A COMPREHENSIVE DISCOURSE ANALYSIS OF A SUCCESSFUL CASE OF EXPERIENTIAL SYSTEMIC COUPLES THERAPY

by

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This study investigated how a therapist and clients created couple change over the course of 15 sessions of Experiential Systemic Therapy (ExST) for the marital treatment of alcohol dependency. The aim of this research was to explore how change occurred during a single case of successful ExST and to refine and expand ExST theory. ExST has been shown to be an effective treatment for couple recovery from alcohol dependence yet little research has focused on how change occurs in ExST.

The case selected for analysis was an exemplar of successful ExST couples therapy. The case met several criteria for success including therapist and client satisfaction with therapy, the cessation of alcoholic drinking, increased marital satisfaction at posttest and follow-up periods, and evidence of in-session couple change. Two therapy episodes containing relational novelty (couple change) were analyzed using the Comprehensive Discourse Analysis procedure.

The results of this study highlighted the existence of a subtype of relational novelty called syncretic relational novelty. Syncretic change refers to the generation of intimacy by therapist and couple where initially there existed disparate beliefs and behaviour that isolated system members.

The study found that the couple's distance oriented beliefs and practices were reconciled and intimacy was enhanced through the employment of intense experiential activities and the provision of a collaborative therapeutic atmosphere. These two activities fostered increased couple intimacy by encouraging clients to engage one another through self disclosure, empathy, shared vulnerability, increased cooperation and greater personal awareness. Couple intimacy was fostered during experiential activity through a carefully
paced intensification of clients' thoughts, feelings and physical sensations. In addition, intimacy was facilitated by the therapist when she accepted clients' experiences and adopted clients' language styles. As well as working collaboratively, the therapist acted as a therapeutic guide interceding during harmful spousal interactions, altering the therapy agenda at client request, promoting joint decision-making and valuing marginalized client experience. Recommendations based on these findings were made for the refinement and expansion of ExST theory.
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CHAPTER I
PURPOSE OF THE STUDY

Increasingly, marital and family therapy process researchers are turning their attention to two streams of inquiry including the study of therapeutic process and the means by which therapy process is related to client change (Greenberg & Pinsof, 1986). Indeed, calls for therapy process studies that highlight the second stream, change process research, have been made since the 1970's (Keisler, 1973). Investigator interest in conducting change process research emerges from a desire to increase our understanding of therapeutic change and insodoing elaborate change theory as it pertains to specifically delineated therapy models (Greenberg, 1986). Typically, marital and family therapy theories (i.e., efforts to understand, describe and explain observed therapy process) are based upon the clinical observations, discussions and the acquired knowledge of their developers (Newmark & Beels, 1994). Change process research offers marital and family therapy theoreticians and researchers the opportunity to test, challenge, confirm or expand theory via empirical means (Greenberg, 1986). The development of therapy theory via empirical theory building offers a rigorous and systematic means to continue the effort to produce ever-evolving explanatory systems.

The purpose of this study is to further the development of experiential systemic marital therapy theory through the in-depth examination of therapy-in-practice. Experiential Systemic Therapy (ExST) is an effective individual and marital treatment for alcohol abuse (Grigg, 1994). ExST was developed by this author, John Friesen, Darryl Grigg and Paul Peel in 1989 at the University of British Columbia in Vancouver, British Columbia, Canada (Friesen, Grigg, Peel,
ExST was developed in response to the need for both a systemic and an integrative therapy model which could be employed to treat individuals, couples and families suffering from alcohol dependence and related problems. As an integrative therapy, ExST provides a theoretical framework that embraces a wide variety of therapist technique and practice. In addition, ExST can be applied to individual, couple and family treatment formats. The importance of ExST in the conduct of therapy for alcohol and drug abuse is that it offers clinicians an opportunity to apply an integrative therapy model to a variety of therapeutic contexts thereby providing an improved service to clients who may require treatment at the individual, couple and family levels of the system.

This research project is concerned with exploring change as it occurs in the marital format of ExST. Buoyed by promising outcome evidence that testified to the overall efficacy of ExST for the treatment of individuals and couples suffering from alcohol dependency and its effects (Grigg, 1994), the present investigation was designed to explore how change occurred in sessions of successful experiential systemic marital therapy. This research represents an empirical theory building effort that seeks to contribute to the continued development of an efficacious form of marital therapy.

The remainder of this chapter will be concerned with the articulation of the aim of this research investigation, the research question posed, and the significance of the study. Also, a brief description of the method employed to answer the research question will be provided followed by the definition of terms used in the conduct of this study. The organization of the chapters will be outlined after the definition of terms is complete.
Research Aim

The goal of this study centers on an interest in the continued development of ExST change theory. This aim includes the exploration of how change occurs during a critical single case exemplar of successful ExST and the observation of the implications these findings have for ExST theory refinement and expansion. Thus, the research aim of this study is to contribute to the continuing development of the ExST theory of change through the in-depth exploration of the means by which change is co-created through interactions between therapist and clients.

Research Question

The advent of videotaped recordings of therapy-theory-in-practice offered theoreticians and researchers an opportunity to base theory development on rigorous, contextually embedded empirical research. As a result, research questions that require the observation and analysis of therapy-in-progress for theory development purposes are more readily answered. The research question formulated to meet the aim of this study asked "How do members of the therapeutic system both explicitly and implicitly influence the creation of relationally novel episodes at the intrapersonal, interpersonal and symptomatic levels of the system over the course of 15 sessions of successful Experiential Systemic Therapy for the marital treatment of alcohol abuse?"

Significance of the Study

ExST has been shown to be an effective treatment for marital recovery from alcohol abuse (Grigg, 1994) yet little research has focussed on how change occurs in ExST. Two studies to date have been conducted with
respect to experiential systemic couple's therapy process and both have centered on single case studies of experiential technique (Dubberley-Habich, 1992; Wiebe, 1993). Dubberley-Habich concentrated on documenting the ways in which an ExST therapist used conversation to guide a particular therapy activity namely, a ritual burning of an extra-marital affair. This research endeavour is an example of the type of marital and family therapy process study that centers on the description of aspects of therapy process without relating the technique or therapy activity of interest to client change.

On the other hand, Wiebe (1993) was concerned more with understanding how change occurred through the employment of a particular experiential activity. Wiebe (1993) studied how change was co-created by therapist and clients when engaged in the externalization of alcohol dependency (a technique known as the symbolic externalization or evocation of alcohol). Thus, Dubberley-Habich's (1992) study is an example of a therapy process study designed solely to document therapist use of an experiential technique while Wiebe's study represents an attempt to study an experiential technique in the context of in-session change.

This dissertation is the third process research endeavour to be conducted concerning ExST process. This effort expands upon the previous two studies by moving beyond the description of technique alone or the study of how a particular therapy technique was linked to in-session change. This study explored ExST change process irrespective of a particular experiential technique to illumine the ExST change construct (relational novelty) for theory building purposes.

As stated earlier, ExST is a recently articulated therapy and little work has been conducted in the area of theory confirmation and refinement. Given
the demonstrated effectiveness of ExST (Grigg, 1994), the on-going clarification and expansion of ExST may help foster its continued efficacious conduct. That is, an enhanced understanding of how change is facilitated through ExST will hone the theory offering experiential systemic therapists increased clinical guidance. In addition, this research will begin to provide ExST with an empirically grounded theoretical base which is uncommon in the field of marital and family therapy (Newmark & Beels, 1994).

ExST theory has been articulated in manual form (Friesen, et al., 1989) and in a more recent overview (Friesen, Grigg, & Newman, 1991). Also, ExST supervision practice and theory (Newman, Friesen & Grigg, 1991) and the ExST theory of change (Newman, 1991) have been detailed. However, ExST continues to be a relatively new therapy and further effort is required to capture the nuances of its various tenets and constructs.

The current flurry of interest in ExST process notwithstanding, several marital and family therapy process researchers have engaged in attempts to understand aspects of therapy process and how clients change from within particular therapy paradigms with varying degrees of success (Pinsof, 1981). A lack of therapy theory articulation, inadequate measures and methods and difficulties linking therapy process to therapy change have hampered efforts to understand change process (Greenberg, 1986; Greenberg & Pinsof, 1986; Keisler, 1973; Pinsof, 1981; Rice & Greenberg, 1984; Safran, Greenberg, & Rice, 1988; Wynne, 1988). The present study sought to build upon past efforts by providing a clear articulation of ExST theory and the ExST change construct (relational novelty) as well as employing standardized measures. In addition, this research effort adopted Comprehensive Discourse Analysis (CDA) (Labov & Fanshel, 1977) as a method of analysis suitable for capturing therapy
change process while maintaining a steady research focus on the manner in which change is created in ExST. The following section briefly describes CDA as the method employed in the provision of an answer to the research question.

Summary of the Method

The answer to the research question posed in this study required the analysis of therapy discourse as it occurred between the therapist and clients. The analysis of therapy discourse included not only what was said in therapy by the therapist and clients but also what was unsaid or conveyed through paralinguistic and nonverbal cues. In addition, therapy discourse analysis required attention to the implicit meanings of the discourse, the assumptions being made by the speakers, the social role obligations conveyed and the sociocultural influences on the speakers and the manner in which speakers attempted to influence each other (Labov & Fanshel, 1977). Given the importance of therapy discourse in the creation of marital change, a response to the research question was sought through the use of CDA. A brief summary of the CDA method will introduce the method by which the research question was answered in this study. The summary will include an outline of the research design, elements of the investigative procedure, and the method of data analysis using CDA.

A critical single case study design was chosen for this research based upon calls for the employment of single case studies to illumine the process of client change within a particular therapy paradigm (Wynne, 1988). This study sought to explore a successful case of ExST for the purposes of theory development. The critical or crucial case selected for analysis was an exemplar of a successful ExST case of marital treatment since it met the three criteria for
success outlined for the purposes of this study. First, these criteria included documented client satisfaction with therapy, the cessation of alcoholic drinking and increased marital satisfaction at posttest and follow-up periods. Second, the change construct of interest was evident in a number of therapy sessions and third, the therapist expressed satisfaction with her work with the couple.

The change construct (relational novelty) examined in this study and embedded in the successful marital therapy case was observed to have occurred in eight of the 15 therapy sessions completed by the couple. Three episodes identified as exemplars of the change construct were selected for analysis based upon six criteria outlined in the ExST theory of relational novelty. Each episode contained all six criteria whereas the remaining relationally novel episodes did not meet all the criteria outlined as important to relational novelty for the purpose of this study. While the remaining episodes were not considered exemplars (i.e., containing all six criteria) they were, nonetheless, relationally novel.

The three episodes were reviewed by three independent expert judges selected for their knowledge and familiarity with ExST. High indexes of interjudge agreement were obtained for the episodes indicating that the construct of interest was identified as occurring in the episodes selected for analysis.

Once the successful critical case was secured and the change episodes exemplifying the construct under investigation were identified, the comprehensive discourse analysis of the three episodes began. Following the analysis of the first two episodes, the analysis was concluded. Due to the thematic commonalities evident in the first two episodes, it became clear that the analyses of the first two episodes of relational novelty were sufficient for the provision of an answer to the research question.
The discourse analysis procedure employed in this study is based upon the work of William Labov, a linguist with training in sociology and David Fanshel, a professor of social work with an interest in the delivery and practice of psychotherapy (Grimshaw, 1979). Labov and Fanshel's (1977) research efforts were motivated by an interest in what occurs in therapeutic discourse as well as a desire to expand the scope of linguistic analysis to conversation as a whole (Grimshaw, 1979). As a result, Labov and Fanshel's (1977) work addressed two issues namely the relationship between what is said and what is meant and how social acts and organization are accomplished through talk. Thus, the social act of change in therapy can be carefully examined using Labov and Fanshel's (1977) methodology.

CDA relies upon a six step process which includes the making of video and audio recordings of therapy as a first step. Therapy sessions, in this study, were recorded with sensitive equipment to provide as clear and crisp a visual and auditory rendition of the therapy as possible. The clarity of the recording was important to the next phase of the CDA procedure namely the transcription of the recordings. The ability to hear and see the therapy discourse clearly aided in the production of the text used in the analysis. The second step, the transcription of the therapy discourse, was a painstaking process of transferring auditory and visual information onto the written page. This process required repeated listening and viewing of the therapy segment selected for analysis to obtain an utterance-by-utterance record of the discourse including paralinguistic and nonverbal cues as well as the spoken word. The third step required by CDA was the expansion of the transcribed text. Utterance expansion included additions to the utterance with what was being implied in the speech act. For example, a question such as "How are you?" may contain within it a genuine interest in the respondent or an
uninterested attempt to be polite depending upon the context. The expansion of the text is designed to articulate the implied meaning of an utterance in context. The fourth step in the analysis was the generation of propositions or assumptions being made by the speaker. Thus, a proposition that fits the expansion of "How are you?" might include the following statement: The speaker is genuinely concerned with the respondent's well being. The text transcription, expansions and propositions were employed in the fifth CDA step which necessitated an interactional analysis. Interactional analyses are concerned with exploring how discourse participants are attempting to influence each other through their speech acts. The interactional statement was crucial in understanding how speakers influence one another and revealed how therapeutic change was brought about. The sixth step in the analysis included an episode summary in which the utterance-by-utterance analysis including expansions, propositions and interaction statements for each speech act were synthesized into a coherent whole. Once the analysis was complete, the work of synthesizing the data to provide an answer to the research question was begun.

This survey of the method used to answer the research question is meant to be an introduction and a further elaboration can be found in chapter three. The introduction of the research aim, question and method in this chapter has required the use of many terms with which familiarity is important. The following section will define the terms used in this study.

**Definition of Terms**

The terms defined in this section are important to a complete understanding of this research effort. These terms will be defined in order to clarify their usage in this study.
Relationally Novel Episodes

Relational novelty refers to the enactment of an atypical way of being in therapy which alters the substantive relational themes represented in rigid cognitive, emotive, and behavioural ways of being with self, others, and the presenting problem. Relationally novel episodes follow a general pattern that can be identified as beginning with therapist attendance to clients' narratives. The therapist begins to collaboratively delve into a salient aspect of the narrative through a therapeutic transaction. If the client(s) consent, either implicitly or explicitly, then the therapist guides them through a deep, intense, and novel encounter with self, other, or the presenting problem. Generally, this encounter ends with a de-intensification during which the therapist may mark client change, congratulate the client(s), summarize the process or ask the client(s) for their views of the experience. The therapist may encourage client(s) to talk about the experience or the client(s) may do so without prompting.

Substantive Relational Themes

Substantive relational themes are recursive patterns of emotion, cognition, behaviour and physiological process that embody intrapersonal and interpersonal themes such as unlovableness, abandonment, unworthiness, undeservedness and rejection. They can also transform into themes of lovableness, worthiness, deservedness and inclusion. Substantive relational themes are descriptive of peoples' intrapersonal and interpersonal thematic experiences of being in the world.

Intensifying and Deepening Experience

The process of intensifying and deepening experience aids clients in evoking their substantive relational themes, problematic behaviours, feelings
and thoughts. Deepening experience is achieved via empathy, the repetition of words or actions, experiential activities that involve the whole body as well as metaphors, art, sculpting, dream work, symbolic externalization and enactment. Intensifying and deepening experience is the means by which clients fully embrace their process such that different ways of being with themselves and others are made possible both in the deepened moment and after.

**Therapeutic System: Therapist and Client Members**

A therapeutic system is created when therapist and client(s) enter into a dynamic interactive relationship. As such, the therapist and client subsystems influence and are influenced by the exchange. They bring a variety of intrapsychic, interpersonal and socio-cultural elements to the relationship. For example, the therapist subsystem may include the influences of co-therapists, colleagues, supervisors, personal issues/values, and agency affiliation and attitudes towards the symptom in therapeutic interaction with the couple subsystem. The couple subsystem may include the influences of personal values, families, extended families, friends, work associates, institutional affiliations, aspects of self and attitudes towards the symptom in interaction with the therapist and either spouse. Thus, therapist and client(s) subsystems combine to form the therapeutic system in which all system members affect one another and share ownership of the therapeutic venture.

**Alcohol Dependence**

The male alcoholic featured in this study satisfied the DSM-III-R (1987) diagnostic criteria for severe Psychoactive Substance Dependence. The man's spouse must not be abusing alcohol. The diagnostic criteria are listed below:
At least three of the following items are evident:

1. The substance is used in larger amounts and for a longer length of time than the person initially intended.

2. There exists a persistent desire or one or more unsuccessful attempts to control the substance abuse.

3. The individual spends a great deal of time attempting to obtain the substance, ingest the substance or recover from its effects.

4. The person is frequently intoxicated or experiencing withdrawal symptoms when expected to fulfill role obligations including work tasks or child care or use of the substance is physically hazardous (e.g., driving while intoxicated).

5. Important social, occupational or recreational activities are given up or reduced due to the substance use.

6. The individual continues to use the substance despite knowledge of recurring social, psychological or physical problems that are caused or worsened by the substance use. These difficulties include problems such as ulcers due to drinking, job loss or family fights concerning the use of the substance.

7. The individual experiences tolerance characterized by the need for increased amounts of the substance to achieve intoxication or the desired effect (at least a 50% increase) or the person observes markedly diminished effects with ongoing use of the same amount.

Items #8 and #9 may not apply to cannabis, hallucinogens or phencyclidine (PCP).

8. The individual experiences withdrawal symptoms.

9. Symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period. The
severity of the Psychoactive Substance Dependence ranges from mild to moderate to severe.

Mild: Few, if any, of the symptoms are in excess of those necessary for the diagnosis. The symptoms result in no more than mild impairment in occupational functioning or social activities or relationships with others.

Moderate: Symptoms or impairment is between "mild" and "severe" in degree.

Severe: The individual has many more symptoms than are required for the diagnosis. The symptoms markedly disrupt occupational functioning, social activities or relationships with others.

**Distressed Couple Functioning**

One or both spouses must indicate marital distress as obtained by a score of 100 or below on the Dyadic Adjustment Scale (Spanier, 1976) in order to be considered maritally distressed.

