A graduate project submitted in partial fulfillment of the requirements

For the degree of Master of Science in Counseling, Marriage and Family Therapy

By

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Dedication

Dedicated to my husband, Andrew, whose tireless love and support bring me healing and hope.
Acknowledgments

I honor Dr. Charles Hanson for graciously teaching me the art of counseling.

I honor my cohort for their patience as they nurtured my growth as a counselor.

I honor my family for celebrating my successes and having compassion for my struggles.

I honor my readers for dedicating hours and energy to support this project.

I honor my current and past therapists for giving fully of themselves for my healing.
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Abstract

Group for Couples Living with a Mood Disorder

By

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Master of Science in Counseling, Marriage and Family Therapy

This graduate project considers couples living with co-occurring mood disorders and couple distress. Chapter I outlines the need for considering this population as well as the possible benefit of treating mood disorders and couple distress in the context of a couples group. Chapter II consists of a literature review on the topics of mood disorders, caregiver burnout, couple distress, role expectations, and the mutually impacting relationship of these topics. Emotionally focused therapy is then presented as a beneficial treatment option for each of these topics, as it has been shown effective for treating depression and couple distress. Though not previously applied to a group curriculum, the topics of vulnerability, negative interaction cycles, and self-soothing drawn from emotionally focused therapy are a natural fit to discuss in the group setting. Chapter III provides details for how the group will be recruited and screened, where it will be held, and who should facilitate it. The appendix provides the group curriculum in a manualized format with a detailed outline of the topics covered in each session.
Chapter I: Introduction

In a recent Boston Globe article entitled “In Sickness and in Health,” which focuses on the effect of mental illness on the spouses of those diagnosed, Baskin (2014) gives voice to many of the spouses and romantic partners of the millions of individuals with serious mental health challenges. Mental illness does not happen in a vacuum. Many in the diagnosed individual’s life are affected, particularly those who are coupled with the individual. Being in an intimate relationship has its own challenges that are only compounded when the couple is attempting to cope with a serious mental illness. Baskin points out that the spouse often becomes the “patient’s caregiver” (p. 3). While this can present a possibility for increased intimacy, being in this role is often uncomfortable, unchosen, and unwanted. This helping role can place incredible strain on the caregiver and the couple relationship, which then can negatively affect the individual struggling with the mental health diagnosis (2014). And so the often mutually harmful, bi-directional relationship of mental illness and couple distress begins. However, with appropriate support, the couple does not have to navigate this challenge alone, gaining support and resources through group therapy for both the couple relationship and mental health challenges.

Statement of Purpose

There is a wealth of current research focused on treating couples affected by mental illness. For example, Beach and O’Leary (1992) present couples therapy as an established
evidence based practice for the treatment of depression. In addition, Dessaulles, Johnson, and Denton (2003) gathered findings supporting that emotionally focused therapy [EFT] may be useful for treating couples with mental illness. However, there is very little current work regarding treating mood disorders in the context of couples therapy in a group setting. The purpose of this master’s project is to present research for the development of a curriculum for a support/psychoeducation group serving couples negatively impacted by mood disorders.

The idea of expanding the treatment to a group setting is also founded in research. McFarlane (2004) presents studies showing the increased efficacy and effectiveness of multifamily groups versus single family treatment for families of individuals with a serious mental illness. In addition, Baucom, Shoham, Mueser, Daiuto and Stickle (1998) raise the issue that due to the effectiveness of multi-family group treatment for the seriously mentally ill and their families, these group must be more commonly accessible. In an analogous way, though current practice focuses on single couple treatment for couple distress associated with a mental health diagnosis, the purpose of this project will be to design a course for multi-couple groups which may increase the efficacy of the interventions. Because it is manualized, this multi-couple group curriculum could be easily implemented for a low-cost in mental health centers, community agencies, and places of worship nationwide.

In order to better understand the relationship between mental health, couple distress, and EFT, it is necessary to review previous research and studies on these topics, which will be accomplished in the following chapter.
Chapter II: Literature Review

This chapter begins with a discussion of mood disorders, a look at how caregivers of those with mental illness experience stress, followed by a review of the literature regarding couple distress. The impact of role expectation on the couple relationship will next be considered. There will then be a presentation and analysis of possible treatments, concluding with an analysis of group therapy in relation to treating mood disorders.

Mood Disorders

The category of mental illness is incredibly varied, and a single group to assist couples affected by all mental health diagnoses would be too broad, and likely ineffective. As such, the sub-grouping of mood disorders is the focus of this literature review. The Diagnostic and Statistical Manual IV-TR (DSM IV-TR, 4th ed., text rev., American Psychiatric Association [APA], 2000), states that mood disorders include major depressive disorder [MDD], dysthymia, cyclothymia, and bipolar disorder [BD] with the common theme being a persistent depressed mood. According to the National Institute of Mental Health [NIMH] (2014), mood disorders are some of the most common mental health diagnoses. The yearly prevalence for American adults is approximately 9.5%, with roughly 45% of these diagnosed individuals qualifying for the ‘severe’ category. The severity of a mood disorder is based on the level of impairment in the individual’s activities of daily living as a result of their current symptomatology. Women are 50% more likely than men to receive a diagnosis of a mood disorder in their lifetime. Only about half of individuals with a mood disorder are receiving treatment for their mental health diagnosis. Sadly,
roughly two-thirds of suicides in the US are caused by depression (NIMH, 2014). These statistics on mood disorders show how common the diagnosis is as well as the risks of impairment and even death as a result of the disorder.

Symptomology. Though they are placed in the general category of ‘mood disorder,’ the diagnoses of MDD, dysthymia, cyclothymia, and BD have differences in symptomology (APA, 2000). One of the key factors in differentiating between the four diagnoses is the level and duration of impairment that the individual experiences as a direct result of the symptoms. A diagnosis of MDD requires an individual to be experiencing serious impairment almost every day for two weeks. In reality, the average length of a major depressive episode is around six months. According to the DSM-V-TR (APA, 2000), symptoms of MDD include an almost continuous depressed mood, loss of pleasure, weight loss or gain, sleep difficulties, feelings of worthlessness, difficulty concentrating, and thoughts of suicide. By way of contrast, dysthymia requires a lower intensity of the above symptoms but a much longer duration of two years to qualify for a diagnosis, one year if the symptomatic individual is a minor. It is possible to qualify for both of these diagnoses at the same time. In such a case, the long term diagnosis would be dysthymia and the individual may occasionally qualify for MDD in circumstances when they also meet criteria for a major depressive episode (APA, 2000).

To qualify for a diagnosis of BD, an individual must meet the criteria for one or more major depressive episodes and additionally meet the criteria for either a manic or hypomanic episode at a separate time. An individual experiencing mania meets at least three of the following criteria for at least one week: sense of grandiosity, decreased need for
sleep, increased talkativeness, distractibility or hyper focus, and engaging in pleasurable but risky behaviors. Hypomania refers to the same criteria but only lasts four days and is usually less intense. Receiving a diagnosis of bipolar I disorder requires at least one manic episode while bipolar II disorder requires instead at least one hypomanic episode. Cyclothymia is similar to BD in that it involves fluctuations between hypomania and depression. However, the criteria is different in that it requires the presence of a mixture of hypomanic symptoms and depressive symptoms that do not meet the standard for a full major depressive episode. Despite differences in levels and duration of impairment and the varying presence of some form of mania, all four of these diagnoses share the common thread of a persistent depressed mood (APA, 2000). As such, the theme of depression will be common throughout this review.

**Resources.** Not only do the individuals living with mood disorders have to manage the symptoms associated with their diagnosis, they must also learn to navigate the mental health system. There are resources available to support consumers through this process. The National Alliance on Mental Illness [NAMI] (2014) was created to bridge the gap between receiving a diagnosis and accessing treatment. Their focus is on helping consumers and their families who are struggling to access and utilize their local systems of care. Once a diagnosis is received, an individual begins the task of researching what resources exist, how to access them, and how to advocate for oneself once in treatment. However, self-advocacy and finding mental health care providers that are a good fit can feel like an insurmountable task when depression is active. Pandya and Myrick (2013), highlight how difficult it is to find recovery oriented care when entering the mental health
system as a consumer. Their model of supporting access to appropriate care involves educating the individuals and families affected by mental illness to work in collaboration with their treatment providers to ensure better recovery outcomes. Ultimately, they support the idea that accessing recovery oriented collaborative care increases treatment adherence which boosts consumer outcomes.

