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Marriage and Family Therapists' Clinical Impressions of Romantic Relationship Dissolution Heartbreak: A Modified Delphi Study

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Marriage and Family Therapists' Clinical Impressions of Romantic Relationship
Dissolution Heartbreak: A Modified Delphi Study

by

Isibel C. Moreno

A Dissertation Presented to the
College of Arts, Humanities, & Social Sciences
In Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University

2019

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by

Isibel C. Moreno

April 22, 2019

Nova Southeastern University

College of Arts, Humanities, & Social Sciences

This dissertation was submitted by Isibel C. Moreno under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, and Social Sciences and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Family Therapy at Nova Southeastern University.

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Dedication

To my amazing, seemingly otherworldly system of family and friends.

Mami, Papi, Tita, Josué: los amo más de lo que unas cuantas palabras puedan expresar.

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Abstract

The Merriam-Webster Dictionary (2018) defines heartbreak as “crushing grief, anguish or distress.” Heartbreak can lead to biological, psychological and social responses and consequences. Heartbreak from the dissolution of a romantic relationship is a form of disenfranchised grief, which is defined as the griever’s belief that society does not recognize their source of grief as legitimate (Doka, 1989). The literature shows that talking about grief helps those who experience it (Fisher & Archer, 2008). Hence, the present study sought to provide a consensus of the best practices that marriage and family therapists have utilized to help broken-hearted clients. I employed a modification of the Delphi technique, a research method which seeks to reach consensus on a topic through group communication between experts in the subject area discussed (Hsu & Sandford, 2007) in order to gather data about best practices from marriage and family therapists on how they have helped their broken-hearted clients. This study consisted of a total of 20 experts, who are licensed marriage and family therapists. The findings suggest that the disenfranchisement of the grief resulting from the dissolution of a romantic relationship is closely associated with the symptom of sadness experienced by the broken-hearted. In addition, the way in which MFTs can help the disenfranchised griever is by providing an empathic presence in sessions, generating historical conversations through the use of a genogram, involving family members in the therapeutic process and having future-oriented conversations. The results of this study have illustrated a plethora of techniques and best practices that have reportedly proven successful in helping the broken-hearted client.

Keywords: heartbreak, disenfranchised grief, MFT, Delphi Technique

CHAPTER I: INTRODUCTION

Heartbreak: An Overview

As defined by the Merriam-Webster Dictionary (2018), heartbreak is a “crushing grief, anguish or distress.” Heartbreak comes in different shapes, sizes, and forms. It can result from many sources, such as the death of a loved one, a miscarriage, news of illness or disease, loss of a sporting event or war, or unrequited love. Case Western Reserve University published research suggesting that 95% of the participants surveyed had rejected someone who was in love with them, and 93% had been rejected by someone they loved (Baumeister, Wotman, & Stillwell, 1993). However, popular culture has trivialized the potentially traumatic experience of heartbreak (Moreno & Boros, 2017).

In many cases, heartbreak becomes a traumatic experience. Research shows that the aftermath of heartbreak can lead to negative health consequences (Field, Diego, Pelaez, Deed, & Delgado, 2011). In fact, the heartbreak that results from the termination of a romantic relationship is said to be one of the most painful events in a person’s life, causing extreme emotions like sadness and anger, and exposing one’s deepest insecurities (Eastwick, Finkel, Krishnamurti, & Loewenstein, 2008).

Heartbreak can lead to physiological responses, including alterations in heart rate, perspiration, weight fluctuations, and hormonal changes, among many others (Chapman, 2011; Field, 2011; Fisher & Archer, 2008). In some cases, the physiology of the heart organ is changed, when the broken-hearted individual experiences the Broken Heart Syndrome, or “Takotsubo Cardiomyopathy,” as it is known in the medical field (Villarreal, Vitola, Stier, Dippe, & Cunha, 2009, p. 847).

Heartbreak may also include emotional repercussions. According to Reichbart (2011), a person who is broken-hearted mourns not only the love lost or the lover gone, but also him or herself in love. Field et al. (2011) assert that pain resulting from the rejection experienced after the dissolution of a romantic relationship goes beyond agony, to the extent that it becomes incapacitating. Another popular recount of what heartbreak feels like to those who have experienced its depths comes from Hunt (2012), who wrote:

You feel wretched, powerless, utterly miserable. You can't imagine ever feeling better, ever again. You're undignified, petulant, self-pitying. You obsess over details, you cry at work. You think constantly about the awfulness of your situation, you spew a kind of irrepressible autobiography, monologuing to anyone who'll listen (p. 1).

Fisher and Archer (2008) report that people can die from a broken heart. Men are three to four times more likely than women to commit suicide; but women exhibit high rates of depression as a result of being broken-hearted. The wave of emotions that inundate a person who is broken-hearted can potentially create an unsafe atmosphere. For example, Knox, Zusman, Kaluzny, and Cooper (2000) explain that two out of nine men abuse alcohol to help them get over a previous partner.

Disenfranchised Grief: A Theoretical Basis

The dissolution of romantic relationships often results in heartbreak (Finkelstein, 2014). Archer (1999) reasons that the death of a loved one and the termination of a romantic relationship are the leading causes of grief. Heartbreak from the dissolution of a romantic relationship is a form of disenfranchised grief, which can be defined as a belief that society does not recognize one's source of grief as legitimate (Doka, 1989). As stated

in the literature, the dissolution of non-marital romantic relationships is more likely to cause a sense of disenfranchisement, as there are no legal ties legitimizing the partners in the eyes of society (Finkelstein, 2014). As such, it is important to explore the experiences of those who have previously grieved or are currently grieving the dissolution of a non-marital romantic relationship. The belief guiding the present study is that marriage and family therapists who have worked with broken-hearted individuals have a collective memory of best practices to help people going through that experience.

Problem Statement

The literature shows that talking about grief helps those who experience it (Fisher & Archer, 2008). One of the major components of disenfranchised grief is that those who live through it often report that their feelings are unreasonable, last too long, or are simply misunderstood by others (Finkelstein, 2014). The present study was conducted to provide a consensus of the best practices marriage and family therapists have employed to help broken-hearted clients experiencing such disenfranchised grief.

Purpose of the Study

I hope this study will shed light on the disenfranchised grief experienced by broken-hearted individuals, so that professionals and individuals may help those suffering from a broken heart, informed by the best practices of marriage and family therapists. This is important data that therapists, doctors, and other helping professionals may utilize to help clients and patients find solace in the midst of their heartbreak. This study ultimately seeks to begin a conversation and instigate further research, as well as provide readers, especially marriage and family therapists, with best practices for supporting

individuals who have experienced heartbreak over the dissolution of a non-marital romantic relationship.

Although previous research has identified therapy as one of the ways in which people experiencing a broken heart may heal (Field et al., 2011; Fisher & Archer, 2008), no specific discipline of psychotherapy has been indicated. The existing literature does not directly link marriage and family therapy with the healing of heartbreak; the present study is expected to provide this link. I posit that one of the ways heartbreak can be understood from the systemic lens guiding marriage and family therapists' work is as an intricate process unique to every person, which may lead to disenfranchised grieving. The current study seeks to contribute to the existing literature by revealing how marriage and family therapists have been able to help broken-hearted clients.

Research Questions

Heartbreak is an understudied phenomenon in need of more academic attention. The fields of counseling, marriage and family therapy, medicine, and many others, can benefit from learning about how marriage and family therapists have helped clients experiencing heartbreak. Ultimately, the study will reveal how marriage and therapists experience people who reach out for therapeutic services to help with their heartbreak. What do marriage and family therapists who have worked with the broken-hearted observe as the symptoms of this experience? What are the common characteristics of individuals who present to therapy for a broken heart? How do marriage and family therapists help these clients heal? What are some of the best practices for helping the broken-hearted?

My hope in conducting this study about how marriage and family therapists have been able to help broken-hearted clients was to learn directly from practitioners in the field about the symptoms of heartbreak and the best practices for treating it.

Definition of Terms

Because of the limited research on the subject of heartbreak in the field of family therapy, the literature does not include quantifiable definitions for some of the terms that will be utilized in this study. The following is a list of definitions for terms that will appear throughout this paper.

- *Breakup*. This term, which is synonymous with romantic relationship dissolution, was used when communicating with the participants of this study.
- *Delphi Technique/Modified Delphi Technique*. The Delphi technique is a research method that seeks to reach consensus on a topic through group communication among experts in a particular subject area (Hsu & Sandford, 2007). The terms Modified Delphi Technique, Modified Delphi Method, and Modified Delphi Study are used interchangeably in this paper.
- *Disenfranchised grief*. Though the literature presents various definitions for this term, in this study, the guiding definition is from Doka (1989, as cited by Kaczmarek and Backlund, 1991). Grief becomes disenfranchised when the griever believes that society does not recognize his or her source of grief as legitimate.
- *Heartbreak*. This term is used to refer to crushing grief, anguish, or distress (Merriam-Webster, 2018).
- *Marriage and Family Therapist*. This term refers to a professional psychotherapist with a license in Marriage and Family Therapy.

- *Romantic relationship.* For the purpose of this study, a romantic relationship is any relationship of a romantic nature, which involved two individuals who were not married.
- *Romantic relationship dissolution.* As used in this study, the termination or ending of a non-marital romantic relationship constitutes a romantic relationship dissolution. The reason for the end of the relationship, the level of commitment prior to the end of the relationship, and the length of the relationship were not explored in the present study.

Overview of Chapters

Chapter I consisted of a brief overview of heartbreak, including some of its biological, psychological, and social responses and consequences. I also provided a brief introduction to disenfranchised grief, which will serve as the theoretical basis for the present study. In addition, I discussed the problem statement, the purpose of the study, the primary research questions, and a glossary of terms utilized in the study.

Chapter II offers a review of the existing literature on heartbreak, including its biological, psychological, and social responses and consequences. It also includes a review of the literature on the theory of disenfranchised grief, as well as an exposé' on the field of marriage and family therapy.

Chapter III details the Modified Delphi Technique, the research methodology for the present study. I also present a profile of my personal experience and interest in this topic. The research questions are restated, along with information about the participants of this study and the procedures I utilized for data collection, recruitment, screening, dissemination of information, and data analysis. Chapter III concludes with a discussion

about the quality control measures of rigor, trustworthiness, validity, reliability, and ethics.

Chapter IV provides detailed information about the data I gathered in the study through the use of tables, charts, and figures.

Chapter V includes a comparison between the data gathered in this study and the information in the existing literature. It also includes a description of the strengths and limitations of the study, as well as the implications for future research and clinical practice for marriage and family therapists. The study is then concluded with a summary of my reflections throughout the process of conducting this research study.

CHAPTER II: REVIEW OF LITERATURE

Chapter Introduction

This chapter offers a review of the existing literature on heartbreak, including its biological, psychological, and social responses and consequences. It also provides a literature review on the theory of disenfranchised grief, as well as an expose' on the field of marriage and family therapy.

Heartbreak

Biological Responses

Heartbreak can lead to physiological responses (Field, 2011), which involve decreased levels of serotonin that result in symptoms such as increased heart rate, trembling, flushing, pupil dilation, sleeplessness, loss of appetite (Field, 2011), sweating, pounding heart, weight loss (Fisher & Archer, 2008), anhedonia, desolation, loneliness, a decrease in dopamine (Chapman, 2011), confusion, fear, shame (Macdonald, 2009), intrusive thoughts, emotional insecurity, and other grief responses (Lepore & Greenberg, 2002). The experience of heartbreak and its corresponding physiological manifestations can result in complicated grief, which consists of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, excessive feelings of loneliness and emptiness, unusual sleep disturbances, loss of interest in personal activities, decreased concentration, distrust, decreased empathy, diminished caring behavior, and hypersensitivity (Field et al., 2011).

In addition to the physiological changes the human body undergoes during heartbreak, there could also be more serious, potentially severe side effects. Field (2011) proposes that heartbreak produces physical pain in the heart or chest and, in some cases,

results in symptoms that mimic a heart attack. Field further describes *broken heart syndrome* as a physical pain in the heart or chest after losing someone. The biggest difference between the symptoms of a broken heart and those of a heart attack is that people who suffer from a heart attack usually present with blocked arteries, which are not present in the brokenhearted, who usually also tend to have a faster recovery time (Field, 2011). The medical term for a broken heart is “takotsubo cardiomyopathy” (Villarroel, Vitola, Stier, Dippe, & Cunha, 2009, p. 847). Takotsubo is the name of a Japanese fishing pot used for catching octopus; it is characterized by its narrow neck and wide base, a shape that resembles the left ventricle of the human heart (Ibanez, Benezet-Mazuecos, Nvarro, & Farre, 2006).

Field (2011) conducted a literature review which revealed that heartbreak resulting from the end of a romantic relationship may lead to bereavement symptoms such as intrusive thoughts and insomnia. The researcher summarized the results of several studies on heartbreak and bereavement and assigned the studies to one of two categories: those focused on bereavement symptoms, which include sleep disturbances, intrusive thoughts, and attempts to control intrusive thoughts, and those focused on potential morbidity factors, which include the broken heart syndrome, endocrine and immune dysfunction, romantic breakups, regional brain activity, Functional Magnetic Resonance Imaging (fMRIs) and biochemical profiles of rejected love compared to romantic love, relationships as social regulators, and psychological attunement.

Since the dissolution of a romantic relationship is a stressful life event, the brains of individuals experiencing it will release hormones that affect the body (Field, 2009). These physiological and biochemical reactions involve the increased release of dopamine

and norepinephrine, which leads to a decrease in serotonin levels and subsequent symptoms of insomnia, food aversion or loss of appetite, dilated pupils, increased heart rate, tremors, and flushing (Fisher, 2006). The biology and chemical presentation of romantic love and romantic rejection are similar (Field, 2011). In other words, the brains of people in love and people experiencing heartbreak from the dissolution of a romantic relationship look the same. Research also suggests that the dissolution of romantic relationships can contribute to heightened anger and disorganized behavior (Field et al., 2009); lower life satisfaction (Rhoades, Kamb Dush, Atkins, Stanley, & Markman, 2011); reduced immune function (Field, 2011; Langeslag, & Sanchez, 2017); general adjustment problems (Barbara & Dion, 2000); and increased rates of psychological distress, depression, insomnia, and other sleep irregularities (Brewer & Abell, 2017). According to Field (2011), rumination about the loss is common among people experiencing heartbreak, and attempts to control those thoughts often result in insomnia.

When a romantic relationship ends, the parties involved must find a way to normalize their routines in a way that differs from the lifestyle they had in the relationship. For example, some romantic relationships include touch; the withdrawal of it can cause physiological dysregulation and immune problems (Field, 2009). The same applies to the well-known phenomenon of partners who sleep in the same bed having trouble falling asleep when their partner is not in the bed at the same time. Following the dissolution of a romantic relationship, the possibility of missing that particular form of touch becomes more imminent.

A study conducted by Flaskerud (2011) uncovered that when observed through neuroimaging, the same area of the brain responds to both emotional and physical pain.