**Successful Treatment**

There are several criteria defining successful treatment for couples complaining of the deleterious effects of alcohol abuse. These criteria include spousal satisfaction with therapy, the attainment of therapy goals including the cessation of alcohol and drug abuse at posttest and follow-up periods and therapist satisfaction with the couple’s progress and her work with the dyad. In addition, the pretest, posttest and follow-up measures should indicate a change towards more personal and marital satisfaction and less personal and marital distress. Finally, relationally novel episodes should be co-created by the therapist and clients throughout the 15 sessions of therapy.
Experiential Systemic Therapy

ExST was created for the treatment of individuals, couples and families complaining of drug and alcohol abuse issues. The theory is complex and aims for an integrative understanding of individual, couple and family functioning in therapy. It strives to access the cognitive, emotional, physiological and behavioural aspects of experience in order to promote change. These aspects of experience are tapped via experiential, symbolic and systemic means in a collaborative, present tense, goal oriented, spontaneous and creative therapeutic atmosphere. Client issues are viewed from a developmental perspective that highlights strengths and resources rather than pathology and dis-ease. ExST subscribes to the notion that human beings develop and maintain their identities in a social or relational milieu from the day they are born through early childhood, youth and adulthood. Experiences that span the life cycle serve to maintain, sustain or perturb human beings sense of self and ways of being in the world. ExST has roots in attachment theory (Bowlby, 1988), interpersonal and existential theory (Kiesler, 1982; May, 1969; Sullivan, 1944; Yalom, 1980), ecosystemic thought (Auerswald 1985; Bateson, 1972, 1979; Bronfenbrenner, 1979), client-centered theory (Rogers, 1961), and experiential (Whitaker & Keith, 1981), strategic (Haley, 1976; Madanes, 1981) and structural (Minuchin & Fishman, 1981) family therapy.

Intrapersonal Level of the Therapeutic System

The intrapersonal level of the system refers to the inner world of the spouses and the therapist including thoughts and emotions internal to the individual. The inner environments of client and therapist may also include various aspects of self which engage in internal dialogue. For example, a critical aspect of self may berate a fearful aspect of self. Also, internal aspects
of self may engage in dialogue with the symptom or people in the individual's world (e.g., a hurt aspect of self may call out to alcohol for relief or a hurt aspect of self may reveal itself to a concerned spouse). The intrapersonal domain is notable in therapy when the clients engage in a dialogue with aspects of self or disclose information about their inner thoughts and emotions.

**Interpersonal Level of the Therapeutic System**

Relationships between the spouses, the couple and the therapist constitute the interpersonal level of the system. The interpersonal level of the system is evidenced in therapy when the spouses interact with one another. Another example occurs when the therapist interacts with either one or both of the spouses.

**Symptomatic Level of the Therapeutic System**

This level refers to the relationship the therapist and clients have with the presenting problem or symptom. One of the therapeutic tasks is to aid clients in bringing this relationship into awareness. The symptomatic level of the system is in evidence when the clients or therapist interact with the presenting problem in its symbolic form.

**Collaboration in Therapy**

Therapist and client collaboration is an important principle of ExST in which therapy is understood as a shared venture involving mutual trust. The therapist is a guide to the therapeutic process and co-develops the therapy with the client. Both the client and therapist own the therapy process and both assume responsibility for the activities. Therapists endeavour to enter the client's world by adopting client language and accepting the client's current state before encouraging clients to experiment with alternate ways of being,
thinking or feeling. The collaborative therapist is considered a part of the therapeutic system rather than a neutral observer, an all knowing expert or a master technician. A collaborative therapist does not understand therapy to be a battle or characterize clients as adversarial or resistant. Instead, clients and therapist work together as co-creators and co-developers of the therapy.

**Therapy Discourse**

Therapy discourse includes both the spoken word as well as that which is left unsaid but still communicated. Discourse in therapy accounts for the implicit meanings of speech acts and the meanings revealed in paralinguistic cues (e.g., sighs, laughter) and nonverbal activity (e.g., headnods, handshakes). In addition, therapy discourse incorporates the suppositions made by the participants in the discourse, their assumed social role obligations (e.g., expectations regarding a father role), the socio-cultural influences on the speakers and the manner in which discourse participants attempt to influence one another (Labov & Fanshel, 1977).

**Organization of the Chapters**

The remaining chapters of this dissertation will provide a review of the literature, an encapsulation of the methodology, a description of the results and a discussion of the conclusions made as a result of this research. Chapter two will incorporate a detailed articulation of ExST theory including the results of a recent outcome study testifying to ExST efficacy and a review of the history of ExST. Following the delineation of ExST theory, relevant quantitative and qualitative marital and family therapy process research will be reviewed. Chapter three describes the critical single case research design and related issues, the investigative procedure used in the conduct of the study and the
CDA method of data analysis employed to yield the results. Chapter four will describe the research results and their importance to ExST theory and chapter five will be concerned with summarizing the results and outlining the proposed refinements to ExST theory based on the findings. Also, limits to the study and future research directions will be discussed in chapter five.
CHAPTER II
SURVEY OF THE LITERATURE

The purpose of this chapter is twofold. First, the aim is to outline why ExST change is worthy of process oriented investigation including a general description of ExST and the change construct of interest namely relational novelty. The second aim of the chapter is to review previous marital and family therapy process research. The literature review will focus on the manner in which marital and family therapy process has been studied and the results garnered from these studies. Both quantitative and qualitative types of investigations will be reviewed.

Experiential Systemic Therapy

This section will offer a discussion of ExST history, theory and efficacy with a view to outlining the development of the therapy and the articulation of the theory including an overview of ExST and an in-depth description of relational novelty. Finally, a recent outcome study testing the efficacy of ExST (Grigg, 1994) will be reviewed to provide a context for this process research effort.

History of Experiential Systemic Therapy

ExST was co-developed by John Friesen, Darryl Grigg, Paul Peel and Jennifer Newman in 1989 at the University of British Columbia. While ExST, in many ways, represents the accumulated experience and knowledge of all these individuals, it was in 1986 that ExST began to form in earnest.

Extensive training sessions conducted by the ExST originators in the area of marital and family therapy for substance abuse with alcohol and drug
counsellors led to the eventual inception of ExST. The training events and discussions with alcohol and drug clinicians across British Columbia, plus the need to clearly explain concepts when imparting them, provided fertile ground for the subsequent articulation of ExST.

ExST developers sought to delineate an integrative theoretical framework capable of embracing a variety of therapy technique and a wide spectrum of human experience in the behavioural, the emotive and the cognitive domains. In addition, ExST was designed to integrate individual practice with a family systems theoretical orientation. The articulation of ExST prompted a large scale research endeavour named The Alcohol Recovery Project (TARP) of which this research is a part.

The general mission of TARP was to test the efficacy of ExST and conduct process research with respect to therapy-theory-in-practice. Also, TARP provided an umbrella for a variety of outcome, descriptive and process studies related to ExST and alcohol dependency in general. Conducted over a period of five years, TARP has received funding from the British Columbia Alcohol and Drug Program (now part of the provincial Ministry of Health and formerly in the Ministry of Labour and Consumer Services) and from the British Columbia Health Research Foundation (Health Services Research Programme). Other assistance has been extended to TARP by the University of British Columbia and the Social Sciences and Humanities Research Council of Canada (SSHRC). These funds and other forms of assistance have enabled the completion of this study, as well as others resulting from TARP activities. SSHRC funding, awarded to the author, was important to the completion of this study. TARP has been conducted under the general direction of the Principal Investigator, John D. Friesen, Ph.D., co-investigator Robert F. Conry, Ph.D., and project coordinator, Darryl N. Grigg, Ed.D. Additional information
regarding TARP may be obtained from Professor John D. Friesen, Department of Counseling Psychology, University of British Columbia.

Currently, ExST is practiced throughout British Columbia in a variety of public agencies as well as private enterprises and research on ExST process and efficacy is ongoing at the University of British Columbia. Also, ExST theory and technique has been adapted to group counseling efforts with single parents at risk for child maltreatment (Newman & Lovell, 1993) and applied to therapy with adolescent substance abusers (Selekman, 1993). The following section will outline ExST theory with reference to composite case examples altered to protect client confidentiality.

**Overview of Experiential Systemic Therapy Theory**

This section will provide an overview of ExST and an elaboration of relational novelty, the change construct under investigation.

Experiential Systemic Therapy (ExST) originated with John Friesen, Darryl Grigg, Paul Peel and Jennifer Newman in 1989. The model was designed in response to a lack of integrated individual, couple and family therapy models of treatment for alcoholism (Friesen, Grigg, Peel & Newman, 1989; Friesen, Grigg & Newman, 1991). The current study represents an empirical effort to continue the ongoing process of theoretical refinement.

ExST is an interpersonal process, the success of which is dependent upon the client’s experience. The observable manifestation of the therapeutic system arises out of the dynamic interaction of its two constituent parts, the therapist and client subsystems. Therapists and clients influence one another through discourse and the ongoing therapeutic relationship is an interactive process.
In some therapeutic models, clients are viewed as resistant or appear unresponsive to the therapist's interventions (e.g., Madanes, 1981). Consequently, such techniques as paradox are used by therapists to out-wit clients. In other approaches, clients are seen as opponents with whom the therapist must struggle against and vanquish through a series of "battles" (Whitaker & Keith, 1981). Such notions can become self-fulfilling therapist prophecies and are incompatible with the Experiential Systemic Therapy theory.

Efforts are made to avoid militaristic language that references combative ways of construing clients and the process of change. Therapy is best seen as something created with clients as opposed to something imposed upon them. Consequently, there is no need to conceive of the therapist/client relationship using metaphors of armed struggle and combat. Therapy is seen as a cooperative venture shared by therapist and client.

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**Figure 1. Therapeutic System and Component Subsystems**
The unified view of the therapeutic system presented schematically in Figure 1, illustrates the interdependent collaborative relationship between the therapist and client subsystems. It is recognized that both therapist and client subsystems are frequently comprised of a complex of constituents and the terms therapist and client will be employed throughout the remainder of this section to denote the subsystems.

The experiences clients bring to therapy are indicative of their struggles with others, themselves and the presenting problem. These experiences are fraught with frustration, tension and stagnation. The therapeutic story initially includes the client's struggles as a starting point while simultaneously incorporating potential for change.

ExST theory assumes therapy has an elevated status in the normal bustle of the client's daily life. It is a weekly or bimonthly ritual that has as its explicit goal, the transformation of the clients' experience and stories. The story of therapy is a story of transformation and as such it is imbued with the kind of respect reserved for the sacred in our culture. It is a special social occasion wherein all acts, thoughts, feelings and physical sensations have symbolic significance. Within this context, anything can happen, the most mundane can become the miraculous and that which was pained can become a joy.

**The Role of Symptoms**

Symptoms are considered indicators of relational difficulty and as such are meaningful signs of distress. Rigid, restrictive and repetitive patterns of interaction characterize the symptom-bearer's relationship to the symptom, self and family members. Similarly, family members may experience a particular relationship with the symptom and the symptom-bearer. Painful intrapsychic, interpersonal and social contexts can give rise to symptomatic behaviour. An
appreciation of the myriad of contexts from which symptomatic behaviour may arise fosters a comprehensive view of symptomatology that includes an acknowledgement of the possible physiological, psychological and social factors that can determine symptom development and maintenance (Donovan, 1988). For example, a comprehensive perspective regarding symptom development and maintenance is helpful when clinicians are required to treat alcoholism. Alcoholism can be understood as a multi-dimensional and systemic manifestation of a physical addiction process interacting with psychological and social factors. Intervention at all three levels is required to interrupt the development and course of the syndrome (Kissin & Hanson, 1982).

This multi-dimensional and systemic view of symptom development and maintenance also offers clinicians a way of understanding the complexity of symptomatic distress (Schwartz, 1982). For example, while the presenting problem may be expressed as depression, secondary relational disturbances such as unemployment or excessive fatigue may be related to the chronicity of the symptom. In addition, previous problematic relations such as childhood sexual abuse may pre-date the emergence of the symptom and be revealed during the course of therapy. Thus, the therapeutic task includes an adequate assessment of the symptom and related factors to help in understanding the problem and its meaning in clients' lives.

To aid in both the assessment and amelioration of symptomatic behaviour, ExST therapists remain curious about the symptom viewing it to be akin to a teacher or messenger. Symptoms are considered teachers or messengers providing either learning opportunities for clients or giving clients messages regarding relationships in need of attention. Clients' relationships to self or others may be in need of care and the symptom or "bearer-of-bad-news" is to be heeded and relieved of its sad duties. The means by which therapists
and clients grapple with symptom relief is found in the symbolic, experiential
and systemic dimensions of ExST. These three dimensions are described in the
following section.

**Dimensions of the Model**

The therapeutic story has a beginning, a middle and an end and like all
stories it is an expression of the authors' talents, needs and limitations.
Experiential systemic stories are centered on three domains including the
symbolic, experiential and systemic dimensions.

**Symbolic dimension.**

The symbolic dimension refers to the notion that therapy is a symbolic
and culturally sanctioned change ritual. Acts in therapy are symbolic and
considered an analogue to the story the clients enact in other life situations. In
addition, actual symbolic objects are employed in therapy to represent parts of
self, interpersonal relationships and presenting problems. Where single words
may be insufficient, symbols provide a meaningful way to describe the totality
of client experience.

**Experiential dimension.**

The experiential nature of the model is also important in facilitating
change. Experiencing in therapy deepens and expands clients alternatives. An
experience is helpful if it increases the clients awareness of their thoughts,
feelings, perceptions and behaviours. New awareness and changed
relationships are achieved through intensified experiencing. Experiencing
represents an integration of behaviour, cognition, affect and perception such
that these constructs are synthesized into a whole.
Action oriented techniques are utilized to achieve the broadening of experience. These may include psychodrama, sculpting, enactment, empty chair work, and two chair techniques. These techniques offer clients an opportunity to experience different ways of being together rather than engaging in a didactic or content oriented discussions about what "should" be done. The rigid manner in which the clients behave begins to erode when they experience a visceral sense of the alternatives open to them. Experiential techniques are not applied for their own sake. They are used to deepen clients experience of the patterns they have encountered with their spouses or children. For this reason, the experience provided must fit the therapist and clients' perceptions of the difficulty at hand.

The characteristics of therapeutic experiencing entail both the enhancement of emotions and cognitions as well as the bringing into prominence the interactive essence of experience. In other words, clients obtain understanding at both an intrapsychic and systemic level. They come to "know" the patterns and relationships they live at a deeper level. These patterns and interactive postures may incorporate purser/distancer, attack/attack, withdraw/attack, withdraw/withdraw and dominate/subjugate dynamics.

Another characteristic important to therapeutic experiencing encompasses the notion of relational novelty. That is, clients obtain a physical, affective, cognitive and behavioural sense of a new "way of being" in the world. Relational novelty is the experiencing of new alternatives that grow out of the special status of the therapeutic context and the experiential nature of the therapy itself. New patterns of interaction are not just felt, talked about, thought or designed, they are born in a moment when all the elements of experiencing converge to form a new coherent whole. Once this has occurred,
clients quite literally, can never be the same again. They see the world anew and they no longer maintain the same rigid patterns of behaviour to which they had previously become accustomed.

These shifts occur through the use of pictorial language, metaphor, intensifying experience through repetition, identifying underlying emotions and the use of symbols. These activities are most meaningful when the clients' metaphoric language is understood and spoken by the therapist and when the therapist and client(s) have entered into a collaborative relationship.

**Systemic dimension.**

The ExST model is based upon a systemic perspective that views relational patterns as malleable and subject to the experiential shifts of the observer. ExST emphasizes the plastic, evolutionary nature of systems rather than a static, self regulatory concept of homeostatic functioning. Systems include a wide of variety of relationships including interactions between parts of self, ideas, problems, people, cultures and nations. These relationships exist in the social domain and are interdependent such that any movement in any given system influences other systems.

The therapist is considered an integral part of the therapeutic system. He or she attends to patterns encountered and enacted by the clients as they interact with the therapist, each other, themselves and their problems. Therapists are socially sanctioned "change agents" who bring the totality of their experiences to the therapy setting. These experiences include professional training and affiliations, personal values and influential life events.

It is within this dimensional framework that the therapeutic story unfolds. Many stories are concerned with creating a consistent style, maintaining a specific length, developing characters and roles, focussing on main dramatic
themes and delineating the role history plays in the present lives of the characters. The following discussion depicts the nature of the therapy story.

Outline of Principles

Experiential Systemic Therapy is problem and pattern focussed in that the clients' presenting problems are noted and relief of these problems is actively sought. Problematic patterns are tracked and various transactions occur between the therapist and clients which address the relational stagnation intrinsic to client complaints. ExST is a brief therapy in that the story ranges from four to 20 sessions in length. It is goal directed and an agreement regarding the focus of therapy is made at the outset.

Developmental perspective.

ExST maintains a developmental perspective which frames the client's difficulties in relation to various human experiences in the life cycle. These experiences can include: a birth of a child, a death of a child, a child leaving home, a parent dying, a marriage or engagement, a divorce or separation, career transitions, housing problems, difficulties with adolescents and caring for aging parents to name a few. The understanding of the developmental nature of life cycle experiences is important for two reasons. Firstly, our society is ever changing and currently blended families, single parent families and extended families are common. As a result, ExST does not assume a "typical" course for family or couple events. The idea of stages of development is limited by the shifting nature of our increasingly cross-cultural and feminized society. As a result, ExST theory considers human dilemmas in light of their universal qualities such as loss, transition and reunion. Secondly, a focus on the evolutionary nature of life events is important in that this frame provides validation for clients who are attempting to make changes in their living
arrangements. Rather than applying an outmoded yardstick to client experience, ExST strives to normalize struggles as valid, understandable and rational given the circumstances.

Therapy is also viewed as a developmental process in which change is construed as an ongoing occurrence. Client regressions to previous problematic states and patterns are understood to be opportunities rather than failures. Clients will revisit outmoded ways of being in order to learn more about themselves, consolidate change and face the loss of familiar states.

Present tense therapeutic focus.

ExST adopts an active here-and-now focus. The story is action packed and told in the present tense. This is not to say that the model ignores the potency of the past. Rather, it recognizes the influence of past events and figures and actively offers these historical legacies a voice as they manifest in present interactive patterns. For example, constraints and problems in the present may indicate that a client's deceased but once sexually abusive father still maintains a stranglehold on his adult daughter's life. If this is the case, the "ghost" of the father is a current reality for the client and her spouse. The haunting figure is not left in the attic but is brought into therapy and attended to by the clients and the therapist as a present tense phenomenon.

Ecological assessment.

In order to engage clients it is essential that the therapist develop an ecological assessment of their difficulties. The story that unfolds is representative of the characters' lives and this entails the observance of all levels of the system in which the characters are involved. This assessment includes gaining an understanding of the individual, couple, family and community contexts (including work, school, medical services and the police)
as well as the societal, political and cultural systems within which the subsystem members operate.