**Stigma.** After finding appropriate care, the diagnosed individual now has to manage the stigma of living with a mental health diagnosis. Wahl (1999) explores how stigma concerning mental health can be a barrier to obtaining appropriate care, housing, jobs, and supportive relationships based on the self-reports of mental health consumers. Although mental health consumers are protected under the Americans with Disabilities Act [ADA] (1991), disclosing a need for reasonable accommodations can be a shaming experience where instead of compassion, the consumer is met with resistance and ignorance (Wahl, 1999). According to Klin and Lemish (2008), stereotypes of violence in the media and lack of positive role models contribute to low self-esteem in many consumers. Klin and Lemish continue by describing the media as portraying individuals living with mental illness to be lazy, poor communicators, unsafe, and unintelligent. Instead of viewing symptom management and even recovery as achievable after a mental health diagnosis, consumers and their families can easily internalize the negative portrayals of diagnosed individuals (Marsh & Johnson, 1997). When individuals are given a mental health diagnosis, he or she is just beginning a long and difficult journey fraught with obstacles to his or her well-being. Nevertheless, the presence of a supportive couple relationship can help to ease this transition (Dessaulles, Johnson & Denton, 2003)
Caregiver Issues

Managing stigma, current symptoms, weekly mental health appointments, and self-advocacy can necessitate the need for additional support by family members or partners. Marsh & Johnson (1997) underscore how the involvement of family members is often the first and last option for caring for individuals living with serious mental illness. Unfortunately, according to the researchers, they seldom receive the professional support and training required to feel successful in their duties. With adequate professional involvement, however, family participation in treatment can increase positive outcomes for diagnosed individuals (McFarlane, 2002). Dessaulles, Johnson, and Denton (2003) illustrate the efficacy of including the diagnosed individual’s partner in treatment, showing how partner participation can help to alleviate depressive symptoms. As is evidenced, families and partners play a large role in supporting and caring for individuals living with mental illness. Whether the relation is by family, love, or marriage the caregivers of those living with mental illness also experience distress, stigma, and negative physical and mental health outcomes (Crowe and Lyness, 2014). Unfortunately, the role of caregiver for a loved one with a mood disorder can be a cause of stress and burnout.

Functioning and communication. Weinstock, Keitner, Ryan, Solomon and Miller (2006) posit that families caring for symptomatic individuals with mood disorders score very low on tests quantifying their family functioning abilities. For Weinstock et al. (2006, p. 1193), family functioning is an overarching term used to describe the broad ability to communicate effectively, solve problems, define roles for each of the family members, create and sustain behavioral standards, and convey appropriate emotional responses. The
stress of caregiving for the diagnosed individual may be a contributing factor to this finding. The results of Weinstock et al. (2006) point to the diagnosed individual having better symptom management and lower impairment in activities of daily living when family functioning scores were higher. However, the study also showed that, even when the families were receiving their highest scores, the average family functioning scored at the cutoff of clinical impairment (2006). Though it is unknown whether the presence of a mood disorder is responsible for the lower family functioning or vice versa, there is a strong correlation. It may be that the long-term stress of caring for an individual with a mood disorder takes its toll on family functioning.

**Burnout.** Heller, Roccoforte, Hsieh, Cook, and Pickett (1997) contend that familial caregivers experience burnout and even anger toward the person with a mental illness. Burnout can occur when a person feels unsupported in their role, when they do not feel called to their role, or when the resources are not available to enable them to be successful in their role. In a caregiving relationship, all three of these scenarios can occur. Heller et al. (1997) found that the majority of caregivers felt they did not know how to best advocate for their diagnosed loved one, they needed more information about services, and they did not understand their loved one’s condition. Feeling inadequate and frustrated with their role can create resentment toward the diagnosed loved one. However, as the authors show (1997), expressing these thoughts and feelings can seem impossible for fear of judgement from the rest of the family or hurting their loved one’s feelings.

**Stigma.** Van der Sanden, Bos, Stutterheim, Pryor, and Kok (2013) contend that caregivers are additionally subject to perceived stigma from their community and stigma by
association with the diagnosed family member. According to their findings, the closer the family relation, the more the family member experienced stigma by association from the community. According to this study, feelings of closeness toward the diagnosed family member were lower for close family members versus extended relatives. Van der Sanden et al. (2013) hypothesize that the stress of the increased stigma experienced by the close relative in connection to the mental health diagnosis dampen the feelings of closeness to the diagnosed family member. While this particular finding generally addresses familial caregivers, which could include parents and siblings, the stigma of the caregiving partner in the couple system is similar. The caregiver can be seen by the community as ill by association or even somehow responsible for their loved one’s struggles. This stigma prevents caregivers from surrounding themselves with the extra support they need as they weather the storms of mental illness (2013). Further study focusing specifically on the effects of mental illness on the caregiving partner is the next step in forming a comprehensive and research-based treatment for couples.

**Couple Distress**

**Distress statistics.** In healthy couple relationships, there is room for mutual growth, pleasure, and satisfaction for both members of the couple system. Rosand, Slinning, Eberhard-Gran, Roysamb, and Tambs (2012) assert that individuals who are able to find and maintain these connections enjoy faster recovery times from illness, lower rates of depression, report higher satisfaction in life, and have a reduced risk of mortality from any cause. Nourishing these types of relationships is one of the key goals for therapeutic
interventions (2012). Unfortunately, as many experience on a daily basis, not all couple relationships are able to provide these benefits to the individual members. Considering couple distress, Snyder, Whisman and Beach (2009) estimate that 31% of US couples are experiencing marital distress at any given time. This number reflects all distressed couples, not only those navigating mental health diagnoses. However, individuals experiencing couple distress are overrepresented as consumers of mental health services, irrespective of whether couple distress was their primary presenting problem (2009). Even if it is not immediately evident to the consumer, couple distress is a main driving force for seeking therapeutic services (2009). It is unclear why the consumer does not always recognize or report couple distress as their presenting problem when seeking treatment.

**Mood disorders and couple distress.** According to Baucom, Shoham, Mueser, Daiuto and Stickle (1998), major studies have been conducted which highlight the link between co-occurring couple distress and mental health challenges. South, Krueger and Iacono (2001) assert that there is a strong correlation between mental illness and couple distress. Snyder et al. (2009) note that individuals in a distressed couple relationship are “three times more likely to have a mood disorder” (p. 1). Finally, Atkins, Dimidjian, Medics and Christensen (2009) point out that depressive symptoms in a member of a couple are 10 times more likely to occur when there is also marital distress. The preponderance of data clearly indicate that where there is a diagnosis of a mood disorder, to be on the alert for marital distress, and vice versa.

This raises the question of whether mental illness causes the couple distress or if couple distress causes mental illness. There may be no definitive answer to this line of
questioning due to the unique qualities of each relationship. In reality, according to South et al. (2011), mental illness and couple distress have a positively correlated relationship where the presence of one increases the likelihood of the other. As such, research cannot indicate whether it is couple distress or mental illness that comes first, but it is clear that they mutually exacerbate each other. Because of this, treatment must focus on the diagnosed individual, his or her partner, and the couple relationship. In this way, the caregiving partner can avoid potential burnout by receiving additional support and resources for their role. Moreover, the strengthened romantic relationship can be a healing factor and support for the diagnosed partner (2011).

**Systemic treatment.** The concept of treating mental illness through focusing on the couple dyad is a core value of family therapy. Though traditionally considered from the standpoint of the individual, Beach and O’Leary (1992) indicate that treating mental illness is done effectively while focusing on the couple system. The link is so strong between mood disorders and couple distress that studies suggest that depression rates could be lowered if marital distress were the sole focus of treatment (Atkins et al., 2009). As previously discussed, the correlation between couple distress and a mood disorder is strongly positively correlated. It stands to reason that if treating an individual for their depression can reduce marital distress, so also could treating a couple’s marital distress help to reduce the individual’s depressive symptoms. Lebow, Chambers, Christensen and Johnson (2012) contend that this logically flows when the strong negative correlation between couple distress and an individual’s mental health is understood. Finally, Heller et al. (1997) underscore the point of how critical it is to treat individuals with mental health
challenges as well as their romantic partners, who often play the role of caregiver in the relationship.