The researcher concluded that the human body responds similarly to hurt feelings as it does to physical injury. The brains of participants in the study were activated in the same way when they were asked to recall memories of devastating heartbreak as when they were suffering from physical pain. Furthermore, participants described emotional distress and emotional heart sensations using words that imply psychological and physical symptoms, such as *heart pounding, trembling, racing, uncomfortable, upset, and uneasy*, among others. Flaskerud explained that in Western cultures, people use the word/concept of heart to convey emotions; when people speak of heartache or a broken heart, they are typically referring to emotional pain. Flaskerud also pointed out that the heart beats irregularly or even leaps as a result of strong emotions; however, the cause of physical pain for the heartbroken individual is the relentless attempt to reconnect with the former lover.

Psychological Responses

Much in the same way that the human body responds physically and biologically to the potential emotional disturbance of heartbreak, the mind responds in a similar manner. In the literature, the dissolution of a romantic relationship is correlated with health problems and major psychiatric and psychological disorders (Overbeek, Vollebergh, de Graaf, Scholte, de Kemp, & Engels, 2006). Romantic relationship dissolution often results in a wide array of possible negative consequences, two of which may be insecurity and emotional distress (Tan, Agnew, VanderDrift, & Harvey, 2015). Other side effects of romantic relationship dissolution include anger, confusion, sadness, and regret (Brewer & Abell, 2017); increased substance use (Fleming, White, Oesterle, Haggerty, & Catalano, 2010; Larson & Sweeten, 2012; Salvatore, Kendler, & Dick,

2014); increased distress (Rhoades et al., 2011); and fluctuation of positive and negative emotions over a short period of time (Sbarra & Emery, 2005). It is important to note that the literature does not include information from recent studies on the grief experiences of broken-hearted individuals responding to the dissolution of a romantic relationship.

Information from Miller's (2009) dissertation, titled *Growth Following Romantic Relationship Dissolution*, guides this section of the current study. According to Miller, trauma is explored in the literature as a precursor to change and growth, as individuals who have traversed a traumatic experience often access higher levels of functioning. Though heartbreak is a common experience, for some people it becomes a new way of living until such time as recovery (Aoki, 2000).

In 1967, Holmes and Rahe, conducted a seminal study that helped shape the way we think about stress and adjustment. The researchers developed the Social Readjustment Rating Scale, in which the dissolution of a romantic relationship is ranked as a stressful event and compared to other stressors such as death and illness. Romantic relationship dissolution is among the most stressful events a person can experience (Frost, Rubin, & Darcangelo, 2016). One of the main reasons breakups are so stressful is that they create many disruptions that the parties involved must cope with, often resulting in varying degrees of psychological distress (Frost et al., 2016).

Those who experience interpersonal stressors, such as those resulting from the dissolution of a romantic relationship, also show symptoms associated with the diagnosis of post-traumatic stress disorder (PTSD) (Miller, 2009). According to Miller (2009), the nature of the trauma—whether it result from rape, death, health stressors, or other forms of personal or interpersonal trauma—does not alter the resulting symptoms. In other

words, regardless of the source of their trauma, people may experience disordered symptoms.

The grief resulting from the dissolution of a romantic relationship has been linked with the onset of mental health problems (Field et al., 2009). Fordwood, Asarnow, Huizar, and Reise (2007) studied 451 people experiencing the dissolution of a romantic relationship and found an increase in suicidality among the participants. The following year, Perilloux and Buss (2008) conducted a similar study and found that suicide threats increased among the participants following the dissolution of a romantic relationship.

One of the main contributing factors to the depression experienced after the dissolution of a romantic relationship is whether the parties involved dwell on the negative interactions that took place during the relationship, or on the subsequent negative feelings that arose (Frost, Rubin, & Darcangelo, 2016). Post-dissolution depression is also influenced by the expectations griever may have about how to manage their symptoms, as well as thoughts they may have regarding how difficult it will be to find a new partner or replace the lost romantic relationship (Miller, 2009).

Some researchers have focused on the interactions some romantic partners experience in the midst of their separation. For example, Dailey, Rossetto, McCrackern, Jin, and Green (2012) point out that this indecision—commonly seen in the proverbial on-again-off-again relationship—often compounds the grief experienced by the parties involved, as they dissolve the relationship multiple times, experiencing the breakup over and over again. Whether deliberately or by happenstance, many former partners will interact with each other in some way after the dissolution of their relationship. According

to Locker, McIntosh, Hackney, Wilson, and Wiegand (2010), the possibility of a reunion contributes to the disenfranchisement of grief for the broken-hearted.

Boelen and Reijntjes (2009) explored the linkages between negative cognitions and emotional problems following the dissolution of romantic relationships and found that emotional problems often evolve after the dissolution of a romantic relationship when the parties involved have overarching negative beliefs about their own reactions and life's vicissitudes in relation to the breakup. In other words, when people believe that things are going to go wrong during the recovery period after a relationship dissolution, they inadvertently self-sabotage the recovery.

Though not directly related to the scope of this study, I would like to mention and Bowlby's (1982) attachment theory, which proposes that throughout life, people seek to maintain the same type of attachment they first found with the person who provided the most nurturance during their early development: their infant caregiver. In a sense, romantic relationships provide an attachment that is similar to that which we experienced with our primary attachment figures. In other words, our romantic partners fulfill the needs for love and nurturance that our infant caregivers once provided. Thus, when this bond is broken through the dissolution of a romantic relationship, grievers are depleted of their most instinctual desire and must find a way to cope with the loss. Failure to adapt to this loss can result in maladaptive behaviors that augment the grief and disenfranchisement of heartbreak (Fagundes, 2012).

Langeslag and Sanchez (2017) found that individuals who reported still having love feelings for their exes also reported feeling upset about the dissolution of that particular romantic relationship (Langeslag, & Sanchez, 2017). These findings reaffirm

that sadness and difficulty recovering from the dissolution of a romantic relationship are positively correlated with lingering love feelings, and negatively correlated with prompt recovery from the dissolution of a romantic relationship (Langeslag & Sanchez, 2017).

The existing literature does not seem to address the connection between significant events that shaped the romantic relationship and the implications those events may have for how grievers experience the dissolution of the romantic relationship (Frost et al., 2016).

Social Responses

“Every society has norms that frame grieving.”

— Doka, 2008, p. 225

Brewer and Abell (2017) assert that romantic relationships are an integral part of the social collective of men and women in most Western societies; and since breakups are a common experience among those who engage in romantic relationships (Norona, Olmstead, & Welsh, 2017), they are bound to result in multiple social components and effects of heartbreak. The end of a romantic relationship is indicative of what type of relationship it was (Norona, Olmstead, & Welsh, 2017) and how close the ex-partners were (Tan, Agnew, VanderDrift, & Harvey, 2015).

Because of society’s structures of kinship based on the legal system, non-marital romantic relationships are often seen as less serious than romantic relationships in which the partners are married (Finkelstein, 2014). Because marriage provides a pseudo kinship, relationships between non-married people do not enjoy the same legitimacy in the eyes of the law and society; therefore, individuals in non-marital relationships become more susceptible to disenfranchisement upon dissolution. It is because of the norms, rules, and laws of some societies that the dissolution of a non-marital romantic relationship is seen

as less valid (Attig, 2004), leading grievers vulnerable to the scrutiny of loved ones when their relationships end.

The literature reveals that it can be difficult to determine how to alleviate the social pain resulting from the dissolution of a romantic relationship, as romantic breakups can be chronically painful and therapeutically costly (Field, 2011). The research shows that people tend to seek support from people they feel close to in times of need, such as when grieving the end of a romantic relationship (Collins & Feeney, 2004). A study by Moller, Fouladi, McCarthy, and Hatch (2003) showed that support from friends and family makes less of an impact on the experience of heartbreak as having a close relationship with someone who listens. This corresponds with the result of an earlier studies on bereavement, in which grievers deemed the advice they received from friends and family inaccurate, ineffective, premature, and unhelpful, regardless of the intention behind it (Lehman, Ellard, & Wortman, 1986).

Regardless of who initiates the dissolution of a relationship, there are repercussions for all parties in terms of daily functioning (Miller, 2009). Of course, these changes last for as long as each person takes to establish new routines. It is common knowledge that when a romantic relationship ends, the friends the couple had in common often choose sides. In most cases, the partners experience changes in their social circle, often losing a friend or two who established alliances with the ex-partner. This may also include loss of social status or restricted access to certain people, things, places, or resources (Harvey, 2002). At one point or another, former partners may have an encounter with one another; as previously mentioned, the possibility of this adds stress to the grieving process of the brokenhearted (Finkelstein, 2014).

One of the most prominent and worrisome concerns is the social isolation that tends to follow the disenfranchised grievers following the dissolution of their romantic relationship (Finkelstein, 2014). As Miller (2009) explains, there seems to be a decrease in social competence among them. People who are going through a breakup may attempt to avoid their ex-partner at all costs, which often entails not doing activities they once enjoyed (LeFebvre, Blackburn, & Brody, 2015); this, of course, has the potential to alter the layout of their social lives.

LeFebvre, Blackburn, and Brody (2015) conducted a study which suggested that when a couple's romantic relationship ends, their social circles somehow find out about it. In some cases, the ex-partners communicate the news directly; in most other cases, as is now becoming the norm, social media plays a role in disseminating the information. Elements of the recount commonly get lost in translation. Furthermore, it has become increasingly common for individuals to cyber investigate—or, as it is now commonly termed, *stalk*—their ex-partners online through social media and similar outlets. However, because of certain features on social media and the interconnectedness of friends who share photos and other memories, it is virtually impossible for two people who were once connected in a romantic relationship to disconnect completely for extended periods of time, especially at the beginning of the breakup.

Disenfranchised Grief

Although most people recover from the dissolution of a romantic relationship, for some it takes considerable time and effort. Breakups often lead to symptoms of heart-break and bereavement (Field, 2011), the symptoms of which correspond with the loss experienced from a death (Field, 2011). Papa, Lancaster, and Kahler (2014) propose that

an individual may experience grief after any type of loss, even those that are non-bereavement related. The dissolution of a romantic relationship is considered a highly stressful event (Field, 2011) and a loss (Kaczmarek & Blacklund, 1991; Holmes & Rahe, 1967) that is accompanied by grief and results in a major life change (Kaczmarek & Blacklund, 1991).

As defined by Doka (1989), disenfranchised grief is not widely recognized by society or acknowledged within the griever's social circle. In 2004, Attig asserted that disenfranchised grief was among the fastest growing research focuses; according to the researcher, its popularity was due, in part, to how difficult it is to recover for those whose grieve is disenfranchised. Doka's theory of disenfranchised grief applies to the current study, as people who experience heartbreak from the dissolution of a romantic relationship are underrepresented in the realm of grief. There is much research on grief following a death or divorce, but the same cannot be said about grief over a romantic relationship that did not include marriage. The common devaluing of intensity, persistence, and legitimacy of heartbreak following the dissolution of a non-marital romantic relationship (Wolfelt, 1990) gives way to the disenfranchisement of this type of heartbreak (Finkelstein, 2014), which can lead to feelings of guilt, shame, and self-blame (Kaczmarek & Blacklund, 1991).

Kaczmarek and Backlund (1991) assert that the disenfranchised tend to experience guilt, inadequacy, and personal failure when they experience a loss that is not recognized. Therefore, the end of a relationship marks not only the loss of a partner, but also the loss of a previously established sense of identity as someone who was involved in a romantic relationship. For this same reason, people who experience the dissolution of

a romantic relationship may be losing a dream of what might have been, a fantasy they may have created for their now lost relationship.

The literature on relationship dissolution reflects that the person who initiates the breakup is likely to have ruminated on the decision, thus arriving at the decision more mentally, emotionally, and otherwise prepared than the person receiving the news that the romantic relationship is ending (Kaczmarek & Blacklund, 1991). This person may feel unprepared and surprised, leading to a sense of helplessness (Kaczmarek & Blacklund, 1991).

Along with the psychological distress that disenfranchised grievers may experience, there is also a sense of stigmatization that occurs (Jones & Beck, 2007), as grievers feel that few people sympathize, much less empathize, with them (Attig, 2004). For this reason, people who are grieving the end of a romantic relationship may enter a cycle that deepens with time, during which they may not seek their family and friends for fear of chastisement or a sense that they are not supported.

Kaczmarek and Blacklund, (1991) propose that disenfranchised grief stems from three main sources: lack of recognition for the griever, lack of recognition for the relationship, and lack of recognition for the loss. They go on to further explain that a lack of recognition for the griever presents itself as an overall devaluing of the griever's loss experience. A lack of recognition for the relationship shows up as minimization of the seriousness and intensity of the griever's romantic relationship. Lastly, a lack of recognition for the loss can present itself as an underestimation of the griever's difficulties in processing the dissolution of the former romantic relationship.

According to Davis and Nolen-Hoeksema (2001), people who are grieving seek to find meaning in their loss by trying to make sense of, and even benefit from, their experience. In their study about how people make sense of loss, the researchers found that people who reported having found meaning in their loss claimed that life is not fair, and that the world is not benign or predictable. The researchers interpreted these findings by stating that it is almost as if the worldview of griever is shattered, and they must come up with new storylines that better fit their grieving process. They continued to assert that since most people search for meaning in loss, they experience despair when they fail to understand their grief, which only compounds it.

Robak and Weitzman (1998) set out to clarify the disenfranchisement of the grieving process that follows the loss of a love relationship, with the expectation that gaining “further understanding of the disenfranchised grief following loss of a love relationship should facilitate the use of traditional grief counseling with this population” (Robak & Weitzman, 1998, p. 206). The researchers supplied 140 graduate and undergraduate students at Pace University with the Loss Version of the Grief Experience Inventory and their self-reported adaptation of the Texas Revised Inventory of Grief (Robak & Weitzman, 1998). Results pertinent to the present study suggested that the grief of women is much more recognized by friends than the grief of men ($F = 10.31$, $p < .01$) (p. 213).

Robak and Weitzman also found that the degree to which friends, parents, and siblings recognized grief following the loss of a love relationship depended on how seriously the couple was considering marriage. This finding supports the idea that disenfranchisement of grief is more likely to occur after the dissolution of a romantic

relationship in which the partners were not married or considering marriage. study showed that “whether one believes that it is one’s own fault or the other person’s fault, the same grief is experienced” (p. 214). However, the respondents of the study reported that if the breakup was initiated by someone else, they had more intense feelings of loss and grief, such as anger ($F = 4.95, p < .01$); loss of control ($F = 3.83, p < .05$); rumination ($F = 4.78, p < .01$); and disbelief ($F = 9.48, p < .01$) (p. 214). Lastly, Robak and Weitzman reported that the average time of recovery from the loss of a love relationship was 7.52 months ($SD = 10.58$). (p. 214).