**Collaborative therapist stance.**

A collaborative therapeutic system is essential to the ExST model since it is within this relationship that the opportunity for client change and the ultimate re-writing of the clients' tale is made possible. Relational novelty occurs within this collaborative setting. The therapist is considered to be a collaborator or co-author with the clients rather than an expert doling out therapeutic advice. This role is flexible and can accommodate many different modes depending upon what is triggered spontaneously in the therapist. The therapist may take on the aspect of a dramatic coach, a dance and movement choreographer, an orchestral conductor, a sculptor or the village idiot given what is "pulled" from her or him during therapy.

**Therapist spontaneity.**

The therapist obtains permission through the therapeutic mandate to be spontaneous with clients as a direct result of maintaining a collaborative stance from the outset. A key element in ExST is the therapist's ability to be spontaneous. Therapist creativity is essential to the model and the fear of making mistakes with clients is a natural concern for any responsible therapist. However, once rapport has been established, the relationship between the clients and therapist can withstand the jostling that sometimes occurs on the way to health. As partners in collaboration, the therapist and the clients can discuss the developing therapeutic subsystem and are encouraged to do so on an ongoing basis throughout the course of therapy. It is at these times that any misunderstandings or differences in viewpoints can be addressed on the part of all therapeutic system members.
Phases of Therapy

A story of literary worth incorporates a certain structure which "moves the action along" at a steady pace so that the reader's attention is sustained. A story begins with an introduction wherein the setting and main characters are introduced and the principle problem or human theme is outlined. After the introduction has been made, the stage is set for the dramatic action which culminates in the story's climax. The climax is reached and is quickly followed by the denouement and story resolution. These narrative elements are reflected in the therapeutic change story by way of the four phases of therapy which may span, for example, 15 chapters or sessions.

The four phases of the therapeutic story include: a) Forming the therapeutic system: Establishing a context for change (introduction); b) Perturbing patterns and sequences and expanding alternatives; c) Integrating experiences of change: Reorientation (action and climax) and finally; d) Disbanding the therapeutic system: Termination and acknowledging accomplishments (denouement and resolution). These phases take place within the sessions or chapters of the tale and are presented in Figure 2.

Figure 2. An overview of the therapeutic system process
Figure 2 depicts the time before therapy begins, the formation of the therapeutic system, the perturbation of the system, the integration of changes and finally the eventual conclusion of therapy followed by post-therapy separation. It portrays the therapeutic system developing over time and illustrates the four phases of therapy as they might occur over the course of 15 sessions. The phases overlap and different elements of each phase may be present in any given session. At the outset of therapy, clients are invited to express their desires regarding the outcome of therapy. This task offers the therapist and the clients a goal around which therapy is organized. While each session has an integrity all its own, the story achieves continuity through the goals agreed upon in the first phase of therapy. In addition, each session ends with an invitation to clients to complete such tasks as experiments with novel behaviour, the completion of a journey or the discovery of a symbol, as a means to the desired goal. The next session begins with a review of the invitation made in the previous one. The story maintains its focus, coherence and continuity in this manner. The therapeutic activities engaged by the therapist and clients during the four phases of therapy have been divided into broad categories or transactional classes. These transactional classes are described below.

**Transactional Class Taxonomy**

There are seven transactional classes used to describe the activities of the therapeutic system. The term transaction is used instead of interaction since it denotes the complexity of the process of accommodation and influence engaged in by members of the therapeutic system. Each class is designed to reflect the mutually interdependent relationships that form what is called the therapeutic system.
**Therapist-Client relationship enabling.**

The focus of this class is on the creation and maintenance of the therapeutic alliance. This occurs throughout the duration of therapy and ensures that clients feel understood and safe with the therapist. The intention behind these transactions is to form a working alliance wherein there is a trust and commitment to the therapeutic process on the part of both the therapist and the client. These transactions can include empathy, self disclosure and immediacy to name a few.

**Process facilitation transactional class.**

The relational patterns observed by the therapist and clients are the focus of this transactional class. Clients are encouraged to become directly involved with one another during the session. The therapist is interested in the recursive nature of client patterns as well as the cognitions, emotions and physiological states that underlie these interactions. The clients cooperate with the therapist in experiencing new patterns of behaviour. They engage in spontaneous dialogues while the therapist utilizes their immediacy to shift otherwise static patterns of interaction. The techniques classified under this class include: blocking, coaching, marking boundaries, framing and encouraging the expression of underlying feelings.

**Expressive transactional class.**

What has previously been private is made public through the process of exploration, naming and owning of experience through verbal and nonverbal means of expression. These are creative transactions that obtain their power through their metaphorical properties and the resources brought to bear on the moment by all members of the therapeutic system. These transactions can include art activities, dance, storytelling, baking and metaphor.
Symbolic externalizing transactional class.

A symbolic representation of some aspect of the clients' world is made and brought to life in therapy. An alcoholic's relationship to the bottle is externalized so that the clients may relate to it from a distance. In this activity a beer bottle is put on a chair and the alcoholic and his spouse are invited to address the bottle. In short, any dilemma, idea, feeling, person or thing can be externalized and brought into therapy. These transactions include empty chair work and two chair work.

Meaning shifting transactional class.

Clients make sense of their worlds in ways that leave little room for flexibility. The therapist can help clients expand their alternatives by aiding them in developing an experience of the problem that implies a solution or that enhances the clients' ability to be compassionate towards one another and themselves. Meaning shifts are important to therapy since they sometimes mark moments of irreversible progress. These transactions include: reframing, normalizing, circular questioning and positive connotation.

Invitational transactional class.

These transactions typically occur at the end of the session. They are invitations to engage in some form of between session homework and allow for continuity between meetings. They provide feedback as to how well clients are maintaining their changes and developing alternatives. Therapeutic tasks may perturb new behaviours and therein promote client self confidence. These transactions include: homework, quests, rituals, journal writing and self monitoring.
Ceremonial transactional class.

These transactions focus on formal acknowledgements of progress and change in clients. These are memorable occasions and are enacted with all due reverence. Ceremonies can demarcate endings from new beginnings, shifts in status and changes in role. They are highly ritualized and jointly planned. These transactions include: closing celebrations, burials, penance, confessions and burnings.

The following example of one client’s story of change describes the phases of therapy and the employment of various transactional classes. The details of "Sue’s" therapy have been changed to protect her anonymity. Sue (a fictitious name), 30 years old and mother to an infant, came to therapy having just ended her marriage of five years. She realized through the painful process of separation that she now wanted to use the opportunity to review some of the events of her past and face that which she had buried along the way. Sue's journey will be used to illustrate each phase of therapy. The transactions employed in therapy will be delineated during the case example. The therapeutic activity employed and the category to which it belongs will be bracketed in the text.

Phase 1 - Forming the therapeutic system: Establishing a context for change.

One of the major tasks of this phase of therapy entails setting the stage for the action to occur. This necessitates the establishment of a bond between client and therapist, an assessment of the nature of the troublesome human dilemma brought to therapy and the development of a commitment to the goals agreed upon by all members of the therapeutic system. This implies the creation of a therapeutic mandate. The mandate is jointly accepted by
therapist and client and is connected to client goals. The therapist requests clients to identify symbols that represent their therapeutic goals. These symbols (which are brought into therapy) may represent a wide range of possibilities including cutouts from magazines, photographs, plant matter, visions, television personalities or families or prized possessions. The therapy story obtains its direction and navigates the troubled client waters through these symbols of desired outcome.

The bond formed between the co-authors of the therapy tale is facilitated through the collaborative stance adopted by the therapist. He or she also employs a host of relationship enabling techniques in order to facilitate the therapeutic relationship. These techniques include empathy, listening and attending.

An ecological assessment is conducted during this phase in order to understand the clients' backgrounds and present roles more fully. The first chapters of the therapeutic story center on the promotion of understanding, respect and trust between the therapist and clients in order to ready the scene for change.

For example, during the first session, the therapist listened closely to Sue as she told of seeing her sorrow contained in "jars of sadness". These jars of sadness were shut in a room (Metaphor: Expressive Transactional Class). Sue was afraid to trust others including the therapist. The therapist commended her for her bravery which propelled her into therapy (Positive Connotation and Validation: Meaning Shift Transactional Class) and added that she would not ask her to go anywhere she was not ready to go.

As part of the ecological assessment, the therapist discovered that Sue had a previously difficult experience in therapy. Sue believed that her previous therapist had not been honest with her. The present therapist said that
honesty was very important to her as well (Self disclosure: Relationship Enabling Transactional Class) and that if Sue ever has any concerns the therapist would like to hear them. The therapist also promised to bring her concerns forward if need be (Immediacy: Relationship Enabling Transactional Class).

Sue is a single mother working in an drafting office and the demands to perform and be "one of the guys" sometimes left her feeling alienated from her office mates. She valued therapy as a place where she could "be herself". Sue is an Anglo-Saxon Canadian and she said that the cultural differences between herself and her husband (who was from Asia) caused a strain on their marriage.

Sue was abandoned as an infant and lived with her father and a series of stepmothers who were more or less accepting of her over the years. The themes of Sue's story were ones of abandonment, alienation and loss. She was afraid to trust others and her career choice offered her healthy remuneration but very little emotional support. However, she valued her ability to survive and the strength of her independence.

Sue was happy to work with the therapist and the therapist echoed this desire. The therapist requested that Sue gather together jars and place the different forms of sadness she experienced into each jar and bring them to therapy the following week (Homework: Invitational Transactional Class). The therapist also asked Sue to reflect upon what she envisioned as the ideal outcome of therapy. Her answer was immediate. She saw an empty room that needed redecorating. The room contained no jars of sadness but was a place of refuge that was in dire need of interior design.
Phase 2 - Perturbing patterns and sequences and expanding alternatives.

During this phase of therapy, the therapist strives to perturb relational novelty and therein directly affect clients' static sequences of behaviour and expand alternatives. The techniques used by the therapist must reflect the collaborative nature of the therapeutic endeavour. The therapist remains flexible and sensitive to the clients' needs at this tender time. The symbolic, experiential, and systemic nature of the model is also evidenced during this phase through the utilization of change skills encompassed in the transactional classes. The therapist's spontaneity is important during this phase and throughout the whole therapeutic process since he or she is required to engage in various forms of psychodrama, symbolic externalization, process facilitation and other metaphorical and intuitive activities. The purpose of this creativity is to trigger shifts in the clients' experience of a rigid and stereotypic world.

The following example illustrates two sessions that occurred during phase two of therapy. In one session, Sue's jars of sadness (Symbolic externalization: Externalization Transactional Classes) were sitting on a chair. After being requested to place the jars in relation to how close or distant she felt from them, Sue put them within arms reach and sat beside them. When the therapist asked her to imagine opening one of the jars (Fantasy: Externalizing Transactional Class), she said, "I'm afraid when I think about doing that. I can go into the room where the jars are but opening them is another matter altogether."

"For so long you have stored these jars and opening them and looking in is a terrifying thought right now. It may be today, may be next week, next month or next year but some day you'll be ready to look" replied the therapist (Empathy: Relationship Enabling Transactional Class).
This led to an exploration of Sue's fear of crying and her belief that she did not get anything accomplished that way. The therapist asked her where her tears lived and Sue pointed to "a third lung in the middle of her chest" (Enactment: Process Facilitation Transactional Class). The therapist remarked that Sue may be afraid she might drown with so many tears in the lung. (Framing: Process Facilitation). Sue nodded adding, "I guess the only way to save myself is to shed the tears. I never thought of it that way."

A session later, Sue was ready to go to the jar she most wanted to explore. The jar contained her father's death. She pulled a symbol of him from the jar and stared at it (Externalization: Externalizing Transactional Class) and commented that what made her most sad was the fact that her father never got to see or play with his granddaughter. Tears trickled down her cheeks at this thought. She let out a tremendous sigh and smiled through her tears at the therapist. The therapist remarked how much courage Sue had to be able to look into this jar and that she was crying healing tears. Sue nodded and another tear fell onto her hand.

The therapist remarked that it was almost as if her father was here now. Sue agreed and the therapist invited Sue to bring her father, in the spirit, into the room. The therapist asked Sue to place the symbol of her father in the therapy room in relation to how close she felt to her father (Externalization: Externalizing Transactional Class). She brought it close to her heart.

Sue had told the therapist that she did not like to try to talk while she was crying because the "tears get in the way". Rather than inviting Sue to talk directly to the symbol of her father (Externalization: Externalizing Transactional Class), the therapist suggested that she close her eyes and imagine him in her mind's eye (Guided Fantasy: Expressive Transactional Class). The fantasy was about a playtime between Sue, her daughter and her father. The therapist
guided Sue through the fantasy and she silently and freely cried as she watched her daughter and father play together.

Sue remarked that this was a precious fantasy for her since she could now visit her father whenever she wished and that she actually witnessed her daughter and her Grandad playing together. She got to say "Goodbye" to her Dad and she felt better than she ever had since his death many years ago. "I guess I never really gave myself a chance to grieve and now I've mourned a bit and feel better," said Sue.

The next sessions in Sue's transformational journey included visiting her father in the therapy room and telling him how much she loved him and also how she felt abandoned by him. She also explored the jars of sadness that contained her aloneness, her marriage, her mentally abusive biological mother and her estranged husband. All these forms of sadness were externalized and discussions were held between Sue, her ex-husband and the mother who abandoned her.

**Phase 3 - Integrating experiences of change.**

The rigidity with which clients once viewed their worlds gives way to relational flexibility. Where once there was hopelessness, anger and hurt there now exists compassion, tolerance, acceptance and forgiveness. The therapist aids clients in generating novel experiences that validate their changes and simultaneously helps them to release, albeit sadly, old patterns of relating. Grieving lost ways of being is also important during this phase of the change story. This can be achieved through the creation of rituals or transformational markers designed to ensure that the changes made can be absorbed into the clients' lives. Once again, the techniques used in this phase are found in the transactional classes and are triggered in response to the client's needs.
The action of the story and the beginning of the end are written in the sessions or chapters that correspond to the two phases previously described. A climax has been reached. This may be embodied in a pivotal moment or it may be the result of an imperceptible twist in the usual course of events. The client and therapist have been party to a transformational journey which is both humbling and invigorating.

During Phase Three, Sue was light and happy. She saw herself as a cookie and felt rich, sweet and complete. All the ingredients were present and nothing was missing (Metaphor: Expressive Transactional Class). She was feeling closer to her friends and less tense at work. The jars of sadness seemed like sad memories or facts rather than raw wounds. Sue was no longer overwhelmed by her sorrow and she began to deal with sad things in her daily life without the added weight of her past sorrows. She felt sad to leave the jars and wanted to refurnish the empty room soon. Sue was reluctant to leave therapy since she wanted to "make sure this is really happening." She could barely believe that what had hurt for so long was no longer as painful. She wanted to ensure that her changes would be lasting. The therapist asked Sue how she would know if she could trust her changes? Sue answered that she had to test them by scanning the jars again and allowing herself to feel any of the feelings this elicited. Sue began the process of sorting the sadness into envelopes that were entitled "sad memories". Those items that seemed to be bittersweet memories or thoughts were filed while those forms of sadness that were still painful were retained. Over the course of this sorting, Sue filed all her past sadness except for the ongoing divorce proceedings.

As these sessions unfolded, the therapist spoke more frequently of the end of the therapy and Sue agreed that this appeared imminent. With that,
both the therapist and the client recognized that the time was right to begin the resolution of the story.

**Phase 4 - Disbanding the therapeutic system: Termination and acknowledging accomplishments in therapy.**

The clients and the therapist begin to experience their meetings as unnecessary during the last few sessions. The purpose of this phase of therapy is to dissolve the therapeutic system in order to bolster client independence. The clients review their journey together sharing pivotal moments and congratulating each other on their changes. A final closing ritual is performed, an evaluation of the process is undergone and therapy is concluded. This ceremony marks the end of therapy and the beginning of life without it. The door is always open and another therapeutic story may be told, but for now the therapy has ended and another journey begun.

For example, Sue and her therapist designed a closing ritual (Ceremonial Transactional Class). Sue baked cookies (Baking: Expressive Transactional Class) symbolizing her completion and wrote down a list of the changes she made as well as her plans for refurnishing the room that the jars once dominated. The therapist brought a "Goodbye" card for Sue, gingerale for a toast and balloons for the therapy room.

A summary and review of therapy was conducted and Sue told the therapist of her most memorable therapeutic moments. The last session was touching for both the therapist and the client. Sue left knowing that this therapeutic story had ended and that she could rely on her new found peace. The therapist felt privileged having partaken in Sue's transformational journey. She marvelled at the happiness Sue's story engendered in her as she closed the file.
In conclusion, this overview has endeavoured to describe the dimensions of the Experiential Systemic Therapy theory, the principles of its conduct, the phases of therapy and finally a brief description of the transactions undertaken by the members of the therapeutic system. In addition, the therapeutic journey has been illustrated through the use of a case example. The model is an integrative one which seeks to bridge individual and systemic paradigms as well as encourage therapist spontaneity over theoretical and practice dogma.

The following section provides a detailed description of the concepts important to the ExST theory of change. These concepts were touched upon in the previous overview but are elaborated in the following section.

**Relational Novelty as a Means to Individual and Couple Change**

The concepts integral to the ExST theory of change center on the utility of a relational paradigm to understand human experience and the importance of substantive relational themes and the intensification process in the creation of relational novelty (Newman, 1991). The following section will expand upon these notions.

The therapeutic journey is a story of courage and transformation and this tale has been retold since millennium through human myth and literature. Myth represents a culture's conceptualization of a Larger Truth and exists in relation to that society's psyche, structure and mores (Lerner, 1986). The consistent theme found in Myths of Transformation can be best expressed metaphorically as Campbell (1988) wrote:

> At the bottom of the abyss comes the voice of salvation. The black moment is the moment when the real message of transformation is going to come. At the darkest moment comes the light. (p. 37)
The content of transformational stories stems from the diversity of situations in which couples and individuals find themselves. The content of the story is important and embedded in the culture and/or subculture to which clients belong. A couple's visit to the campus marriage counsellor is different from a Native Canadian's visit to a trusted Elder. However, while the narratives may be dissimilar these heroic journeys contain the common theme of transformation. This transformation can occur in the individual, the couple, the family and perhaps, in larger fields of socially constructed experience (Hoffman, 1990).