**Role Expectations**

One aspect of the strong link between mood disorders and couple distress is that oftentimes, mood disorders interrupt a person’s ability to fulfill certain relational expectations. According to Jacob, Kornblith, Anderson and Hatz (1978), all relationships naturally come with expectations. Whether it be with a family member, friend, neighbor, or co-worker, there are distinct relational rules that must be upheld for a person to be considered to be acting within societal norms. Expectations in a romantic relationship are arguably even stronger and more rigid. These beliefs about how partners should act in a couple relationship are often subconscious but extend to the realms of childrearing, household chores, sexual expression, and emotional support. These expectations are often learned through repeated exposure from one’s culture and upbringing. In typical couple relationships, failure to meet these expectations, whether realistic or not, provides an opportunity for conflict. Over time, if unresolved, these conflicts create an overall sense of couple distress (1978). Individuals diagnosed with a persistent mental illness often have even greater difficulty fulfilling these expectations than the typical person, especially during symptomatic episodes (NIMH, 2014).

This is made clear when considering the above expectations in conjunction with the aforementioned criteria for depression. Jacob et al. (1978) assert that individuals experiencing low self-esteem, fatigue, and feelings of worthlessness will be less likely to
have the motivation and energy to take care of their portion of household duties, have sex, or participate in bonding dyadic activities. Without placing blame on the diagnosed partner, this undoubtedly has an effect on the caregiving partner, his or her attitude about the diagnosed partner, and the relationship in general. In response to the role expectations not being met, the caregiving partner may begin to build up resentment and either subtly or overtly express those feelings to the diagnosed partner. The diagnosed partner may then sense that their initial feelings of worthlessness and low self-esteem are only confirmed, leaving them even more hopeless and alone. This feedback loop clearly shows how an individual’s lack of ability to fulfill his or her partner’s expectations within the couple dyad significantly contributes to couple distress. Because of this, it is crucial to address the partners’ expectations of each other in treatment. This would be accomplished in the form of challenging unreasonable beliefs and allowing each partner to share their needs with one another, adjusting expectations accordingly (1978).

**Group Theoretical Orientation**

This group will be based on principles from EFT. According to Lebow et al. (2012), EFT is an evidence-based practice that strives to strengthen the couple relationship. This is done through identifying and changing negative interaction cycles and identifying and expressing primary emotions related to attachment. It is based on a mixture of systemic principles and attachment theory with a strong empathic stance on the part of the therapist (2012). Current research shows EFT to be an effective treatment for both couple distress as well as depression (Lebow et al., 2012; Dessaulles, Johnson & Denton, 2003).
As this multi-couples group specifically targets both the issues of couple distress and mood disorders, EFT is a natural choice to guide the curriculum. However, there is currently no group curriculum for couples affected by mental illness available based on the theory and unique interventions of EFT.

**EFT for treatment of depression.** According to Lebow et al. (2012), EFT has been shown to be efficacious in treating depression. In a recent study, these researchers found that EFT in conjunction with antidepressants showed equal results for treating depression as using anti-depressants alone. However, only those participants who received both treatments had a significant increase in relationship satisfaction (2012). In a different study on EFT efficacy, Dessaulles et al. (2003) found that out of the partners originally diagnosed with depression, none continued to meet the criteria for depression at the conclusion of treatment. This is likely due to the effect of EFT’s promotion of strong attachment to one’s romantic partner which supports affect regulation, a key component to treating mood disorders (Goldman & Greenberg, 2013). This new research is showing the impact of looking at mood disorders as diagnoses that must be considered through a relational lens. Though these illnesses have a strong basis in biology, medication is not the only or even most effective form of treatment. EFT, which promotes strong relational attachment, is just as effective in treating depressive symptoms as psychopharmacological drugs and has the additional benefit of strengthening the couple relationship (Dessaulles et al. 2003).

**EFT as treatment for couple distress.** The efficacy of EFT as a treatment for couple distress has been shown through multiple studies including one meta-analysis by
Lebow et al. (2012), which reports a 70-73% recovery rate. When considering couple distress, Meneses and Greenberg (2014) contend that EFT conceptualizes problems as arising from difficulties stemming from unfulfilled needs related to attachment, identity, and liking. When there is a rift in the relationship, EFT therapists seek to identify how primary attachments needs were not met or how old attachment wounds were re-triggered. This may occur without the offending partner even realizing that they are triggering old attachment wounds. On the other hand, these wounds may also happen when the offending partner does something knowingly to betray the relationship, such as having an affair, lying, or abandonment (Meneses & Greenberg, 2014).

**Vulnerability.** Whether the attachment wounds were triggered from a previous relationship or created fresh with a recent betrayal, Meneses and Greenberg (2014) posit that EFT seeks to create an environment safe enough for the partners to be able to be vulnerable in sharing their attachment injuries. Research indicates that the offending partner, if the injury was a fresh wound of betrayal, must express a sense of shame that they are the type of person who would commit such a hurtful act. In response to the vulnerability of expressing shame, the offended partner is more likely to have empathy and offer genuine forgiveness. These “expressions of vulnerability invite connection” (2014, p. 4) and are the first step in healing the attachment wounds of the wronged partner. Even if the offending partner inadvertently re-triggers an old attachment wounds from a previous relationship, this ability to be vulnerable in expressing sadness and remorse is key for moving forward with healing (Meneses & Greenberg, 2014).
**Self-soothing.** Additionally, Goldman and Greenbert (2013) state that a partner’s ability to self-soothe when distressing feelings arise related to old attachment wounds is crucial to a couple’s satisfaction. Attachment-related wounds from previous family and romantic relationships are bound to be re-triggered in an individual’s current romantic relationship. In addition to increased vulnerability, a core goal in EFT is to assist each partner in learning to self-soothe when possible if they are re-triggered accidentally. This helps to build each partner’s sense of identity, a target for many EFT interventions. Self-soothing will look different for each person but could include a partner creating reminders for themselves of attraction, love, attachment, and appreciation for their partner (Goldman & Greenberg 2013).

**Interaction patterns.** One of the hallmarks of EFT is its focus on interaction patterns between the members of the couple. The creator of EFT, Johnson (2008) describes these patterns as dances or as demon dialogues. When a couple begins to relate to each other consistently through these dialogues, they become trapped in the dance and the intimacy and attachment in their relationship suffer. Instead of a free expression of thoughts, feelings, and needs, the couple becomes entrenched in constant criticism, making demands, or fleeing the relationship. The first of these, a form of constant criticism, Johnson labels ‘find the bad guy.’ Here, the couples are so terrified of being vulnerable and fearful of being rejected, they go on the attack and accuse their partner for whatever is going wrong. The second dialogue, a continuous way of making demands, Johnson describes as ‘the protest polka.’ When one member of the couple has a need, they begin demanding that need be met by the use of verbal or emotional force. The other member of
the couple responds by pulling back even harder in resistance to their partner’s need. The third dance is termed ‘freeze and flee’ by Johnson. Here, couples have lost hope that their partner can meet their needs so they retreat in despair. Identifying and interrupting these patterns is a core intervention for EFT (2008).

**Group Type**

Group therapy is fairly common modality for clients searching for additional support. There are many different types of groups, and some provide a combination of approaches to best treat the target population’s needs, such as support and psychoeducation. In a group setting, Yalom (1985) contends that members are able to receive feedback from one another regarding their thoughts, behaviors, and feelings by focusing on the here-and-now interactions between group members. This can be particularly beneficial for couples as one member of the couple may be resistant to feedback from his or her partner but more open to hearing it from another group member. Groups also provide hope in that the attendees recognize that they are not alone in their problem (Yalom, 1985).

Group therapy has not yet attempted to tackle both issues of couple distress and depression simultaneously. However, the group modality has been shown to be helpful for each of these presenting problems. Though a less common form of group therapy, multi-couples groups can have positive outcomes. According to Ginsberg (2006), couples report an increased ability to remain non-judgmental, increase emotional expression, and take responsibility through evidenced based conjoint group therapy. Kanas and Leszcz (2002) report that at the end of treatment, one-third of group members had reduced clinical
symptoms, increased life satisfaction, and overall higher life functioning. Although there is no current research on groups treating both depression and couple distress, there is precedent for treating each of these topics in a group setting.

**Support and psychoeducation.** The group will provide both support and psychoeducation for the participating couples. Though this group will be therapeutic in nature, a support group is different than group therapy in that much of the affirming interactions will be provided by the group members themselves (Yalom, 1985). In general, Yalom (1985) contends that support groups provide a place for individuals to find hope and commonality between themselves and their fellow group members who have shared experiences. Heller et al. (1997) assert that support groups provide a place where the caregiving partners, in relation to their diagnosed partner, can become better advocates, reduce anger, gain information about providing better care, and reduce stigmatizing feelings about mental illness. The diagnosed partner also benefits, with research indicating that factors such as recovery, life meaning, and life satisfaction are all positively impacted when adults participate in support groups for consumers (Kaplan, Salzer, & Brusilovskiy, 2012).

