



Contrasting Cases in Two Psychotherapeutic Processes Based on Integrative Behavior Couple Therapy

Contraste de casos en dos procesos psicoterapéuticos basados en la terapia de pareja conductual integradora

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Abstract

The present study proposes an evaluation of the therapeutic process in relation to the following aspects: the therapist adherence, the items which are more and less characteristic in the treatment and the interaction structures, along the therapeutic process of two cases of couple therapy, one with significant positive clinical change and one with significant negative clinical change, in the couple's evaluation. This work used Integrative Behavioral Couple Therapy model, one of the approaches of the third wave therapies. The method was a study of contrasting cases. The similarities and differences between the cases were discussed, reaching the conclusion that there are aspects of the couple, the therapist, the therapeutic relationship and the context that may have contributed to the different outcomes.

Keywords: Couples Therapy; Psychotherapeutic Processes; Marriage; Case Reports

Resumen

El presente estudio propone una evaluación del proceso terapéutico en relación con los siguientes aspectos: la adherencia del terapeuta, los ítems más y menos característicos en el tratamiento y las estructuras de interacción, a lo largo del proceso terapéutico de dos casos de terapia de pareja, uno con cambio clínico positivo significativo y otro con cambio clínico negativo significativo, en la evaluación de la pareja. En este trabajo se utilizó el modelo de Terapia de Pareja Conductual Integrativa, uno de los enfoques de las terapias de tercera ola. El método fue un estudio de casos contrastados. Se discutieron las similitudes y diferencias entre los casos, llegando a la conclusión de que hay aspectos de la pareja, del terapeuta, de la relación terapéutica y del contexto que pueden haber contribuido a los diferentes resultados.

Palabras clave: Terapia de Parejas; Procesos Psicoterapéuticos; Matrimonio; Informes de Casos

INTRODUCTION

Contextual Behavioral Therapies or Third Generation Therapies are defined by Steven Hayes (2004) as especially sensitive to the context of a psychological event and, mainly, to its functions. This is the basis of Integrative Behavioral Couple Therapy (IBCT) (Jacobson & Christensen, 1998). It has three essential characteristics regarding functional analysis as the basis for formulating the case, the concept of acceptance as a support for a lasting change, and it proposes to evoke private events instead of prescribing changes. Most marital therapeutic approaches concentrate directly on the problem behavior, whereas the frequency of positive and negative behaviors in the relationship between the partners is a critical determinant of marital problems, so that struggling couples often have increasing cycles of destructive behaviors in the relationship (South et al., 2010). Thus, rather than focusing on positive behavioral changes in the relationship, IBCT focuses on emotional acceptance because, when partners learn to genuinely accept themselves, positive changes occur naturally (Cordova et al., 1998; Christensen et al., 2018).

The therapeutic process is characterized by an initial stage of four sessions (the first and the last one with the couple and the two intermediaries with one spouse at a time), one phase of the therapeutic process itself and a final phase. For the evaluation and formulation of the case, the DEEP analysis is performed: differences in relation to the theme, existing emotional issues, external stressors that may be interfering with the situation and the pattern of interaction that the couple is working in an attempt to solve their problem. In the fourth session, when the couple receives a feedback of what was evaluated, it is considered the degree of suffering of both, which are the main areas of disagreement, or problem areas, the reason why they are so polarized, if the couple is committed to solving their problems. and remain together, which are the strengths of the relationship, and in what ways the therapy can help. To begin the couple therapy, a book is offered in order to be used as psychoeducation about marital relationships, acceptance, change, with exercises that can be used as homework (Christensen et al., 2018; Jacobson & Christensen, 1998; Vandenberghe, 2015).

The active treatment phase usually lasts for several months of weekly joint sessions, although an individual session may be scheduled when necessary. This part of the treatment focuses on significant recent incidents that triggered strong emotions. Incidents may be positive or negative and represent the prominent themes in the couple's relationship. Upcoming events may also be related to current problems and may be discussed during this phase (Christensen et al., 2018; Jacobson & Christensen, 1998; Vandenberghe, 2015).

The approach proposes acceptance strategies (Empathic Joining – EJ, Unified Detachment – UD and Tolerance Interventions – TI) and change strategies (Communication Skills Training, Problem Solving and Behavior Exchange). The EJ proposes a more empathic connection to problems that are undermining the relationship by accessing the underlying “softer” emotions – i.e., resentment – which are often obscured by the “harder” emotions and behaviors – i.e., verbal aggression and rage. It gives partners the opportunity to express their vulnerable side and allows them to interact and respond in more careful and constructive ways. UD proposes acceptance as each partner considers problems from a more objective and less emotional perspective by identifying and understanding the triggers, the context, and the sequence of behaviors and events that contribute to the conflict. TI also makes it possible to increase emotional acceptance by helping the couple understand that the intensity of a behavior can be controlled (for example, saying something in a less painful way) by identifying positive (i.e., functional) aspects of a problem, by observing the impact of their own behavior and by increasing self-care which helps lessen the demands each partner has on the other. Change strategies propose behavior exchange, communication skills training, and problem solving, which are techniques of traditional behavioral couple therapy and are used to help both partners develop more effective ways to communicate and solve their problems (Jacobson & Christensen, 1998; Vandenberghe, 2015).