The tale of the means to Experiential Systemic change exists within a current Western conceptualization of healing; notably an intimate relationship between clients and trained professional therapists. The means by which the intrapsychic and relational abyss is explored, the nature of the abyss, and the products of the darkest moment and the return to light will be discussed within the Experiential Systemic Therapy theory from intrapersonal, interpersonal and environmental viewpoints. In effect, this work represents an effort to combine individual and systems thinking in order to explain the means by which relational beings change.

The Importance of a Relational Paradigm

Sullivan (1953) maintained that interpersonal relationships represent a powerful human need and human life is characterized by continuous patterns of interpersonal interactions which occur over a life time. The infant's relationship with a valued attachment figure is important to the formation of his or her mental models of self and others. These cognitive frames or representational models influence later adult intrapsychic and interpersonal functioning. Representational models of self and attachment figures integrated in the mind
during childhood, reflect the treatment children receive at the hands of their parents and the observations they make of the relationship between their caregivers (Bowlby, 1988). The experiences children have with their caregivers in the past and the present, form the basis of the representational models they use in adulthood. Adults who have matured in unfortunate circumstances, tend to have little faith that the person to whom they have attached is either available to them or trustworthy. Bowlby (1973) wrote:

Thus, an unwanted child is likely not only to feel unwanted by his (sic) parents but to believe that he (sic) is essentially unwantedable, namely unwanted by anyone. Conversely, a much-loved child may grow up to be not only confident of his (sic) parent’s affection but confident that everyone else will find him (sic) lovable too. (pp. 204-205)

The stability of these relational patterns is not just a product of the child’s innate temperament. As children grow older they absorb daily interactions with their parents as part of their ontological realities or ways of being and these facilitate the generation of similar relational patterns between the children, their friends and other adults (Stroufe, 1985). In Bowlby’s (1988) work with clients it is apparent that he favours the shifting of working models of self through cognitive means. This is an outgrowth of his notion that working or representational models are internal blueprints of the world "out there". However, the child’s experiences are of the child’s ontology and for this reason cognitive, emotional, behavioural and physiological aspects of human functioning are intertwined to offer us a view of the child’s patterned experience. In other words, there is a lack of separation between the child’s experience of the world and the world in which he or she lives. How the child relates in the world is how the world is to that child until new experiences alter this relationship. Thus, while the individual’s being in the world may have
thematic undercurrents of unlovableness, these themes are not prescriptive maps of the world. These themes are the observer’s description of themes underlying an individual’s being in the world based upon all four aspects of ongoing experience namely cognition, emotion, behaviour and physiology. Childhood and later-life experiences combine to influence the development of emotional, cognitive, behavioural and physiological relational patterns that have as an undercurrent themes such as lovableness, security or unlovableness and abandonment.

ExST focuses on perturbing patterns of relationship between parts of self, self and important others and self and the larger socio-cultural context. Perturbing these intrapsychic, interpersonal and socio-cultural patterns entails the generation of new experiences in each of these domains such that novelty and change occur at the cognitive, emotional, behavioural and physiological levels of functioning. Human patterns of interaction are subject to the influence of life events (e.g., births and deaths, cultural events, societal forces, transitions and good fortune) and as such they are amenable to modification and change in therapy. Since relationally novel intrapsychic, interpersonal and environmental experiences can elicit change in these three systems, it is important to note that early and ongoing traumas do not guarantee unrelenting systemic distress in the future (e.g., West & Prinz, 1987).

Ecosystemic Thought and the Process of Relationship Formation

The experiences that result from the interactive process between the child and his or her caregivers are influential in the child’s way of being in the world. Childhood experiences of self and others play an important role in the construction of relationships in adulthood. These relationships include internal relations between aspects of self, relations with others and the environment
(e.g., workplace, culture, community). The processes whereby we are both
being and becoming are manifest intrapsychically and interpersonally and as
such the work of individual, couple and family theorists (Bateson, 1972;
Bogdan, 1984; Carson, 1982; Kiesler, 1982) combine to explain both one's
relationship to different aspects of self and one's relationship to others and the
larger context.

Maturana (1978) maintained that the conduct of two or more interactive
systems, over time, establishes the individuals in some form of being-in-the-
world as well as creating an interlocking mutuality termed the "consensual
domain". He uses the concept of "structural coupling" to describe how two or
more subsystems "negotiate" their existence. Maturana (1978) notes that
"changes of state of one system become the perturbations for the other
[system] and vice versa in a manner that establishes an interlocked, mutually
selecting, mutually triggering domain of state trajectories" (p. 36). Maturana
(1978) is referring to interpersonal relationships in his work. However, these
notions may be applied to intrapersonal functioning as well as interpersonal
relations. If one substitutes the words "aspect of self" for "system" in the
quote above, it becomes theoretically possible that the process of structural
coupling could occur at both the interpersonal and the intrapsychic levels. The
myriad of internalized aspects of self garnered from and evident during
interpersonal interactions relate within the individual through the process of
structural coupling.

As human beings we are inseparable from our environment. We rely on
the earth and the air we breath to sustain us. According to Sullivan (1944) we
experience a similar need for protection and affiliation. He likens our cultural
environments to oxygen and food and maintains that our society is necessary
to us as are food, air and water. If Sullivan (1944) and Maturana (1978) are
correct then it may be conceivable that the same patterns of relationship that characterize our interpersonal and cultural existences may also characterize our intrapsychic existence.

The similarity between intrapsychic and interpersonal functioning has important ramifications for the systemic treatment of both individuals and couples in therapy. In the case of the systemic treatment of individuals, we can broaden our notions of what constitutes a system to include not only who and what exists in the clients' outer worlds (e.g., presenting problems, Racist Attitudes, Homophobia, Bottles of Beer, Cancerous Cheese, family members, spouses, workmates, neighbours, etc.) but "who" and "what" exists in their inner worlds (e.g., different aspects of self including unloved aspects, pained aspects, hopeful aspects, presenting problems, fear of gays, jars of sadness, little boys and little girls and nests of terror protected by little birds). These inner and outer worlds are intimately connected and are often indiscernible from one another. It is for purposes of explanation that these somewhat artificial boundaries are made by clients, therapists and society. However, these distinctions can be exceptionally useful in therapy as representations of the whole. The use of metaphor and symbol in ExST (Bateson, 1979; Friesen et al., 1991) provides a kind of shorthand that encapsulates both the individual and couple's issues and offers a means by which changes in intrapsychic and interpersonal patterns may be perturbed. Thus, changes in one part of the intrapsychic, interpersonal and/or environmental system have an influence at each level and may serve to perturb new patterns of interaction or relational novelty in the system as a whole.
Recursive patterns of relating.

Past painful attachments (Black, 1979; Herman, 1981); present difficulties with intimacy (e.g., Carey, 1986); life transitions (e.g., Finkelstein, 1988) and the anticipation of continued alienation (Carson, 1982) combine to create years of patterned isolation from self and others. Consistently rigid and sequential patterns of relationship between aspects of self and others are observable phenomena (Breunlin & Schwartz, 1986) that occur within the therapeutic context. ExST therapists are interested in identifying the recursive relational patterns and substantive relational themes underlying their clients' problems.

ExST draws upon the notion of informational recursivity (Cottone & Greenwell, 1992) to describe interaction patterns in which individuals can be held accountable for their actions. Informational recursivity refers to a cause and effect chain such that behaviour of one spouse serves as information to influence the behaviour of the other in a temporal sequence. Taken in the context of violence being the responsibility of the perpetrator, informational recursivity allows for the description of abusive sequences of behaviour without blaming the battered woman or excusing the abusive man.

For example, Joe and Sue decided to obtain couple's therapy in order to improve their marriage. This case example is a composite of several cases of couple's therapy and identifying details of the "case" are omitted or changed to protect confidentiality. Joe completed an intensive residential treatment program for alcoholism one year ago. The couple hoped that Joe's sobriety would be the answer to their marital problems. Unfortunately, certain patterns of interaction which characterized the marriage while Joe drank continued to be problematic after he was sober. Previously, a cycle of binge drinking followed by verbal and physical abuse ended in a honeymoon period of guilty
attentiveness on the part of Joe. This phase was later followed by more binge drinking and abuse. The same pattern continued after Joe’s sobriety except that alcoholic drinking was no longer involved in the cycle.

Following a year of sobriety, the couple’s fights continued to be marked by Joe attacking Sue verbally and physically while she defended herself and retaliated by verbally abusing Joe and throwing things at him. Afterwards, Sue went to a Women’s Shelter or a friend’s house and Joe courted her with remorse and attentiveness until she returned home a few days later. After returning home, Sue remained distrustful of the "new and improved Joe" and kept him at arms length. The uneasy truce would end several months later when fighting escalated and Joe became abusive again. Although Joe obtained residential treatment and was able to maintain his sobriety through AA, the pattern of abuse remained and both partners were doubtful that their marriage could be salvaged. Sue saw marital therapy as a last resort before divorce.

This repetitive pattern of violence can be understood at three interconnected levels of the system: the environmental, the interpersonal and the intrapsychic levels. At the environmental level, the struggle between Joe and Sue has socio-cultural significance. That is, certain socio-cultural messages impinged upon both Joe and Sue promoting a rigid understanding of appropriate male/female behaviour. For example, societally based warnings to refrain from vulnerable self disclosure, keep control and "got it alone" may have affected Joe’s ability to maintain an intimate relationship (Miedzian, 1991). In addition, socio-cultural messages regarding Sue’s responsibility in the relationship for caregiving and loyalty may affect her ability to experience personal agency (Lawler, 1990). In this way, both spouses found their roles and ways of being together increasingly detrimental.
Interpersonally, both Joe and Sue noticed how incredibly angry they were with one another. They experienced little trust and anticipated the worst in the relationship. Sue experienced herself as constantly fearful around Joe and Joe experienced something akin to walking on eggshells around Sue. Neither spouse felt loved or supported by the other. They reported that these feelings of fear, anger, distrust and hurt exploded into physical and emotional abuse. Joe broke Sue's nose on one occasion and she told the emergency doctor that she fell down the stairs. On another occasion, while escaping, Sue pushed Joe down the stairs and threw a plate at him. Both spouses claimed that although the physical damage had healed, the emotional scars remained.

Intrapsychically, both Joe and Sue experienced self invalidation of unloved and pained aspects of self (Miedzian, 1991). Neither spouse experienced him or herself as lovable or deserving of love or care. Their experiences of one another and their families of origin maintained and sustained this relationship to these unloved and undeserving aspects of self.

Patterns of relating with self, others and the environment are interconnected. Cultural prescriptions for rigid gender roles combine to ensure that interpersonally abusive interactions are reflected intrapsychically as invalidated aspects of self. The invalidation of suffering aspects of self constitutes a form of intrapsychic violence and in this way abusive interactions are found at each level of the system in the form of cultural, interpersonal and intrapsychic violence.

**Substantive relational themes.**

Client stories of emotional, cognitive, physiological and behavioural patterns provide cues about the underlying substantive relational themes (Friesen et al., 1991). The notion of substantive relational themes is used to
describe the underlying essence of the clients' stories. Substantive relational themes are descriptive rather than prescriptive since they describe the child's and the adult's experience of being in the world. Clients' recursive patterns of emotion, cognition, and behaviour embody relational themes such as unlovableness, abandonment, unworthiness, undeservedness and rejection.

Substantive relational themes underlie the client's intrapsychic, interpersonal and environmental experiences in the world. The themes of unlovableness and abandonment, for example, may be similar to a stream running through the client's experience at each level of the system. Appendices A, B and C depict how the interconnected recursive patterns of relating, described earlier, manifest themselves at each level of the system. The three systems depicted in Appendices A, B and C have been divided for the purposes of detailed explanation. Appendix D depicts a composite view of the three recursive patterns and their underlying substantive relational themes. These patterns and their underlying relational themes are maintained via structural coupling (Maturana, 1978) and socially constructed experience (Gergen, 1985; Hoffman, 1990) such that once a pattern has been set in place it is sustained until a new experience perturbs it. These new experiences are termed relational novelty and they constitute change in therapy.

**Relational Novelty**

Relational novelty refers to the enactment of a new way of being in relationship which alters the thematic undercurrent represented in the substantive relational theme. It is within the intrapsychic, interpersonal and environmental domains that relational patterns are enacted and relational novelty occurs. This section provides a description of the intrapsychic,
interpersonal and environmental systems and how relational novelty is introduced into each of them through therapy.

**Presenting problems.**

Clients have a special relationship with the dilemmas they bring to therapy. One of the tasks of the Experiential Systemic therapist is to help clients bring this relationship into awareness through therapeutic experiencing. How the clients "are" with their dilemma is also reflected in how they "are" with themselves, each other and the world in which they live. For example, Sue and Joe entered therapy in order to end the physical and emotional violence that continued to occur despite Joe's sobriety. Relational novelty in therapy can occur most effectively in a safe context and this is of paramount importance when physical and/or verbal abuse is part of the couple's pattern of interaction. In the case of verbal and/or physical abuse, the safe context is created and maintained when the couple continue both individually and collectively to reiterate their explicit commitment to end the violence in their relationship. The establishment of this goal occurs at the outset of therapy and is explicitly agreed to by both spouses before therapy progresses. A frank, open atmosphere facilitates the discussion of this topic from the outset. In addition, a safety plan is created between the couple that may include leaving the house and walking before a fight escalates into violence, phoning the police, visiting a shelter, phoning a supportive friend or taking time-outs with relatives. This plan is developed collaboratively between the therapist and the clients. The therapist must remain sensitive and ready to bring concerns regarding client safety before, during and after sessions to the fore. ExST makes the explicit assumption that physical and verbal violence is under the control of the perpetrator and is therefore a matter of choice. Because violence
is controllable and a matter of choice it can end and be replaced by constructive ways of being.

Violence and the threat of violence divided the couple from one another and made intimacy impossible. The therapist explored the violence by asking each for a description of the abuse they endured and the violent acts they committed. Joe said that when he broke Sue's nose and called her a "whore", he felt like a pressure cooker exploding. He said when Sue called him "dickless" or threw things at him, he felt like a "Little Joe" who was two feet tall. Sue said when Joe punched her, she felt like a rag doll and when she swore and threw things at him, she felt like a frightened avenger. At this juncture, the couple may be requested to bring symbols into therapy that represent these aspects of the violence. Joe's pressure cooker and representation of himself as two feet tall and Sue's rag doll and frightened avenger metaphors can be brought to life in therapy. The therapist can explore each symbol and track the patterns that occur with respect to them.

The intensified experience of relating to concrete symbols such as bottles of beer, pressure cookers and ragdolls is relationally novel in that the dilemma presented is framed as something that divides the couple and is therefore amenable to change. The couple is invited to band together to explore and change their relationship to violence and remove it from their partnership. Fully experiencing their respective relationships to violence at the physiological, emotional, behavioural and cognitive levels also enables the couple to gain an expanded understanding of the problem and each other. For example, Joe's pressure cooker has a distinct relationship to Sue's ragdoll and her frightened avenger while Sue's frightened avenger has a particular relationship to Joe's pressure cooker and Little Joe. Similarly, Little Joe has an important relationship with the pressure cooker while the frightened avenger has a potent
relationship with the ragdoll. These relationships can be intensified in therapy and this exploration is extremely important in the creation of an atmosphere of experimentation and collaboration.

In sum, relational novelty occurs with respect to the presenting problem when, through experiencing their relationship to the dilemma, the clients engage the problem rather than minimizing it; explore their own and their partner's pain and experience the deleterious effects of violence on their relationship in a safe therapeutic context.

**Intrapsychic system.**

This system refers to how aspects of self (e.g., unloved) and the individual interrelate with other aspects of self (e.g., sad). Clients often have a particular relationship with aspects of themselves which are manifest in the presenting problem, interpersonal and environmental domains. Relational novelty occurs at the intrapsychic level when the client experiences abandoned or unloved aspects of self while simultaneously experiencing new loving and committed aspects of self in therapy. In addition, the act of entering into a "dialogue" with previously avoided or little understood aspects of self constitutes a relationally novel experience.

The bringing of substantive relational themes into individual awareness through therapeutic experiencing is in and of itself novel since many clients tend to stave off deep pain in an effort to cope with it and survive. The body and mind are capable of putting the experience and themes underlying trauma on hold just as severe wounds may be anesthetized with ether. Threats of punishment or death (Bowlby, 1988); the phenomenon of splitting (Masterson, 1981); loyalty and shame can create a situation wherein traumatic occurrences remain out of client awareness for long periods of time. Traumatic experiences
such as physical, sexual, and psychological abuse, neglect, parental death and loss embody substantive relational themes which may be out of client awareness but are reflected in their pained ways of being in the world and with themselves.

Through the story of Joe and Sue's struggle, we may observe how hurt, unloved and frightened aspects of self are invalidated by guilty and/or self blaming aspects of self. Powerless and helpless parts of self further invalidate these pained aspects and anger, self hatred and hopelessness result (see Appendix A). The process of experiencing and intensifying these powerless and helpless parts of self is a relationally novel experience for the couple since each individual gives her or his pain a forum. Hurt, powerless, guilty and/or self blaming aspects of self are transformed into loving, compassionate and hopeful aspects of self as therapy progresses.

For example, in a sculpt of their relationship as it appeared in the present, both spouses depicted themselves as reaching out while keeping their guards up. Joe placed himself sideways with one arm extended to Sue whom he saw as turning away from him. Sue saw herself as reaching out with her right arm while holding the left one in a stop sign position. She positioned Joe to face her but had him look off to the side with his arms across his chest. When asked to speak through her extended stop sign hand, Sue said she felt distrustful of Joe, helpless in the marriage and that she blamed herself for the problems they shared. When the reaching hand was given a voice, Sue cried saying she wanted Joe to love her but she wondered if he ever would and if she really deserved love at all. Joe stood sideways to Sue and from this position he experienced extreme frustration, guilt and powerlessness. With his extended arm, Joe experienced frightening vulnerability and a sense of being unloved and unworthy of love from Sue and others.
The clients were able to experience their mutual themes of unlovableness and abandonment together. The experiencing and sharing of the substantive relational themes that underlay attacking, defending, withdrawing and retaliatory interactions was a novel experience for the clients who until this point had characterized each other as spiteful, frightening, deceitful and manipulative. This intimate exchange marked a shift in the clients' usual pattern of interaction and represents how the intrapsychic system of functioning is closely connected to the interpersonal system of functioning.