Beyond having the group only provide support, psychoeducation is a key component to this group. Psychoeducation will include providing information on mood disorders, emotional expression, and primary and secondary emotions. Pickett-Schenk et al. (2006) show that greater caregiving satisfaction is one of the benefits of educating family members of individuals diagnosed with a chronic mental illness. In addition, McFarlane (2002) states that psychoeducation for caregivers of individuals with a mental
illness helps reduce relapse rates. The National Alliance on Mental Illness (NAMI, 2014) has done extensive research and created multiple programs and groups dedicated to providing psychoeducation to both families and consumers. Their qualitative studies have revealed psychoeducation to be an important factor to the success of their groups for mental health care consumers (2014).

**Conclusion**

Individuals living with mood disorders are attempting to manage often debilitating symptoms which interfere with activities of daily living, relationships, employment, and housing. When their main source of support is their romantic partner, this relationship can become strained as the partner steps into the role of caregiver. If caregivers do not receive adequate support, they can quickly enter into burnout. An active mood disorder and caregiver burnout combine to create an increased risk of couple distress, which can then further contribute to the symptoms of the mood disorder. Both members of the couple may struggle to fill their desired role expectations adding to the sense of distress. Through evidenced based treatments, such as EFT, the couple can receive the support and psychoeducation they need in order to enter into emotional and relational recovery. A couples group for relationships affected by mood disorders utilizing EFT does not currently exist. Based on the studies cited in this literature review, this type of group may prove to be both efficacious and effective in the treatment of co-occurring mood disorders and couple distress. The following chapter will further discuss the group’s structure and logistics.
Chapter III: Project Audience and Implementation Factors

Recruiting and Screening Process

Group members will be referred through a variety of sources including private practices, agencies, churches, and walk-ins. Six weeks prior to the group’s first session, the facilitators will begin advertising through each of these avenues by distributing the group flyer. Once a location for the group has been obtained, that information will also be included on the flyer (see appendix for flyer). The group facilitators will then begin receiving follow up phone calls from interested couples. During this initial phone contact, the facilitators will provide more information about the group, including the eight week commitment and the participant qualifications. Once the facilitator deems the couple as a potential candidate for participation, they will ask the couple to attend a brief in-person intake interview to make sure that this group would be a good fit for the couple (see appendix for couple intake). Jacobs, Mason, Harvill, & Schimmel (2012) are adamant that in-person interviews are the most expedient way to ensure that both the facilitator and the group participant are in agreement in terms of qualifications and expectations.

During this intake, the facilitator will discuss the couple’s mental health history, current and past stressors, and relationship history. The basic qualifications for participation are that one member of the couple has a diagnosed mood disorder, that the individual is currently in treatment with a therapist, and the therapist supports their participation in the group. If the diagnosed partner is not currently in therapy, the facilitator can make referrals to assist in obtaining appropriate treatment. It is not necessary that the diagnosed partner be taking medication, as some individuals are able to cope using
other means (NAMI, 2014). However, should the facilitator assess that the individual’s symptoms are not adequately managed, the facilitator would have to ask the couple to wait to join the group until there is a measure of stability. Other reasons for a couple to be disqualified from participation is current domestic violence or untreated substance abuse. The facilitator will not discriminate based on the gender, sexual orientation, religion, or age of the couples.

**Group Size & Characteristics**

The group will be limited to between three and five couples. This allows for the group to continue even if one couple drops out or misses a week. More than five couples would make the group too large, limiting the time each couple could share and the feelings of trust and intimacy between group members (Yalom, 1985). There are benefits to either the couples being roughly the same age or having a diversity of ages. In the former, the couples may have an easier time relating to one another, aiding in the quick building of trust in the group environment. In the latter, the additional experience of the older couples may bring a valuable perspective to the group, giving hope to the younger couples. Ultimately, it will depend on the openness of the group members and the skills of the facilitators as to how the differences between the couples are embraced. During the first meetings, these age differences should be discussed and any barriers to trust building addressed.

As the group is open to the community, there will be a diversity of backgrounds and beliefs included in the group members. During the initial assessment, the couples will be
invited to reflect on the idea that the other couples in the group may differ from them in areas of religion, sexual orientation, age, ethnicity, and/or racial background. To participate in the group, the couples must be willing to accommodate these differences, showing respect to the other group members. According to Phillips (2014), diversity promotes group creativity and aids in challenging people’s subconscious beliefs and assumptions. The group will benefit from this diversity as it can provide a wider pool of experience, perspective, and wisdom from which to draw in finding solutions for the couple’s unique challenges.

**Group Logistics**

Sessions will be 90 minutes in length and the group will meet weekly. This length of session is based on Yalom’s (1985) recommendations that sessions be roughly 90 minutes in length to forego the group members becoming fatigued or bored. Although Yalom (1985) recommends meeting twice a week, that frequency may become prohibitive to the group members, interrupting their family life, work schedule, and self-care. The sessions will be guided by the co-facilitators according to the group curriculum. Each week, there will be a psychoeducational presentation, a skill building exercise, and processing/support opportunities. While no group member will be forced to participate if they are not feeling comfortable, the couples will be encouraged that the more fully they are able to invest in the group process, the more likely they will be to benefit from it.

In starting a group, the logistics of cost, format, and location need careful consideration. The cost will be free to the participants as the program will be funded
through community agencies. Cost of the supplies for the group is minimal and does not extend much beyond paper, printing supplies, and pens. The agency will provide whatever materials will be needed for the activities and psychoeducation. The group will have a closed format, meaning that once the group has begun, no new members will be added until the next cycle of the group begins. This is intentional due to the group discussing topics such as mental illness, sex, and relational issues that will require deep levels of trust (Yalom, 1985). If the group were to be open, the level of trust needed, with members coming and going, might not be reached. The participants will be allowed one absence of eight total sessions.

**Facilitator Qualifications**

The group will be led by two therapists, with at least one therapist at the intern or licensed level. It will be useful to the group process to have the leaders reflect the couples’ experience by also being in a professional couple relationship. In this way, the facilitators can model having differences in opinion, belief, background, and personalities while also maintaining respect and promoting helpful dialogue. It will also be helpful to have at least one of the facilitators be at an intern or licensed level as the group members are living with chronic and debilitating mental illness. The senior therapist will be responsible for continually assessing for the safety of the diagnosed group members.

In addition, the facilitators should have experience working with couples. Couples counseling is one of the more challenging modes of therapy. It requires the therapist to attune to two people simultaneously, while also remaining an individuated and professional
counselor. Often in couples’ therapy, the members of the couple vie for the therapist’s alliance with their point of view. It is crucial for the therapist to have enough experience to be able to balance the therapeutic alliance with both members of the couple through honesty and attunement.

An additional reason why previous couples counseling experience is crucial is the high risk of the facilitator experiencing countertransference while working with couples. This can include having the therapist’s own unresolved relationship issues be triggered in session. Countertransference can also involve having the therapist’s unresolved feelings about their friends’ or parents’ relationship be triggered. Ultimately, any time the therapist’s personal issues negatively impact the therapeutic relationship, countertransference becomes unprofessional. It is also common for the therapist to strongly identify with one member of the couple and struggle to find empathy and understanding for the other. For all these reasons, receiving supervision while working with couples and discussing countertransference issues will be important for the facilitators to ensure they are providing ethical and therapeutic services.

In addition to having previously worked with couples, the facilitators should also have experience leading groups. Yalom (1985) explores in detail the unique aspects of group dynamics. His writings focus on what characteristics contribute to making a group successful including the group member’s level of trust with both the facilitator and the other members. In the every stage of the group, the facilitator must be aware of the varying levels of trust occurring in a multi-couples group. First, the trust between each member of the couple needs to be assessed. This trust will depend on how well the couple is coping
together with the diagnosis and other life stressors. Second, the trust between the three to five couples will need to be established and maintained. Although these couples have a mental health diagnosis in common, they will also have differing backgrounds that may be difficult for some group members to embrace. Lastly, the trust between the facilitators and the couples must be supported. Many individuals and families with mental health diagnoses have experienced trauma at the hands of the mental health care system through misdiagnosis, stigma, or over-medication (Crowe & Lyness, 2014). Ultimately, the therapists must be skilled in facilitating intra-couple trust, inter-couple trust, and couple to therapist trust.