Given the above, and due to the fact that contextual therapies are new in Brazil, there is a need to expand research on couple psychotherapy in this theoretical approach. With regard to studies on the effectiveness of psychotherapies, there is an idea that all of them offer similar results, as the common factors are the aspects that have potentiated the improvements. However, it is important to be cautious in this stance, due to the existence of few studies that prove the Dodo bird verdict, that is, “everyone wins and everyone deserves awards”, as there is a need to research how interventions happen (González-Blanch, & Carral-Fernández, 2017; Jones & Pulos, 1993; Serralta et al., 2010). Another aspect brought by César González-Blanch and Laura Carral-Fernández (2017) is loyalty to the therapeutic model, that is, the researcher is more likely to find positive results from their study model, so it is important not only the analysis of cases of therapeutic success, but also those which had other outcomes.

Bruce E. Wampold (2015) points out that success in psychotherapies may refer to common treatment factors, i.e., a trust-based patient-therapist relationship, an accepted and legitimized therapeutic context, a justification (or explanation) for problems and for therapeutic procedures that demonstrate the

competence of the therapist. The most studied common factor is the Therapeutic Alliance, as the main predictor of changes in different theoretical approaches. However, for González-Blanch and Carral-Fernández (2017), there are several different mechanisms that may produce similar results. Thus, beyond a particular theoretical approach, it is necessary to study how the techniques, the specific factors of a particular theory, and the common factors relate to each other (Norcross & Wampold, 2011).

Couple therapy also has common factors, which validate the approach to be followed. According to Lisa A. Benson et al. (2012), a couple therapist, compared to an individual therapist, generally has a more active attitude, in order to prevent the session from being a fighting arena and for the work to be effective. Thus, there are five basic principles for effective couples' therapy. The first one refers to altering the couple's view of the perception of their problem, excluding the "blame game", noticing the influence of their context as well as the form of dyadic interaction. The second principle focuses on modifying the dysfunctional behavior. Careful assessment should be made to see if clients are at risk for abusive situations. Even if the risk is not serious, IBCT's "take a break" strategy can be used, i.e., to stop the interaction and resume it at another time with less emotional reactivity (Mairal, 2016; Christensen et al., 2018; Jacobson, & Christensen, 1998). The third common factor, according to Benson et al. (2012), proposes to reduce the avoidance of emotions, and the therapist helps members to reveal their feelings, vulnerabilities and express their thoughts in a way that may bring them closer. The fourth factor is aimed at improving communication. All effective couples' therapies focus on helping partners communicate more effectively. The fifth common factor refers to the highlighting and appreciation of the strengths of the relationship, especially in the final stage of therapy, when the goal is to reinforce functional interactions.

It should be emphasized that IBCT has three clinical trials to support its effectiveness as a viable treatment for marital difficulties (Christensen et al., 2010). In Brazil, no process studies focused on couple therapy were found. This type of investigation should be performed in the natural therapeutic setting to be more reliable to clinical practice, to provide records with greater methodological rigor and to allow the inclusion of instruments that measure process variables (Serralta et al., 2010).

Benson et al. (2012) report that there is a reciprocal relationship between therapy and the client's internal processes and the relationship between the therapeutic session and behavioral change outside the session. It further suggests that the use of acceptance-based strategies is related to the results, but we are still limited in our understanding of how these processes work. Moreo-

ver, these aspects have not been examined at IBCT. Thus, the present study proposes to evaluate the therapeutic process (therapist adherence, more and less characteristic items in the treatment and main interaction structures) of two contrasting cases of couple therapy according to the IBCT model, one with significant positive clinical change and another with significant negative clinical change (Dyadic Adjustment Scale, Spanier, 1976; Couple Questionnaire, Christensen, 2009).

METHOD

Research was carried out with a contrasting case study design, which proposes a comparison between different cases, demonstrating that there is no need for uniformity in the trajectories of change, revealing the plurality of social forms (Giraud, 2009; Yin, 2015).

Participants

We analyzed the cases of two couples who underwent Couple Integrative Behavior Therapy, which had contrasting clinical outcomes (Table 1).

RP Couple is made up of Ricardo, a 31-year-old lawyer and Paula, a 28-year-old pharmacist. The couple had been together for seven years. They came to couple therapy at a time when they broke up and resumed their relationship to help them decide whether or not to stay together. They were living in separate houses. One of the main disagreements was about the threshold between individuality and conjugality. Ricardo liked to go out with friends for a happy hour and Paula felt left out, thinking that this kind of activity should be with the couple together. At the end of the therapeutic process, the couple chose to officialize the relationship and get married.

AC Couple is made up of Alex, 35, hairdresser and Camila, 35, receptionist. They had been together for six months. They dated in their teens, got back together and decided to live together. The pursuit of couple therapy was due to many fights. They also said they disagreed about everything and each had one opinion without listening to the other. In times of quarrel, she insisted on speaking and imposing her opinion, while he got very angry and left the house. During the therapeutic process, they started working together, as well as there was the pregnancy and birth of the couple's daughter. At the end of the therapy, the couple chose to separate.

Therapists: There were two distinct therapists. The couple's therapist of RP couple (TPR) has had clinical experience for six years, and the couple's therapist of AC couple (TAC) has had for fifteen years. Both have specialization in

couple and family therapy, in contextual behavioral therapies, have had IBCT training with both the author of the approach, Andrew Christensen, as well as with the first author of this article, and underwent weekly supervision throughout the therapeutic process of the cases.

Couple therapy was performed based on the IBCT. The process of RP couple lasted 20 sessions and AC couple in 40 sessions. For the present study, 15 sessions of each case were analyzed, five at the beginning of the therapeutic process, five at the middle, and five at the end.