Marriage and Family Therapy

Marriage and Family Therapy is a branch of psychotherapy. As stated on the webpage of the American Association for Marriage and Family Therapy (AAMFT), “Marriage and Family Therapists (MFTs) are mental health professionals trained in psychotherapy and family systems and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems” (AAMFT, 2018, Who Are Marriage and Family Therapists? section, para. 1). Unlike most other branches of psychotherapy, MFTs subscribe to the belief that problems happen in relationships between people, as opposed to within any given person. In other words, treatment with a marriage and family therapist involves more than just the person in the room (AAMFT, 2018). In the case of the heartbroken client, this mode of therapy may be particularly useful, as MFTs can help their clients elucidate the problem from different angles and with the inclusion of different parties.

In the United States alone, there are more than 50,000 MFTs actively treating individuals, couples, and families (AAMFT, 2018). Marriage and family therapists

undergo an extensive education and training program prior to licensure, which is required to utilize the title of MFT (AAMFT, 2018). In the United States, MFTs hold a master's degree, which takes two to three years to complete, or a doctorate degree, which can be completed in three to five years, with the option of completing post-graduate clinical training programs that last between three to four years (AAMFT, 2018).

The AAMFT (2018) reports that the clients of MFTs show “marked improvement in work productivity, co-worker relationships, family relationships, partner relationships, emotional health, overall health, social life, and community involvement” (Why Use a Marriage and Family Therapist? section, para. 2). Because MFTs are concerned with the holistic wellbeing of individuals, their families, and other pertinent relationships, treatment and treatment goals have shown positive outcomes and benefits for all parties involved (AAMFT, 2018). Though there is no limit to the number of sessions—which also varies according to the specific modality—on average, MFTs work from a brief standpoint, with an end in mind; they focus on solutions and collaborate with clients to set specific, measurable, attainable, realistic, and time-framed therapeutic goals (AAMFT, 2018).

A distinctive feature of marriage and family therapy is that even though practitioners in this field are licensed to diagnose and treat all mental and emotional disorders, MFTs take a systemic and relational approach to therapy, meaning that they conceptualize treatment within the context of marriage, couple, family systems, or other relevant relationship (AAMFT, 2018). One of the hallmarks of my understanding and application of systemic thinking is that we are all interconnected as part of a larger system. I view therapy as a systemic continuum of development and believe that life is a

series of jigsaw puzzle pieces we must put together one piece at a time (Eron & Lund, 1996). The process of putting together life's puzzle brings with it innumerable challenges, some of which require us to adopt different perspectives or the occasional reframe; that is where the therapeutic relationship comes into play. The therapy room and the therapeutic relationship should be judgment-free environments, where clients and therapist can candidly explore any and all topics without reservations. I firmly believe that the therapeutic process is a space where clients are able to transform their thinking about the circumstances that would best fit their desired outcomes. Sometimes, clients require a therapist to help identify and put together some pieces of the puzzle, as perhaps they have gotten stuck in a pattern or cycle while putting the puzzle together. This analogy applies to individuals, couples, families, and groups who at some point get stuck; and that is where therapy may help the brokenhearted. Therapy may well prove to be the vehicle that helps the heartbroken get unstuck.

According to Flemons (1990), "a systemic or relational approach to therapy is distinguished by its commitment to contextual understanding" (p. 113). With this theory as a guiding principle, I believe that MFTs take the time to process the varying contextual factors involved in the client's life, as well as the circumstances that resulted in the heartbreak, while still remaining connected to the therapeutic process. This, in turn, leads to an understanding that as humans, we are all connected to a multitude of systems, and that any step we take towards change will indeed reverberate throughout those systems. Bateson (2000) asserts that "philosophically viewed, this first step is not a surrender; it is simply a change in epistemology, a change in how to know about the personality-in-the-world" (p. 313). Any ideas that may result from the therapeutic relationship in a systemic

context may have the potential to help brokenhearted clients following the dissolution of a romantic relationship.

As discussed by Miller (2009), mental health professionals are in a unique position and, in my opinion, have the professional responsibility to provide support and interventions that help clients who seek professional help and are experiencing a broken heart. Seeking professional help has been correlated with a decrease in negative symptoms (Frazier & Cook, 2003; Herbert & Popadiuk, 2008; Tashiro & Frazier, 2003). Benton, Robertson, Wen-Chih, Newton, and Benton (2003) studied the frequency with which students seek help from mental health professionals and found that more than 50% of the students they surveyed had sought counseling services for help with their relationship problems.

Research indicates that after the dissolution of a romantic relationship, individuals are not initially inclined to seek professional help for their healing process; instead they tend to exhaust many unsuccessful methods of coping with their heartbreak. The literature reflects that time plays a key role in influencing whether or when people seek professional help to process their heartbreak. It is estimated that, on average, the first professional contact with a therapist takes place approximately 11.9 months after the dissolution of a romantic relationship (Robak & Weitzman, 1995).

Another form of therapeutic intervention that has been shown to yield positive outcomes is group therapy, reportedly because it lends itself to providing extra support for those involved in the group (Finkelstein, 2014). Though the literature suggests that support from others is helpful in the process of grieving a lost relationship, grievers tend

not to seek that much needed support from their family members or other peer groups (Finkelstein, 2014).

Although a great deal of research has been conducted on the biological, psychological, and social responses that humans have to heartbreak, very little research has been dedicated to how therapists might help the broken-hearted. Specifically, literature on how MFTs can or have helped those who are heartbroken is nonexistent. As a licensed marriage and family therapist, I find that our field can contribute enormously to the plight of those who are experiencing the symptoms of heartbreak. The purpose of this study is to identify the best practices for how MFTs have helped the broken-hearted.

Taking into consideration the systemic outlook of marriage and family therapy, I invited MFTs to explore the symptoms of the clients they have treated with broken hearts, and to share possible best practices to help those who are broken-hearted.

CHAPTER III: METHODOLOGY

Chapter Introduction

Chapter III details the Modified Delphi Technique as the research methodology for the present study. I also present a profile of my personal experience and interest in this topic. The research questions are restated, along with information about the participants of this study and the procedures I utilized for collecting data, recruiting and contacting participants, screening, disseminating information, and analyzing the data. Chapter III concludes with a discussion about quality control, including rigor, trustworthiness, validity, reliability, and ethics.

Modified Delphi Study

Rationale for the Use of a Modified Delphi Study

According to Briedenhann and Wickens (2002), the Delphi technique is “a rapid, effective process of collecting and distilling expert opinion, and gaining consensus from a group of knowledgeable people” (p. 8). In the present study, I sought to form group consensus by facilitating structured information among all group members (Briedenhann & Wickens, 2002). I chose to employ the Delphi Method to obtain information from a diverse group of MFTs, as the method is often utilized to explore a collective of subjective opinions, assumptions, and judgements on various interconnected issues and determine possible alternatives for explaining a phenomenon (Briedenhann & Wickens, 2002). The modification applied to the present study is found in the fact that the expert participants were MTFs associated with Nova Southeastern University.

Mixed Methods Design

The Delphi Method served as the system for data collection for the present study. I found the approach to be appropriate for addressing the primary research questions, as it enabled me to gather the input of various experts while reaching a consensus on possible best practices for helping heart-broken clients. I hypothesized that there would be themes and commonalities within the best practices of MFTs for helping clients explore their broken hearts.

The Delphi technique is often used by researchers who want to find or build consensus within a group (Briedenhann & Wickens, 2002). One key advantage to utilizing this approach is that it helps avoid conflict that may arise from varied opinions, differences in personalities or experiences, intellectual style, or antagonistic emotions among the participants (Briedenhann & Wickens, 2002). This is particularly important for the current study, because of the potentially delicate topic that was explored. The Delphi technique helps guard against losing focus with conversations tangential to heartbreak, which can sometimes arise in group interactions (Briedenhann & Wickens, 2002). In this format, the group interaction is implicit, not explicit. In other words, the various group members do not meet face-to-face, which allows them to participate without being swayed by the opinions of others in the group.

Self-of-the-Researcher

Heartbreak resulting from the dissolution of a romantic relationship is a phenomenon experienced by many people at some point in their lives. I am fortunate to have answered the question for myself of whether it is better to have lived and loved than to have never loved at all. I have loved and lost—and through all my personal pain and

trauma, I have decided that it is better this way. In my journey through heartbreak, I initially found support through my friends and family; however, after a few short weeks, I was advised to move on and get over it. I also recall speaking with a mental health professional who validated my feelings but pathologized my process. The literature review and findings presented in this paper resemble my experience with heartbreak. As an MFT, I practice from the point of view that we are all interconnected, and problems happen between people and not necessarily within an individual. I view the disenfranchisement of heartbreak over the dissolution of a romantic relationship as a product of our society and the way we think about relationships. Marriage and family therapists are experts in relationships (AAMFT, 2018). Thus, I sought to produce data about what MFTs suggest as best practices to help clients recover from the aftermath of the heartbreak that results from a romantic relationship dissolution.

Research Questions

The first round of inquiry in this study consisted of four open-ended questions: What have you observed as the symptoms of heartbreak? How does a broken-hearted client present? How have you helped these clients heal? What are your best practices for helping the broken-hearted? The second round was determined by the responses yielded by the participants during the first round.

Procedures

The sample for this study consisted of 20 MFTs. This section will offer a detailed exploration of the elements involved in successfully executing this study. Table 1 delineates the schedule that resulted during the data collection (Briedenhann & Wickens, 2002).

Table 1

Data Collection Timeline

Data Collection Timeline		
Step #	Description	Time Frame
Step 1	I sent letter of invitation, informed consent and clarification of requirements	2 weeks for responses
Step 2:	I sent out first round of the study with the research questions posted above	At the end of the 2 weeks
Step 3:	Participants responded to the first round	2 weeks for responses
Step 4:	I collected and summarized the responses of first round	1 week for analysis
Step 5:	I sent out second round, a summary from the first round	At the end of the 1 week
Step 6:	Participants responded to second round	2 weeks for responses
Step 7:	I collected and analyzed the data from the second round	1 week for analysis
Step 8:	I distributed the summarized report to all participants	At the end of the 1 week

Data Collection

The Delphi technique employs several rounds of questions and surveys requiring feedback exchanged between the researcher and the participants (Sprenkle & Piercy, 2005). According to Turroff (1975), a minimum of four rounds of information exchange typically yield significant results in a Delphi study; however, other researchers have found that three rounds can suffice (Hsu & Sandford, 2007; Skulmoski, Hartman, & Krahn, 2007), and in some cases, just two rounds provide the necessary consensus (Burnett, 1992). The number of rounds is determined by the level of agreement among the participants or when consensus has been reached. According to Hsu and Sandford (2007), consensus is reached when at least 80% of the participants' responses are in agreement.

One of the benefits of conducting different rounds of questions and feedback is that it “enables participants with differing points of view, and cognitive skills, to contribute to those sections of the research topic for which they have particular knowledge and understanding” (Briedenhann & Wickens, 2002, p. 10). After each round of questions is collected, the researcher then summarizes the answers and sends them back to the participants. Participants are extended the courtesy of reporting when or if their opinions were not taken into consideration for any of the rounds (Briedenhann & Wickens, 2002), a measure that serves to minimize the potential for researcher biases.

Recruitment

After receiving approval from the Nova Southeastern University (NSU) Institutional Review Board (IRB) (see Appendices A and B), I conducted random sampling to recruit 55 licensed MFTs who are current or former students, or otherwise

affiliated with, the Department of Marriage and Family Therapy at NSU. I conducted all recruitment via secured, password-protected email. I also posted a recruitment flyer (see Appendix C) on Facebook, which yielded one participant. I sent the first round of open-ended questions after having collected 20 signed Informed Consent forms ($N = 20$).

Participants

When considering the factors for inclusion in a sample, it is essential to identify a random, yet carefully selected sample. Briedenhann and Wickens (2002) suggest that for a Delphi study, it is pertinent to first identify the inclusion criteria to then solicit participation from the experts to be involved in the research. It is also imperative that the problem to be studied and the questions posed to the participants fit with their interests, and that the results from the study provide benefits to the participants, especially since they will be involved with the project for a considerable amount of time. Briedenhann and Wickens also recommend that the sample size for a Delphi study be kept between 10 and 15 participants, in order to achieve a homogenous sample. I modified the authors' recommendations in the present study by soliciting participation from 55 prospective participants and including a total of 20 participants, who were actively involved in both rounds of the study.

Initial Contact, Screening, and Dissemination of Information

For the purpose of this study, it was not important whether the therapists' clients were the initiators or recipients of the news of the romantic relationship dissolution (Finkelstein, 2014). The only pertinent requirements were that the clients described by participants were involved in a romantic relationship and were broken-hearted as a result of its dissolution by the time they sought therapy. In my interpretation of a true systemic

lens, heartbreak resulting from the dissolution of a romantic relationship knows no fault. Because there were two people involved in the relationship, either has the potential to experience heartbreak.

Since age, race, ethnicity, number of years practicing family therapy, and specialization in therapeutic services offered were not the focus of the present study, these factors were not part of the inclusion criteria. Other data points that I deemed immaterial to the present study were the gender, sexual orientation, sexual identity, race, ethnicity, socioeconomic status, and cultural background of the therapist participants or the anonymous clients on which the therapists based their answers.

Once I received affirmative responses for participation, I emailed those participants with instructions to complete the Informed Consent document electronically (see Appendix B), via a secure online form. After obtaining consent from the participants, I emailed them a web-based link to the first round of questions, which I created using Google Forms (see Appendices D and E).

To ensure the privacy and confidentiality of the participants, I have not presented any identifying information in the study. Instead, I assigned each participant a code consisting of letters and numbers, and have used those codes to indicate participants and their responses.

Data Analysis

The data of a Delphi study are analyzed utilizing distribution calculations (Stone & Piercy, 2005). According to Stone and Piercy (2005), the key statistics to report for each item of the questionnaires, at each round of the study, are “medians and interquartile ranges, to identify the rates of group agreements and consensus for each item that a

panelist makes as a statement” (p. 244). The means are used to determine the average level of agreement or disagreement among the participants for each item, whereas the interquartile ranges determine the degree to which the participants have reached consensus on their descriptions or answers to each item being studied (Stone & Piercy, 2005). Hsu and Sanford (2007) suggest that consensus has been reached when at least 80% of the participants’ responses fall within the same categories or are in agreement; .

Since the Delphi technique is a mixed methodology, this study has both a qualitative and a quantitative component (Hasson, Keeney, & McKenna, 2000; Hsu & Sanford, 2007). As previously stated, each round of a Delphi study builds on the previous, with the first round composed of the original research questions set by the researcher (Hasson et al., 2000). Given that for the present study, the research questions were open-ended, the data generated from the first round are qualitative in nature, as is customary in most Delphi studies. Hasson et al. (2000) suggest that the data collected from this first round should be analyzed by grouping them together, taking care to only make minor edits as needed, so as not to corrupt the original opinions of the participants. Traditionally, studies utilize qualitative data analysis software for analyzing large amount of data; however, because the number of participants for the present study was 20 ($N = 20$), I analyzed the data manually (Shariff, 2015).

I also manually analyzed the qualitative data for the study, as the sample size was not large (Fish & Busby, 2005). Shariff (2015) asserts that the data produced from the second round and beyond are both nominal and ordinal. As stated above, the quantitative analysis in a Delphi study consists of finding a mean, mode, standard deviation (Shariff, 2005), and interquartile ranges (Stone & Piercy, 2005).