**Intended Audience**

This group is open to the community and accepts couples where at least one member of the couple is diagnosed with a mood disorder. It is important for the individual’s diagnosis to be a mood disorder and not another mental health diagnosis as the interventions and the supporting research are targeted toward the treatment of depression. Though the couples may be at different stages of their relationship, both members of each couple must be committed and intending to remain in the relationship. This group is not intended as a last resource for couples considering divorce or separation. The couples do not need to be married to qualify. Adults over the age of 21 are invited to participate as similarity in maturity and developmental levels amongst group members will aid in the building of trust and support. Facilitators are encouraged to adapt the curriculum materials to fit the needs of the group members, which includes considering the educational level,
developmental level, and English proficiency of each participant. Open time to encourage questions for clarification is recommended.

Environment and Equipment

The group meetings can be held at local community centers, agencies, or churches, as long as there is a private room large enough to hold the group. Privacy is key as there will be a fair amount of intimate sharing and trust building occurring throughout the sessions. To facilitate this, the room should be able to be closed off and the ambient noise in the building should be minimal. If possible, the room will be sound-proofed or a white-noise maker will be used for added privacy. For equipment, each member and facilitator will need a chair. Some of the exercises involve writing so sitting at a table or having clipboards on which to write will be helpful. A white board or chalk board for noting the group’s responses is preferred. The facilitator will be responsible for bringing the pens and handouts to the group members each week. Any additional supplies for the interventions will be provided by the facilitators.
Chapter IV: Conclusion

According to the NIMH (2014), almost one in 10 Americans has a diagnosis of a mood disorder. In addition, Snyder et al. (2009) point out that roughly one third of couples are experiencing clinically significant levels of distress at any given time. A meta-analysis conducted by Atkins et al. (2009) indicates that there is a strong negative correlation between these mood disorders and couple distress and that treating one is effective in reducing symptomatology of the other. It is undetermined if couple distress causes the mood disorder or vice versa, though research shows that they reciprocally aggravate each other (South et al., 2011). Jacobs et al. (1978) contend that the couple relationship is strained by mood disorders in multiple ways, including the diagnosed partner’s limited ability to fulfill certain relational expectations. Findings on caregiver burnout could also be a contributing factor to the relationship between mood disorders and couple distress. Knowing all this, it is crucial to treat individuals living with a mood disorder in conjunction with their romantic partner in order to decrease both the depressive symptoms as well as their experience of couple distress.

EFT is a researched based theoretical orientation based on attachment principles. It is a logical approach to treating co-occurring couple distress and mood disorders as it has been shown to be effective through multiple studies in both treating depression and couple distress. Topics of shame, primary and secondary emotions, emotional injuries, and self-soothing will be themes throughout the group process. Though it has not been applied to a group modality, the theory and interventions of EFT are easily translated to a group setting. Yalom (1985) supports the idea that increased hope and support as well as here-and-now
relational feedback are benefits to the group modality. McFarlane (2004) additionally presents the idea that treatment of a person diagnosed with a serious mental illness should include treating the family system. Depression (Kanas & Leszcz, 2002) and couple distress (Ginsberg, 2006) have both been effectively treated in group therapy. For these reasons, increased efficacy in a group setting may occur due to the effectiveness of groups in treating both couple distress and depressive symptoms.
References


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Appendix: Group Curriculum

Session 1

**Goal:** This session will introduce the purpose of the group and set the tone of the group, which is to be supportive and psychoeducational in nature. Confidentiality and its limits will also be explained.

**Objectives**
- Introduce members to each other and group leader
  - Explain purpose of group
  - Explain rules of group, including confidentiality and mandated reporting requirements
  - Begin to build trust

**Activities**
- Each member of the couple dyad will introduce their partner, expressing two items of appreciation for that person
  - Each member will be asked to share their hopes for what they will gain personally and relationally from participating in the group

**Homework**
- Ask couples to notice during the week what traditions, activities, or interactions that they currently have that they would like to continue

**Detailed Outline:**

*First 10 minutes*—Introduce group facilitators including why this group is important to them personally. Explain that the purpose of the group is intended to support the couple dyad that is experiencing co-occurring couple distress and a mood disorder, which includes depression and bipolar diagnoses.
10 minutes—Explain confidentiality and the consent to treat form. Read the form aloud and invite any questions from the members. Ask all members to sign form and collect the forms to be copied and placed in their files after the session is finished.

10 minutes—Introduce group rules by reading them aloud with the group members. Invite reflection on the group rules and explore if the group would like to add to or change any of the rules provided to them.

30 minutes—Invite the group members to introduce their partner and share two things they appreciate about them. When the group has gone around, ask the group members to share their responses to their partner’s introduction.

- Were you surprised?
- Was it easy or difficult for you to think of appreciations?
- When was the last time you expressed and received an appreciation from your partner?
- How are you feeling now that you’ve received the appreciation?

20 minutes—Ask group member to share what they are hoping to gain from the group. If the expectation is unrealistic, facilitators will gently provide information on what this group is able to offer to the members. Highlight the similarities between the responses of the members to promote a sense of unity amongst the group.

Last 10 minutes—Give group members a 10 minute warning. Ask the group members to share if there was anything they would like to share but did not get a chance to. In closing, ask members to notice during the week what traditions, activities, or interactions that they currently have that they would like to continue.
Session 2

Goal: This session will introduce the theory and treatment model of EFT. Participants will be notified that they are participating in a curriculum inspired by, but not solely based on, EFT.

Objectives
- Understand primary and secondary emotions
- Process and share support for feelings surrounding attachment related injuries
- Continue to build trust

Activities
- Couples will be asked to identify the last minor argument and identify the primary and secondary emotions involved

Homework
- Couples will be asked to notice a time during the week when they felt a secondary emotion and see if they can identify the primary emotion underneath
- If the diagnosed partner is feeling too emotionally numb to participate in homework, they will be given the option to actively listen to their partner describe his or her experience of noticing the secondary emotion

Detailed outline:

First 10 minutes—Check in with couples on their homework assignment of what about their relationship they would like to stay the same. Ask each member to share.

15 minutes—Introduce the concepts of primary and secondary emotions based on EFT. Facilitator will explain that anger is a common secondary emotion and visually present the idea through the “Anger Iceberg” handout below. Invite group members to reflect on a
time when they expressed anger but underneath felt hurt, rejected, or scared. Describe how sometimes, it feels safer to express anger because it makes you feel powerful rather than hurt or fearful, which may make you feel vulnerable.

**ANGER ICEBERG HANDOUT**

25 minutes—Introduce the idea of event triggers.

Facilitator can use this example:

Imagine you are responsible for a child at a busy shopping center. You turn around and the child is nowhere to be found. You are immediately anxious and scared for the child’s wellbeing as well as frustrated because you told the child to stay with you. After several minutes of looking for the child, you find her wandering by herself in an aisle. You have two options of how to respond. (1)

Instead of telling the child how scared and frustrated you were, you express anger by lashing out at the child, berating her for her stupidity. You may even humiliate her by completing this tirade in public only to finish it by dragging her out of the
store in front of the other shoppers. (2) You tell the child how worried you were, checking in with her about her emotions. You may also express your frustration, but you do this in a vulnerable way, showing how afraid you were that she could have been hurt.

Each time you experience an event trigger like this, you have the opportunity to become caught in the anger cycle or the intimacy cycle.

Invite the group to reflect on how they connected to this example and how they see it applying to their relationships.

30 minutes—Ask group members about the last argument they had with their spouse where they noticed the secondary emotion of anger getting in the way of their primary emotion.

- How did the anger impact your sense of intimacy and vulnerability with your partner?
- What were your feelings after the argument ended? Loneliness? Regret? Shame?

Conversely, invite group members to discuss the last time they responded with anger but were able to be vulnerable and express the deeper emotion.

- How did the expression of the deeper feeling impact your sense of intimacy and vulnerability with your partner?
- What were your feelings after the argument ended? Connection? Peace? Love?

Last 10 minutes—Invite group members to reflect on the experience of being vulnerable with their partner and the group.

- Was it scary to access and express the underlying emotion?
- How are you feeling now about yourself? Your partner? The other group members?
Encourage group members to participate in homework of noticing their primary and secondary emotions during the next week.
Session 3

Goal: This session will provide education on mood disorders as well as deepen the group’s level of trust as members will be asked to share personal stories related to their diagnosis.

Objectives
- Understand characteristics of mood disorders
- Process and share support for feelings related to diagnosis
- Continue to build trust

Activities
- Ask each couple to share their “diagnosis story”

Homework
- Invite couples to spend a brief amount of time each day (if possible) touching each other (either in a hug or holding hands) and notice how the physical touch effects them.