**Interpersonal system.**

The client's relationship to important others can take the form of aspects of self relating with aspects of the other as presented in the previous sculpting example. Relations between individuals, family members and the therapist constitute interpersonal interactions during which presenting problems, intrapsychic aspects of self and environmental influences overlap. Relational novelty occurs when spouses, through the process of intensification, experience commonalties in their substantive relational themes and engage in a different way of being with one another. The experience of being vulnerable with one another in a safe context represents a departure from a formerly abusive cycle. Rigid symmetrically escalating battles or caregiver/caretaker complementary relationships can be transformed into flexible parallel unions (Lederer and Jackson, 1968) characterized by the latitude to engage in either symmetrical or complementary interactions dependent upon the couple's circumstances and desires.

For example, Sue and Joe's experience in therapy of being vulnerable and unloved while being affirmed by one another constituted a relationally novel experience in both the intra and interpersonal domains. Intraperso
both Sue and Joe related more lovingly to hurt aspects of self while interpersonally they experienced confirmation of their worthiness and lovableness from a validating other. This more compassionate, commonality seeking experience was radically different from the couple's usual experience of one another.

Environmental system.

The role of environmental influences is worthy of consideration whenever we seek to explore human dilemmas. The relationship between aspects of self, one's interpersonal and familial relationships and the larger socio-cultural context is of great importance if we are to understand how it is that substantive relational themes come to be observed and how human beings shape and are shaped by the world in which they live. The existence of sexist, racist (Ng, 1982), classist and homophobic (Pharr, 1988) events and relationships come into play at this level. Clients are often involved as victims, perpetrators, interveners or bystanders in sexist, racist, classist or homophobic socio-cultural acts.

Joe's father was alcoholic. In drunken rages he beat his children and their mother. Joe remembered being very angry at his father and betrayed by his mother when she would not leave the marriage. He described himself, his brother and his mother as "sitting ducks." Sue's mother was a binge drinker who left Sue and her brother with a girlfriend for days while she "partied." Sue's father left the family when she was two and was never seen again. Social services was aware of the difficulties in both families and alternately suggested visiting child care workers, parenting programs, drug and alcohol counselling and threatened to apprehend the children.
The themes of unloveness and abandonment can be observed in both these family stories. But where do we look for answers or ways to understand this kind of pain? We may move quickly to blame Joe's mother for not protecting her children or herself from her husband or we may blame Sue's mother for abandoning her children. Or we may view the Social Services lack of success with the families and reluctance to apprehend the children as child abuse. We may wish to view Joe's father and Sue's mother as abusive offenders or as individuals badly in need of treatment. We may choose not to wonder about Sue's father at all or we may ask about his responsibility to the family. Each of these questions arise out of the larger socio-cultural domain. The socio-cultural context contributes to how these events are interpreted, construed and finally imbued with meaning by those involved and by society at large.

One socio-cultural lens through which to view the plight of Joe and Sue and their families of origin is that of gender socialization. It has been hypothesized that violence towards women and children has been made increasingly possible by outmoded and rigid views of appropriate male and female behaviour (Barry, 1979; Brownmiller, 1975; Lerner, 1986; Luxton, 1982; Martin, 1983). The difficulties Joe and Sue encounter reflect this pertinent concern. If Joe has adopted the socio-cultural message that "men shouldn't need anyone," this would have profound effects on Joe's ability to be in an intimate relationship which necessitates both care-giving and care-receiving behaviour. The message that a committed focus on being in an intimate relationship is a sign of "dependency and symbiosis" reflects a similar cultural bias against the value of relatedness (Lawler, 1990) and has ramifications for Sue's ability to give and receive care. It is in the realm of relatedness that we can gain both competence in caring for others and a
healthy sense of self (Lawler, 1990) and it is also in this realm that people experience both trauma and healing. Perhaps the means to our physical survival and our psychological health is the acceptance of our interdependence and the development of ways to facilitate relational healing. Relational novelty in cultural terms would provide for the experiencing of new possibilities of feeling, thought and action and open the way for people to continue finding new solutions to their problems (Friesen, et al., 1991). These solutions may involve the jettisoning of rigid socio-cultural role expectations in favour of more flexible ways of relating. The experiencing of new ways of being as a culture will involve the interconnection of the three levels of the human system namely the intrapersonal, interpersonal and environmental domains.

**The process of intensification.**

An important means by which clients therapeutically experience their relationships with the presenting problem, different aspects of self and others; the therapist; and the environment is through intensification. Intensification is the process with which the therapist aids clients in evoking, enhancing and deepening their substantive relational themes and introducing relational novelty into the system. This method of amplification of experience is similar to focussing (Gendlin, 1978; Mathieu-Coughlan & Klein, 1984) or intensifying (Greenberg & Safran, 1987). Through experiential and symbolic means therapists tap the four aspects of human functioning (behaviour, cognition, emotion and physiology) and intensify the client’s experience. Therapists use expressive means such as art, storytelling, sculpting, enactment and guided fantasy to heighten client themes (Friesen et al., 1991). Therapists also employ symbolic externalizing transactions (Friesen et al.) to bring symptoms, aspects of self, and dreams to life. In addition, meaning shift transactions
(Friesen et al.) are utilized to expand clients' alternatives through reframing, questions and positive connotation. Finally, ceremonial transactions (Friesen et al.) are created to mark client and therapist changes through celebration and ritual. The experiential techniques used to intensify experience are drawn and modified from Symbolic-Experiential Family Therapy (Whitaker & Keith, 1981); Gestalt Therapy (Perls, 1973); Psychodrama (Fine, 1979); Family of Origin work (Bowen, 1978) and Structural Strategic Therapy (Andolfi, Angelo, Menghi and Nicolo-Lorigliano, 1983; Madanes, 1981).

The therapist's collaborative (Friesen et al., 1991) or relational participant stance (Chrzanowski, 1982) is essential to the process of client experiencing. Therapists must be experientially involved with their clients in order to be adequate guides to the experiencing process. A more removed therapeutic stance decreases the potential intensity inherent in therapeutic experiencing and is based on the traditional assumption that it is possible for the therapist to be solely an observer of the system (Sluzki, 1985; Varela, 1989). Transformational experiencing in therapy is an wholistic here-and-now encounter with ones own ontological reality and substantive relational themes.

In conclusion, client's stories of transformation are heroic tales that require "the courage to face the trials and to bring a whole new body of possibilities into the field of interpreted experience" (Campbell, 1988, p. 41). Relational novelty is the creation of these new alternatives and the simultaneous experiencing of them. Underlying these novel experiences are changed substantive relational themes that describe compassionate interactions with self, others and the world. Themes of relationship such as hope, forgiveness, caring and acceptance describe transformed ways of being for individuals and couples whose prior experience has reflected pained ways of being in the world.
ExST is based on notions found in Attachment Theory (Bowlby, 1988), Interpersonal Theory (Sullivan, 1953), Ecosystemic Thought (Auerswald, 1985), Client-Centered theory (Rogers, 1961), and Experiential and Structural Strategic family and individual therapy and as such embodies a relational paradigm. This system of thought recognizes that as humans we cannot not be attached. The process of individuation is achieved in relation to other people, parts of self and the environment just as necessities of affiliation are contextually and relationally based. Culturally, this notion defies the ideal of "personal individuality" (Sullivan, 1944) and maintains that this is an impossible state while arguing for individual commitment to the collective discourse. It also includes the collective valuing of the individual’s contribution while understanding the inseparable nature of our existence together. This understanding, when pared down, centers on what occurs "between" entities. The realm of relatedness exists between Me, Myself and I; I and Thou; Us and Them; and Me and It and ultimately, it is in relationship that we experience both the profane and the sacred (Berenson, 1990).

**Experiential Systemic Therapy Empirical Status**

This section will describe a recent outcome study testing the efficacy of ExST (Grigg, 1994). The goal of describing this outcome investigation is to detail the research context and rationale for the present process study of ExST change theory.

Grigg (1994) conducted a differential treatment outcome study comparing ExST to a behavioural monitoring treatment called Supported Feedback Therapy (SFT). In addition, he compared ExST for the individual treatment of alcohol dependency to experiential systemic marital therapy for the same problem. One hundred and fourteen families were randomly assigned
to one of three treatment conditions including either ExST individual treatment focused on the alcoholic drinker or ExST couple treatment focused on the alcoholic and his spouse or SFT. SFT was provided for the individual alcoholic only. The participating families met the inclusion criteria requiring a maritally distressed alcohol dependent father and a non-alcohol abusing mother residing together with at least one child living at home. Pretest, posttest and three month follow-up data were collected using questionnaires tapping alcohol use, intrapersonal well-being, couple satisfaction and adjustment and family satisfaction. Therapy was conducted at two out-patient clinics in a rural and urban setting respectively. Participants engaged in up to 15 sessions of therapy conducted over a 20 week period.

While 114 families were screened into the study, 60 families completed therapy and all the questionnaires at each measurement occasion as required by the data analysis. A multivariate analysis of the data indicated no significant differences between ExST and SFT, however both treatments were shown to have fostered highly significant and clinically relevant improvements on indices of drinking behaviour, intrapersonal symptomatology, marital adjustment and family satisfaction. There were no significant differences between ExST couples treatment and ExST individual treatment but both spouses reported highly significant post-treatment changes which were sustained at follow-up.

The clinical relevancy of these findings centered on the important client changes reported in this study. For example, as a group, the alcoholics scored in the high end of the moderate alcohol dependency range and were found to score in the psychiatrically symptomatic range at pretest. In addition, the alcoholics reported marital distress and low family satisfaction at pretest. However, these men reported mild alcohol dependency, psychiatric
symptomatology in the normal range, non-distressed marital adjustment and normal levels of family satisfaction at posttest. Secondly, similar to the men, the non-alcoholic women experienced psychiatric symptomatology in the normal range, reduced marital distress and normal levels of family satisfaction at posttest.

The study was limited by the unavailability of a wait-list control group. A wait-list control group was not included by Grigg (1994) for ethical reasons since participants may have been required to wait 20 weeks before beginning therapy. In addition, clients who received SFT were not required to complete follow-up questionnaires therefore no data exists regarding the enduring quality of SFT changes.

Nevertheless, this outcome study indicated that ExST is an effective therapy for both the individual and couple treatment of alcohol dependency. The large sample size, varied clinical settings, and the ecological assessment package employing a variety of standardized instruments made this study unique. In addition, the multivariate approach to data analysis and the care taken to monitor the delivery of the therapy rendered this study a significant contribution to the field of marital and family therapy for substance abuse problems.

The empirically demonstrated effectiveness of ExST is important to this study since a question could arise concerning the utility of delving into a single case of either an untested therapy or an ineffective one. Since ExST is effective, with a large representative sample, exploration of a single successful case to understand how change occurred is both clinically and theoretically useful. In the past, marital and family therapy outcome studies have been critiqued for failing to provide information regarding how the therapy studied was effective (Pinsof, 1981; Safran et al., 1988). While this study is not
designed to account for the creation of successful change in a large sample of ExST cases (large "O" outcome), a single case study of in-session or proximal change can shed light upon the change process as it occurs in ExST.

A review of previous marital and family therapy process studies centering on therapy models including ExST will be undertaken in the next section. This literature review will survey previous therapy process research results to examine the findings for their utility with respect to theory building and the expansion of knowledge regarding the therapy theory under investigation. Also, this examination will be employed to inform the conduct of this therapy process study.

Marital and Family Therapy Process Research

The study of therapy-in-progress has been made possible with the advent of audio and video recordings of therapy practice. The examination of therapy-as-it-occurs provides for an enhanced understanding of therapy process and therapy change. The probing of audio and videotapes of therapy has been traditionally achieved through the use of coding systems that quantify aspects of therapy process. More recently, efforts to explore therapy-as-it-occurs have included the hermeneutical analysis of therapeutic discourse on an utterance-by-utterance basis providing a qualitative examination of therapy process and therapy change. The following sections will offer a review of both quantitative and qualitative research efforts designed to explore therapy-as-it-occurs for the purpose of increasing knowledge concerning marital and family therapy process and change. This section will review the marital and family therapy process literature based on various therapy models including ExST to situate this study in the marital and family therapy process literature.
Quantitative Marital and Family Therapy Process Research

The following review will survey studies examining marital and family therapy process using quantitative methods that inspect videotaped or audiotaped segments of therapy process.

Zuk, Boszormenyi-Nagy and Heiman (1963) studied the effect of time (session quarter) and person (who speaks) on the frequency of laughter in a family with a schizophrenic daughter. The investigators believed that laughter was the family’s means of disguising anxiety and was both a function of intrapersonal and situational factors. Zuk et al. relied upon a laughter frequency count based on the last 13 sessions of family psychotherapy. The researchers coded and summarized client laughter across sessions. The laughter measure reflected which family member laughed, at which point in the session they laughed and whose comment triggered the laughter. Zuk et al. demonstrated that mother and father laughed most during the first 15 minutes of therapy and their daughter laughed most 30-45 minutes into the session. The investigators concluded that the schizophrenic’s anxiety increased as the session intensified. Unfortunately, the study did not tap client anxiety. Also, the use of a frequency count precluded an understanding of what kinds of statements precipitated the laughter and how the laughter was associated with client affect. This early quantitative family therapy study targeted general process and did not relate therapy process to client change. In addition, the model of treatment used in the study was not clearly articulated and the therapist's contribution to the family dynamics was not addressed.

Winer (1971) improved upon Zuk et al.'s (1963) study by attempting to investigate client change as it occurred in couples group therapy. Four couples were engaged in therapy with therapist/theoretician Murray Bowen although not every spouse attended every session. Winer was interested in verbal
markers of couple change captured on audio recordings of live sessions covering a 3.5 year span. In particular, she was concerned with indicators of change with respect to increased statements of self-differentiation on the part of clients. The construct, self-differentiation, refers to the ability to speak for oneself, the ability to refrain from engaging in blaming behaviour as well as being goal directed and desirous of self change rather than change in others. Self-differentiation is an important construct and change marker in Bowenian therapy.

Winer (1971) hypothesized that as clients became more differentiated, the number of "we", "our" and "us" statements would decrease. Winer developed a Change Ratio to quantify "differentiated" and "nondifferentiated" client statements. The Change Ratio was a qualified pronoun count based on the number of "I" statements made by each client divided by the number of "we", "our" and "us" statements. The higher an individual's Change Ratio, the greater the degree of differentiation of self. The pronoun count change index was meant to reflect decreased symbiotic involvement between couples. Winer compared two early sessions in which all couples were present to a session closer to the end of the course of therapy. The study findings indicated that six out of eight clients used fewer "I" statements than the sum of "we", "our" and "us" statements in early sessions. In addition, all eight clients used more "I" statements than the sum of "we", "our" and "us" statements in later sessions. Unfortunately, Winer's study was limited by the utilization of poor selection criteria for coded sessions; a lack of formal analysis of the data generated and an informal after-the-fact analysis of couple scores. Winer was concerned mainly with whether or not clients changed with regards to self-differentiation as opposed to how spouses came to use more "I" statements as
a result of therapy. Also, the therapist's role in the client's shift towards self-differentiation was unclear.

In a similar vein, Postner, Guttmann, Sigal, Epstein, and Rakoff (1971) coded familial affective expression and the quality and quantity of both family and therapist participation and related these variables to final therapy outcome. Postner et al. studied family therapy with adolescents who were brought to therapy for a variety of issues including discipline problems, poor school attendance, attempted suicide and perversions. Eleven families participated in the study receiving a treatment designed to bring reward and punishment patterns to the family's attention, interpret family transactions and explore motivation and transference phenomena as it related to family dynamics. Postner et al. sampled 20 minute sections of audiotaped therapy at six week intervals obtaining a total of 49, 20 minute transcripts for the 11 participating families. Four coders recorded therapist behaviours and family affective expression. The therapist behaviour measuring tool coded therapist "Drive" (e.g., stimulating family interaction, requesting information, giving support) and therapist "Interpretation" (e.g., making process comments and identifying the underlying meaning of family dynamics). The family measure recorded negative or Emergency emotions (e.g., anger and sadness), positive or Welfare emotions (e.g., happiness and joy) and Neutral emotions including information giving. The families were divided into two groups, those who experienced a good outcome and those who displayed a poor outcome as measured in an interview and on a self report questionnaire. Although there were no significant differences between the families with respect to affective expression and therapy outcome, the study demonstrated that, regardless of outcome, clients spoke more to family members than they did to the therapist as therapy progressed. The investigators also observed that the expression of pleasant or
Welfare emotions increased over time in therapy. Postner et al. accounted for an inability to demonstrate a relationship between family emotion and therapy outcome by noting that the session sampling method employed reduced the opportunity for tapping subtle family changes. This investigation mapped certain shifts in therapist and client speech over the course of therapy but was not intended to explore how these shifts were fostered by the treatment. However, Postner et al. focussed on both the therapists and the families verbalizations in their study which differed from earlier efforts.

Dechenne (1973) also focussed on couples and therapists in a study of how spouses differed in their levels of experiencing when speaking to one another and the therapist. Dechenne pioneered the marital therapy application of a sophisticated verbal process measuring instrument called The Experiencing Scale (see Klein, Mathieu-Coughlan, & Keisler, 1986 for a recent version). The scale is noted for its design and predictive and discriminant validity (Pinsof, 1988). Ten couples were included in the study in which one hour of therapy was audiotaped and coded. Unfortunately, the couple’s presenting problems and which session was coded was not revealed. The nine therapists who participated in the study were said to have been eclectic but all engaged in the facilitation of deepened client experiencing. Dechenne found that spouses were more likely to engage in deep experiencing behaviour in response to therapists than in response to one another. He observed that when the therapist spoke to a client, the client responded more expressively than when spoken to by a spouse. Dechenne concluded that marital relationships in which deep experiencing occurred were more constructive and less structure bound than relationships in which deep experiencing did not occur. Although the relationship between deep experiencing and subsequent couple change was not
addressed in this study, the notion that deep experiencing was related to increased marital health was interesting from a theoretical viewpoint.

To increase the clinical relevancy of therapy process research, some investigators turned their attention to the study of important clinical phenomena. Patterson and Forgatch (1985) conducted two studies examining therapist impact on client resistance. In the first study, they explored six mother-therapist dyads to observe the potential impact of therapist activities on the mother's behaviour. Other family members were present during the sessions but only data concerning mother-therapist interaction was analyzed. The families were in treatment for child management problems. The treatment offered was characterized by a parent training model drawn from social learning theory in which the mothers were taught methods to alter a problem child's behaviour.

