence and starts watching TV right away (*specifies the content focus*). Instead of talking about how mad each of you is, I would like you to talk about what it "means" to you, and the feelings that arise from those meanings. Are you sad, hurt, or something else? Try to express that. For the partner who is listening, I would like you to avoid defending yourself. Don't think of what you are going to say next. Instead, try to understand what your partner is feeling (*sets expectations for attachment-based expression and listening*). After one of you has had a chance to talk, I would like the listener to reflect back to the other one what they seem to be feeling. Don't worry about whether you agree with them or not. In fact, you probably won't agree with them. That is okay. You don't have to agree in order to understand. For now, you are working on understanding each other rather than proving your point (*sets expectations for positive communication process*). I will sit back out of the way and may occasionally give brief directions or suggestions, but I want you to talk to each other rather than me. I can tell if you are talking to me when you start to use third-person pronouns, such as he or she, so avoid that. At times I may slide my chair behind one of you and speak as if I were you. When I do that, you can choose to agree or disagree with what I say (*explains role of both spouse and therapist, requesting first-person language*). So, who wants to go first? (*therapist slides back, removing herself or himself from couple interaction*)

Intervention Phase

Lotta: I'll go. Spencer, you really hurt me when . . .

Therapist: Remember "I messages," Lotta (*promotes positive expression*).

Lotta: Oh, that's right. Spencer, I really miss you. I have felt really lonely with you being gone so much lately. I'm not angry—just hurt. I just don't know what I can do to help our relationship remain the way it was for so long so I get frustrated and lash out at you. I remember how special I used to feel to you. Now I wonder if you don't want to be around me. I really feel lonely. I just miss you, Spencer.

Spencer: I had no idea you felt this way [pause].

Therapist: Lotta, I really like how you were able to express what you were really feeling to Spencer. I know it can be hard to make yourself so vulnerable (*commends positive interaction*). Spencer, you were telling Lotta that this is a side of her you had not seen before [motions to Spencer to continue the dialogue].

Spencer: Right. I can't believe you have been hiding how you felt from me all this time! You sure could have come out with this a lot earlier and saved us both a lot of . . .

Therapist: [Holds up a time-out signal] Whoa, Spencer—time out for a second (*interrupts negative interaction*)! [Calmly] I can tell this is a new thing for you to hear from Lotta right now. First of all, what is Lotta saying to you (*promotes positive attending*)?

Spencer: Well, she seems to be telling me . . . [therapist gestures to Lotta, indicating that Spencer should talk to Lotta rather than to the therapist] (*maintains positive couple interaction*) Oh yeah. You are saying that you feel lonely—that you wonder if I really want to be around you anymore. You are feeling hurt and you miss me.

Lotta: Yes, that is exactly how I am feeling.

Therapist: [After a pause during which Spencer seems stuck] How might you respond to her in a way that will make her feel safe enough to be able to continue talking with you like she is (*promotes attachment-based responses*)?

Spencer: I realize now that I hurt you by coming home late. I am sorry. I really had no intention of hurting you.

Lotta: I still don't understand why you keep coming home late! If you didn't want to hurt me, what were you doing? Of course you hurt me!

Therapist: Lotta, perhaps you could say, "Spencer, I am confused. If you didn't mean to hurt me, please help me understand what you did mean to do by coming home late" (*assists positive expression*).

Lotta: Yeah, that really is what I am feeling. [In her own words, Lotta repeats what the therapist said.]

Therapist: [After a long pause during which Spencer seems genuinely stuck] Spencer, I am going to speak as if I were you. I will try to speak from the emotions and needs that I perceive underlie what might want to say. I'll need your help. After I am done, clarify, correct, or add to what I said as you see fit. Then continue speaking where I left off [therapist slides his/her chair behind Spencer]. "Lotta, I sincerely didn't know what else to do. I was afraid that I would get hurt by your yelling at me when I came home, so I would just stay at work. I want to help so badly, but I just don't know how to reach out without getting bitten, so it seems safer to stay away. I'm scared" (*promoes attachment-based expression*).

Spencer: [Therapist slides his or her chair back to its original position] Lotta, that is exactly how I feel. I feel helpless, even a little scared—like I don't know how to reach out.

Lotta: Yeah, okay. That makes sense.

Therapist: Lotta, go a little deeper. See if you can reflect back to Spencer what you perceive he is feeling (*promotes attachment-based listening*).

Lotta: You are feeling really scared [pause]. I had no idea that I came across as scary to you. I just didn't know how else . . . [starts crying]

Spencer: [Holds her hand and looking into her eyes until she stops crying] It's okay. I can see how I would not have been very approachable. This mess is my fault as much as it is yours.

Lotta: I am sorry too. I can see how my nagging could be a little overwhelming.

Evaluation Phase

Therapist: Unfortunately, we are running out of time. I am really impressed with the progress you are both making. When we began this session, what goals did you have (*reviews enactment goals*)?

Spencer: We wanted to understand each other's emotional experience more fully.

Therapist: What was each of you going to do in order to reach this goal (*reviews enactment roles*)?