Detailed outline:

First 10 minutes—Check in with couples as to how the previous week’s homework went.

- Were you able to catch yourself in the moment expressing a primary versus a secondary emotion?
- Is there anything you learned about yourself over this past week in reference to your fears of being vulnerable with your partner?

10 minutes—Present information on mood disorders. Facilitator can follow this script, spending time on any questions or comments as they arise:

Mood disorders include the diagnoses of major depressive disorder, dysthymia, bipolar disorder (I and II), and cyclothymia. In the US, 9.5% of adults are diagnosed each year with a mood disorder. For as many people as have a mood disorder, there are different experiences of mood disorders. However, the common
theme amongst all these diagnoses is a persistent depressed mood that negatively impacts the individual’s attitude, energy, thoughts, and feelings. This depressed mood comes along with feelings of worthlessness, low energy, inability to enjoy activities that usually bring pleasure, and changes in sex drive, appetite, weight, and sleep. Many individuals who live with a mood disorder experience social stigma related to their diagnosis. Generally speaking, stigma can look like prejudice and discrimination from people in the community in the areas of housing, education, and employment simply on the basis of having a mental health condition. Some people experience depression due to difficult life circumstances, trauma, loss, or genetic factors. Regardless of the cause, the symptoms of depression can be an incredible challenge to the diagnosed individual.

The impact of a mood disorder does not end there. When a diagnosed person is in a couple relationship, the partner is also affected. Often, when the diagnosed partner is experiencing such strong depression that they cannot care for themselves or their responsibilities, the other partner begins to play the role of caregiver. This can be a fulfilling role for some, but most often comes with huge amounts of stress. The caregiver can quickly experience burnout and stigma related to being in a relationship to a person with a mental health diagnosis. Burnout can feel like resentment, fatigue, or even anger relating to the diagnosed partner. Just as the diagnosed partner feels judged and misunderstood by society as a result of their challenges, the caregiver often feels as though they too are marginalized by association. This new relationship of patient and caregiver can also place strain on
the couple relationship. The diagnosed partner can feel guilty or ashamed for their needs related to their mental health but also desperate to have them met. The caregiving partner can be resentful of the tasks associated with their new role but guilty that it is their beloved partner having to live with the symptoms. In a couple, the mental illness happens to the relationship, not just the individual.

60 minutes—Invite each couple to share their diagnosis story. This will include the point of view of the diagnosed partner as well as the caregiving partner. Each couple will be given uninterrupted space to share their story. At the end of each couples’ sharing, the other members can make comments or express appreciation. Some questions that can facilitate the conversation include:

- How did you come to receive your diagnosis?
- Were you partnered when you received your diagnosis?
- How did your partner respond to your diagnosis?
- How has your life changed after your diagnosis?
- How is your couple relationship different (positive and negative) due to the diagnosis?

Last 10 minutes—Leave room for any closing reflections from this intimate time of sharing. Invite the couples to engage in homework that encourages vulnerability by spending a few minutes every day over the next week in close physical contact with their spouse. This could include cuddling, hugging, or holding hands. They will be asked to report the next week on how this impacted their relationship.
Session 4

Goal: The goals of this session is to explain negative interaction cycles, assist members in identifying such cycles in their relationship, and help members see that it is the cycle that causes distress, not their partner.

Objectives
- Understand and identify negative interaction cycles
- Process and share support for feelings related to negative interaction cycles

Activities
- Do ‘finish the sentence’ exercises to assist group members in identifying their behaviors in the context of the negative interaction cycle with their partner (e.g., When we fight, I _______ and you_______, which makes us end up ________.)

Homework
Notice the start of a negative interaction cycles and develop a signal to redirect them

Detailed outline:

First 20 minutes—Check in with group members about how their homework impacted them.

- Were you able to complete the homework?
- Did you notice any changes?
- Was this homework difficult for you? Easy? Refreshing?
30 minutes—Facilitators will provide psychoeducation on the negative interaction cycles that EFT highlights. Time should be taken for questions and examples from the group.

Facilitator can use the following script:

Two weeks ago, we talked a bit about primary and secondary emotions and how expressing the secondary emotion of anger pushes intimacy away whereas being vulnerable and expressing the underlying emotion creates intimacy. Being vulnerable can look like simply telling your partner how you are feeling or asking for what you need in the moment. This idea is at the core of Sue Johnson’s Emotion Focused Therapy [EFT]. Her 2008 book, Hold Me Tight, goes on to describe what she calls ‘demon dialogues.’ These are interaction patterns between couples that most couples engage in but that inevitably lead to pain, loneliness, and frustration in the relationship. Johnson likens these patterns to a dance with partners each making their own moves in relation to the other. Interaction patterns are a description of how one person acts/what one person says, how the other person responds, and so on.

The first demon dialogue is called ‘find the bad guy’ where both members of the couple become stuck in blaming the other for what they do not like about the relationship. Usually, the person is really feeling defensive because he or she was hurt (i.e. the underlying emotion) in the past. However, the person uses anger, the emotion that is often safer to express, to attack the other person. Finding the bad guy may have started as a way of trying to defend oneself but it ends with verbally attacking the other person. This can look like both members of the couple always
being ready, even if there is no argument currently going on, to point out the fault or failure of the other member. While the individual could claim they are trying to point out areas for their partner’s improvement, this dialogue blocks closeness.

The second demon dialogue is called ‘the protest polka’ where the essential pattern is for each member of the couple to ‘poke’ or ‘pull’ their partner to try to get their needs met. This poking or pulling can look like nagging or complaining. The individual’s hope is that if he or she pulls harder and pokes stronger, his or her partner will finally see how much they need ________. However, what ends up happening is that instead of softening and meeting the need, the other partner digs his or her heels in to protest being poked or pulled on. This often only serves to make the first partner nag more! This interaction cycle leaves both partners feeling alone and often triggers hopelessness for the couple.

The last demon dialogue happens when the couple has lost hope of their needs being valued and met by their partner. This dance is called ‘freeze and flee.’ Both members of the couple see their partner as unable to share their wants, needs, and feelings that are needed to create feelings of closeness. Both members are emotionally shut down and instead of coming to each other for comfort, they isolate themselves. The couple has given up and wonders why they are in the relationship at all. However, there is still hope for couples stuck in each of these dances as long as they are able to begin identifying the dance in the moment. In each of these demon dialogues, if both members can begin expressing their wants, needs, and
feelings in a safe and non-blaming way, the couple can begin rebuilding their feelings of closeness (Johnson, 2008).

**30 minutes**—Couples will be invited to do a “finish the sentence” activity using this outline:

When we fight, I ________ and you________, which makes us end up _________. Follow up questions to this exercise include:

- How do you feel after you engaged in a negative interaction cycle with your partner?
- How do you soothe yourself when you are feeling this way?
- How you do repair the relationship after the interaction takes place?

**Last 10 minutes**—Invite couples to participate in the homework of trying to notice one time in the next week that they are engaging in a negative interaction cycle. Ask couples to develop a signal for their partner that one of them has noticed the cycle so they can both be made aware. Affirm that because these patterns have become habits, they might notice a lot of these at first and that this is normal.
Session 5

Goal: This session will encourage members to look at the emotions that fuel the negative interaction cycles and begin to repair those through vulnerability.

Objectives
- To identify and access the primary emotions that are triggered in the negative interaction cycles
- To begin to safely express these primary emotions to partner and group
- Introduce ideas of role expectations and how they fit into negative interaction cycle

Activities
- Create list of role expectations between the couples.

Homework
- Identify moments throughout the week where partner is able to avoid negative interaction cycles.

Detailed outline:

First 10 minutes—Invite couples to share how it was to try to notice the negative interaction cycles in the midst of the cycle.

- Was it difficult?
- Did noticing it change how you or your partner interacted?
- Were you able to identify the type of interaction cycle?

10 minutes—Provide group members with the opportunity to greater descriptiveness of their primary emotions. Using a white board, the members will be asked to give other words for ‘sad’ and the facilitator will write them on the board. This list should include words like ‘numb,’ ‘down,’ ‘blue,’ ‘depressed,’ ‘sullen,’ ‘tearful,’ and ‘low.’ The group members will then be asked to scale the terms from most to least intense. The facilitators
can distribute Plutchik’s wheel of emotions handout to show how this can be done with many different emotions.