Measures

a) Sociodemographic data sheet: composed by age, profession, education, income, workload, relationship time, number, and age of children, among other characteristics.

b) Couple Questionnaire (Christensen, 2009). Evaluates marital satisfaction using a short 4-item form of the Satisfaction Index (Funk & Rogge, 2007), marital violence, and relationship commitment. It is used during the early phase of treatment to assess these three areas of functioning. The measure has an alpha of 0.94. Scores range from 0-21, with an average of 16 and a standard deviation of 4.7. Scores below 13.5 are considered in a critical range.

c) Dyadic Adjustment Scale – DAS (Spanier, 1976): Consisting of 32 items, with four domains: consensus, cohesion, satisfaction, and expression of affection. Of the 32 items, 30 score on a 6-point likert scale and 2 items have yes and no answers. In a Brazilian study presented by José Hernandez (2008), the total Cronbach's alpha of the scale was 0.93.

d) Frequency and acceptability of partner behavior inventory – FAPBI (Christensen & Jacobson, 1997; Doss & Christensen, 2006). It evaluates the frequency of positive and negative behaviors presented by the partners, and the acceptability of each behavior through 20 questions. Cronbach's alphas for acceptability and frequency of positive behaviors were higher than 0.75. However, Cronbach's Alphas for the acceptability and frequency of negative behaviors were lower (Acceptability: husband = 0.65; wife = 0.69) (Doss et al., 2005).

e) Therapist Fidelity and Competence Ratings (Doss & Christensen, 2006; Jacobson et al., 2000). It assesses aspects of the therapist divided into three parts: first, whether the therapist has organized a session agenda and structure, neutrality, understanding of the aspects brought about by the couple; the therapist's degree of interpersonal effectiveness; and the quality of the therapeutic alliance. The second part assesses initial aspects of treatment that involve case conceptualization: whether the therapist has performed case evalu-

ation and conceptualization according to IBCT principles, and feedback to the couple. The third part evaluates the strategies and techniques used. For each item, the therapist is rated on a scale (0-poor; 1-poor adequate; 2-average; 3-satisfactory; 4-good; 5-very good, and 6-excellent).

f) Couple Therapy Process Q-Set – CTQS (Keituri, 2013). It evaluates the therapeutic process of couple from PQS (Ablon & Jones, 1999; Jones & Pulos, 1993; Serralta et al., 2010). It is a technique of escalation for recording different aspects of therapy through session analysis. Consisting of 100 items that describe and classify the therapeutic process to fit a quantitative analysis. It evaluates the therapist and couple dyad interaction, the mood of the session, the therapist behaviors and the couple behaviors and experiences. The application of CTQS was authorized by its author, Pekka Peura, from the University of Jyväskylä in Finland. The sessions were recorded and submitted to the judges' evaluation.

g) Weekly Questionnaire (Christensen, 2009). There are questions about satisfaction, if there have been any episodes of spousal violence, it asks for an example of a positive and a negative interaction and if there will be any incident in the near future that may generate discomfort or concern between them. This is scored by adding the total of items. Scores range from 0-21, with an average of 16 and standard deviation of 4.7. Scores below 13.5 are considered in a range representing a critical situation. The measure has a Cronbach alpha of 0.94.

Ethical considerations and Procedures

This study was based on Resolution No. 510/2016 of the National Health Council and the approval of the Research Ethics Committee of UNISINOS (Opinion number 1,873,399). The participants signing the Informed Consent Form (ICF). The self-report instruments were applied at the beginning and the end of the therapy and a follow up six months later. For data collection for both therapeutic process evaluation and therapist adherence to the IBCT model, the sessions were recorded, and this footage was used only for the analysis of the results and watched by two independent judges, blinded to the cases and trained for both the Q methodology and the IBCT evaluation.

Data analysis

Initially, the outcome data were compared pre-test, post-test and follow up, by analyzing the Reliable Change Index (Jacobson & Truax, 1991) using an Excel Macro. The data from the measure that evaluates the therapist's adherence were entered in the database and the intraclass correlation coefficient was an-

alyzed among the judges, obtaining agreement indexes above .85. For process analysis, a specific database for the CTQS was prepared. Each session was scored by the judges, seeking an intraclass correlation coefficient of at least .70. When the index was not obtained, a third judge scored the session and, if it was not yet reached, the session was discarded. This occurred with three sessions of the AC case. After the judges' scores, the average of each session was calculated in the SPSS to form composite scores used in subsequent analyzes. It was then calculated the average of the items in the sessions, distinguishing the most and least characteristic during the whole treatment. For factor analysis, items with a mean of between 3.5 and 6.5 (scored as neutral) were excluded. In order to identify the main Interaction Structures, a factor analysis of the principal components, with Varimax rotation, was performed.

Table 1. Pre-treatment, post-treatment and six-month follow-up couple's evaluation

	RP Couple						AC Couple					
	Wife P			Husband R			Wife C			Husband A		
	Pre	Post	Follow									
Dyadic Adjustment ¹	81	79	88	52	67*	85*	70	78	34*	77	66	33*
Consensus ¹	42	39	48	20	33	51	31	36	3	37	22	22
Cohesion ¹	12	10	18	11	13	15	10	10	2	12	15	1
Satisfaction ¹	23	28	20	19	18	17	26	30	27	25	27	30
Affection ¹	9	7	8	7	7	8	7	5	2	7	3	4
Couple Questionnaire ²	14	18*	17	13	17*	16	12	8*	1*	12	6*	0*
Positive Frequencies ³	178	817	440	83	89	112	165	61	3	521	87	28
Negative Frequencies ³	5	2	1	1	4	0	19	3	7	19	10	37
Positive acceptability ³	51	59	63	82	55	57	75	68	85	85	50	99
Negative acceptability ³	63	80	78	80	74	81	21	71	43	66	70	81

Note. ¹ (Spanier, 1976); ² (Christensen, 2009); ³ (Christensen & Jacobson, 1997; Doss & Christensen, 2006); * Significant Clinical Change compared to pretreatment.