Patterson and Forgatch (1985) hypothesized that "therapist efforts to teach and confront would be followed by increased likelihoods of noncompliance" (p. 847). The coded sessions averaged 47 minutes in length and the average number of sessions was 21. Cases were randomly assigned to the coders by treatment session preventing coder bias with respect to either familiarity with the family or expectation based on sequence. Client and therapist behaviour was scored separately by two groups of coders. Client behaviour was recorded on the Client Noncompliance Code which included categories such as interruption, negative attitude, confrontation, pursuing own agenda and failure to track. Therapist behaviour was scored on the Therapist Behaviour Code which tapped support, teaching, questioning, confronting, facilitating and reframing behaviour. The investigators found that therapist effort to teach and confront mothers was associated with noncompliance while
therapist use of facilitation and support decreased the likelihood of noncompliance.

In a second study, Patterson and Forgatch (1985) sought to discover causal links between therapist efforts to teach and confront clients and their subsequent noncompliance. The investigators used an ABAB design wherein they instructed therapists to refrain from teaching and confronting in the A condition and begin confronting and teaching in the B condition. Each condition lasted 8-12 minutes and a shift from the A condition to the B condition was signalled to the raters via the manipulation of a notebook. The therapist left the notebook on his or her lap during the A condition and placed it on the floor in the B condition.

Patterson and Forgatch (1985) noted that it was difficult for the therapists to return to baseline when required and the clinicians doubled their teaching and confronting behaviours during the second nonteach/nonconfront condition. Nevertheless, the study indicated that therapist teaching and confronting behaviours increased the likelihood of client resistance. Patterson and Forgatch concluded that therapists employing social learning parent training models should learn skills and techniques that will ameliorate resistant behaviours evoked when parent skill training is undertaken.

While theoretically grounded units of analysis were studied and both therapist and client behaviour was coded in this investigation, therapist impact on client noncompliance was not linked to proximal (in-session), intermediate (between session) or long-term therapy outcome. Despite the theoretical and clinical relevance of the results, the findings were not employed to comment upon the social learning parent training techniques that engendered resistance.

Few marital and family therapy studies account for the relationship between therapy process, therapy theory and client change. Yet, research that
leads to the delineation of models of change in specific in-session contexts is considered to be crucial to the growth of marital therapy (Beach & O'Leary, 1986; Johnson & Greenberg, 1988). In an attempt to address therapy change process and theory, Johnson and Greenberg (1988) focussed on client performance when resolving negative interaction cycles during an effective marital therapy called Emotionally Focussed Therapy (EFT). The investigators were interested in exploring the in-session processes that were associated with successful EFT outcome. EFT emphasizes the role of affect, and intrapsychic experience in therapeutic change. EFT follows a systemic approach that focuses on communication and interactional cycles in the maintenance of marital problems. EFT is designed to help clients access and explore key emotional experiences so that new aspects of self are encountered thereby evoking new responses from the marital partner.

EFT change theory identifies two process variables associated with positive outcome including deep levels of experiencing and corresponding affiliative and accepting interpersonal responses. These two change process variables were measured using The Experiencing Scale (ES) (Klein, Mathieu-Coughlan, & Keisler, 1986) and the Structural Analysis of Social Behaviour (SASB) (Benjamin, 1974). The Experiencing Scale coded the level of client emotional and experiential involvement in therapy. The SASB coded interpersonal responses that constituted and elicited change including autonomous rather than submissive or coercive interactions and affiliative rather than hostile or distancing transactions.

Johnson and Greenberg (1988) hypothesized that couples who showed improvement in therapy would exhibit high levels of experiencing, more autonomous and affiliative responses and more instances of increased vulnerability (softening). Six couples were selected for the study and divided
into two groups of three. The poor outcome group revealed the least amount of change in marital distress as measured by the Dyadic Adjustment Scale (DAS) (Spanier, 1976) and the good outcome group revealed the largest amount of marital change on the DAS.

A best session of therapy was selected for each couple in each group. A best session consisted of one in which the therapist rated the couple as making the most progress and the couple reported the session as being most useful in resolving their issues. All verbal statements in the last half of the best sessions were transcribed and coded by independent raters blind to the research hypotheses and the couple's therapy outcome. The results of the study showed that couples who had successful therapy outcomes engaged in more affiliative and autonomous responses and deeper experiencing than did couples who did not improve. In addition, evidence of "softening" was found to occur in the best sessions of successful EFT while the "softening" change event was absent from the unsuccessful couples' sessions.

Johnson and Greenberg (1988) suggested that "successful couples displayed less dominance and more affiliation in their interactions, with blamers replacing hostile and coercive behavior towards their spouses with more affiliative and accepting behaviors" (p. 181). In addition, successful couples had deeper levels of disclosure and experiencing than did unsuccessful couples. The investigators suggested that therapists, who employ experiential approaches to marital and family therapy such as EFT, focus on facilitating deeper levels of experiencing, self-disclosure and affective exploration. The study is theoretically relevant in that the investigation supports some of the explanations for change outlined in EFT theory.

Johnson and Greenberg's (1988) effort to explore in-session processes that contributed to successful EFT outcome was an important contribution to
the field of marital and family therapy process research. By focussing on the process of change in EFT, the investigators hoped to explain how certain interventions created change in a given therapeutic context. Johnson & Greenberg endeavoured to specify therapeutically helpful client behaviours and the interventions that fostered them. However, questions arise regarding the therapist role in the facilitation of deep experiencing and softening events. In addition, the means by which these change events were created through interactions between therapists and couples remained unaddressed. Finally, the contribution of the therapy sessions surrounding the "best" hours could not be tapped when the "best" sessions were removed from the rest of treatment for coding purposes.

A review of the quantitative marital and family therapy process literature revealed an evolving interest in how positive client change was fostered in therapy. However, the review of literature highlighted some of the clinical, theoretical and methodological limits encountered when attempts were made to capture complex interactions between therapy participants using coding and rating systems. The review of literature showed that coding systems designed to quantify therapy process have difficulty tapping the complexity of therapy participant interaction and the subtleties of the therapeutic process. Indeed, previous researchers and reviewers have questioned the reliance on quantitative methods to pursue therapy process research goals (Wynne, 1988). In an overview of family therapy research, Wynne lamented the reduced clinical and theoretical contributions made when quantitative methods were employed to understand therapy change process. As a result, Wynne recommended that change process research involve exploratory, discovery-oriented, single and multiple case study approaches. Also, Yin (1989) suggested that research questions focussed on how an event, phenomenon, situation, state or process
came to exist be addressed through qualitative means using case study design methods. The following section provides a survey of investigations answering the call for qualitative studies that contribute to knowledge regarding marital and family therapy process and theory.

**Qualitative Marital and Family Therapy Process Research**

This section will review qualitative marital and family therapy process research studies that have applied discourse analysis methods to the study of therapy as it occurs. However, a study centered on group therapy process has been included in the review since it delved into interactions between a therapist and more than one client. Finally, two qualitative studies focussing on ExST process and technique will be reviewed.

Turner (1972) identified the socio-organizational properties of group therapy as a social structure. He asked the question: How is group therapy socially organized such that a therapist would be prompted to comment on the start of the group? Turner noted that the group therapist repeatedly signaled the formal start of the group via three different openers. They included utterances such as "Look before we start . . .", "Well, we might as well start . . .", "Well, I think what we had better do is start." Turner used discourse excerpts to establish his findings and distilled five properties of pre-therapy and therapy talk. Turner identified two pre-therapy talk properties which included:

1. Pre-therapy talk is small talk done while waiting for therapy to begin. All participants must be present or accounted for in order to begin the session. Pre-therapy talk becomes irrelevant when the therapist or authorized "starter" enters.

2. Small talk is generated via the embracing of a topic with which the broadest number of participants can engage. Alternately, if the
topic is inaccessible, the excluded participant will relate the topic to another known party and therein gain access to the conversation. For example, two group members were discussing working in a mill and logging camp. Another participant was unable to join in the conversation with her own experience. However, she gained access to the discussion by introducing her brother's desire to work in these areas.

Turner also identified three social organizing properties embedded in therapy talk. These included:

1. The clients' experiences of accountability to the group prompt them to formulate their presenting problems in such a way as to identify commonalities between themselves and other group members. In sum, clients' attempt to construct accounts of their concerns with which other group members may resonate.

2. Clients are responsible for delineating and meeting their own goals in group therapy and sometimes do not understand that this task is an integral part of their treatment. The therapist did not comment on how well the clients were doing in therapy nor did he answer questions as to why the client was attending therapy.

3. There is no time-out in group therapy since the therapist gives a "theory governed hearing" to all participants during therapy. That is, all group member discussion is understood to be linked to client issues during the therapy period. The therapist was considered to be the session initiator and silence acted as a boundary marker between pre-therapy and therapy talk. References to the start of therapy served to differentiate between the ordinary, face value
pre-therapy talk and the therapy oriented session talk in which all utterances were considered significant to treatment.

In this study, Turner (1972) offered clinicians an understanding of how ordinary conversation was different from therapy conversation. He also identified clients' struggles with creating and meeting their own goals in the absence of therapist intervention. And lastly, Turner observed a similarity between pre-therapy and therapy talk in that group members construct speech acts in order to be included in the group discussion in either instance.

A paucity of Information about the therapy theory employed by the therapist in Turner's (1972) study, identified the importance of the articulation of theory in discourse analysis investigations. For example, Turner's conclusions may have been augmented by a broader discussion of group theory and a report of which sessions were used in the analysis. Unfortunately, it is difficult to know how many times the group met and in which session the discourse excerpted is situated. The result of these oversights was to prevent an analysis of the discourse based on the developmental life of the group. For example, the group's pursuit of identifying commonalities in their presenting problems may be a function of the early life of the group during which time inclusion issues come to the fore (Schutz, 1958).

Turner's (1972) study could have benefited from a further exposition of the theory that governed the therapist's "theory-governed hearing" of the group members' utterances. For example, the assumption behind the rule that therapists must not answer questions about how the client is doing in therapy or why the client attends therapy in the first place is theory driven. The technique of reflecting these concerns back to the client is also theory based. Turner refrained from explicitly delineating the therapist's theory of change and
in so doing appeared to support the notion that this rule and technique are generic therapy maxims that transcend a particular theoretical orientation.

Unlike Turner (1972), Gale (1991) provided a more detailed articulation of the therapy theory under investigation. Gale (1991) used conversation analysis to answer two research questions. He was concerned with understanding theorist-clinician William O'Hanlon's therapy skills and how change was constructed in Solution Oriented therapy (Gale, 1989, 1991). Gale (1991) selectively quoted examples of transcript culled from a 45 minute therapy session in which the presenting problem was the husband's affair. This was the first and only session with the couple and was conducted before a live audience.

Gale (1991) utilized discourse examples to illustrate the wife's, husband's and therapist's agendas in therapy and to compile a list of therapist interventions. He noted the manner in which the therapist worked to change the session topic from a problem oriented one to a solution oriented focus.

According to Gale (1991), the wife pursued an agenda designed to blame her husband for an extra-marital affair, withhold forgiveness, punish him and refuse to accept responsibility for (in the client's words) "driving" him to the other woman. The husband's agenda was to remain noncommittal about the status of the affair, refrain from accepting responsibility for it and appease both his wife and the therapist. The therapist's agenda was to maintain a focus on how the wife could put the affair behind her, regain trust in her husband and end dwelling on the affair. He also encouraged the couple to share their feelings with one another at scheduled times, engage in renewing their wedding vows and burning the bill for the roses (a gift for the girlfriend).

Gale (1991) documented nine procedures whereby the therapist pursued this agenda. These included pursuing solution oriented responses, overlapping
client talk and reformulation. Gale (1991) also documented interventions such as ignoring the listener's misunderstandings and rejections of the therapist's assertions, modifying an assertion, clarifying unclear references and offering a candidate answer. Gale's (1991) analysis also revealed O'Hanlon's technique of posing rhetorical questions or problems and answering them and engaging in humor designed to change the topic from a problem oriented focus to a solution oriented focus.

The following example, illustrates Gale's (1989) understandings of the first four procedures described above. The therapist suggested that the husband believed he had paid his dues and admitted he was wrong and crazy to have had an affair. However, based on the passage selected for analysis, it is unclear as to whether or not the husband recognized any wrongdoing. It appeared that O'Hanlon diminished the importance of a yet ongoing affair in pursuit of a solution. He attributed culpability and a statement that the affair had ended to a noticeably silent husband (reformulation). The therapist then turned to an exploration of a time when the relationship was more enjoyable (pursuing solution oriented responses). The husband immediately responded with a story about an enjoyable day trip with his wife to which the woman countered with an alternate view. She did not perceive the day trip to the game park as enjoyable because the husband still maintained a relationship with his girlfriend. The woman then questioned her husband's current commitment to the marriage until the therapist interrupted (overlapping client talk). O'Hanlon "ignores what the wife had just said about her concerns and instead, returns to the topic of the (enjoyable) day trip . . . " (Gale, 1989, p. 89) (ignoring the listener). When the therapist requested more accounts of good times in the relationship (pursuing solution oriented responses), the woman reiterated her inability to trust her husband.
Gale (1991) concluded that O'Hanlon's therapy skills could be encapsulated in the nine procedures cited above and therapeutic change was constructed by the therapist and clients in an interactive system. That is, Gale (1991) observed that change was made possible when the therapist accommodated the client's therapeutic agendas through talk but maintained a solution oriented focus.

Gale (1991) provided a strong description of the therapy theory behind the treatment being analyzed. He also clearly articulated and answered his two research questions. This study represents an influential process description of solution-oriented-therapy-in-practice conducted by one of its creators. However, an expansion upon the clinical implications of the study would have been helpful to practitioners.

O'Hanlon's theoretical orientation from the point of view of the impact it had on the clients and particularly on the woman involved remained unaddressed. Gale (personal communication, October, 1993) viewed this type of analysis to be important but outside the scope of the study. Nevertheless, it would have been clinically and theoretically interesting if Gale (1989) could have expanded upon his observation that "the wife would paint one picture of the husband, while O'Hanlon would try to describe another understanding of the husband's behaviour" (p. 189). For example, during O'Hanlon's attempts to positively reformulate the husband's behaviour, the husband remained silent and watchful. It appeared that the technique of reformulation may have contributed to the underplaying of the woman's distress while offering the husband an opportunity to temporarily avoid owning his behaviour and understanding his wife's pain. Gale's observations of the couple's reactions to the downplaying of an ongoing affair as part of a solution oriented agenda were interesting from a theoretical point of view. In particular, it seems that ignoring
certain types of problem focussed concerns may sometimes delay resolution and closure and hinder a solution oriented focus.

Gale's (1991) intriguing and informative study highlighted the future research importance of considering the overall context in which therapy is conducted, the necessary balance between informed investigation and scientific curiosity, the effects of theory-in-practice on clients and the gender context in therapy.

In a similar fashion to Gale (1991), Todtman (1990) tapped discourse meanings through the use of Comprehensive Discourse Analysis (Labov & Fanshel, 1977). He conducted a study of conversations between a team of psychotherapists-in-training as they collaborated to provide therapy to Rose and her husband, Jimmy. Todtman (1990) analyzed eight instances of consultative talk between therapy team members. His analysis revealed that covert struggles within the team regarding therapist competency influenced how the team conducted the therapy and perceived client changes. This finding, as revealed in the transcripts, differed from the therapist's perceptions that their therapy model organized how they worked. Todtman (1990) concluded that "this meant the therapy delivered to the clients was constructed out of the discourse in the social situation and much less by the method of the therapy model" (p. viii).

Todtman's (1990) study provides a fascinating account of the utility of the CDA method and the rich understandings it can offer. The investigator expanded the text cogently, and consistently without the benefit of paralinguistic cues. He also provided propositions that followed logically from the expansions. However, Todtman (1990) could have outlined the interactional sequences (i.e., what impact speech acts have on listeners) to supply added meaning to the expansions and propositions.
Todtman (1990) described the therapists' theoretical orientation (i.e., Mental Research Institute (MRI) family therapy) well. An additional discussion regarding the role of conflict in groups and the influence the trainee role has on questions of competency may have provided important background. Todtman (1990) observed that the therapy team alternately questioned the key therapist's competence in executing the MRI model of therapy, the client's competency as a client for MRI therapy (she was considered too emotional) and the competency of the MRI model in caring for emotional clients. It appears that rather than question the model's efficacy with emotional clients, the therapy team opted to construct a scenario in which the therapist and the client were found to be operating well within the tenets of the model. This act served to prevent a serious team crisis in which the therapist, client and model were considered potentially incompetent and unsuitable.

The therapy was deemed helpful by the therapists although they strayed from the MRI model's criteria for success. That is, success was purportedly measured on the basis of whether or not the client obtained relief from a specific problem. The problem Rose identified seemed to be centered on the individual and marital effects of her husband's affair. The therapists briefly discussed the fact that they had not dealt with the affair in therapy but dismissed this concern citing the fact that the clients mentioned it only once and did not bring in any new problems. The similarity between the client's issue of marital infidelity and the team's struggle with fidelity to the MRI model, the therapist and the client was not noted in the analysis. Interestingly, both the therapy team and the clients avoided open discussion of this infidelity.

Conversation and discourse analysis methods have been employed to study several diverse theories of therapy including group therapy process, Solution Oriented Therapy and the Mental Research Institute approach to family
therapy. In addition, conversation and discourse analysis has been utilized to explore ExST process and the following section will provide a review of the two studies conducted to date using this qualitative approach.

**Qualitative Experiential Systemic Therapy Process Studies**

Dubberley-Habich (1992) conducted a study exploring the manner in which an ExST therapist utilized speech acts to facilitate a burning ritual in therapy. Dubberley-Habich’s aim was to "guide therapists in learning the concrete characteristics of the therapist’s style in the successful application of rituals in ExST" (p. 2). A single session of experiential systemic marital therapy with an alcohol dependent man and a nonalcoholic woman was studied employing conversation analysis (CA) to investigate a ritual burning of an extra-marital affair. Conversational analysis inquires into the rules of verbal interchange with a specific interest in the structure and conventions of communication.

The therapy employed to treat the couple was Experiential Systemic Therapy. ExST is an effective marital therapy that employs experiential, symbolic and systemic theory and technique to aid in the amelioration of alcohol dependence and its effects. ExST focuses on the intensification of emotional, cognitive and behavioural experiencing in a collaborative context using experiential and symbolic means.