Quality Control

Rigor and Trustworthiness

All methods of research have their respective strengths and areas of limitation. The Delphi technique is often criticized for containing inherent judgement, assumptions, and opinions (Briedenhann & Wickens, 2002). Because it requires purposive sampling, critics of the method propose that any selected group of people may not be representative of the population at large, and that different groups may yield different results (Briedenhann & Wickens, 2002). Others contend that a limitation of this method is “the level of influence and the potential for bias in the design of the questionnaires, the interpretation of responses and the processing of results, which may be significant” (Briedenhann & Wickens, 2002, p. 9). Advocates of the Delphi technique propose that it facilitates interaction among group members or experts who do not have the opportunity to be in the same room because of distance, finances, or other reasons.

Validity and Reliability

Richey (2005) asserts that validity corresponds with the degree to which a model is linked to the intended context. In other words, validity is a measurement of how much the results reflect what was originally intended to be measured (Sekara, 2003), whereas reliability is a measure of consistency and accuracy (Cwalina, 2013). Since this Delphi study called for an expert panel, the validity of their answers was implied by way of their expertise and professional credentials, which in this study were the licenses of the MFTs (McKay II, 2012). Another safeguard of validity in the Delphi technique is that because the participants are experts, it is presumed that the content received will be valid, reliable, and of high quality (Richey & Klein, 2007).

As mentioned above, another measure I have taken to prevent biases that could potentially affect validity and reliability was to keep the participants' identities confidential. I also maintained a quick turnaround time between inquiries for the participants (see Table 1), in order to avoid loss of interest or other factors that could hinder active participation in the study. In addition, I intentionally formatted the emails I sent to all participants and the web-based survey program on Google Forms (see Appendices D, E, F, G, H, and I) to provide the participants with an opportunity to voice their opinions about the data analysis, thus creating yet another checkpoint to guard the validity and reliability of this study (Cwalina, 2013). In addition, as previously mentioned, I solicited feedback from participants at the end of each round to ensure that my analysis of their responses remained transparent and reliable. Furthermore, by virtue of the dissertation committee reviews, my analysis of the participants' responses was reviewed by readers other than myself. The overall validity of the present study is found in the potential adaptability, practicality, and usability of the participants' suggestions for best practices.

Ethics

As stated above, in order to comply with ethical considerations regarding privacy and confidentiality, the names and all other identifying information of the participants were unidentified and remain concealed. The only information that has been made known is that the participants are licensed MFTs and the gender breakdown of the experts.

I conducted all correspondence through password-protected email and the password-protected Google Forms application. I kept signed documents, such as the

Informed Consent (see Appendix B), in a password-protected folder on my password-protected personal computer.

I asked the participants not to disclose personal information about any of the clients they discussed in their responses. In addition, I offered therapeutic services to all participants, in case they felt a need or desire to process their experiences while participating in this study.

CHAPTER IV: RESEARCH FINDINGS AND DISCUSSIONS

Chapter Introduction

Chapter IV provides detailed information about the data gathered in the study through the use of tables, charts, figures, and a synthesis of all three.

Statement of the Problem

I conducted the present study in an effort to contribute to the literature about heartbreak by incorporating the perspectives of MFTs . In addition, I set out to uncover the best practices MFTs have employed to help clients experiencing heartbreak resulting from the dissolution of a romantic relationship.

Participant Profile

I emailed a letter of invitation to 55 prospective participants; 20 of them (36%) replied confirming that they met the requirements for the study. Thirty of those remaining (54%) did not reply to the request for participation, and five (9%) declined to participate because they did not meet criteria. Of the five participants who declined participation, two (3%) reported that they did not have experience with the broken-hearted and three people (5%) reported that they hold licenses other than MFT. Of the 20 participants that completed the study, three (15%) are males and 17 (85%) are females.

Inquiry Rounds 1 and 2

I began the analysis for the Round 1 data by compiling all responses in a Microsoft Word document (Shariff, 2015). Since, I utilized an online form, it was not necessary for me to transcribe the responses. Once I had gathered all responses, I started the analysis by identifying words and phrases that corresponded under each question, and

grouping them by the number of instances each answer appeared in the collected data. Soon after beginning the analysis, I realized that the themes I was identifying were similar to the concepts explored by Blow and Sprenkle (2001) in their article titled *Common Factors Across Theories of Marriage and Family Therapy: A Modified Delphi Study*; I categorized all of the participants' answers according to these factors of therapy. According to Blow and Sprenkle, there are a series of factors commonly found in the practice of marriage and family therapy: client/extratherapeutic; therapeutic relationship; model/technique; placebo, hope, and expectancy. The authors identify the factors unique to the practice of MFT as those involving relational conceptualization; the expanded direct treatment system; the expanded therapeutic alliance; behavioral, cognitive, and affective common factors in MFT; and privileging of clients' experiences (Blow & Sprenkle, 2001, p. 386).

I chose to categorize all of the data resulting from Round according to the client/extratherapeutic factors, which are those factors of clients' lives and surroundings that contribute to change—in this case, healing from a broken heart. Client/extratherapeutic factors include “client characteristics, such as inner strengths, religious faith, goal directedness, personal agency, and motivation, as well as things outside of the control of the client, such as fortuitous events, social support, and winning the lottery” (Blow & Sprenkle, 2001, p. 386). Therapeutic relationship factors refer to nuances in the therapeutic relationship, such as “warmth, respect, genuineness, and empathy” (Blow & Sprenkle, 2001, p. 387). Model/technique factors are those that can be derived from the specific model or technique used the by therapist (Blow & Sprenkle,

2001). Lastly, the placebo, hope, and expectancy factors are those that, “reflect changes simply because the client is in treatment of some kind (Blow & Sprenkle, 2001, p. 387).

After I grouped Round 1 into themes and the common factors categories stated above, I asked the participants to rate the grouped data on a 7-point Likert scale (see Appendices D and E). After two weeks, once I had received all the responses from Round 2, I began the analysis of this data. The Google Forms application collated the data into graphs, which are presented in Tables 2-16 and Figures 1.1-12.1 below. The analysis for Round 2 consisted of calculating the mean, mode, standard deviation, and interquartile ranges for each data set. As previously stated, the mean, median, and mode measure the level of agreement, whereas the standard deviation and the interquartile ranges measure the level of consensus. For the purpose of this study, consensus was determined by 80% agreement in participants’ responses. Since this was reached after Round 2, subsequent rounds were rendered unnecessary. Since each data set was rated on a 7-point Likert scale, it was calculated that a rating of 5.6 constituted 80% of 7, the highest end of the scale; therefore, the possible average for each data set, and acceptable consensus rate was between 5 and 7. In the statistical analysis, 80% agreement is represented by an interquartile range between 5 and 7.

The following is a spread of all 12 points of grouped data sets resulting from the study. I have arranged each data set into a different table. All tables follow the same formatting with the responses from Round 1, followed by the ratings from Round 2 and a statistical analysis of the data set.

Question 1

Question 1 stated: What are the symptoms of a client experiencing heartbreak?

This question served the purpose of identifying the different types of symptoms that therapists observe from their broken-hearted clients. Below are the lists of symptoms that the participants identified, which are grouped by the symptoms that relate to biological responses, psychological responses, and social responses, respectively. Each set of symptoms is accompanied by the cumulative ratings received in Round 2 and the statistical analysis of those ratings.

Table 2

Biological Responses

2	Breathing difficulties	1	Heartburn	1	Sleep disturbance
1	Changes in appetite	2	Low energy	2	Somatic distress
2	Chest pains	1	Memory loss	2	Stomach pains
5	Crying	1	Negative thoughts	2	Stress
1	Fatigue	1	Physical pains	1	Tightness of the chest
2	Headaches	1	Restlessness	5	Weight Gain/Loss

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 1.1.

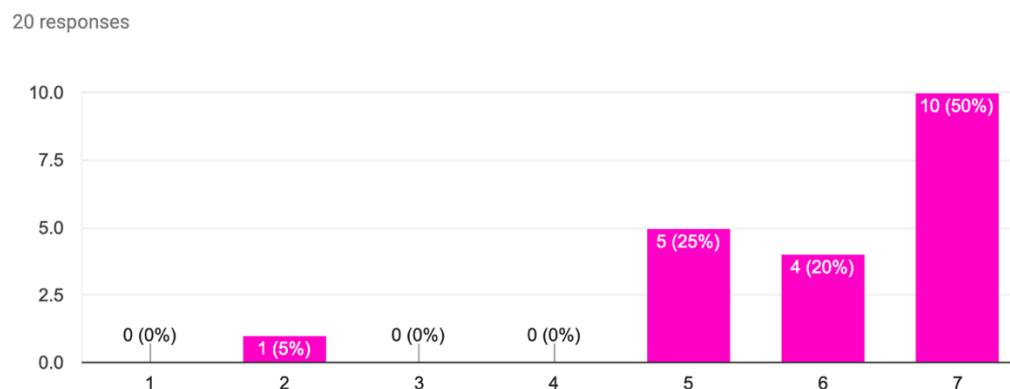
Round 2 Corresponding Ratings for Table 2

Table 2.1.

Statistical Analysis for Figure 1.1

Mean	6.05
Median	6.5
Mode	7
Standard Deviation	1.27630222
Range	2-7
1st Quartile	5
3rd Quartile	7
Interquartile Range	5-7

The participant ratings in this sample displayed a mean of 6.05, standard deviation of 1.276, and interquartile range of 5-7 ($M = 6.05$, $SD = 1.276$, $IQR = 5-7$). The biological responses most readily identified by the study participants were crying and weight

fluctuations (gain and/or loss), followed by breathing difficulties, chest pains, headaches, low energy, somatic distress, stomach pains, stress, and others.

Table 3

Psychological Responses

3	Anger	2	Disbelief	2	Irritability	1	Regret
1	Anhedonia	1	Double bind	1	Justifying	2	Ruminating thoughts
3	Anxiety	2	Doubt	4	Lability	11	Sadness
	Addictive		Emotional				
1	behaviors	2	Pain	1	Loss on interest	1	Self-criticism
1	Bargaining	5	Grieving	4	Loss of motivation	1	Shock
1	Blaming	1	Guilt	3	Low self-esteem	1	Suicidal
5	Confusion	1	Helplessness	1	Low self-worth	1	Thoughts of self-harm
3	Denial	5	Hopelessness	1	Mood swings	1	Upset
5	Depression	1	Insomnia				

-
- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 2.1.

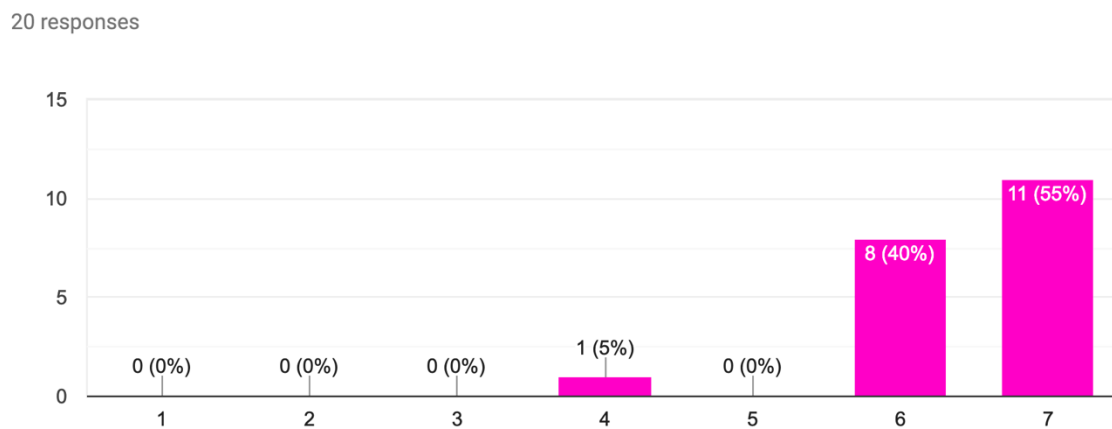
Round 2 Corresponding Ratings for Table 3

Table 3.1

Statistical Analysis for Figure 2.1

Mean	6.45
Median	7
Mode	7
Standard Deviation	0.75915465
Range	4-7
1st Quartile	6
3rd Quartile	7
Interquartile Range	1

The participant ratings in this sample displayed a mean of 6.45, standard deviation of .759, and interquartile range of 6-7 ($M = 6.45$, $SD = .7591$, $IQR = 6-7$). The psychological responses most readily identified by the study participants were sadness, confusion,

depression, grieving, hopelessness, lability, loss of motivation, anger, anxiety, denial, low self-esteem, and many others.

Table 4

Social Responses

1	Avoiding people	2	Isolation	1	Withdrawal from daily activities
---	-----------------	---	-----------	---	----------------------------------

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 3.1

Round 2 Corresponding Ratings for Table 4

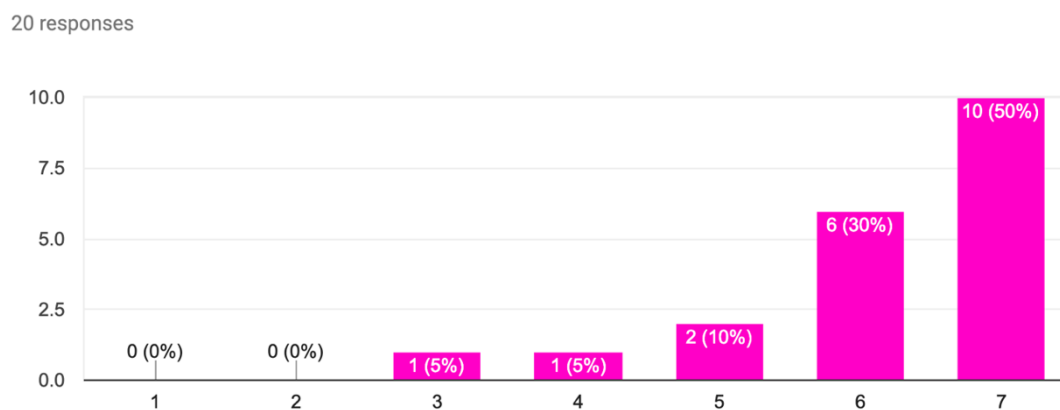


Table 4.1

Statistical Analysis for Figure 3.1

Mean	6.15
Median	6.5
Mode	7
Standard Deviation	1.13670808

Range	3-7
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

The participant ratings in this sample displayed a mean of 6.15, standard deviation of 1.137 and interquartile range of 6-7 ($M=6.15$, $SD=1.137$, $IQR=6-7$). The three social responses identified by the study participants were isolation, avoiding people and withdrawal from daily activities.