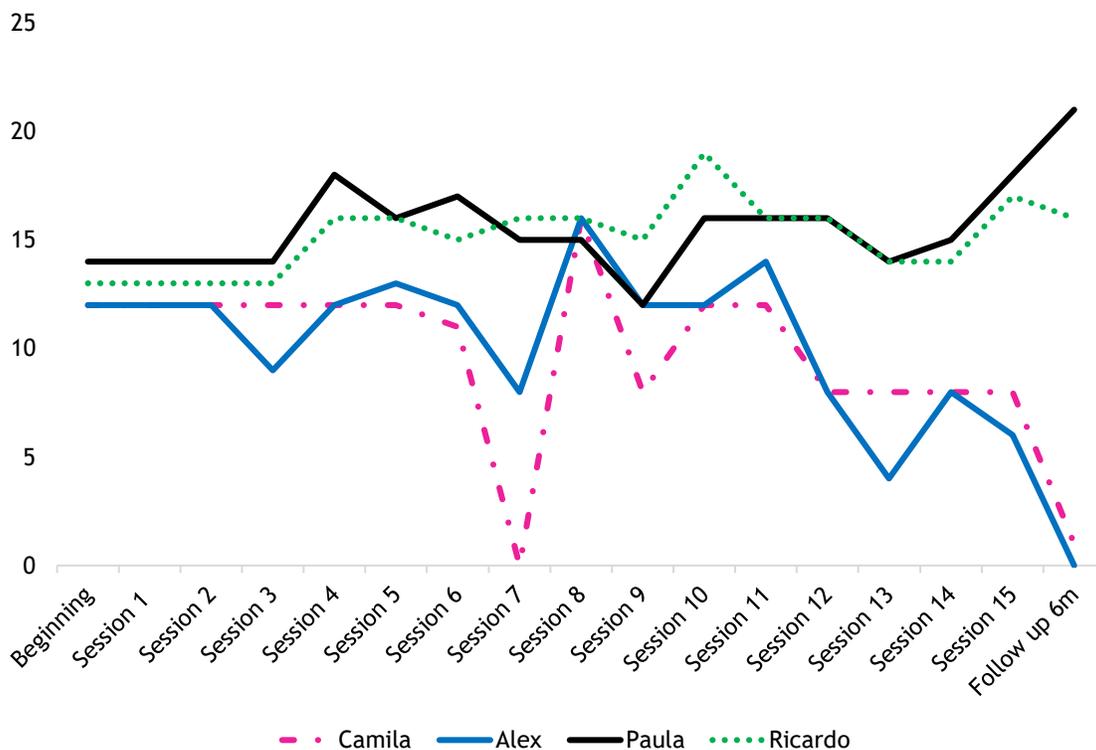
Results and Discussion

The results will be described according to the dimensions analyzed, presenting data from both couples (with significant positive and negative clinical change).

Satisfaction throughout the therapeutic process according to the Weekly Questionnaire

Regarding satisfaction during the therapeutic process, there was a variation in the level of satisfaction of both couples, but with greater stability in the PR couple. Paula already started at a good level of satisfaction, had negative variation in session 9, but ended the process more satisfied and showed even more satisfaction in the follow-up. Ricardo started at a critical point of satisfaction and showed a similar variation, with a fall in session 13. He ended the process more satisfied than he started, and had a slight drop in follow-up at six months. The AC couple started at a critical level. Camila had variations of lower satisfaction in sessions 7, 9 and 12, and higher satisfaction in sessions 8 and 11. She ended the process less satisfied than she started. Alex showed a similar variation, with a decrease in satisfaction in sessions 3, 7 and 13, and an increase in sessions 8 and 11. Both showed great dissatisfaction at follow-up six months after the end of therapy, period in which the separation of the couple occurred (Figure 1).

Figure 1. Weekly Questionnaire



The clinical change of the couple was reliable when comparing pre and posttest (RCI = 2.46) and ended at a non-clinical level (17.5), which coincides with the literature of IBCT studies, with long-term results (Christensen et al., 2006). Comparing with the level of satisfaction of the AC couple, there is a reliable clinical change (RCI = 3.07), but with a decline in the satisfaction of both. Throughout the treatment there were many variations, with extremes of satisfaction and dissatisfaction, probably associated with discontent due to the couple's emotional instability. At the end of the therapy, Alex was more dissatisfied than Camila, while at follow-up, both were extremely dissatisfied, probably reflecting the separation that occurred.