The ritual burning, in which both spouses participated, occurred in session seven and was meant to aid in the healing of the effects of the husband’s extra-marital affair. Unfortunately, the couple did not attend more than seven sessions of a possible 15 sessions offered. Despite initial progress, the clients dropped out of therapy following session seven. The preceding session, session six, was not attended by the husband who had resumed a
high level of alcohol consumption and continued to see his girlfriend. Session seven marked the end of therapy when neither spouse was heard from again following the ceremony. Follow-up data and outcome information was unavailable since the research staff’s efforts to establish either telephone or written contact were not returned.

Dubberley-Habich observed that the ritual burning of items given to the husband by the girlfriend engaged three phases of ritual including separation, liminal and integration stages (Cooper, 1987 in Dubberley-Habich, 1992). In addition, the investigator identified eleven elements that described the ritual conducted in the session. These items included the occurrence of couple myths that centered on differing spousal stories regarding their desires for closeness and distance, the use of symbol in the form of concrete representations of the affair, and experiential processing using an empty chair technique.

In addition, externalization was found to be an important aspect of the ritual during which the effects of the affair and the husband’s secrets were evoked. Increased couple distance due to the affair was symbolized by moving a chair representing the girlfriend to a place between the couple and the husband’s secrets were symbolized by a locked box. Also, the intensification of emotions such as grief, sadness, guilt and defensiveness were identified as important to the conduct of the ritual.

A theme referring to the contextual and systemic properties of the ritual highlighted the role played by the husband’s parents and his girlfriend in maintaining the drinking behaviour and the affair. Meaning shifts were identified as important in the ceremony when the therapist encouraged the wife to focus her anger onto the affair rather than her husband to help foster cooperation between husband and wife in ending the affair. Also, a positive
frame was placed on the husband's reason for ending the affair since ending it for his wife's sake underscored the importance of her hurt feelings.

Also, therapist empathy and genuineness was cited as important to the conduct of the ritual and the theme of couple/therapist collaboration reflected the therapist's guiding and exploring function in her bid to represent both partner's experience. Lastly, therapist artistry was observed in the creation of the ritual. The therapist intensified the couple's interactions by adopting a reverent stance and employing metaphoric language. The investigator concluded that cataloguing these elements of ritual would aid therapists in the execution of a burning ceremony.

Although Dubberley-Habich (1992) stated that she employed CA procedures in the study of an ExST ritual, she did not provide a record of the utterance-by-utterance analysis of the rules of conversation or turn-taking sequences that led to her conclusions. The record of the text analysis was missing from the report of findings thereby decreasing the reliability of the study. In addition, the ritual ceremony analyzed occurred in the last session of therapy after which the couple dropped out of treatment. The reported progressive improvement of the couple in the first five sessions, followed by a sudden relapse in the sixth session and the abrupt end of therapy after the seventh session represented an important contextual issue that remained unaddressed in the analysis of the ritual session.

The study of ExST intervention strategies was continued when Wiebe (1993) analyzed a symbolic externalization activity. The activity was conducted in the context of a successful case of couples therapy in which the spouses personal and marital satisfaction increased and the husband ceased alcoholic drinking. The symbolic externalization of alcohol dependency included the manipulation of an empty beer bottle as the embodiment of problem
drinking. Wiebe improved upon Dubberley-Habich’s (1992) study of a burning ritual by selecting the marital therapy case for investigation using rigorous means and providing a detailed account of the analysis conducted.

Wiebe (1992) was interested in how therapist and clients co-created relational change using a symbolic externalization intervention in a case of successful experiential systemic marital treatment for the husband’s alcohol dependence. The husband was severely dependent on alcohol and had attempted to abstain unsuccessfully on eight or nine occasions. Despite participation in Alcoholics Anonymous and having obtained psychiatric care, the husband continued to drink at dangerous levels.

Wiebe (1993) employed a critical single case study design to tap therapeutic change as it was fostered through the externalization of alcohol in a successful case of marital therapy conducted over 15 sessions. The therapy was observed to be a success based on the couple’s reports on a battery of standardized questionnaires administered at pretreatment, posttreatment and at a three month follow-up period. The couple reported the cessation of alcoholic drinking on the Michigan Alcoholism Screening Test (Selzer, 1971) and the Alcohol Dependency Data Questionnaire (Raistrick, Dunbar, & Davidson, 1983) and increased marital satisfaction as measured by the Dyadic Adjustment Scale (Spanier, 1977). In addition, the spouses observed notably decreased personal distress as measured by the Symptom Checklist 90 Revised (Derogatis, 1983) and the Beck Depression Inventory (Beck & Steer, 1987).

The investigator utilized Comprehensive Discourse Analysis (Labov & Fanshel, 1977) to explore the text of session two which contained the externalization segment. CDA provided the researcher with the opportunity to account for conventions and rules of speech as well as the implicit meanings observed in the speech act. The CDA method employs an expansion model in
the analysis of therapeutic discourse. Text expansions conducted on an utterance-by-utterance basis are designed to make therapeutic subtleties explicit. Also, CDA utilizes an interactional analysis to explore the impact utterances have on therapy participants to ascertain what is being achieved interpersonally through the discourse.

Wiebe (1993) observed eight themes that contributed to the creation of relational change when the symbolic externalization of alcohol dependence was employed. The first theme concerned the creation and maintenance of a collaborative atmosphere. The therapist was observed to have aided the establishment of this cooperative context by encouraging a therapy agenda in which clients expressed behavioural, emotional, cognitive and physiological experiences. To foster the expression of differential states, the therapist maintained a present tense and systemic focus during therapy as well as validating and normalizing couple difficulties and strengths.

The second theme, challenging propositions and competence, referred to Wiebe's observation that the husband frequently countered the therapist and his wife's challenging statements regarding the troublesome nature of alcohol by encouraging them to change their viewpoints in favour of his own. The husband asserted that alcohol was not a problem for him since to acknowledge a difficulty with alcoholic drinking jeopardized his view of himself as competent head of household. When challenged by the therapist or his wife regarding his ability to abstain from alcohol, the husband provided evidence of his success with sobriety. The therapist indirectly challenged the husband's view of the nonproblematic nature of alcohol noting its proximity made abstinence difficult and his cravings for alcohol were a normal part of recovery. In addition, the therapist helped the wife express her concerns regarding her partner's excessive drinking. Previously, the woman had been instructed by her
husband, in a sometimes intimidating fashion, to refrain from commenting on his drinking activities. Nevertheless, challenges to the husband's assertions of competence with respect to his ability to control alcoholic drinking introduced new information into the couple system thereby promoting relational novelty.

A third theme, that of reframing alcohol as a seducer, was important to the change perturbed by the symbolic externalization intervention. Alcohol was viewed as benign by the husband until the therapist introduced the notion that alcohol was a powerful seducer. The therapist asserted that since alcohol was a powerful tempter, the husband was not weak or incompetent for having failed to avoid its enticements. Once alcohol was perceived as the problem, the couple could work together to remove it.

The fourth theme included moving from an individual to a relational view of the problem. The therapist maintained a systemic perspective throughout the episode by highlighting both spouse's decision-making responsibilities with respect to the whereabouts of alcohol. In particular, the therapist helped the husband begin to include his wife in the recovery process and in so doing helped elevate the woman's status in the relationship. The fifth theme, observed to be a contributor to couple change during the intervention, included the accentuation of the couple's commonalities. For example, the therapist accentuated the couple's agreement that alcohol should be removed from the home by highlighting consensus. That is, when the woman stated she did not need or desire alcohol in the home, her husband answered that he could get rid of alcohol if he chose. In response to the couple's interchange, the therapist highlighted the notion that alcohol could be removed from the home. The identification of commonalty helped the couple shift away from a challenging and defending interaction pattern towards the acknowledgement of similar goals.
The sixth theme focussed on diffusing tension and defensiveness in the therapeutic system. The therapist and the clients engaged in indirect communications that reduced tension and anxiety. The therapist reduced tensions through the use of positive connotation, validating client's experiences and highlighting strengths. The husband diffused tension through face-saving devices, humour and the avoidance of contentious issues while the wife adopted a tentative speaking style and used "I" and "we" statements to reduce anxiety and defensiveness. A seventh theme important to the change perturbed by the intervention included regulating the intensity of experience. The therapist employed humour, a respect for the client’s pacing needs and the gradual intensification of experience to regulate the degree of intensity. The couple monitored the level of intensity in the session by employing laughter, seeking the meaning of their experiences cognitively and changing topics. The management of intensity enabled the clients to explore and incorporate their experiences during the intervention contributing to the decision to remove alcohol from the home. Lastly, the eighth theme observed by Wiebe (1993) was a deepening of contrasting states fostered by the intervention. The husband decided that alcohol was a problem for him after experiencing a shift from apprehensive to relaxed feelings following the removal of alcohol from the room.

Wiebe's (1993) study was well-grounded theoretically, employed a rigorous method of analysis and yielded an extended understanding of the symbolic externalization strategy as an aid to the creation of relational novelty in ExST. The study provided an interesting account of the nuances of in-session process focussing on the employment of an experiential technique designed to facilitate client change. The CDA method employed by Wiebe provided an extensive amount of information regarding the case under
investigation. The complexity of the information generated by CDA poses a challenge to researchers. Wiebe struggled to limit her synthesis of the results to provide an answer to the research question but sometimes included insights that were outside the stated domain. For example, the discussion of what maintained and reinforced the husband’s use of alcohol was adjunct to the research topic.

**Summary of the Literature Review**

The review of both the quantitative and qualitative marital and family therapy process literature has pinpointed the importance of therapy process research and its clinical and theoretical utility. The results garnered from the research efforts reviewed above, provide a plethora of clinical and theoretical insights into the therapeutic process from the perspective of a variety of therapy paradigms. The following section will highlight the theoretical and clinical significance of investigations that offer insight into the therapeutic process found in group therapy formats, Bowenian Therapy, family therapy with children and adolescents, Solution Oriented Therapy, the MRI model of family therapy and experiential marital therapies such as EFT and ExST.

Two noteworthy studies, conducted by Winer (1971) and Turner (1972), centered on group therapy and offered clinically and theoretically relevant insights into group therapy process. First, practitioners aligned with the Bowenian Therapy school and engaged in group therapy with couples were informed as to the use of couple group therapy and the importance of encouraging spouses to employ "I" statements to promote differentiation (Winer, 1971). Second, group therapists were introduced to information regarding the social organization of group therapy in Turner’s (1972) qualitative study of the beginning moments of group counselling. Turner noted that client
desires for inclusion prompted them to construct accounts of their presenting problems that highlighted commonalities between themselves and other group members. Also, Turner provided therapist's with insight into the difference between pre-therapy talk in which client utterances are typically taken at face-value and therapy talk in which all client utterances are considered significant to treatment.

Therapist's treating families with children and adolescents benefitted from Patterson & Forgatch's (1985) work on parent training, Postner et al.'s (1971) study of family therapy with adolescents and Zuk et al.'s (1963) study of schizophrenics and their parents. Patterson & Forgatch (1985) contributed to therapist knowledge regarding the conduct of parent training models based on social learning theory. The researchers observed that therapist efforts to teach and confront mothers with child management difficulties were associated with parental noncompliance. Indeed, the therapist's teach and confront behaviours increased the likelihood of resistance from the mother. In a study of adolescent family therapy, Postner et al.'s (1971) investigation of familial affective expression indicated that familial interaction and the expression of positive emotions were important to therapy and occurred more often as therapy progressed. Clinicians working with schizophrenics and their parents were alerted to the possible link between laughter and the reduction of in-session anxiety when Zuk et al. (1963) reported parental laughter early in the session and an increase in laughter on the part of the schizophrenic daughter as the session progressed and intensified.

Therapists utilizing Solution Oriented marital therapy were introduced to the means by which therapist/theorist William O'Hanlon pursued a solution oriented agenda during therapy for marital distress due to an ongoing extra-marital affair (Gale, 1989). Gale observed the therapist employing techniques
such as overlapping client talk, ignoring client rejections of therapist solution-oriented viewpoints and engaging humour and rhetorical questioning to shift topics from a problem based to a solution-oriented focus.

Supervisors and clinicians alike were informed as to important therapist-in-training issues in a study of the implementation of the MRI model of marital therapy (Todtman, 1990). Todtman observed how struggles concerning trainee competency influenced the conduct of marital therapy as well as the perceptions the trainees had of the success of the therapy they delivered. He noticed that the marital treatment was informed more by covert competency struggles between trainees than the treatment model.

Lastly, therapy process research findings regarding experiential therapies such as EFT and ExST have been helpful to clinicians and theorists. For example, in a research study focussing on an ExST experiential technique, Dubberley-Habich's (1992) study of marital ritual supported previous writings on the phases of ritual process in psychotherapy (Cooper, 1987 in Dubberley-Habich, 1992). Similarly, Dubberley-Habich's research provided support for the assertion that symbolic and activity oriented techniques were significant to the conduct of experiential systemic marital therapy. In addition, the investigation highlighted the importance of reframing as well as therapist empathy, artistry and genuineness during a marital ritual. Lastly, therapist/client collaboration was considered essential to the ritual experience.

Wiebe (1993), in her study of a symbolic externalization intervention employed in ExST, joined with Dubberley-Habich (1992) in observing the importance of collaboration to the intense expression of affective, cognitive and physiological states in experiential therapy. Also, Wiebe concurred with Dubberley-Habich's (1992) findings when both investigations noted the use of
reframe and the identification of spousal commonalty during experiential exercises.

However, unlike other investigations of experiential marital therapy (i.e., Dechenne, 1973; Dubberley-Habich, 1992; Johnson & Greenberg, 1988), Wiebe (1993) touched on the influence of gender issues in heterosexual marital therapy. She observed the therapist’s utilization of a systemic paradigm to raise the woman’s status in the marriage during an experiential activity. Nevertheless, Wiebe’s findings paralleled those of Dechenne (1973), Dubberley-Habich (1992) and Johnson & Greenberg (1988) in that all four investigators pinpointed the importance of deep experiencing for the promotion of marital affiliation when experiential therapy was employed to foster marital change.

As well as informing theoreticians and clinicians about therapy process, a review of the literature revealed the challenges faced by researchers in their bid to study and understand therapy process and therapy change. Research challenges were experienced by quantitative and qualitative researchers alike and have centered on methodological, procedural and contextual limits, omissions and oversights.

Notwithstanding the important clinical contributions made by quantitative therapy process studies, the review of quantitative marital and family therapy process literature revealed three key aspects of the therapeutic process which were elusive when coding systems were employed. These untapped aspects of the therapy process reflect a degree of clinical comprehensiveness unavailable when therapy process is quantified. The three aspects include tapping the manner in which therapist/client interaction promoted change, the role played by the therapist in the facilitation of couple change and the complexity of the therapeutic endeavour. The employment of coding and rating scales in the study of therapy process limited the clinical comprehensiveness of quantitative
therapy process studies resulting in the suggestion that alternate paradigms and methods for the exploration of therapy process be considered (Wynne, 1988). Accordingly, researchers are focussing on the therapy change process using exploratory and discovery-oriented means found in the in-depth qualitative analysis of therapeutic discourse.

The potential for expanding our understanding of therapy change and related issues was shown in the review of qualitative discourse analysis studies. The qualitative investigation of therapy process yielded a more encompassing and wholistic understanding of a variety of the processes under examination. However, the literature review revealed a series of procedural and contextual oversights that limited the investigations. Procedural gaps noted in the review of qualitative literature included difficulties mapping the logic of the analysis and problems articulating the therapy theory under investigation. In addition, a hesitation in applying the analysis results to therapy theory, and struggles with synthesizing a large body of data were evident in the discourse studies. The contextual issues noted as problematic in previous qualitative studies rested predominantly on analyst oversights regarding the influence of setting on the therapy being analyzed. For example, Todtman (1990) might have augmented the depth of his analysis by delving further into the role played by group dynamics and competition amongst therapy trainees in an academic program. Additionally, the therapeutic conversation investigated by Gale (1989) may have been influenced by the “one-shot”, audience-oriented therapy format used to demonstrate Solution Oriented Therapy. Similarly, sensitivity to the influence of gender issues on male/female discourse (West & Zimmerman, 1985) has been recommended but largely absent from previous studies (Maltz & Borker, 1982; B. McKellin, personal communication, January 31st, 1992).
Nevertheless, qualitative studies of therapy discourse have made important clinical contributions to our understanding of therapy process despite procedural and contextual omissions. In particular, discourse analysis provides a clinically and theoretically rich method of analysis when applied to the therapy setting. The CDA method is well suited to furthering our understanding of therapy and the change process since it taps human interaction and the interactional meanings embedded in therapeutic discourse. Unlike quantitative methods of analysis such as coding systems, CDA can reflect more of the subtlety of the therapy process. The exploratory nature of the CDA procedure lends itself to process oriented inquiry and was chosen for use in this study due to its utility in investigations of therapy change process. The following chapter will present the CDA method, the research design and the investigative procedure utilized in this study.
CHAPTER III
METHODOLOGY

The literature review revealed the utility of qualitative research designs as well as the adequacy of discourse analysis methods in the exploration of therapy change process. This chapter will focus on the design of the current study, the investigative procedure employed, and the method of data analysis utilized to answer the research question posed in this investigation.

Design

This research investigation employed a single critical case study design to examine the manner in which relational novelty was created by the members of a therapeutic system. A single case is analogous to a single experiment and can be used in the analysis of therapy to "confirm, challenge or extend the theory" (Yin, 1989, p. 47). A single critical case design necessitates the selection of a case example considered to be an exemplar of a particular theory, idea or organizational structure for intensive examination. Thus, an efficacious example of marital therapy conducted in the ExST tradition that exemplified the change construct of interest was selected for analysis.

Investigative Procedure

The following section outlines the investigative procedures including the criteria employed to select both a successful case of ExST and the episodes of relational novelty examined in this study. In addition, a description of the research participants and the change episodes chosen for analysis will be provided. Lastly, the videotape and audiotape production format utilized in the data analysis will be outlined. The procedure employed in this study will be
described under three headings. These headings include: Identification and Description of a Successful ExST Case of Marital Therapy, Identification and Description of Relational Novel Episode, and Videotape and Audiotape Production.