PLUTCHIK’S WHEEL OF EMOTIONS

15 minutes—Introduce the concept of role expectations to group members. Facilitator can use the following script:

In all of our relationships, we play a certain role. If you work outside the home, your role is usually defined by your job description. Sometimes, though, you are expected to do more than your job description and this can be a great source of frustration. Another possible source of frustration is when you have limited tools and resources at your current disposal to meet your job description. These
limitations can include time, energy, money, and adequate support staffing. In these situations, not only do you feel frustrated, but your boss and coworkers may begin to be annoyed because you are not fulfilling their expectations of your position. [Invite group members to share how they relate to this in their work place and how it feels to not be able to meet their role expectations in the work sphere].

We experience these role expectations with our friends and family as well. With friends, this can look like the unspoken expectation that one of you always arranges the get-togethers or initiates the conversations. Family role expectations can include concrete issues like household chores, paying bills, earning a paycheck, and yardwork. There are emotional and spiritual role expectations as well which can include spiritual guidance of the family or the availability of emotional stability and support. However, just the like the job example, frustration can arise for you and your family members when you are not able to fill certain spoken or unspoken role expectations. This is a common issue in couples when one member of the couple is living with a chronic physical or mental illness.

15 minutes—Invite the group members to reflect on the spoken and unspoken role expectation they have of each other in the couple relationship. Write these on a white board. Ideally, you should have a long list that includes concrete, emotional, social, and sexual expectations.

30 minutes—Prompt the group members to now consider the primary and secondary emotions they have when they or their partner are unable to fill these expectations.

• What gets in the way of you or your partner filling these role expectations?
• How does the mood disorder come into play?
• How do you feel when you or your partner are unable to meet these expectations?
• Are there consequences when you or your partner are unable to meet these expectations?
• Can you identify the primary and secondary emotions you feel when your partner does not meet your role expectations?
• What would you like for your partner to do or say when you are struggling to meet the expectations you have of yourself or they have of you?

Last 10 minutes—Thank group members for participating in such an emotionally intense meeting. Invite them to share a quick appreciation for their partner. Give homework of noticing this next week when their partner is able to avoid negative interaction cycles.
Session 6

Goal: This session will provide the insight and coping skills to begin changing the negative interaction cycles.

Objectives
- To begin the process of couples altering their negative interaction cycles
- To help members identify self-soothing skills

Activities
- Do ‘finish the sentence’ exercises to assist group members in identifying the primary and secondary emotions of the negative interaction cycle with their partner (e.g., When we fight, I look like I’m ________ but I’m really feeling ________ and I need you to ________.)
- Introduce mindfulness as a way to self-soothe and ask members to share one other way they self-soothe in a healthy way

Homework
- Ask couples to interrupt their negative interaction cycles twice during the week, implementing self-soothing when possible

Detailed outline:

First 10 minutes—Ask group members to share how the experience was of attempting to avoid negative interaction patterns.

- Did you notice yourself beginning to enter into a negative pattern?
- Were these patterns triggered by role expectations?
- How was it for you to stop a pattern?
- Did you notice any changes in your relationship as a result of stopping a negative interaction cycle?
20 minutes—Invite group members to participate in a ‘finish the sentence.’ Facilitator can introduce the activity by using the following script:

We have talked before about the primary and secondary emotions that play into our common negative interaction cycles. As a refresher, the secondary emotion is usually the one expressed and often takes the form of anger. The primary emotion, a few layers below the secondary emotion, is often one of hurt, fear of loss and abandonment, or fear of being viewed as fundamentally unworthy or incapable. The next exercise we will be doing looks a little closer at the primary and secondary emotions involved in our ‘demon dialogues’ as EFT labels them.

[Facilitator will pass out pens and 3x5 cards that already have the body of the sentence filled in, leaving blanks for the participants to write their primary and secondary emotions]. Let’s take a moment to reflect on the last time you and your partner were caught in a demon dialogue. Now, I invite each of you to write on your card the secondary emotion in the first blank space and the primary emotion you were feelings underneath in the second blank space. In the third blank space, try to imagine what you needed from your partner in that moment to help soothe your primary emotion.

- What would this look like?
- Would your partner have said something to soothe you?
- Would you need a physical interaction to help you express your vulnerable primary emotion?
• Would you first need some physical and emotional alone time and then like to attempt one of the above options?

30 minutes—Facilitators will now promote the sharing of these cards with the group members. Ideally, group members will have built enough trust with one another so that they will be able to share deeply and vulnerably with one another. Facilitators will promote the deepening of sharing by repeating key words or phrases that the participants disclose. Facilitators will highlight the universality of the challenges inherent in vulnerable communication by pointing out the ways in which the group members respond similarly.

10 minutes—Facilitators will move into the topic of mindfulness as self-soothing using the following script:

The last blank place on our 3x5 cards left room for the opportunity to ask your partner for what you need from them to be soothed. However, sometimes our partners are not emotionally available to soothe us in the moment. Instead of feeling frustrated that our emotional needs are not being met and letting that resentment feed into the demon dialogue, let’s discuss ways we can soothe ourselves while we allow time to pass before we reattempt emotional vulnerability with our partner. What are some ways you currently soothe yourself or help yourself calm down after engaging in a negative interaction cycle? [Facilitators will use a white board to list the group members’ current coping strategies]

Based on this list, you already have a lot of tools to soothe yourself when you feel stuck in a negative cycle. Another helpful way to acknowledge your feelings in a nonjudgmental way is through mindfulness. Some of you may have
heard of this practice. It is not associated with any particular religion, though people from many beliefs and backgrounds practice mindfulness. The goal of mindfulness is to be fully aware of your body, your emotions, and your thoughts while remaining nonjudgmental of each of these. Mindfulness involves being curious about these inner and outer states and uses a focus on the breath as a way to bring your attention back when your mind begins to wander.

10 minutes—Facilitators will invite the group members to participate in a mindfulness practice. At the end of the practice, invite the group members to reflect on the experience. The script is as follows:

I invite you to find a position in your chair that feels comfortable for you with both feet on the ground. You may place your hands with palms facing up or down, resting gently on your thighs. If you are comfortable, gently close your eyes or softly focus on a point in the room. If it is available to you, allow breathe to enter your nose, fill the tops of your lungs, sink down into your belly, and root you to your chair. When you are filled with breath, slowly release the air out through your mouth. Let your breath be constant and nurturing to you throughout this mindfulness practice.

Begin to notice your physical body, where it is tense and where it is relaxed. Notice where you feel pain and where you feel at ease. Begin at your feet, moving to your ankles, calves, knees, thighs, hips. Continue your deep breaths in through your nose and out through your mouth as you bring your curious attention to your stomach, chest, arms, shoulders, neck, face, and head. You do not have to fix or
change anything. Simply notice how your body feels in this moment. Continue to breathe just the way your body knows how. Try to be curious about how your breath interacts with what you noticed about your physical body. If your mind begins to wander, gently bring your attention back to your breath and to the sound of my voice.

Next, begin to notice what feelings you are experiencing in this moment. Notice if you have more than one feeling in this moment. Notice if you are judging your emotions as good or bad, wanted or unwanted. I invite you to have compassion on yourself for whatever you are feeling, whether it is sad, resentful, hurt, open, connected, or hopeful. Be curious to see if you are experiencing your emotions in your physical body. You may feel your emotion in your heart, your throat, your stomach, your hips, or you may not notice your emotions anywhere in your physical body. Allow your emotions to be present now with the knowledge that they will change, as that is the nature of all emotions. If you are struggling to remain present, gently bring your attention back to your breath and to the sound of my voice.

I invite you to next bring your awareness to your thoughts. Be aware of any persistent thought that has been coming to your mind during this practice. Allow yourself to be compassionate if you have been distracted by this thought and bring your awareness back to your breath. This thought may be connected to the emotions you are feeling and the physical sensations you are experiencing, or it may not. Try to be curious about how this thought may be affecting your physical body.
and emotions without any judgment. Taking a slow deep breath in through your nose, into your lungs, your belly and your hips, allow yourself to be filled with air and breathe out all thoughts, feelings, and physical sensations.

As we close this mindfulness practice, take a deep breath and express gratitude for the commitment you have made to yourself and each other to be present and vulnerable through this growth process. When you are ready, you can gently bring your attention back to the room and open your eyes.

Last 10 minutes—Invite group members to interrupt their negative interaction cycles twice during the next week, implementing the added element of each member asking for what they need from their partner to be soothed. Ask group members to practice curiosity and nonjudgmental acceptance of their own and their partner’s emotions during the week, utilizing mindful breathing when appropriate.
Session 7

Goal: This session will begin the consolidation of the support and education received through the group process.