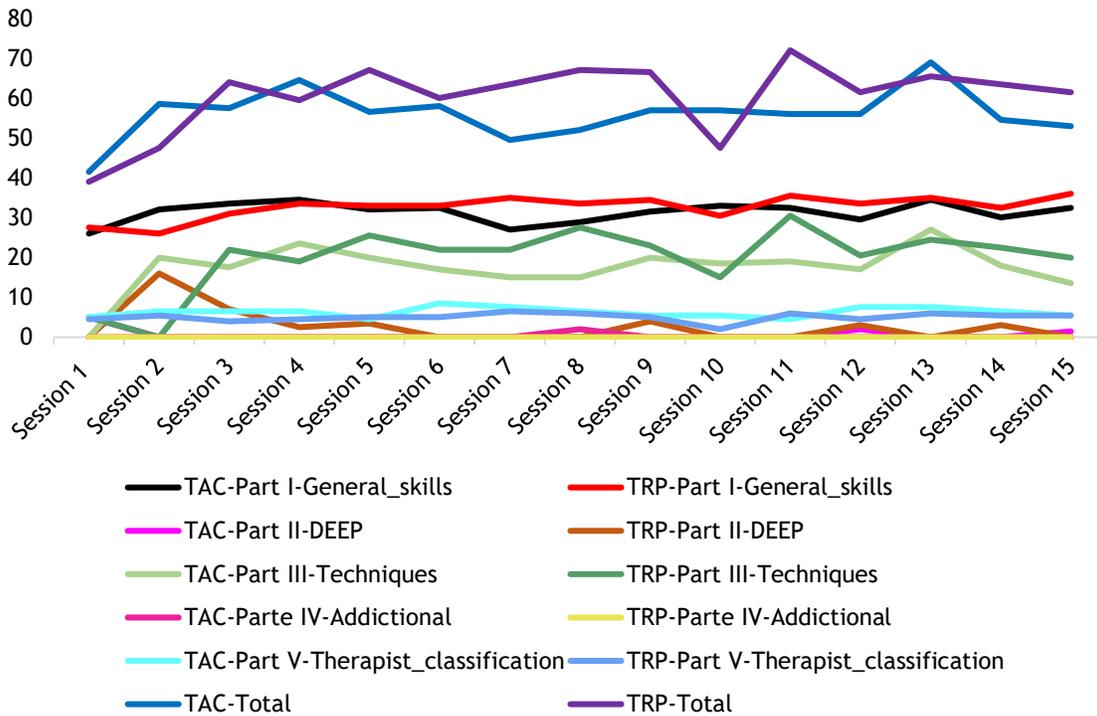
Brian Doss et al. (2005) examined the frequency and acceptability of target behaviors identified by the client as potential change mechanisms. There is evidence to suggest that increases in acceptance decrease the frequency of negative behaviors and increase the frequency of positive behaviors associated with better IBCT outcomes (Christensen et al., 2010; Silva, 2019; South et al., 2010). The results of this study for RP couple and AC couple are in agreement with the FAPBI studies (Buyukcan-Tetik et al., 2017; Doss & Christensen, 2006), which indicate that frequency and acceptance of positive and negative behaviors has an impact on marital satisfaction.

Therapist adherence to IBCT model

Referring to Part I of the instrument, the couple's therapist (TRP) and the couple's therapist AC (TAC) presented adequate general skills in most meetings: they organized the session agenda, kept the focus of each service, with a neutral attitude, capturing the different points of view of the couple, with listening skills, empathy and good quality of therapeutic alliance. Part II also indicated similarities between the therapists, considering that both performed an appropriate DEEP case formulation and feedback to the couples at the beginning of the treatment. Part III refers to strategies and techniques, where differences in results are noticed, with higher scores for TRP and greater use of repertoire of IBCT techniques (EJ acceptance strategies, UD, mindfulness practices and change strategies, and mainly communication skills training). Throughout the therapeutic process, a significant increase was observed in sessions 3 and 11 (maximum score) when the work was very effective. The variation of the CAT was more stable, with a more linear posture when applying the techniques, very often directed to the regulation of emotions. Part IV for both cases reveals that there was no additional consideration or justification for leaving the model. Finally, Part V rated that, overall, TRP was an excellent IBCT therapist, while TAC was a very good IBCT therapist. It is noteworthy that

the AC couple had a more difficult component for the therapeutic work due to the emotional deregulation of both partners (Figure 2).

Figure 2. Adherence of the Therapists to the IBCT model



Most and least characteristic items according to CTQS

By analyzing the most and least characteristic items of the selected sessions of the two couples, it was observed that the most specific items for both cases refer to the behaviors of the therapists. There was a good relationship between couples and therapists. For example, therapists communicated clearly, were receptive, and asked for more information. What is noticeable in both cases is that for the PR couple there are more characteristic items that refer to the therapist being neutral (item referring to the therapist), that the therapist and couple work to achieve common goals (item referring to the therapeutic alliance), and the relationship between the spouses is mediated by empathy, affection, and respect (item referring to the couple). For AC Couple, the most characteristic items, different from the RP couple, refer to the fact that the spouses bring important issues (item related to the couple), the therapist asks for perceptions about the relationship of the couple and other family members and the therapist is active. in the session (both referring to the therapist).