Lotta: We were going to listen to the other person and then respond nondefensively. We were also

going to try to express ourselves in terms of our "softer" emotions instead of the usual anger or silence.

Therapist: How do these goals fit into your goals for the "larger picture" of therapy (*reviews therapy goals*)?

Spencer: Well, if we could do that we would likely stop arguing and overall feel more love for each other.

Therapist: What about this interaction allowed you to reach your goal of understanding each other's emotional experience more fully (*invites the couple to notice what went well*)?

Spencer: Lotta, I really appreciated the way you refrained from attacking me. That really helped me open up a lot. I felt a lot safer around you today.

Lotta: Thanks. The fact that you started telling me what was bothering you really helped a lot. I can get so frustrated not knowing what is going on with you—it is easy to start assuming the worst. I appreciate you taking the risk to open up to me.

Therapist: I noticed the same things, and admired the courage you both showed in taking the risks that you did today (*adds to the commendations for successes*). Tell each other what pushed you away from your goal (*invites clients to note where change is needed*).

Spencer: Well, I noticed that when you started nagging again, I immediately shut down. You are really intimidating to me when you nag. I realize now that a big reason that you nag is because I close down, but it really helps me not close down when you don't nag.

Lotta: Well, it is the same for me. I found myself getting really frustrated when you would close down. I would think, "Oh no, here we go again," and just give up.

Therapist: Given what went well and what didn't, decide together on some goals you would like to set to ensure future conversations go well (*invites process commitments*).

Spencer: I realize that you nag when I close up. I am willing to start opening up more.

Lotta: And I am willing to stop nagging. I can see how my nagging would make you want to close up. I think it would also help if we kindly called each other on the carpet when we started to nag or close up. Sometimes it is hard for me to realize that I am nagging.

Spencer: I think that is a good idea. We could stop and resolve to go about solving things differently.

Therapist: What could you do to ensure that there are no hurt feelings in the future if Spencer did come home late or if Lotta did nag Spencer when he came home (*invites content commitments*)?

Lotta: Well, Spencer, if you came home and I started nagging could you just ask me what is wrong? Maybe I have just had a bad day or something, and my nagging won't have anything to do with you coming home late. If it does, just call me on it and I will try to stop.

Spencer: I can do that. If I have to come home late from work, I promise that I will call you as soon as I find that out. I won't come home late because I am afraid of coming home anymore. I will only come home late if there is a legitimate reason.

Therapist: I was very impressed with the way you were each able to open up and be more emotionally vulnerable. Tell each other what you can do to ensure that this will continue in the future (*invites attachment-based commitments*).

Lotta: I think that it is just a matter of being more aware of what the other may be feeling and responding accordingly. Taking responsibility for responding in ways that help the other partner show their vulnerability is also a big part.

Spencer: I agree. If we can both do each of those things, we should be able to be much more emotionally genuine with each other.

LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

Our model of enactments has been developed primarily for couples. Significant developmental differences and power dynamics at play in families may necessitate significant adjustments to the structure of enactments, a task that is beyond the scope of this article. In addition, our proposed model of enactments differs from and is not intended to supercede specialized methods of using enactments within specific models, such as those described elsewhere for structural therapy (Minuchin & Fishman, 1981; Nichols &

Fellenberg, 2000). Also, our model utilizes emotional reactivity in the couple as a primary guiding element when conceptualizing when to use an enactment, how structured it should be (Butler & Gardner, 2003), and to what purpose it should be used. We recognize that some systemic therapists do not think in terms of emotionality, and acknowledge that such clinicians would have to adapt our model to suit their purposes.

Future process research investigating the effects of enactments on therapy outcome promises to be interesting. Specifically, we would be interested to see if the effects of enactment-oriented therapy on outcome and follow-up are different from primarily therapist-centered therapies. We hypothesize that, since therapist-coached enactments offer a vehicle for a couple to achieve self-reliant interaction that is not found in therapist-centered therapies, positive effects of enactment-based therapies would be stronger at follow-up than therapist-centered therapies.

CONCLUSION

Recent interest in change-promoting clinical process and mechanisms common across models of therapy has spurred our consideration of enactments as a possible common clinical process dimension promoting change in relationship-oriented therapy. The dynamic utilization of relationships to bring about change is a characteristic unique to MFT, both conceptually and operationally. A primary operation in MFT is relational mediation and coaching, which presupposes the use of enactments. Most MFT models utilize enactments in some form or another in their attempt to facilitate relationship change. However, despite their widespread use, research suggests that therapists may not understand how to effectively use enactments (Nichols & Fellenberg, 2000). This problem is compounded by the absence of a theoretical basis and operational profile of enactments for therapists from diverse theoretical orientations wishing to know when and to what purpose to use enactments (Butler & Gardner, 2003). Existing explications of enactments emphasize a structural perspective (Allen-Eckert et al., 2002; Nichols & Fellenberg, 2000).

We believe that the Bowenian concepts of relationship, neutrality, and responsibility (Butler & Harper, 1994; Kerr & Bowen, 1988), provide a useful and general theoretical framework for modeling the purpose and profiling the operations of enactments. We have elaborated a three-component model of enactments based on this foundation that hopefully will help clinicians to know when, to what purpose, and how to use enactments, regardless of theoretical orientation.