Table 5

Question 1 Combined Data

Mean	6.21666667
Median	6.15
Mode	7
Standard Deviation	0.26754275
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

When combined, all data from Question 1 suggest that consensus was reached for that question because the interquartile range is 6-7, meaning that over 80% of the responses are in agreement. The overall mean for the responses from question 1 is 6.216, with a standard deviation of .267 ($M = 6.216$, $SD = .267$). The most frequently cited biological responses to heartbreak are crying and weight fluctuations (gain and/or loss), followed by breathing difficulties, chest pains, headaches, low energy, somatic distress, stomach

pains, stress, and others. The psychological responses that were mentioned the most are sadness, confusion, depression, grieving, hopelessness, lability, loss of motivation, anger, anxiety, denial, low self-esteem, and many others. The most commonly identified social responses were isolating, avoiding people, and withdrawing from daily activities.

Question 2

Question 2 stated: How does a broken-hearted client present? This question was intended to gather information about how clients present during sessions, which is most often associated with the presenting symptoms. Below is the list of client presentations that the participants identified, followed by the cumulative ratings received in Round 2 and the statistical analysis of those ratings.

Table 6

Client Presentation

14 Sadness (Extreme)	1 Despaired	1 Listless	1 Relieved
5 Angry	1 Disheveled	1 Little eye contact	1 Second guessing life
3 Depressed	1 Disillusioned	1 Loneliness	1 Slouchy
3 Guilty	1 Easily distracted	1 Lost	1 Slow speech
2 Anxious	1 Exaggerative	1 Miserable	1 Solemn
2 Confused	1 Fast speech	1 Overwhelmed with emotion	1 Somatic ailments
2 Hurt	1 Frustrated	1 Physical pain	1 Substance abuse

1 Apathetic	1 Grieving	1 Preoccupied	1 Symptoms masked as something else
1 Bleak	1 Hopelessness	1 Questioning life and themselves	1 Tearful
1 Crying	1 Keeping busy	1 Regretful	1 Upset
1 Demotivated towards social interactions	1 Labile		

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 4.1

Round 2 Corresponding Ratings for Table 6

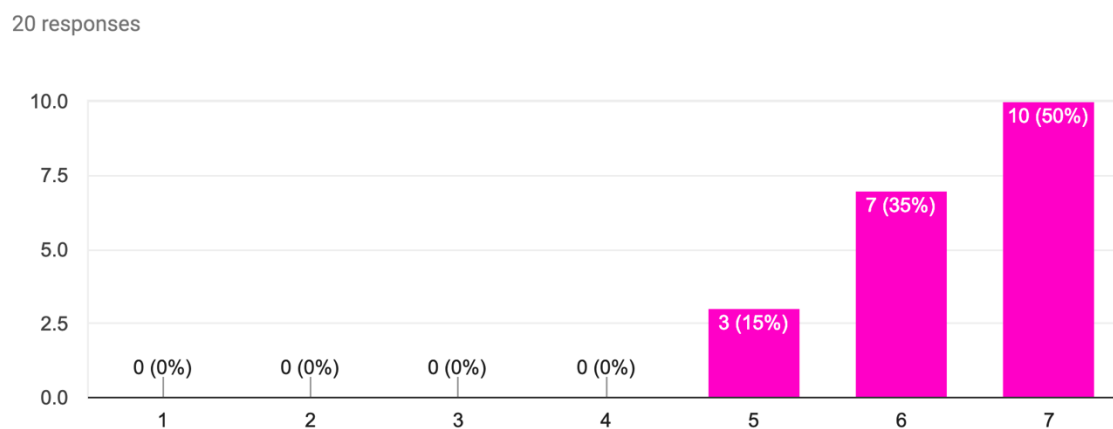


Table 6.1

Statistical Analysis for Figure 4.1

Mean	6.35
Median	6.5
Mode	7
Standard Deviation	0.74515982
Range	5-7
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

The data from Question 2 suggest that consensus was reached for this question because the interquartile range is 6-7, meaning that over 80% of the responses are in agreement. The overall mean for the responses from Question 2 is of 6.35, with a standard deviation of .745 and interquartile range of 6-7 ($M = 6.35$, $SD = .745$, $IQR = 6-7$). The client presentation most readily identified by the study participants was sadness (extreme). Clients also present as angry, depressed, guilty, anxious, confused, hurt, among others.

Question 3

Question 3 stated: How do marriage and family therapists help these clients heal?

This question served the purpose of gathering information about the different types of techniques that therapists utilize to help their broken-hearted clients heal. Below are the lists of techniques that the participants identified, which are divided into the common factors suggested by Blow and Sprenkle (2001). Each set of factors is accompanied by the cumulative ratings received in Round 2 and the statistical analysis of those ratings.

Table 7

Client/Extratherapeutic Factors

6	Identify coping skills/self-care activities
4	Identify support systems
3	Acknowledge the client's strengths
1	Recommend support groups

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 5.1

Round 2 Corresponding Ratings for Table 7

Client/extratherapeutic factors are ingredients in the life and environment of the client that contribute to change. T...y (Blow & Sprenkle, 2001, p. 386).

20 responses

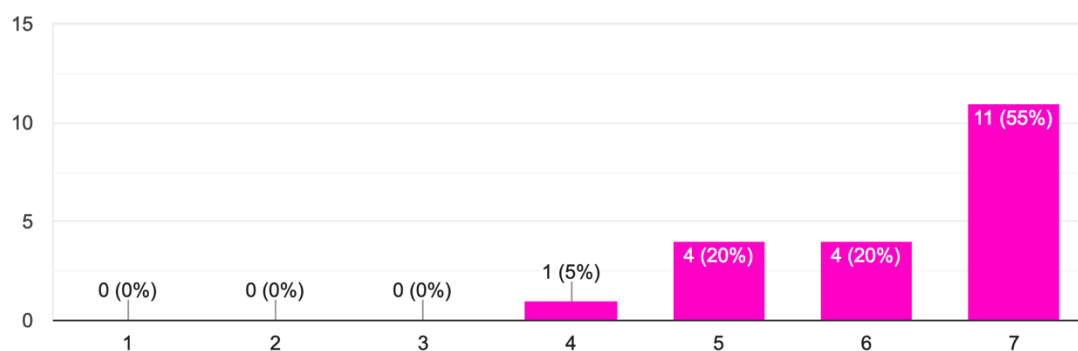


Table 7.1

Statistical Analysis for Figure 5.1

Mean	6.25
Median	7
Mode	7
Standard Deviation	0.966545667
Range	4-7
1st Quartile	5.75
3rd Quartile	7
Interquartile Range	5.75-7

The participant ratings in this sample displayed a mean of 6.25, standard deviation of .967, and interquartile range of 5.75-7 ($M = 6.25$, $SD = .967$, $IQR = 5.75-7$). The client/extratherapeutic factors most utilized by the study participants were identifying coping skills/self-care activities, identifying support systems, acknowledging the client's strengths, and recommending support groups.

Table 8

Therapeutic Relationship Factors

6	Validate the client's feelings/thoughts/emotions/symptoms
6	Empathy and therapeutic curiosity
4	Listen / Allow silence in session
4	Encourage release of pain: crying, weeping, etc.
3	Match the pace of the client
2	Acknowledge the pain

-
- 2 Normalize
 - 2 Be open and transparent
 - 1 Establish that grief is unique to every person
 - 1 Do not give advice
 - 1 Maintain sense of humor
 - 1 Do not feel sorry for the client
 - 1 Remain emotionally present but intellectually independent
 - 1 Never tell clients to just move on
-

a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 6.1

Round 2 Corresponding Ratings for Table 8

Relationship factors are relationship-mediated variables that occur between therapist and clients in the therapy ro...y (Blow & Sprenkle, 2001, p. 387).

20 responses

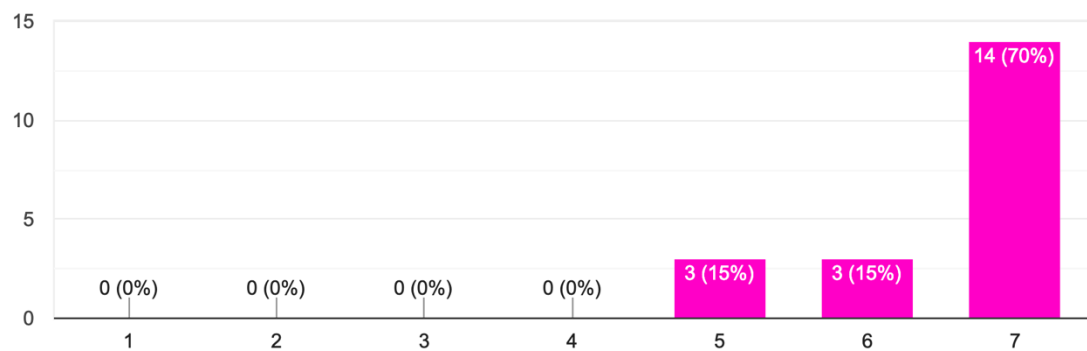


Table 8.1

Statistical Analysis for Figure 6.1

Mean	6.55
Median	7
Mode	7
Standard Deviation	0.75915465
Range	5-7
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

The participant ratings in this sample displayed a mean of 6.55, standard deviation of .759, and interquartile range of 6-7 (M=6.55, SD=.759, IQR=6-7). The therapeutic relationship factors most utilized by the study participants were validating the client's feelings/thoughts/emotions/symptoms, showing empathy and therapeutic curiosity, listening and allowing silence in session, encouraging the release of pain, and matching the pace of the client, among others.

Table 9

Model/Technique Factors

4	Identify past loss and how it was dealt with before / Exceptions
3	Take a collaborative/Not knowing stance
3	Homework: How to honor the past relationship
3	Maintain systemic perspective: Emphasize shifts in the self and relational changes
2	Set goals

2 Be curious about what they want in a partner/future relationships

2 Create a Genogram

2 Empowerment

2 Process / Explore the heartbreak and its symptoms

2 Establish that there is no quick fix

1 Rule out suicide intent

1 Highlight lessons learned from the heartbreak

1 Lean on the loss

1 Challenge catastrophic thoughts

a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 7.1

Round 2 Corresponding Ratings for Table 9

Model/technique factors are those factors that are unique to specific theories of therapy (Blow & Sprenkle, 2001, p. 387).

20 responses

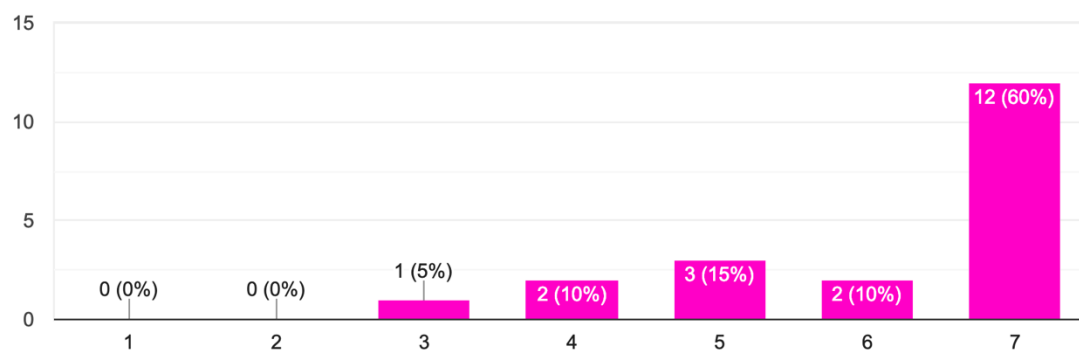


Table 9.1

Statistical Analysis for Figure 7.1

Mean	6.1
Median	7
Mode	7
Standard Deviation	1.293709477
Range	3-7
1st Quartile	5
3rd Quartile	7
Interquartile Range	5-7

The participant ratings in this sample displayed a mean of 6.1, standard deviation of 1.294, and interquartile range of 5-7 ($M=6.1$, $SD=1.294$, $IQR=5-7$). The model/technique factors most utilized by the study participants were identifying past losses and how they were dealt with, finding exceptions, taking a collaborative/not knowing stance, giving homework to honor the past relationship, maintaining a systemic perspective, and emphasizing shifts in the self and relational changes, among others.

Table 10

Placebo, Hope, and Expectancy Factors

1	Verify it is heartbreak and not something else
1	Do not assume that therapy is "healing"
1	Talk about a future without heartbreak
1	End sessions on a positive note

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 8.1

Round 2 Corresponding Ratings for Table 10

Placebo, hope, and expectancy factors reflect changes that occur simply because the client is in treatment of s...d (Blow & Sprenkle, 2001, p. 387).

20 responses

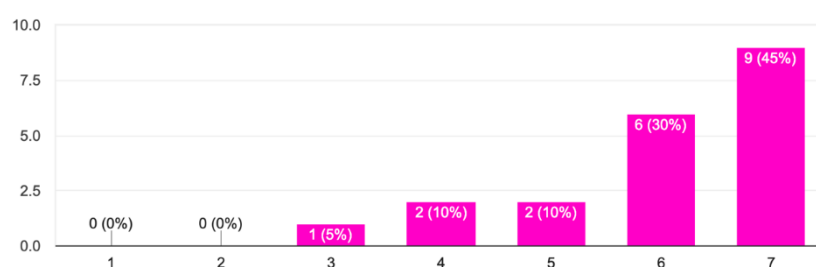


Table 10.1

Statistical Analysis for Figure 8.1

Mean	6
Median	6
Mode	7
Standard Deviation	1.213953957
Range	3-7
1st Quartile	5.75
3rd Quartile	7
Interquartile Range	5.75-7

The participant ratings in this sample displayed a mean of 6, standard deviation of 1.214, and interquartile range of 5.75-7 ($M = 6$, $SD = 1.214$, $IQR = 5.75-7$). The four placebo, hope, and expectancy factors reported by the study participants were to verify that the

client is in fact presenting with heartbreak and not something else, to not assume that therapy is “healing,” to talk about a future without heartbreak, and to end sessions on a positive note. One participant noted disagreement on this section by commenting that to end the session on a positive note may imply that the client “needs to just get over it.” The participant suggested a rephrasing to say that “ending the session in a safe place” might be better wording in this category.

Table 11

Question 3 Combined Data

Average	6.225
Median	7
Mode	7
Standard Deviation	0.24327801
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

When combined, all data from Question 3 suggest that consensus was reached for that question because the interquartile range is 6-7, meaning that over 80% of the responses are in agreement. The overall mean for the responses from question 3 is 6.225, with a standard deviation of .243 ($M = 6.225$, $SD = .243$).

Question 4

Question 4 stated: What are some of the best practices for helping the broken-hearted? This question served the purpose of identifying the best practices that therapists employ to help their heartbroken clients. Below are the lists of best practices that the participants identified, which are grouped once again following the common factors

identified by Blow and Sprenkle (2001). Each set of best practices is accompanied by the cumulative ratings received in Round 2 and the statistical analysis of those ratings.

Table 12

Client/Extratherapeutic Best Practices

5	Coping skills: Recommend breathing exercises / meditation
3	Highlight the client's support system
1	Encourage the client to try new things
1	Give the client resources

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 9.1

Round 2 Corresponding Ratings for Table 12

Client/extratherapeutic factors of best practices allude to ingredients in the life and environment of the client that ...y (Blow & Sprenkle, 2001, p. 386).