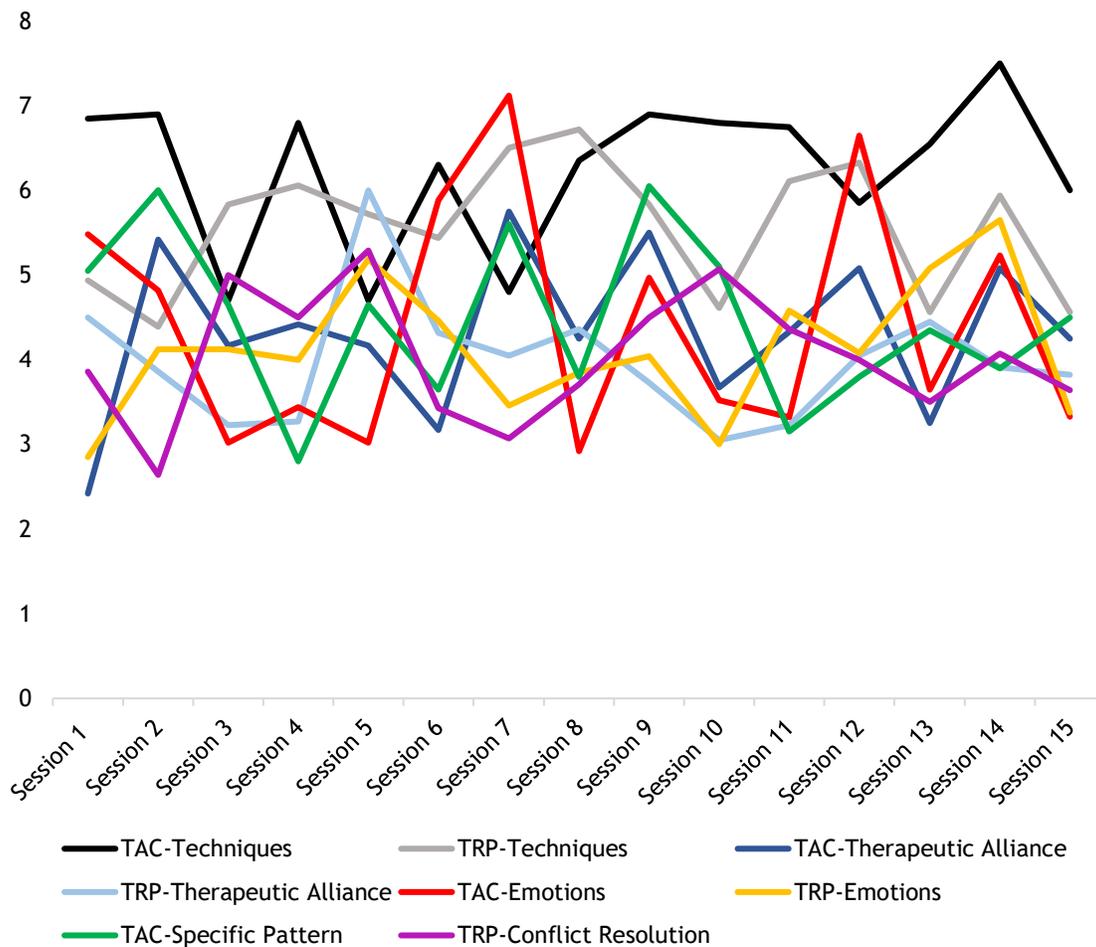
As for the least characteristic items, the comparison between the two couples indicates that, for both, the therapists have tact, the spouses have no difficulty understanding them, they feel confident, and they do not expect therapists to solve their problems. The least distinctive items are, for the RP couple, that the spouses interact with conversations that focus on the debate, feel understood by the therapist, and agree with the ideas regarding the problem, reaction patterns, and motivation (all relating to the couple). In turn, the less characteristic items for the AC couple, differently from the first couple, refer to the couple not having to seek the affection or sympathy of the therapist (item referring to the couple), as this validated the perceptions of the spouses and did not seem to be activated by the couple's questions (both referring to the therapist).

In both cases, the most characteristic items concern the therapist's conduct, a fact that converges with the IBCT, which advocates a more active posture (Jacobson & Christensen, 1998; Mairal, 2016). The main difference regarding the more and less characteristic items shows that the RP couple worked together with the therapist, in a great therapeutic alliance and considering the relationship, whereas the AC couple was more individualized, focused on each partner's internal issues, how they felt and with the expectation of changing the other.

Interaction Structures (IS) according to CTQS

The factorial analysis of the CTQS items of the therapeutic process showed for the RP couple four IS that represented 49.95% of the treatment variance and for the AC couple four IS that represented 59.85% of the variance. The most significant Interaction Structures of the RP couple were classified into Emotions (IS 1 with 17.79% of therapeutic variance and $\alpha = 0.896$), Technique (IS 2 with 11.75% of therapeutic variance and $\alpha = 0.867$), conflicts (IS 3 with 11.16% of therapeutic variance and $\alpha = 0.862$) and Therapeutic Alliance (IS 4 with represented 9.23% of therapeutic variance and $\alpha = 0.895$). In turn, the most significant ISs of the AC couple were Emotions (IS 1 with 28.99% of therapeutic variance and $\alpha = 0.981$), the same IS as the PR couple, but with greater variation, Technique (IS 2 with 12.28% therapeutic variance and $\alpha = 0.873$), Specific Pattern (IS 3 with 10.03% of therapeutic variance and $\alpha = 0.896$), which is different from the RP and Therapeutic Alliance (IS 4 with 8.55% therapeutic variance ($\alpha = 0.855$), according to Figure 3.

Figure 3. Variation of ISs of couples



IS 1 Emotions for the RP couple referred to the couple experiencing unpleasant affections, for example, Paula felt angry and sad when Ricardo wanted to go out with friends and said nothing to her. He was angry at the thought that Paula wanted to control him, guilt for leaving her alone, and feared that she would start a fight. Both were saddened by the consequent withdrawal of the couple. In therapy sessions, they both feared to talk openly about these feelings. IS 1 Emotions for the AC couple also covered aspects of the painful affections both experienced, especially anger and sadness. Both Camila and Alex had high emotional sensitivity, which was frequently triggered and generated intense arguments. Camila was jealous of Alex’s relationship with her clients and acted aggressively. Alex, in turn, was angry with her when he thought he was being unfairly judged. Sometimes, in these moments, Alex would leave home. This

behavior happened twice in the therapeutic setting. There were times when the couple would be reluctant to talk to avoid triggering intense emotions.

Regarding the interaction structures provided by the factor analysis, the IS Emotions was present in both cases, but with a higher variance in the AC couple. This fact can be attributed to the emotional instability of both partners.