Objectives
- Couples will begin the “goodbye” process with the group
- Begin to consolidate what has been gained through group process

Activities
- Reflect on helpfulness of sessions, interventions, and facilitators
- Report on ability to alter negative interaction cycles and role expectations and how the depression has been affected by these changes

Homework
- Invite members to reflect during the week on what they have gained from the group process

Detailed outline:

First 10 minutes—Ask group members to share how their journey into nonjudgmental curiosity over the past week.

- Were you able to catch yourself judging your or your partners emotions?
- Were you able to interrupt any negative interaction cycles?

40 minutes—Introduce the topic of the group closing the next week. Facilitators will assure the group that they will have a chance to discuss their appreciations for one another and reflect on personal growth in the next session. Facilitators can use this script:

Over the past 6 weeks, we have learned a lot about primary and secondary emotions, role expectations, negative interaction cycles, and self-soothing. We have been able to witness your growth as individuals as well as in your couple relationships. [Facilitators can mention specific ways in which they have witnessed
group growth]. We will be able to reflect more on the growth you have seen in yourselves, your partner, and the group next week in our last session. Today, we will do some reflecting but it will focus more on your thoughts on the group curriculum and feedback for the facilitators. We will start by asking you several questions to prompt your reflection on the previous weeks’ sessions.

- Was there a particular week that stood out to you as being particularly helpful? What was it about that week that stands out to you as being helpful?
- Was there a particular week that stood out to you as being particularly unhelpful? What was it about that week that stands out to you as being helpful?
- Was there a particular activity we did that was helpful/unhelpful for you?
- Was there a particular topic presentation that was helpful/unhelpful for you?
- Can you reflect on the facilitators and how they were helpful or unhelpful for your process and growth?

30 minutes—Invite the group members to reflect on how their or their partner’s depressive symptoms have been affected by the shift in role expectations and interaction cycles. Facilitators will promote discussion on behaviors, thoughts, and feelings.

Last 10 minutes—Thank group members for beginning the closing experience and reflecting on the group process. Invite the group members to participate in the homework of reflecting on what they have gained personally, their gains as a couples, and their appreciations for the other group members.
Session 8

Goal: This session will be used to say “goodbye” as well as consolidate the benefits of the group. Couples will be given referrals for further treatment options should they want them.

Objectives
- Close group
- Consolidate what has been gained through group process

Activities
- Use gratitude exercise to promote the sharing of appreciation and the feeling of connectedness between group members
- Celebrate the connections and growth made in the group by sharing a meal together

Detailed outline:

First 30 minutes—Facilitators will introduce the session’s topics of gratitude and reflection. Facilitators will invite couples to share their reflections on their personal growth through the group, how they feel their couple relationship has changed, and how they see their partner has grown.

30 minutes—Each group member will be asked to give a brief compliment to the other members in the group, acknowledging their growth or giving them gratitude for what that group member contributed to their personal growth. Facilitators should participate in the giving of compliments and sharing of gratitude.

Last 30 minutes—Group members will be invited to share a meal together to celebrate the connections and growth made together. At the close, facilitators will provide any necessary referrals to the group members.
Do you or your partner live with depression?

In couple relationships, a person diagnosed with depression or another mood disorder (dysthymia, cyclothymia, bipolar disorder) does not struggle alone. Their romantic partner and intimate relationships are often affected. In this group, you and your partner will be able to receive support and education with other couples who truly understand your unique struggles and successes.
COUPLES GROUP INTAKE

Date of intake:_____________________

Partner 1
Name: _______________________________ Date of Birth: ________________

Partner 2
Name: _______________________________ Date of Birth: ________________

Best Phone #:____________________

How were you referred to the couples group?
________________________________________________________________________
________________________________________________________________________

Are there any recent major life changes or difficulties that you are currently facing which led you to contact us?
________________________________________________________________________
________________________________________________________________________

Has either partner been diagnosed with a mood disorder? Please specify diagnosis and date of diagnosis below:
________________________________________________________________________
________________________________________________________________________

How do you as a couple currently cope with and treat this diagnosis?
________________________________________________________________________
________________________________________________________________________

Are you currently in counseling? If yes, please provide information regarding therapist’s name, agency, contact information, length of treatment, and current treatment outcomes:
________________________________________________________________________
________________________________________________________________________

Do you currently have suicidal thoughts or are you taking suicidal actions? □ Y □ N
Have you ever attempted suicide? □ Y □ N If yes, please specify when and under what circumstances:
_________________________________________________________________________
_________________________________________________________________________

Do you ever self harm? □ Y □ N If yes, please specify below:
_________________________________________________________________________

Have you experienced domestic violence? □ Y □ N If yes, please specify below:
_________________________________________________________________________
_________________________________________________________________________

With whom do you currently live?
_________________________________________________________________________
_________________________________________________________________________

How long have you been together as a couple?
_________________________________________________________________________
_________________________________________________________________________

What is your highest level of education?
_________________________________________________________________________
_________________________________________________________________________

What do you hope to gain from this group/what are your expectations?
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
COUPLES GROUP CONSENT TO TREATMENT

What to expect

- Group therapy can provide a safe place for you to receive education and support surrounding your current struggles and strengths.
- Participation is encouraged during each session. We hope you will find that the more you invest in the process, the greater the personal return.
- Sometimes in starting therapy, you begin to feel worse before you feel better. If this is true for you, please let a group facilitator know that you need extra support.

Confidentiality

- Therapy is a confidential and privileged relationship between the clients and the therapists. However, because safety is a top priority, there are some exceptions to confidentiality including suspicion of child, elder, or dependent abuse. Also, if you report that you or someone you know is suicidal or homicidal, the therapists may need to take action to protect the identified individual.

Timing and attendance

- Sessions are 90 minutes in length. You will be permitted to be 15 minutes late. In order to promote the group’s format and best support the group members, you will not be able to join the session if you are more than 15 minutes late.
- There are eight sessions in this group cycle. If you are unable to attend a session, please contact your group facilitator to let them know. Again, to promote the
group’s format and best support the group members, only one absence will be permitted.

Fees

- There is no cost to participate in this group.

Emergencies

- In case of emergency, please call 911 or go to the nearest emergency room.
- If you are in need of additional emotional support beyond the group setting, see the facilitators after session or contact them by phone.

Please sign below in acknowledgment that you have read, understand, and agree to the group consent to treatment.

Client name______________________  Client signature______________________

Date___________

Client name______________________  Client signature______________________

Date___________

Facilitator name______________________  Facilitator signature______________________

Date___________

Facilitator name______________________  Facilitator signature______________________

Date___________

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COUPLES GROUP RULES

Values

- The diversity of backgrounds and beliefs represented here are considered valuable contributions to the group process.

- This group is not to be used as a means of evangelizing or converting members. All attempts to persuade group members to agree with your personal beliefs are discouraged.

Sharing

- All members are invited to share their thoughts, feelings, and reactions to the presented material during the group. Please be considerate in the amount of time you share so that all members have a chance to participate.

- When a group member is sharing, active listening is encouraged. Side conversations and phone distractions are discouraged.

Timing and Attendance

- Prompt attendance is a way to show respect to the facilitators and your fellow group members.

- Arriving later than 15 minutes after group begins is discouraged.

- Of the eight sessions in this group cycle, one absence is excused.
Support

- This is an environment of unconditional positive regard and non-judgmental acceptance. We are all here to learn from and support each other.

Client name_________________________  Client signature__________________________

Date___________
COUPLES GROUP TREATMENT PLAN

Client name:____________________

Problem definition: Client experiences co-occurring couple distress and mood disorder. Client’s couple distress is heightened by unrealistic role expectations, caregiver burnout, and a weakened attachment between the members of the couple. Client’s mood disorder symptoms are heightened by the unrealistic role expectations, caregiver burnout, and a weakened attachment between the members of the couple.

Treatment goals: Promote healthy attachment between members of the couple and reduce symptoms of mood disorder.

Short term goals:  

| (1) Define appropriate and mutually agreed upon role expectations between members of the couple | (1) Provide psychoeducation on role expectations |
| (2) Promote self-care and utilization of coping skills | (2) Promote discussion between couples to identify appropriate role expectations |
| (3) Identify current methods of self-care | (4) Introduce mindfulness as a method of self-care |

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(3) Promote affective communication and increase attachment between the members of the couple

(5) Provide psychoeducation on primary and secondary emotions

(6) Promote sharing of primary emotions between couples

Facilitator signature_______________________________   Date___________

Facilitator signature_______________________________   Date___________