20 responses

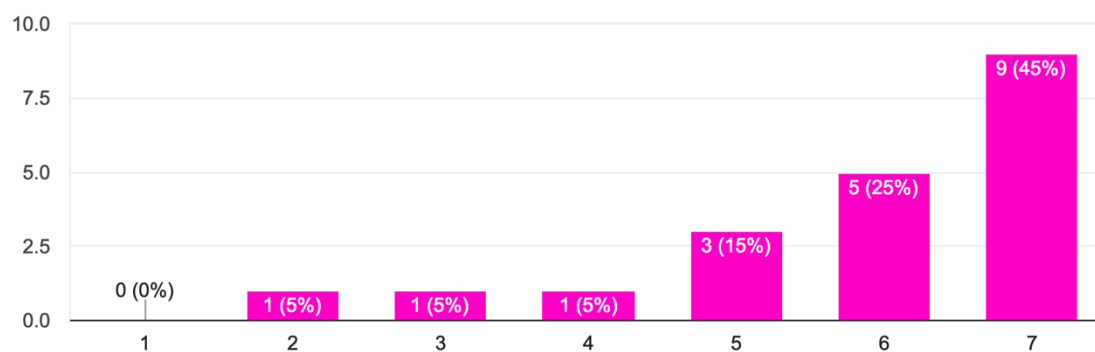


Table 12.1

Statistical Analysis for Figure 9.1

Mean	5.85
Median	6
Mode	7
Standard Deviation	1.460893742
Range	2-7
1st Quartile	5
3rd Quartile	7
Interquartile Range	5-7

The participant ratings in this sample displayed a mean of 5.85, standard deviation of 1.46, and interquartile range of 5-7 ($M = 5.85$, $SD = 1.461$, $IQR = 5-7$). The best practices related to client/extratherapeutic factors most utilized by the study participants were to work on coping skills, highlight the client's support system, encourage the client to try new things, and give the client resources.

Table 13

Therapeutic Relationship Best Practices

8	Empathetic Listening / Allow the client to share their story
7	Allow space and time for the client to process their heartbreak
5	Validate the client's feelings/thoughts/emotions
4	Be curious and non-judgmental
3	Acknowledge strengths
2	Be present for the client
2	Normalize
2	Provide emotional support
1	Be Compassionate
1	Encourage

- a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 10.1

Round 2 Corresponding Ratings for Table 13

Relationship best practices are relationship-mediated variables that occur between therapist and clients) in the t...y (Blow & Sprenkle, 2001, p. 387).

20 responses

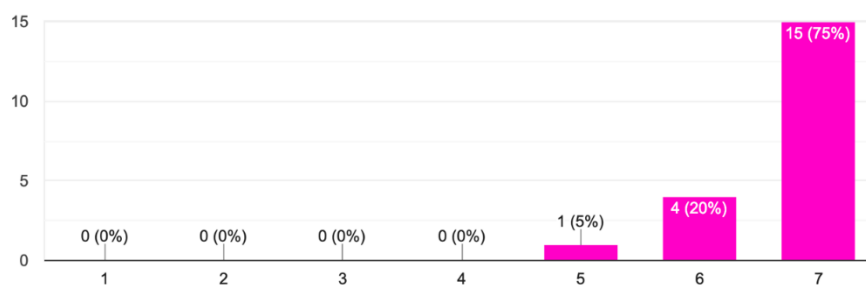


Table 13.1

Statistical Analysis for Figure 10.1

Mean	6.7
Median	7
Mode	7
Standard Deviation	0.571240571
Range	5-7
1st Quartile	6.75
3rd Quartile	7
Interquartile Range	6.75-7

The participant ratings in this sample displayed a mean of 6.7, standard deviation of .571, and interquartile range of 6.75-7 ($M=6.7$, $SD = .571$, $IQR = 6.75-7$). The best practices related to therapeutic relationship factors most utilized by the study participants were to provide empathic listening and allow clients to share their story; allow space and time for clients to process their heartbreak; validate clients' feelings, thoughts, and emotions; and be curious and non-judgmental; among many others.

Table 14

Model/Technique Best Practices

4	Genogram / Involve the client's family
3	Maintain systemic stance and explore the loss with a relational focus
2	Highlight lessons learned from the heartbreak
2	Reframe
2	Set goals

-
- 1 Educate
 - 1 Empowerment
 - 1 Help client accept the reality of the loss
 - 1 Honor the past/lost relationship
 - 1 Hypnotherapy
 - 1 Identify past loss and how it was dealt with before / Exceptions
 - 1 Managing one's own anxious responses to the situation.
 - 1 Separate the person from the problem
 - 1 Use Evidence Based Practices to target symptoms such as depression, substance abuse, etc.
-

a. The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 11.1

Round 2 Corresponding Ratings for Table 14

Model/technique best practices are unique to specific theories of therapy (Blow & Sprenkle, 2001, p. 387).

20 responses

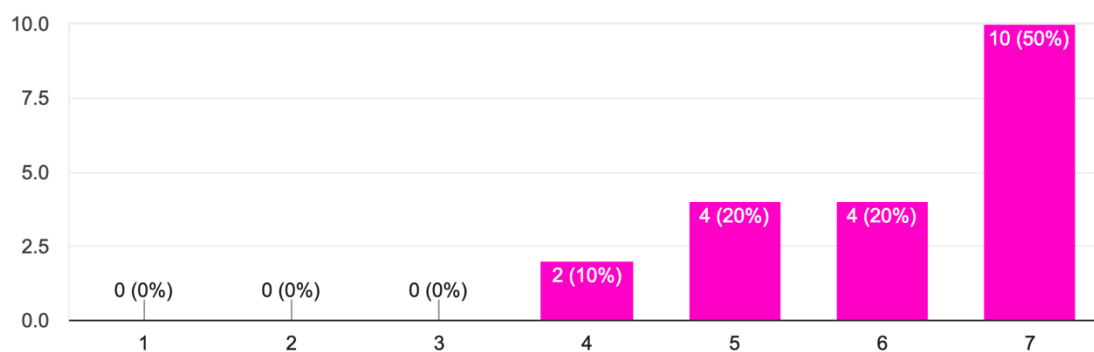


Table 14.1

Statistical Analysis for Figure 11.1

Mean	6.1
Median	6.5
Mode	7
Standard Deviation	1.071152847
Range	4-7
1st Quartile	5
3rd Quartile	7
Interquartile Range	5-7

The participant ratings in this sample displayed a mean of 6.1, standard deviation of 1.071, and interquartile range of 5-7 ($M = 6.1$, $SD = 1.071$, $IQR = 5-7$). The best practices related to model/technique most utilized by the study participants were to develop a genogram and involve the client's family, maintain a systemic stance and explore the loss with a relational focus, highlight lessons learned from the heartbreak, reframe, and set goals, among many others.

Table 15.

Placebo, Hope, and Expectancy Best Practices

2	Have future-oriented conversations
1	Allow client to discover their ability to overcome heartbreak
1	Give the client something different than what they get from their family and friends
a.	The number next to each entry is the amount of times each term appeared in the responses from Round 1.

Figure 12.1.

Round 2 Corresponding Ratings for Table 15

Placebo, hope, and expectancy best practices reflect changes that occur simply because the client is in treatme... (Blow & Sprenkle, 2001, p. 387).

20 responses

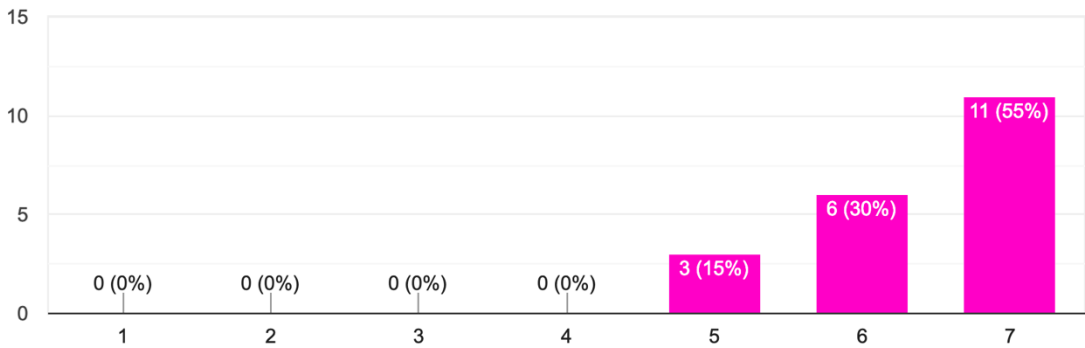


Table 15.1.

Statistical Analysis for Figure 12.1

Mean	6.4
Median	7
Mode	7
Standard Deviation	0.753937035
Range	5-7
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

The participant ratings in this sample displayed a mean of 6.4, standard deviation of .754, and interquartile range of 6-7 ($M = 6.4$, $SD = .754$, $IQR = 6-7$). The best practices related to placebo, hope, and expectancy factors most utilized by the study participants were having future-oriented conversations, allowing clients to discover their ability to overcome heartbreak, and giving clients something different than what they get from their family and friends.

Table 16

Question 4 Combined Data

Mean	6.2625
Median	6.75
Mode	7
Standard Deviation	0.3902013
1st Quartile	6
3rd Quartile	7
Interquartile Range	6-7

When combined, all data from Question 4 suggest that consensus was reached for that question because the interquartile range is 6-7, meaning that over 80% of the responses are in agreement. The overall mean for the responses from question 4 is 6.262, with a standard deviation of .390 ($M = 6.262$, $SD = .390$).

Synthesis

Altogether, the results from the present research study reflect that the 20 surveyed participants agreed that broken-hearted clients present with specific symptoms, and that certain techniques and best practices may enable therapists to help their clients heal from

a broken heart. The participants of this research study reached consensus in every question asked by the end of Round 2.

For Question 1, the statistics showed a 6-7 interquartile range, a mean of 6.216, and a standard deviation of .267 ($IQR = 6-7$, $M = 6.216$, $SD = .267$), supporting the claim that some of the biological responses to heartbreak are crying and weight fluctuations (gain and/or loss), followed by breathing difficulties, chest pains, headaches, low energy, somatic distress, stomach pains, stress, and others. The psychological responses identified were sadness, confusion, depression, grieving, hopelessness, lability, loss of motivation, anger, anxiety, denial, low self-esteem, and many others. Lastly, the social responses identified include isolating, avoiding people, and withdrawing from daily activities.

For Question 2, the participants of this study agreed that the most commonly occurring presentations of clients with a broken heart are sadness (extreme), anger, depression, guilt, anxiety, confusion, and hurt, among others. These presentations are supported by the statistical data of a 6-7 interquartile range, a mean of 6.35, and a standard deviation of .745 and interquartile range of 6-7 ($IQR = 6-7$, $M = 6.35$, $SD = .745$).

Question 3 elucidated that there was consensus among the participants on some of the ways MFTs have helped clients heal from a broken heart. These include identifying coping skills/self-care activities, identifying support systems, acknowledging the client's strengths, recommending support groups, validating the client's feelings/thoughts/emotions/symptoms, showing empathy and therapeutic curiosity, listening and allowing silence in session, encouraging release of pain, matching the pace of the client, identifying past loss and how it was dealt with before, finding exceptions,

taking a collaborative/not knowing stance, giving homework to honor the past relationship, maintaining a systemic perspective, emphasizing shifts in the self and relational changes, verifying that the client is in fact presenting with heartbreak and not something else, not assuming that therapy is “healing,” talking about a future without heartbreak, and ending sessions on a positive note. These techniques are supported by mean of 6.225, a standard deviation of .243, and an interquartile range of 6-7 ($M = 6.225$, $SD = .243$, $IQR = 6-7$).

Finally, Question 4, and the main focus of this research study, centered on the best practices used among MFTS for helping clients heal. With a mean of 6.262, a standard deviation of .390, and an interquartile range of 6-7 ($M = 6.262$, $SD = .390$, $IQR = 6-7$), the MFTs of this study revealed that the best practices MFTs use that can help clients heal from heartbreak are working on coping skills; highlighting clients’ support system; encouraging clients to try new things; giving clients resources; providing empathic listening and allowing clients to share their story; allowing space and time for clients to process their heartbreak; validating clients’ feelings, thoughts, and emotions; being curious and non-judgmental; developing a genogram and involving clients’ families; maintaining a systemic stance and exploring the loss with a relational focus; highlighting lessons learned from the heartbreak; reframing; setting goals; having future-oriented conversations; allowing clients to discover their ability to overcome heartbreak; and giving clients something different than what they get from their family and friends.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

Chapter Introduction

Chapter V includes a comparison of the data gathered in this study and the existing literature, as well as some of the strengths and limitations I identified in the study. I also provide a list of the implications for future research, as well as those for the practice of MFTs. I then conclude the study with a summary my reflections throughout the process of conducting this research study.

Comparison to Previous Research

As mentioned in other sections of this document, the literature on heartbreak does not feature the experiences of MFTs. For this reason, I have chosen to link this study with the existing literature through the exploration of symptoms presented by brokenhearted clients.

In the existing literature, some of the most frequently cited biological responses to heartbreak include loss of appetite (Field, 2011), psychological distress, higher rates of depression, higher rates of insomnia and other sleep irregularities (Brewer & Abell, 2017), heightened anger, disorganized behavior (Field et al., 2009), lower life satisfaction (Rhoades, Kamp Dush, Atkins, Stanley, & Markman, 2011), reduced immune function (Field, 2011; Langeslag & Sanchez, 2017), and overall problems adjusting (Barbara & Dion, 2000), to name a few. The results gathered from the present study are similar in nature to the results in the literature, as the participants most frequently cited biological responses to heartbreak, such as crying and weight fluctuations (gain and/or loss), followed by breathing difficulties, chest pains, headaches, low energy, somatic distress, stomach pains, stress, and others.

The participants in the present study agreed that psychological responses to heartbreak include sadness, confusion, depression, grieving, hopelessness, lability, loss of motivation, anger, anxiety, denial, low self-esteem, and many others. The literature reveals that some of the psychological responses to heartbreak include insecurity and emotional distress (Tan, Agnew, VanderDrift, & Harvey, 2015), anger, confusion, sadness and regret (Brewer & Abell, 2017), increased distress (Rhoades et al., 2011), and fluctuation of positive and negative emotions (Sbarra & Emery, 2005).

Lastly, the social responses most highlighted by the participants of this study were isolating, avoiding people, and withdrawing from daily activities. The existing literature also points out that isolating (Finkelstein, 2014); avoiding people, especially the ex-partner (LeFebvre, Blackburn, & Brody, 2015); and fluctuating between positive and negative emotions (Sbarra & Emery, 2005) are all symptoms of the heartbroken person. Overall, there were no significant variations between the symptoms identified in this study and those presented in the existing literature.

Strengths and Limitations of the Study

Though the Delphi Technique makes provisions to check for bias through the process of member checking, I would be remiss if I did not make note of the items I most readily identify as possible biases. As mentioned previously, I have personally been heartbroken before, and I have sought professionals to help me heal. It is, therefore, possible that I may have subconsciously neglected to steer the research in a particular direction, given my personal interests.