The IS 2 Technique for the RP couple covers the therapist's requests for the couple to present a typical pattern of interaction, for example, to ask Ricardo to show how he was planning his birthday with different groups, and that Paula would not be invited and what she did when she knew. The therapist provided the opportunity to analyze thoughts and emotions through various mindfulness practices, as well as communication and EU skills training, for example, by asking the couple to observe their feelings and to connect with their learning stories. Since Ricardo felt invaded by his mother's behavior, he avoided too much proximity to Paula so as not to be controlled, while she only spoke of superficial things, not mentioning how sad she was feeling because, in her learning history, the family did not talk about deeper issues. The EU's proposal was for the couple to turn to each other and talk without accusation about their perceptions and feelings. The IS 2 Technique for the AC couple points out to therapist strategies, especially those focused on working with emotions: psychoeducation, mindfulness practices (Walser & Westrup, 2009), UD when observing the repercussions of this pattern on the relationship and strategies for emotional dysregulation of Dialectical Behavior Therapy (Linehan, 1993). The therapist validated their feelings, was self-assured and self-confident, and had the sensitivity to deal with both.

The Technique IE also present in both cases, even with a similar variance, presented some different behaviors among therapists. TRP used acceptance strategies such as EJ in helping the couple access the soft emotion, UD at times when it helped to have a perspective look at the problem which was being worked and many mindfulness techniques. It also applied tolerance strategies, and especially the change strategy of communication skills training. In turn, TAC had as its differential the work focused on the regulation of emotions.

IS 3 for the RP couple was Conflict Resolution, being an IS different from the AC couple. It revealed that the RP couple began to deal with conflicts positively. Ricardo started talking to Paula about his schedules with his friends and Paula, feeling included, did not care so much about him going out without her, so the difference being considered is that she was participating in the decision of the situation with him and not just being communicated as it used to happen. IS 3 for AC couple is Specific Pattern. It refers to the couple's emotional reactivity pattern, relating it to the impact of private events and the situations

of their learning history. Alex's father left the family when he was little. He was raised by his mother, who fought a lot with him and his sister. Camila's parents were very critical and invalidating, nothing she would do was seen as positive, so she felt abandoned. As a possible repercussion in the relationship, Alex's main strategy as an attempt to solve problems was to leave home (similar to his father) and in the face of any criticism of Alex towards Camila, she felt very invalidated and reactive, as she used to towards her parents.

The third IS of the couples was different. For the PR couple it was Conflict Resolution, involving strategies that helped them in the definition of their problems, while for the AC couple it was a Specific Pattern, reporting the repercussions of their learning histories on their marital life, especially about feelings of abandonment.

The IS 4 Therapeutic Alliance is also common to both cases. Therapists and couples worked together, partners felt confident in addressing difficult issues or showing their vulnerability. The TRP worked hard on a process of discrimination and observation of internal issues. TAC worked hard on the couple's emotional deregulation, using emotion validation and tolerance strategies to contain verbal aggression.

Regarding the common principles of couple therapy (Benson et al., 2012), the following aspects were observed in the cases analyzed: the first principle proposes a change in the couple's view of the relationship. For both couples, the formulation of the DEEP case was adequately made and presented, which showed their differences, emotions, stressors, and pattern of interaction. The second principle points to the reduction of the dysfunctional behavior driven by emotion. There are important differences in both cases. For the RP couple, the biggest difficulty was expressing their emotions, and their behavior was governed by criticism and withdrawal. The therapist used mindfulness techniques to discriminate their internal processes and communication skills training to learn how to express themselves more functionally. On the other hand, the AC couple had a hard time managing their emotions and consequent behaviors derived from their impulses (Camila criticized, invaded Alex's privacy, and he fought and walked away, both feeling very angry). The therapist used a variety of strategies, including Dialectical Behavioral Therapy-DBT (Linehan, 1993, 2014) for emotional regulation training. She also applied the "take time" procedure to stop the escalation of conflict (Christensen et al., 2018; Jacobson & Christensen, 1998).

The third principle proposed by the authors (Benson et al., 2012) refers to eliciting private behavior, that is, couples who avoid expressing their personal feelings are at greater risk of becoming emotionally distant and therefore

withdrawing. It can be said that, in different ways and with different strategies, this was the main aspect dealt with the PR couple so that the therapist decreased emotional avoidance. In the AC case, the therapist tried to access private events. In the therapeutic session, the couple allowed more openness, but at home, the dysfunctional pattern of blaming the other remained. Both couples in their learning history received no reinforcement in the face of expressing their emotions. The repercussions on the couple's life were that Ricardo avoided being too close to Paula so as not to feel controlled, and she only talked about superficial things with him, while feeling sad. In the AC couple, Alex's main strategy as an attempt to solve problems was to leave home (like his father), and in the face of any criticism Camila received, she felt very invalidated and very reactive, as she did with her parents. These data converge with the study by Denise Falcke et al. (2008) that refer to the repercussion of family experiences of origin in the marital relationship.

Regarding the fourth principle, increasing constructive communication patterns (Benson et al., 2012), the PR couple therapist used various training techniques of communication skills, or change strategies for IBCT (Christensen et al., 2018; Jacobson & Christensen, 1998), to help them learn to speak more sympathetically and with understanding. For example, she proposed role playing, mindfulness practices, observing the consequences of behaviors in the relationship, and talking about them. These strategies were also used in the AC couple, but with less frequency and intensity.

The fifth principle, highlighting the strengths of the relationship so as not to lose sight of the areas that work effectively (Benson et al., 2012) was used for both couples, following the initial assessment protocol, but it was not much explored during the therapeutic process of either case. In the end, TRP valued the couple's strengths, such as openness to emotions, empathy, change movement and acceptance of differences. For the AC couple, the strategies were so focused on regulating emotions that even with validation techniques that the therapist used, there was no room to explore the couple's strengths.