REFERENCES

Allen-Eckert, H., Fong, E., Nichols, M. P., Watson, N., & Liddle, H. A. (2001). Development of the family therapy enactment rating scale. *Family Process, 40,* 469–478.

Anderson, H., & Goolishan, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 21,* 371–393.

Aponte, H. J., & VanDuesen, J. M. (1991). Structural family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy:* Vol. I (pp. 310–360). New York: Brunner/Mazel.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–55). Washington, DC: American Psychological Association.

Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy, 27,* 385–401.

Butler, M. H. (1996). *Effects of direct and indirect therapy styles on therapist-couple struggle, cooperation, and responsibility.* Unpublished doctoral dissertation, Texas Tech University, Lubbock, TX.

Butler, M. H., & Bird, M. H. (2000). Narrative and interactional process for preventing harmful struggle in therapy: An integrative model. *Journal of Marital and Family Therapy, 26,* 123–142.

Butler, M. H., & Gardner, B. C. (2003). Adapting enactments to couple reactivity: Five developmental stages. *Journal of Marital and Family Therapy, 29,* 311–328.

Butler, M. H., & Harper, J. M. (1994). The divine triangle: God in the marital system of religious couples. *Family Process, 33,* 277–286.

Butler, M. H., & Wampler, K. S. (1999). Couple-responsible therapy process: Positive proximal outcomes. *Family Process, 38,* 27–54.

Carrère, S., & Gottman, J. M. (1999). Predicting divorce among newlyweds from the first three minutes of a marital conflict discussion. *Family Process, 38,* 293–301.

Driver, J., Tabares, A., Shapiro, A., Nahm, E. Y., & Gottman, J. M. (2003). Interactional patterns in marital success and failure: Gottman laboratory studies. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (pp. 493–513). New York: Guilford Press.

Gottman, J. M., & Gottman, J. S. (1999). The marriage survival kit: A research-based marital therapy. In R. Berger & M. T. Hannah (Eds.), *Preventive approaches in couples therapy* (pp. 304–330). Philadelphia, PA: Brunner/Mazel.

Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples.* New York: Guilford Press.

Guerney, B., Jr., Brock, G., & Coufal, J. (1986). Integrating marital therapy and enrichment: The Relationship Enhancement approach. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 151–172). New York: Guilford Press.

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles.* New York: Brunner/Mazel.

Johnson, S. M. (1996). Creating connection: *The practice of emotionally focused marital therapy.* New York: Brunner/Mazel.

Johnson, S. M., & Greenberg, L. S. (1995). The emotionally focused approach to problems in adult attachment. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 121–141). New York: Guilford Press.

Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach to Bowen theory.* New York: W. W. Norton.

Lambert, M. J. (Ed.). (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.). New York: John Wiley.

Miller, S., Nunnally, E. W., & Wackman, D. B. (1976). Minnesota Couples Communication Program (MCCP): Premarital and marital groups. In D. H. L. Olson (Ed.), *Treating relationships* (pp. 21–39). Lake Mills, IA: Graphic.

Minuchin, S., & Fishman, C. H. (1981). *Family therapy techniques.* Cambridge, MA: Harvard University Press.

Nichols, M. P. (1984). *Family therapy: Concepts and methods.* New York: Gardner Press.

Nichols, M. P, & Fellenberg, S. (2000). The effective use of enactments in family therapy: A discovery-oriented process study. *Journal of Marital and Family Therapy, 26,* 143–152.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy.* New York: Norton.

Sexton, T. L., & Alexander, J. F. (2004). Levels of evidence for the models and mechanisms of therapeutic change in family and couple therapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 590–646). New York: John Wiley.

Sexton, T. L., Ridley, C. R., & Kleiner, A. J. (2004). Beyond common factors: Multilevel-process models of therapeutic change in marriage and family therapy. *Journal of Marital and Family Therapy, 30,* 131–149.

Sexton, T. L., & Ridley, C. R. (2004). Implications of a moderated common factors approach: Does it move the field forward? *Journal of Marital and Family Therapy, 30,* 159–163.

Shields, C. G., Sprenkle, D. H., & Constantine, J. A. (1991). Anatomy of an initial interview: The importance of joining and structuring skills. *American Journal of Family Therapy, 19,* 3–18.

Simon, G. M. (1995). A revisionist rendering of structural family therapy. *Journal of Marital and Family Therapy, 21,* 17–26.

Sprenkle, D. H., & Blow, A. J. (2004*a*). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30,* 113–129.

Sprenkle, D. H., & Blow, A. J. (2004*b*). Common factors are not islands—they work through models: A response to Sexton, Ridley, and Kleiner. *Journal of Marital and Family Therapy, 30,* 151–157.

Sprenkle, D. H., Blow, A. J., & Dickey, M. H. (1999). Common factors and other non-technique variables in marriage and family therapy. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 329–359). Washington, DC: American Psychological Association.

Wampler, K. (1997). *Systems theory and outpatient mental health treatment: Twelve priorities for MFT research.* Paper presented at the Inaugural AAMFT Research Conference, Santa Fe, NM.