In Question 3 of this study, I asked the participants to list the ways in which they have helped their clients heal. Through the process of member checking, one of the

participants pointed out that while MFTs' work with broken-hearted clients is hopefully helpful, we should not assume that healing is taking place or that we have helped with that portion of the client's process. What I understood from this feedback is that as therapists we are limited to providing the best services possible, yet healing is something personal that rests entirely on the client. As therapists we cannot assume responsibility or glory for a client's healing. In addition, though healing may be the goal for some, it is pertinent to mention that growth can occur following the heartbreak that results from the dissolution of a romantic relationship (Miller, 2009).

One of the questions that became clear during each step of this process, and was evidenced by the responses received, is whether the Delphi Technique is the most appropriate research methodology to use with a population that has specific and homogenous characteristics. In other words, I surveyed MFTs, who by definition have a similar set of skills. It follows, then, that their responses will also be similar in nature, thereby rendering consensus much easier and faster than if the population were more varied in skill. It is also worth noting that there were no outlandishly innovative techniques uncovered in this process. Due to the nature of the field, there are only so many techniques and models MFTs use; this study did not uncover new techniques never seen before, nor was it the aim of the present study to arrive at such findings.

Another criticism presented by one of the participants in the present study is that the process of the Delphi Technique does not allow for highlighting of the uniqueness of each case. Though is it by design of the Delphi Technique, the uniqueness with which each participant expressed their ideas merged into the responses of the other participants from Round 1 to Round 2. This was a product of the necessary step of summarizing the

responses and coming up with themes and categories. While I chose the Delphi Technique because its analytical process could help me arrive at a shared opinion among a group of professionals, this process necessarily obscures the individual experience of each therapist and their respective clients. Researchers seeking to highlight individuality are not best served by the use of the Delphi Technique.

As presented in the methodology portion of this study, in this modification of the Delphi Technique, I intentionally selected the sample size for the present study in order to solicit participants' expertise. Thus, the sample is not necessarily representative of the population at large. In addition, the participants in this study were mainly recruited from NSU's campus and associated alumni. Perhaps a larger, more comprehensive national or international sample would yield more generalizable results.

Due, perhaps, to the formatting of the questions or the way I sent the questions to the participants, depth seems to have been lost in the responses received. I found the techniques and accompanying best practices to be perfunctory. A large majority of the responses did not delve into how the techniques are applied or for what reason. The participants seemed to have limited their responses to the naming of overarching techniques, without including detail or depth.

Another key point that this research study did not aim to investigate is the accuracy of the MFTs' self-report that they were helpful to heartbroken clients. In other words, this study did not aim to find out whether it is true that these MFTs were able to help their heartbroken clients. This study did, however, achieve a consensus among the MFT participants on what they think are the best practices for helping heartbroken clients.

Implications for Future Research

The present study utilized a modification of the Delphi Technique to reach consensus on a topic that has yet to be explored from the lens of MFTs. The modification was to survey MFTs associated with Nova Southeastern University, as opposed to a more varied sample. As the research on heartbreak grows and MFTs get more of a voice in this line of inquiry, the present study can serve as a starting point in the conversation about how MFTs can help clients who are heartbroken, and what the best practices are for accomplishing this task. The present research study provides MFTs and other mental health practitioners with valuable tools for honing in on their conversations with heartbroken clients.

The results showed that the preferred best practices among the MTF participants were exploring coping skills, being empathetic and allowing the client space, utilizing the genogram, involving family members, and having future orientated conversations. Therefore, future studies could delve into the particularities of those types of coping skills that show the strongest results with clients, such as the most affirming talking points that reflect empathy, the most appropriate length of genogram path, or the degree of depth within future-oriented conversations, among many others. It would also be of interest to the field to conduct longitudinal studies on the therapists and their practices, as well as on clients of MFTs. This may be studying clients when they first seek therapy and again at the point when clients can report that they have found solace in their journey.

As mentioned above, the present study did not investigate the accuracy of the therapists' self-reports about how they have helped their broken-hearted clients. Perhaps

future research could focus on clients' reports of their work with MFTs and their perceptions about the most helpful interactions in their quest to heal from heartbreak.

A different aspect that could be further explored and highlighted is the level of expertise of the participants. Future studies may be able to extrapolate different results from therapists who are at different levels of expertise and have varying numbers of years practicing in the field as well as different specializations within the field. In addition, the research on heartbreak may benefit from the inclusion of data points such as age, gender, sexual orientation, sexual identity, race, ethnicity, socioeconomic status, and cultural background, among many others.

Another way this line of research could flourish is to ask MFTs to report on the different reasons for the dissolution of their clients' romantic relationships. It may be that the reason for the heartbreak may somehow correlate with the type of best practice that was found most helpful. In addition, as mentioned in the introductory pages of this study, there are many different types of heartbreak. It may be of interest for future researchers to explore how MFTs can help their clients with other types of heartbreak. Furthermore, all the suggestions found in this section can be further amplified by exploring these topics within other branches of psychotherapy and other helping professions.

Implications for Marriage and Family Therapists

Helping professionals have no easy task. When faced with a client who is experiencing a gut-wrenching mixture of emotions, thoughts, and feelings, such as in the case of heartbreak, it could be distracting and seemingly arduous to help these clients. The results of this study have illustrated a plethora of techniques and best practices that have reportedly proven successful in helping clients experiencing heartbreak.

Marriage and family therapists are trained to understand relationships. We are taught to consider different vantage points to help our clients gain a perspective they had not seen before. The present study provides those in the helping professions with many different ways to help clients see things differently when it comes to their heartbreak. I hope that the readers of this document can pass these findings forward and help educate others about the multitude of ways in which we can help those experiencing heartbreak resulting from the dissolution of a romantic relationship.

As trained mental health professionals, we have been taught that helping others often involves challenging ourselves to become creative and open-minded about the circumstance that brought our clients to us. Likewise, we must remain open to exploring the different ways in which we can be helpful to our clients. My hope is that this study shines a light on the different ways that others have helped their clients find solace in their heartbreak. Before the present study, information about MFTs has not been published within research on the specific topic of helping clients experiencing heartbreak resulting from the dissolution of a romantic relationship. Though the present study does not present groundbreaking information or introduce extremely innovative techniques, it marks the beginning of a conversation that involves MFTs.

Researcher's Reflections

Going into this project, I had no preconceptions about how the finished product would look. Many aspects of my interactions with the therapist participants were a pleasant surprise to me. Through the narrative of the responses received, I noted the level of empathy and creativity that MFTs apply to their work with heartbroken clients. As reflected in the fact that consensus was reached after only two rounds of the study, I can

say that this process has made me more attuned to what other therapists in the field think; it also revealed that my experience with broken-hearted clients is more common than I thought. At times, I was able to recall my own clinical work, remember how I applied each factor or technique, or reflect on how I could have. Beyond being affirmed that I am doing the right work and involved in the right field, I also found this project to mirror who I am as a therapist, client, and researcher.

There was one response that I found to be particularly brilliant, as it was much different from the others and made sense to me. This particular participant wrote that sometimes clients come to therapy with symptoms that do not point to heartbreak, but when we sit and have an honest conversation, we soon find out that a broken heart is at the center of the client's decision to seek therapy. This claim rang true to my experience as a therapist. I could also identify with this idea on a personal level, because when I was going through my most intense heartbreak, I also did not know what was going on with me, and I sought help from different professionals who did not recognize my symptoms. It is only in retrospect that I am able to make the correlation and realize the importance of being aware of this phenomenon and, of course, asking the right questions.

Conclusion

Heartbreak is a phenomenon experienced by many people at some point in their lives. It is common knowledge that most people are able to surpass their heartbreak; however, for many, the experience lingers and brings with it numerous consequences. As revealed throughout this study, heartbreak may have biological, psychological, and social repercussions. Because these symptoms are not easily recognized, and their magnitude not socially accepted, the broken-hearted may find themselves disenfranchised in their

grieving. Given the results of the present study, a correlation can be made that the disenfranchisement of the grief resulting from the dissolution of a romantic relationship is closely associated with the sadness experienced by the broken-hearted.

Because I intended this study to be exploratory in nature, there was no hypothesis to be proven. Instead, I wanted to uncover current therapeutic best practices that might be helpful to the broken-hearted. Disenfranchised grievers feel disenfranchised because they have received feedback that their grief is not widely accepted for what it is. According to the results gathered in this study, the way MFTs can help clients through the experience of disenfranchised grief is by providing an empathic presence in session, generating historical conversations through the use of a genogram, involving family members in the therapeutic process, and having future-oriented conversations. I conducted this study to shine a light on a topic that is often overlooked but can have major consequences in a person's life. I would consider myself lucky and accomplished if this dissertation reaches at least one person and helps elucidate the importance of exploring heartbreak and helping others heal.

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Appendix A

IRB Approval – Exempt Letter



I

MEMORANDUM

To: **Isibel Moreno**

From: **Ransford Edwards,
Center Representative, Institutional Review Board**

Date: **December 17, 2018**

Re: **IRB #: 2018-670; Title, "Marriage and Family Therapists' Clinical Impressions of Romantic Relationship Dissolution Heartbreak: A Modified Delphi Study"**

I have reviewed the above-referenced research protocol at the center level. Based on the information provided, I have determined that this study is exempt from further IRB review under **45 CFR 46.101(b) (Exempt 2: Interviews, surveys, focus groups, observations of public behavior, and other similar methodologies)**. You may proceed with your study as described to the IRB. As principal investigator, you must adhere to the following requirements:

- 1) **CONSENT:** If recruitment procedures include consent forms, they must be obtained in such a manner that they are clearly understood by the subjects and the process affords subjects the opportunity to ask questions, obtain detailed answers from those directly involved in the research, and have sufficient time to consider their participation after they have been provided this information. The subjects must be given a copy of the signed consent document, and a copy must be placed in a secure file separate from de-identified participant information. Record of informed consent must be retained for a minimum of three years from the conclusion of the study.
- 2) **ADVERSE EVENTS/UNANTICIPATED PROBLEMS:** The principal investigator is required to notify the IRB chair and me (954-262-5369 and Ransford Edwards, respectively) of any adverse reactions or unanticipated events that may develop as a result of this study. Reactions or events may include, but are not limited to, injury, depression as a result of participation in the study, life-threatening situation, death, or loss of confidentiality/anonymity of subject. Approval may be withdrawn if the problem is serious.
- 3) **AMENDMENTS:** Any changes in the study (e.g., procedures, number or types of subjects, consent forms, investigators, etc.) must be approved by the IRB prior to implementation. Please be advised that changes in a study may require further review depending on the nature of the change. Please contact me with any questions regarding amendments or changes to your study.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Cc: Martha Marquez
Ransford Edwards

Appendix B

Informed Consent Form

College of Arts, Humanities,
and Social Sciences
NOVA SOUTHEASTERN UNIVERSITY



General Informed Consent Form NSU Consent to be in a Research Study Entitled

*Marriage and Family Therapist's Clinical Impressions of Romantic Relationship
Dissolution Heartbreak: A Delphi Study*

Who is doing this research study?

College: College of Arts, Humanities, and Social Sciences and Department of Family Therapy

Principal Investigator: Isibel C. Moreno, M.S.

Faculty Advisor/Dissertation Chair: Martha Marquez, Ph.D.

Co-Investigator(s): N/A

Site Information: Nova Southeastern University, Brief Therapy Institute, 3301 College Ave, Maxwell Maltz Building, Fort Lauderdale, FL 33314

Funding: Unfunded

What is this study about?

The purpose of this research study is to reach a consensus about the symptoms that Marriage and Family Therapists have observed from their heartbroken clients. In addition, this study seeks to uncover how Marriage and Family Therapists have helped clients who experience heartbreak resulting from the dissolution of a romantic relationship or a break up.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you are a licensed Marriage and Family Therapist and have reported having experience in providing therapeutic services to clients who have experienced heartbreak resulting from the dissolution of a romantic relationship.

This study will include between 10 and 50 people.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, you will be asked to participate in two to four rounds of questions about your experience with heartbroken clients.

Research Study Procedures - as a participant, you will receive an email instructing you on how to begin. In this original e-mail you will be asked to answer the two eligibility questions of whether you are a licensed Marriage and Family Therapist and if you have ever served a client who experienced heartbreak. Following your affirmative response, you will receive a second e-mail with the research questions and the informed consent form to be signed and returned to the researcher via email. The first round will consist of

four open-ended questions, which should take approximately 20 minutes total to complete. The subsequent rounds will be a reiteration of your responses in addition to the responses of all other participants. The four questions will remain the same throughout the entire process, as the goal of this study is to achieve consensus between all participants. Each round after the first round should take approximately 20 minutes to complete. All correspondence will be completed via e-mail, with a new round approximately every two weeks. Your participation in the study may span over eight weeks with active participation only when replying to the four questions and the subsequent three iterations. You can expect to spend approximately 1.5 hours total answering the original questions and revising your responses.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, what you will be doing has no more risk of harm than you would have in everyday life. You may find some questions asked to be upsetting or stressful as you remember past experiences. If so, we can refer you to someone who may be able to help you with these feelings.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, there will be no penalty. If you choose to stop being in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. We hope the information learned from this study will teach us about the symptoms that marriage and family therapists observe in their brokenhearted clients and how the professionals were able to help those heartbroken clients.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. All correspondence will be conducted through password protected email. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data, such as this informed consent, will be kept securely in an electronic format, in a password protected folder within a password protected central processing unit (CPU) or computer which has a security system and firewall protection. All participants will be asked to not disclose personal information of any of the clients on which they will be basing their responses. All data will be kept for 36 months from the end of the study and destroyed after that time by micro cut shredding of any resulting paper materials and digitally erasing all electronic files, followed by formatting the storage discs.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:

Isibel C. Moreno, M.S. can be reached at (954) 815-8036

If primary is not available, contact:

Martha Marquez, Ph.D. can be reached at (954) 262-3056

Research Participants Rights

For questions/concerns regarding your research rights, please contact:

Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

All space below was intentionally left blank.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

Adult Signature Section

I have voluntarily decided to take part in this research study.

_____	_____	_____
Printed Name of Participant	Signature of Participant	Date
_____	_____	_____
Printed Name of Person Obtaining Consent and Authorization	Signature of Person Obtaining Consent & Authorization	Date

Appendix C

Recruitment Flyer

Research Study

Nova Southeastern University
Department of Marriage and Family Therapy

Research participants needed

Study Title: Marriage and Family Therapists' Clinical Impressions of Romantic Relationship Dissolution Heartbreak: A Delphi Study

This study seeks to uncover how Marriage and Family Therapists have helped clients who experience heartbreak from a break up.

- What are the symptoms of a client experiencing heartbreak?
- How does a broken-hearted client present?
- How do marriage and family therapists help these clients heal?
- What are some of the best practices for helping the broken-hearted?

If you are a licensed Marriage and Family Therapist and have ever worked with a client who experienced heartbreak as a result of the dissolution of a romantic relationship, you may be eligible to participate in this study.

Eligible Marriage and Family Therapists will be asked to participate in 2 to 4 rounds helping develop an answer to the 4 questions posted above. Your participation is voluntary and confidential.