Another important aspect refers to the concept of acceptance as a mechanism for change for IBCT (Doss et al., 2005; Jacobson & Christensen, 1998; Silva, 2019; South et al., 2010). It is, in fact, the partner's willingness to give up the struggle to change the other that can, paradoxically, lead to changes in that partner's behavior. For the RP couple, the fact that Paula stopped demanding that Ricardo stay at her side all the time, in response to a pattern in her learning history, made him want to get closer, so that he even officialized the relationship with an engagement proposal. On the other hand, the fact that Ricardo stopped running away from Paula, fearing her demands and control, made

her respect his individuality and not focus all his life on the marital relationship. For the AC couple, there was no improvement in their relationship, even though they both reported they learned a lot in therapy, such as observing before speaking, but the pattern of interaction of distrust and jealousy remained.

It is also observed that the AC couple had factors that interfered in the process. One of them was the emotional deregulation of both partners, who were referred for individual therapy. Another was the fact that they started working together, a situation that intensified the pattern of control and jealousy. And one more aspect was the context of life cycle change, that is, the pregnancy and birth of the couple's daughter, a situation that required more emotional energy to cope with the transition to new roles and functions, also sexual difficulties, promoting more withdrawal of the couple. An important issue is that therapy does not always promote couple union, it can also help in a separation, a circumstance that need not necessarily be considered negative (Owen, 2013). The skills and knowledge gained through the therapeutic process can assist in learning important issues for each partner, both to make the breakup a friendlier one, to benefit in the next relationship, and to provide greater insight. There are more significant differences in the comparison between the two cases, which refer to the aspects of the couples, the therapists, the therapeutic relationship, and the context of each case, as shown in Table 2.

Table 2. Main differences between cases

	Couple RP	Couple AC
Couple Aspects	-Relationship-oriented and each seeing their own part in the process; -Difficulty expressing emotions	- Inner world-oriented and blaming each other; -Emotional reactivity, expressing emotions without impulse control
Therapist Aspects	- Mindfulness, UD, EJ work and communication strategies; -Posture focused on couple interaction	-Work focused on the regulation of emotions; -Most active stopping to contain eventual impulsivity
Aspects of the therapeutic relationship	-Trust, neutrality -Very stimulating for the couple to talk to each other	-Trust, neutrality -Each member of the couple talked more to the therapist
Context	-Separation before couple therapy, a fact that may have contributed some distance to better observe the internal processes of each one.	-Started working together, she as the owner, feeling jealous of the clients; gestation of the daughter who required changing roles, new family organization, generating more distance for the couple

Regarding the perceptions of their internal processes, there were also differences. Both Ricardo and Paula, through the strategies and techniques proposed by the therapist, from the beginning of the therapeutic process were able to observe their share of responsibility in the functioning of the relationship and, from then on, try out new forms of interaction, a fact that resonates as one of the common factors of couple therapy, i.e., failing to blame the partner (Benson et al., 2012). However, Alex and Camila, even evolving in the perceptions of thoughts, emotions, and the consequences of emotional deregulation in the relationship, ended the process with the idea that the other was responsible for the discomfort triggered and consequently, the other was the culprit and would have to change. In the follow-up interview, both mentioned that therapy was important for them to learn issues about themselves and each other, including questions that they mentioned that they would no longer like to be together as a couple.

CONCLUSIONS

Not all therapies work in the same way with all the people (González-Blanch, & Carral-Fernández, 2017), according to what was presented in the processes of these two couples. There is a need to explore which elements are effective in validating, refuting, or modifying existing therapeutic approaches. With regard to couple therapy, Benson et al. (2012) state that a couple's therapist requires special skills, and it is important to recognize that the actions of both partners affect the nature of the relationship. An important step in the couple therapy process is for each spouse to recognize this. It is known that the change in couple therapy is supposed to occur in a sequence, in such a way that the processes which occur within therapy sessions lead to intermediate changes, depending on how partners think or act outside the session, known as mechanisms of change. For the PR couple, the main mechanisms of change referred to mindfulness of their internal processes and ability to express them, while for the AC couple the mechanisms of change that occurred were limited to observing and recognizing their emotional reactivity. It should be emphasized that the five principles of effective couple therapy (Benson et al., 2012) suggest ways that couples can build and maintain close relationships positively. The help in reducing dysfunctional behaviors, sharing emotions, communicating effectively, and emphasizing what is working was clearer in the PR couple and little was achieved with the AC couple.

One of the processes of change expected by IBCT (Jacobson & Christensen, 1998) is that individuals, rather than seeking to change their partners' problematic behavior, change their reaction to this behavior due to a greater un-

derstanding of the context in which it occurs, that is, to develop greater acceptance. At the end of the therapeutic process of the RP couple, the transformations were clear, such as returning to live together, feeling closer and a greater partnership, organizing visits to their families and making the relationship official. In turn, the AC couple ended the therapeutic process by saying that they would consider splitting up.

More important is the fact that each relationship has its unique challenges and strengths, and this should be noted for the couple therapist to give the relationship the best chance of survival. It is noteworthy that the findings of the present study cannot be generalized beyond the cultural context of the current sample. However, evidence suggests that common factors should be considered therapeutical, and that IBCT-specific factors such as mindfulness, Empathic Union, and Unified Distancing strategies were essential in assisting the PR couple to significantly improve, in addition to the mechanisms of change (communication skills and problem solving) that interfered with increased acceptance and decreased negative behaviors.

Other studies should be conducted to deepen the theory, research, and practice of couple therapy, and it is important not only to look at successful stories, but also to study different outcomes. Added to this is the need to measure the individual characteristics of the partners, which was the main limitation of the present study, since a possible individual psychopathology interferes directly in the marital relationship. Finally, it is observed that worsening marital adjustment can be a healthy outcome if the option is for separation and the spouses continue with their lives in the way they choose to, but a life worth living.

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