If you would like to participate in this study please call, text or email:

Isibel C. Moreno, LMFT at (954)815-8036 or Isibel@mynsu.nova.edu



Appendix D

Round 1 – Google Form

Heartbreak Study - Round 1 - Questions

This is the first round of the research study. At minimum we will have 2 rounds total and at maximum there will be 4 rounds. The number of rounds is contingent on the variation in agreement after each round. I will guide you through everything step by step.

This first round is the only round where you are expected to type any information. The remaining rounds you will be asked to rate the answers on a Likert scale. Again, I will make it a breeze!

Question 1 of 4

In this question please list the symptoms you have noticed that relate to heartbreak.

What are the symptoms of a client experiencing heartbreak?

Your answer



NEXT

Page 1 of 4

Heartbreak Study - Round 1 - Questions

Question 2 of 4

For this question please list how a client presents to sessions, this may be related to the symptoms. For example, heartbroken clients present as: euthymic, extremely happy or extremely sad.

How does a broken-hearted client present?

Your answer



BACK

NEXT



Page 2 of 4

Heartbreak Study - Round 1 - Questions

Question 3 of 4

Please list some of the techniques that therapists can use to help heartbroken clients.

How do marriage and family therapists help these clients heal?



Your answer

BACK

NEXT



Page 3 of 4

Heartbreak Study - Round 1 - Questions

Question 4 of 4

Of all the techniques available, please list the one(s) you think would better help heartbroken clients.

What are some of the best practices for helping the broken-hearted?



Your answer

BACK

SUBMIT

 Page 4 of 4

Appendix E

Round 2 – Google Form

Heartbreak Study - Round 2

Welcome to Round 2 of the study. Here you will be asked to rate the complied responses of all participants on a scale 1 to 7.

Question 1: What are the symptoms of a client experiencing heartbreak?

Please rate each set of symptoms with your corresponding level of agreement.

Biological Responses					
2	Breathing difficulties	1	Heartburn	1	Sleep disturbance
1	Changes in appetite	2	Low energy	2	Somatic distress
2	Chest pains	1	Memory loss	2	Stomach pains
5	Crying	1	Negative thoughts	2	Stress
1	Fatigue	1	Physical pains	1	Tightness of the chest
2	Headaches	1	Restlessness	5	Weight Gain/Loss

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐
☐
☐
☐
☐
☐
☐

Agreed! 😊

Psychological Responses					
3	Anger	2	Disbelief	2	Irritability
1	Anhedonia	1	Double bind	1	Justifying
3	Anxiety	2	Doubt	4	Lability
1	Addictive behaviors	2	Emotional Pain	1	Loss on interest
1	Bargaining	5	Grieving	4	Loss of motivation
1	Blaming	1	Guilt	3	Low self-esteem
5	Confusion	1	Helplessness	1	Low self-worth
3	Denial	5	Hopelessness	1	Mood swings
5	Depression	1	Insomnia	1	Regret
				2	Ruminating thoughts
				11	Sadness
				1	Self-criticism
				1	Shock
				1	Suicidal
				1	Thoughts of self-harm
				1	Upset

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐
☐
☐
☐
☐
☐
☐

Agreed! 😊

Social Responses

1 Avoiding people 2 Isolation 1 Withdrawal from daily activities

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! 😞

☐
☐
☐
☐
☐
☐
☐

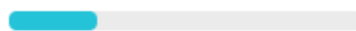
Agreed! 😊



Optional: Please use the space below to add any notes, comments, concerns, or questions you may have regarding this section.

Your answer

NEXT



Page 1 of 4

Heartbreak Study - Round 2

Question 2: How does a broken-hearted client present?

Please rate the list of client presentation terms according to your level of agreement.

Client Presentation					
14	Sadness (Extreme)	1	Despaired	1	Listless
5	Angry	1	Disheveled	1	Little eye contact
3	Depressed	1	Disillusioned	1	Loneliness
3	Guilty	1	Easily distracted	1	Lost
2	Anxious	1	Exaggerative	1	Miserable
2	Confused	1	Fast speech	1	Overwhelmed with emotion
2	Hurt	1	Frustrated	1	Physical pain
1	Apathetic	1	Grieving	1	Preoccupied
1	Bleak	1	Hopelessness	1	Questioning life and themselves
1	Crying	1	Keeping busy	1	Regretful
1	Demotivated towards social interactions	1	Labile		

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐
☐
☐
☐
☐
☐
☐

Agreed! 😊



Optional: Please use the space below to add any notes, comments, concerns, or questions you may have.

Your answer

BACK

NEXT

Page 2 of 4

Heartbreak Study - Round 2

Question 3: How do marriage and family therapists help these clients heal?

Please rate each set of factors with your corresponding level of agreement.

Client/extratherapeutic factors are ingredients in the life and environment of the client that contribute to change. These factors include client characteristics, such as inner strengths, religious faith, goal directedness, personal agency, and motivation, as well as things outside of the control of the client, such as fortuitous events, social support, and winning the lottery (Blow & Sprenkle, 2001, p. 386).

Client/Extratherapeutic Factors

- 6 Identify coping skills/self-care activities
- 4 Identify support systems
- 3 Acknowledge the client's strengths
- 1 Recommend support groups

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐
☐
☐
☐
☐
☐
☐

Agreed! 😊

Relationship factors are relationship-mediated variables that occur between therapist and clients in the therapy room. These factors include variables, such as warmth, respect, genuineness, and empathy (Blow & Sprenkle, 2001, p. 387).

Relationship Factors

- 6 Validate the client's feelings/thoughts/emotions/symptoms
- 6 Empathy and therapeutic curiosity
- 4 Listen / Allow silence in session
- 4 Encourage release of pain: crying, weeping, etc.
- 3 Match the pace of the client
- 2 Acknowledge the pain
- 2 Normalize
- 2 Be open and transparent
- 1 Establish that grief is unique to every person
- 1 Do not give advice
- 1 Maintain sense of humor
- 1 Do not feel sorry for the client
- 1 Remain emotionally present but intellectually independent
- 1 Never tell clients to just move on

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐
☐
☐
☐
☐
☐
☐

Agreed! 😊

Model/technique factors are those factors that are unique to specific theories of therapy (Blow & Sprenkle, 2001, p. 387).

Model/Technique Factors	
4	Identify past loss and how it was dealt with before / Exceptions
3	Take a collaborative/Not knowing stance
3	Homework: How to honor the past relationship
3	Maintain systemic perspective: Emphasize shifts in the self and relational changes
2	Set goals
2	Be curious about what they want in a partner/future relationships
2	Create a Genogram
2	Empowerment
2	Process / Explore the heartbreak and its symptoms
2	Establish that there is no quick fix
1	Rule out suicide intent
1	Highlight lessons learned from the heartbreak
1	Lean on the loss
1	Challenge catastrophic thoughts

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐ ☐ ☐ ☐ ☐ ☐ ☐

Agreed! 😊

Placebo, hope, and expectancy factors reflect changes that occur simply because the client is in treatment of some kind (Blow & Sprenkle, 2001, p. 387).

Placebo, Hope, and Expectancy Factors	
1	Verify it is heartbreak and not something else
1	Do not assume that therapy is "healing"
1	Talk about a future without heartbreak
1	End sessions on a positive note

The number next to each entry is the amount of times each term appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐ ☐ ☐ ☐ ☐ ☐ ☐

Agreed! 😊



Optional: Please use the space below to add any notes, comments, concerns, or questions you may have.

Your answer

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Heartbreak Study - Round 2

Question 4: What are some of the best practices for helping the broken-hearted?

Please rate each set of best practices with your corresponding level of agreement.

Client/extratherapeutic factors of best practices allude to ingredients in the life and environment of the client that contribute to change. These factors include client characteristics, such as inner strengths, religious faith, goal directedness, personal agency, and motivation, as well as things outside of the control of the client, such as fortuitous events, social support, and winning the lottery (Blow & Sprenkle, 2001, p. 386).

Client/Extratherapeutic Best Practices

- 5 Coping skills: Recommend breathing exercises / meditation
- 3 Highlight the client's support system
- 1 Encourage the client to try new things
- 1 Give the client resources

The number next to each Best Practice is the amount of times each Best Practice appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐ ☐ ☐ ☐ ☐ ☐ ☐

Agreed! 😊

Relationship best practices are relationship-mediated variables that occur between therapist and clients) in the therapy room. These factors and best practices include: warmth, respect, genuineness, and empathy (Blow & Sprenkle, 2001, p. 387).

Therapeutic Relationship Best Practices

- 8 Empathetic Listening / Allow the client to share their story
- 7 Allow space and time for the client to process their heartbreak
- 5 Validate the client's feelings/thoughts/emotions
- 4 Be curious and non-judgmental
- 3 Acknowledge strengths
- 2 Be present for the client
- 2 Normalize
- 2 Provide emotional support
- 1 Be Compassionate
- 1 Encourage

The number next to each Best Practice is the amount of times each Best Practice appeared in the responses from Round 1.

1 2 3 4 5 6 7

Disagree! ☹️

☐ ☐ ☐ ☐ ☐ ☐ ☐

Agreed! 😊

Model/technique best practices are unique to specific theories of therapy (Blow & Sprenkle, 2001, p. 387).

Model/Technique Best Practices	
4	Genogram / Involve the client's family
3	Maintain systemic stance and explore the loss with a relational focus
2	Highlight lessons learned from the heartbreak
2	Reframe
2	Set goals
1	Educate
1	Empowerment
1	Help client accept the reality of the loss
1	Honor the past/lost relationship
1	Hypnotherapy
1	Identify past loss and how it was dealt with before / Exceptions
1	Managing one's own anxious responses to the situation.
1	Separate the person from the problem
1	Use Evidence Based Practices to target symptoms such as depression, substance abuse, etc.

The number next to each Best Practice is the amount of times each Best Practice appeared in the responses from Round 1.

	1	2	3	4	5	6	7	
Disagree! ☹️	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Agreed! 😊

Placebo, hope, and expectancy best practices reflect changes that occur simply because the client is in treatment of some kind (Blow & Sprenkle, 2001, p. 387).

Placebo, Hope, and Expectancy Best Practices	
2	Have future oriented conversations
1	Allow client to discover their ability to overcome heartbreak
1	Give the client something different than what they get from their family and friends

The number next to each Best Practice is the amount of times each Best Practice appeared in the responses from Round 1.

	1	2	3	4	5	6	7	
Disagree! ☹️	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Agreed! 😊



Optional: Please use the space below to add any notes, comments, concerns, or questions you may have.

Your answer

BACK

SUBMIT

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Appendix F

Initial Email to Participants

Marriage and Family Therapists' Clinical Impressions of Romantic Relationship Dissolution Heartbreak: A Delphi Study

Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314-7796

Subject: Initial email

Dear _____:

Thank you for expressing interest in participating in this research project.

To qualify for this research, you must answer affirmative to the following two questions:

- 1) Are you a licensed Marriage and Family Therapist?
- 2) Have you ever provided therapeutic services to client(s) who experienced a broken heart as a result of the dissolution of a romantic relationship or a break up?

Please reply to this email answering the above questions in order to confirm your eligibility to participate in this research study.

Thanks in advance for your prompt reply and your willingness to participate in this research study. My aim with this study is to provide best practices for MFTs to help their broken-hearted clients.

Thanks again for your support.

Sincerely,

Isibel C. Moreno, LMFT
Isibel@mynsu.nova.edu
(954)815-8036



Appendix G

Second Email to Participants

Marriage and Family Therapists' Clinical Impressions of Romantic Relationship Dissolution Heartbreak: A Delphi Study

Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314-7796

Subject: Informed Consent

Dear _____:

Thank you for expressing interest in participating in this research project. By answering affirmative to the questions of whether you are a licensed marriage and family therapist and if you have provided therapeutic services to clients experiencing heart break as a result of the dissolution of a romantic relationship, you have qualified to participate in this study.

The next step in the participation process is for you to provide your written consent. Please review the attached informed consent form. If you agree with all the points in the informed consent form, please sign it and return to me via e-mail.

Should you have any questions, comments or concerns, please do not hesitate to contact me at the information provided below.

Thanks again for your support.

Sincerely,

Isibel C. Moreno, LMFT
Isibel@mynsu.nova.edu
(954)815-8036



Appendix H

Thank You Message to Participants After Each Round

Heartbreak Study - Round 1 - Questions

Dear Participant:

Thank you for completing the 1st round of questions for the study on MFTs and heartbreak. I will be sending you the next round of questions within the next 2 weeks.

For more information about heartbreak, inspirational quotes, statistics, etc, please visit <http://www.Facebook.com/TheHeartbreakCenter>

I truly appreciate your continued participation and investment in this study.

I am confident that your perspective will prove invaluable to the study and may help other MFTs inspire their heartbroken clients.

Thanks again for your support.

Sincerely,

Isibel C. Moreno, LMFT
Isibel@mynsu.nova.edu
(954)815-8036

Appendix I

Project Completion Email for Participants

Marriage and Family Therapists' Clinical Impressions of Romantic Relationship Dissolution Heartbreak: A Delphi Study

Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314-7796

Subject: Project completion email

Dear _____:

Thank you for completing the final round of questions for the study on MFTs and heartbreak. The participant input part of the project is now complete, as we have reached a census on the 4 research questions originally posted. Attached please find the final narrative that will be included in my dissertation.

I suspect that the dissertation will be completed by the end of this summer. If you would like to receive an electronic copy of the dissertation, please reply to this email with your interest.

Once again, I truly appreciate your continued participation and investment in this study. Now more than ever, I am confident that your perspective will prove invaluable to the study. Our heartbroken clients and their therapists will certainly reap the benefits of your experience.

Thanks-a-million for being part of my dissertation!

Sincerely,

Isibel C. Moreno, LMFT
Isibel@mynsu.nova.edu
(954)815-8036



Biographical Sketch

Isibel C. Moreno was born in Santo Domingo, the Dominican Republic to her parents, Victor and Victoria. She is the middle of three children and has two siblings, Luz del Alba and Victor Josue. Her family migrated to the United States on February 27, 1995. Isibel began her undergraduate studies at Nova Southeastern University in the fall of 2002 as a pre-dental major. Soon after, Isibel discovered that her true passion was psychology; as a pragmatic young woman, she decided to double major in Psychology and Business Administration. Isibel then graduated with a master's degree in Mental Health Counseling, also from Nova Southeastern University, in the fall of 2006. The journey towards her Ph.D. started with a desire to teach and train other professionals in the field.

Isibel is a Licensed Marriage and Family Therapist, Florida State Approved Hypnotherapist, Clinical Fellow and Approved Supervisor of the American Association for Marriage and Family Therapy (AAMFT), member of Alpha Phi Omega and Delta Kappa Omicron. As an author and presenter, Isibel has traveled to various countries exposing her ideas on the topic of heartbreak and how therapists can help clients who experience this phenomenon. In the future, Isibel hopes to write a series of books, become part of a faculty at a university, and expand her private practice. She also plans to further develop her clothing, shoes, and accessories line and brand, IsMo Designs. Isibel currently lives in Fort Lauderdale, Florida.