**Identification and Description of a Successful ExST Case of Couples Therapy**

The main goal of this section is to outline the criteria for the selection of the marital therapy case under analysis and provide a description of the successful case selected for examination. The data analyzed in this single case study of relational novelty was garnered from a large data pool generated during a programmatic research effort named TARP. The couple featured in this study was one of 150 families participating in TARP. The TARP inclusion criteria for clients and therapists will be detailed later in this section.

The single case exemplar of ExST theory-in-practice selected for this study was identified according to three eligibility criteria including therapist and client satisfaction with therapy, demonstrated client improvement on a package of change sensitive instruments, and evidence of relational novelty during therapy. This section describes these three criteria in detail and offers information regarding questionnaires employed to ascertain positive therapy outcome. In addition, the section provides a case description including pertinent therapist and client eligibility and background information. The case description describes the eligibility requirements met by the therapist and clients for inclusion in TARP as well as detailing therapist educational background and client history.

**Critical Case Selection Criteria**

The single case selected for examination met three criteria of success for the purposes of this research project. First, the therapist and the clients were
satisfied with the therapy experience. The clients indicated a desire to anonymously endorse the ExST treatment program in print and on television. Subsequently, the couple's story of therapeutic success appeared in a local newspaper and on a regional television news program. In addition, the therapist indicated that she considered her work with the clients to be well within the ExST model of treatment and an example of her "best effort".

Second, a package of pretest, posttest and follow-up measures, completed by the couple as part of the TARP protocol, showed change toward increased personal and marital satisfaction and decreased personal and marital distress. The couple attained their therapy goals including less marital distress and the cessation of drug and alcohol abuse as indicated by self report and questionnaires. In addition, the couple's marital satisfaction and the husband's abstinence from alcohol was sustained at a three month follow-up occasion. The questionnaire array employed to identify successful therapeutic outcome in this investigation included measures describing client functioning and change with respect to alcohol dependency and personal and marital stress.

Third, following reports of therapeutic success evidenced in therapist and client testimony and positive outcome questionnaire data, a review of the videotape record was undertaken by the researcher. The videotape review revealed that therapist and clients co-created eight relationally novel episodes over the course of 15 sessions of therapy. Three of the eight episodes exemplified all the conditions outlined for relational novelty in ExST theory. The three episodes were chosen for analysis using the CDA procedure. A detailed account of the episode selection process will be provided in the Identification and Description of Relationally Novel Episodes section.
Instruments

The questionnaire package included in this investigation was drawn from a larger battery of TARP questionnaires reflecting three levels of client functioning including level of alcohol dependency, intrapersonal distress, and marital adjustment. The instruments selected for use in this study were descriptive of client issues and sensitive to change at the three levels of client assessment (Grigg, 1994).

The measures selected include the Michigan Alcohol Screening Test (MAST) (Selzer, 1971); the Alcohol Dependency Data questionnaire (ADD) (Raistrick, Dunbar, & Davidson, 1983); the Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1983); the Beck Depression Inventory (BDI) (Beck & Steer, 1987); the Structural Analysis of Social Behaviour (SASB) (Benjamin, 1974) and the Dyadic Adjustment Scale (DAS) (Spanier, 1976).

Pretreatment measures were administered between the screening meeting and the first therapy session, and posttreatment questionnaires were completed after the 15th and last session of ExST. The follow-up questionnaires were administered 15 weeks after the posttreatment tests were completed. As participants in TARP, the couple completed a battery of questionnaires measuring alcohol dependency, intrapersonal, and interpersonal characteristics at pretreatment, midtreatment, posttreatment and follow-up testing occasions. However, data collected during the midtreatment testing period was omitted for the purposes of this single case study since midtreatment scores were unnecessary in the demonstration of positive outcome.
The Michigan Alcohol Screening Test.

The Michigan Alcohol Screening Test (MAST) (Selzer, 1971) was used for screening purposes to identify alcoholic drinkers for TARP. The MAST consists of 25 questions answered with either "Yes" or "No". Items are weighted and total scores obtained on the test may range from 0 to 53. Subjects who scored 5 or greater on this test were accepted as having alcohol problems.

The MAST has been employed in alcoholism research and is accepted as a measure of alcoholism by researchers and clinicians alike (Selzer, 1971). The questionnaire provides a consistent measure of alcoholic drinking and is unaffected by current drinking or abstinence practices. That is, it is possible to score as an alcoholic after many years of sobriety (Hedlund & Vieweg, 1984). Internal consistency coefficients drawn from a review of 6 studies yielded alpha coefficients ranging from .83 to .95 (Hedlund & Vieweg, 1984). The MAST has a test-retest reliability of .84 for an average 4.8 month test-retest period for 91 psychiatric patients (Skinner & Sheu, 1982). In addition, MAST total scores have been significantly correlated to several other measures of alcoholic drinking including the General Alcoholism Factor of Alcohol Inventory (Skinner, 1979), the MacAndrews Alcoholism Scale (Friedrich & Loftsgard, 1978), the Alcohol Volume Index and the Alcohol Pattern Index (Sokal, Miller & Debanne, 1981).

Alcohol Dependency Data questionnaire.

Although the MAST was employed for screening purposes in TARP, the Alcohol Dependency Data questionnaire (ADD) (Raistrick, Dunbar, & Davidson, 1983) was used as a primary indicator of change in severity of alcohol dependence. The ADD was employed at pretest, posttest and follow-up
occasions. The questionnaire was designed to tap the full range of dependence including no, mild, moderate and severe dependency. The instrument is sensitive to changes in dependency levels over time. The measure consists of 39 items, rated on a 4-point scale ranging from never = 0 to nearly always = 3, yielding a possible maximum dependence score of 117. A score of 0 indicates no dependency, scores ranging from 1-30 suggest mild dependency and a score between 31 and 60 identifies moderate dependence. Severe dependence on alcohol is indicated when a score ranging from 61-117 is obtained.

A shortened form of the ADD consisting of 15 items was created and compared to the original form. The correlation between the 39 item questionnaire and the 15 item test was highly significant (r = .92). The shortened version of the ADD has a split half reliability of r = .87. Measures of internal consistency based on Spearman Rank correlations between items and total score indicated significance levels ranging from < 0.03 to < 0.001.

The Symptom Checklist-90 Revised.

The Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1983) was developed to measure the "psychological symptom patterns of psychiatric and medical patients" (p. 2.). The SCL-90-R was completed by clients at screening, posttest and follow-up periods. The measure employs a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). The SCL-90-R measures nine symptom dimensions and three global indicators of distress. The 9 symptom dimensions include: (1) Somatization, (2) Obsessive-Compulsive, (3) Interpersonal Sensitivity, (4) Depression, (5) Anxiety, (6) Hostility, (7) Phobic Anxiety, (8) Paranoid Ideation, (9) Psychoticism. The three global indicators of distress include: (1) Global Severity Index (GSI), (2) Positive
Symptom Distress Index (PSDI), and (3) Positive Symptom Total (PSI). The global indicators of distress provide an overall assessment of the respondent's psychological dysfunction (Derogatis, 1983).

The measure is well-suited to pre-post treatment evaluations since significant "practice" effects that could bias the profile after repeated administrations have remained undetected (Derogatis, 1983). The SCL-90-R has been used widely in studies concerning alcoholism (Derogatis, 1983). In particular, studies evaluating couple treatment change and in-home investigations of alcoholic families have utilized the measure (Steinglass, 1979; Steinglass, 1980; Steinglass, 1987).

The SCL-R-90 has been successfully contrasted with various scales of the MMPI (Derogatis, Rickels, & Rock, 1976), the Hamilton Depression Scale, the Social Adjustment Scale (Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977), the Maudsley Obsessional-Compulsive Inventory (Sternberger & Leonard, 1990), and the Cancer Inventory of Problem Situations (Schag, Heinrich & Ganz, 1983). The SCL-90-R sub-scales were significantly correlated with the aforementioned instruments. The SCL-90-R is considered reliable with internal consistency coefficients for each dimension ranging between .77 for Psychoticism to .90 for Depression. The SCL-90-R test-retest coefficients range between .78 for Hostility and .90 for Phobic Anxiety.

**The Beck Depression Inventory.**

The Beck Depression Inventory (BDI) (Beck & Steer, 1987) is a 21 item questionnaire measuring the incidence and severity of depression. The BDI was completed at pretest, posttest, and follow-up intervals. Respondents were requested to circle the statement choice and corresponding number (0-3) that
best applied to them with regards to a particular aspect of depression. For example item #1 states:

0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

A total score from 0 to 9 is considered within the normal range while scores of 10 to 18 indicate a mild to moderate level of depression. A score of 19 to 29 suggests a moderate to severe depression and scores of 30 to 63 signal a severely depressed state.

The BDI is internally consistent with an alpha coefficient of .86 and is considered a reliable measure of depression (Beck & Steer, 1987). The measure has been used successfully as a change index in treatment evaluation studies (Beck, Steer & Garbin, 1988).

The Structural Analysis of Social Behavior-introject.

The Structural Analysis of Social Behaviour (SASB) (Benjamin, 1974) is a circumplex model of interpersonal relations and their intrapersonal representations. The instrument consists of two sections devoted to the measurement of intrapersonal self concept and interpersonal relations. Only the intrapersonal portion of the SASB, (SASB-I) was utilized in this study.

This theoretically complex instrument derived from the work of Murray (1938), Sullivan (1954, 1956) and the interpersonal models of Leary (1957) and Schaefer (1965), was completed at pretest, midtest, posttest and follow-up intervals. The SASB-I consists of 36 items rated on a scale of 0 to 100 at 10 point intervals with 0 representing "Not at All" descriptive; 50 representing "Moderately" descriptive and 100 representing "Perfectly" descriptive.
Benjamin (1987) generated a cluster model in which all the questionnaire items were collapsed into eight sub-scales. These clusters include: (1) Spontaneous Self, (2) Self-Accepting and Exploring, (3) Self-Nourishing and Cherishing, (4) Self-Protecting and Enhancing, (5) Self-Monitoring and Restraining, (6) Self-Indicting and Oppressing, (7) Self-Rejecting and Destroying and, (8) Daydreaming and Self-Neglecting.

Cluster scores reflect the degree to which the respondent agrees with the items identified as important to that cluster. For example, items in cluster #1 Spontaneous Self, center on easy going and carefree attitudes towards self and items in cluster #2 Self-Accepting and Exploring, tap self-acceptance and self-trust. Items in cluster #3 Self-Nourishing and Cherishing, highlight self-care and liking of self while items in cluster #4 Self-Protecting and Enhancing, pinpoint desires to advocate in a positive manner for oneself and ones own interests. The items in cluster #5 Self-Monitoring and Restraining, center on the degree to which respondents manage and control themselves and cluster #6 Self-Indicting and Oppressing, highlights respondent desires to punish and denigrate self. Cluster #7 Self-Rejecting and Destroying, taps the degree to which respondents attack and harm themselves intrapsychically. The items in cluster #8 Daydreaming and Neglecting of Self, focus on reckless and ignoring behaviours toward self.

The two key orthogonal dimensions of SASB are affiliation and autonomy. Affiliative items range from friendly and loving attitudes toward self represented in clusters #1 to #4 to hostile and attacking attitudes towards self reflected in clusters #5 to #8. Autonomy is represented by SASB items tapping freedom oriented attitudes towards self epitomized by cluster #1 and controlling attitudes toward self captured in cluster #5. All 36 items included in the SASB-I are a blend of the two dimensions of affiliation and autonomy.
The SASB has an internal consistency coefficient of approximately .90. Autocorrelations, factor analyses and discriminant functions performed in a variety of studies have shown the rating scale to be reliable, internally consistent and capable of differentiating between distressed and normal groups (Benjamin, 1974; Humphrey & Benjamin, 1986). The SASB has been described as a detailed, ambitious and clinically relevant tool for tapping self perception (Wiggins, 1982).

The Dyadic Adjustment Scale.

The Dyadic Adjustment Scale (DAS) (Spanier, 1976) measures marital satisfaction. The DAS consists of 32 items tapping 4 dimensions of the marital relationship. The total score obtainable on the instrument ranges from 0 to 151. The four sub-scales of the DAS include: (1) Dyadic Consensus which taps the degree to which couples agree on important relationship matters, (2) Dyadic Satisfaction which pinpoints degree of satisfaction and commitment to the relationship, (3) Affectional Expression reflects the degree to which the respondent is satisfied with the expression of affection and sex in the marriage and, (4) Dyadic Cohesion refers to couple togetherness. A total score of below 100 indicates marital dissatisfaction.

The measure has an internal consistency coefficient of .96 with reliability of .73 for the Affectionate Expression sub-scale, .86 for the Cohesion sub-scale, .90 for the Consensus sub-scale and .94 for the Satisfaction sub-scale.

Originally, the DAS was evaluated by three judges to discern whether the items were relevant to dyadic relationships, carefully worded and consistent with definitions of adjustment (Spanier, 1976). In later studies, the single principle of adjustment was found to underlie the entire instrument (Antill & Cotton, 1982; Kozak, Jarmas & Snitzer, 1988; Sharpley & Cross, 1982). In a
concurrent validity study, the DAS was compared to the Marital Adjustment Scale (Locke & Wallace, 1959) and the correlations between the two tests were .86 among married couples and .88 among divorced respondents (p. < 001) (Spanier, 1976).

**Case Description**

The following case description outlines the selection criteria employed to determine therapist and client suitability for inclusion in TARP and the current study. Also, the therapist's educational and professional background will be delineated in this section. In addition, the couple's demographic and family backgrounds, the presenting problems for which they sought help and the couple issues with which they struggled prior to therapy will be described. The scores obtained on the measures administered to the couple are reported throughout the case description.

**Therapist selection and description.**

The therapist featured in this study was one of five ExST therapists chosen for participation in TARP. To be eligible for participation in TARP, therapists had to hold a graduate degree in Psychology, Social Work or a related field. In addition, therapists had to have a minimum of three years experience in the alcohol and drug counselling field. Also, clinicians were required to complete specialized training and supervision in the conduct of ExST and demonstrate competency in the delivery of the therapy.

As part of the eligibility requirements for participation in TARP, therapists submitted five videotapes of sessions demonstrating experiential systemic marital therapy with alcohol-involved couples. The videotapes were assessed by an adjudication committee whose membership consisted of two co-developers of ExST. The committee rated two randomly selected videotaped
sessions from the five videotapes provided. The Therapist Competency Form (TCF) (Appendix E) was employed to screen therapists for participation in TARP and this research. A score of three or above on the TCF indicated competency in the conduct of ExST. The therapist featured in this study obtained a score of 3.35 on the TCF and was included in TARP.

In addition, the therapist held a Master of Arts degree in Counselling Psychology and had four years experience in the alcohol and drug counselling field when she conducted the therapy analyzed for this study. The marital therapy examined in this investigation was conducted by the therapist at a publicly funded alcohol and drug treatment clinic in an urban area of British Columbia.

The therapist is white, originating from an Anglo Saxon background, and was in her early 50's at the time of the treatment delivery. She was trained in the conduct of ExST by the co-developers of the therapy model. The therapist received 24 days of theory and skill training followed by 10 hours of direct supervision of clinical work with both individuals and couples. The therapist was offered clinical supervision during TARP by two co-developers of ExST, one of whom was the researcher. Live and videotape supervision formats were employed by TARP supervisors in the management of therapy. However, supervisory input was minimal with respect to the marital therapy analyzed in this study due to the therapist's ease with the case and her faithful adherence to the ExST model throughout treatment.

**Client selection and description.**

The couple selected for participation in this research was recruited through a radio broadcast advertising TARP. To be eligible for inclusion in TARP, the couple was required to meet the following eligibility criteria:
1. The couple must be comprised of a male alcoholic living with a non-alcohol abusing female partner. The alcoholic had to have consumed alcohol within the last three months to be considered eligible. The non-alcohol abusing female partner had to have no alcohol dependency problems in the last five years.

2. Both spouses must be between 21-65 years of age.

3. The couple must be experiencing marital distress while maintaining a commitment to repair the relationship.

4. The couple must be parenting at least one child currently living at home.

5. The clients had to be living together as a married or common-law couple for a minimum of one year.

6. The couple must be willing to complete 15 sessions of treatment over 15 to 20 weeks.

7. The couple must be willing to complete five periods of assessment including screening, pretest, midtest and posttest occasions concluding with a follow-up testing occasion of 15 weeks.

8. Remarried or blended families were eligible for participation in TARP.

Once the couple featured in this investigation met the inclusion criteria, they were screened into TARP.

The following case description is based upon client report and questionnaire information. The names and identifying client details that jeopardize anonymity have been changed for the purposes of the case description.

Sam and Jill entered therapy in January, 1991 and concluded treatment in May, 1991. They completed all the research questionnaires at pretest,
midtest, posttest and follow-up measurement occasions and returned them promptly. Sam and Jill re-contacted the investigator in January, 1994 to report that Sam continued to abstain from alcohol consumption. Also, in January, 1994, both spouses agreed they were satisfied with their marriage and Sam spent more time with the children since quitting drinking.

Sam and Jill live in British Columbia and have three children. Sam has a child from a previous relationship with whom he has occasional contact. At the time of therapy, the couple had been married 10 years. Neither spouse had been previously divorced or widowed. Their total family income was in the $50,000-$59,000 range and both Sam and Jill were white, having originated from Anglo Saxon backgrounds. Sam worked full-time in computer system sales and Jill worked part-time as a florist.

Sam is the youngest of three children. He traced alcoholism through his family on his father's side into the 1800's. Sam's father died alone of alcoholism. Sam's mother had asked his father to leave the family home when Sam was a toddler. Sam remembers being bullied by his older brother and physically abused by both his father and mother. Also, Sam suffered from severe and frightening convulsions as a child. Sam's mother raised her children without financial or paternal assistance and Sam remembers longing for more time from his mother as he grew. Sam resented his father for his absence and the fact that his mother had to work long hours to support the family.

Jill is the second eldest of five children. Jill's mother died and her father quickly remarried. Jill found her stepmother to be insecure, moody and abusive. Jill felt a great deal of emotional distance from her father and grieving her mother's death was forbidden when all references to her were removed from the home. Jill characterized her father as seldom intervening on her behalf and generally following the path of least resistance when it came to
conflict. Jill's mother's death and her father's withdrawal occasioned a sense of being abandonable which continued into adulthood. Jill recalled being silenced as a child as well as having her educational aspirations thwarted. Jill was told that girls did not need an education by her family. Jill observed that there was no alcoholism in her background noting family members to be "special occasion" drinkers only.

The couple entered therapy due to Sam's alcoholic drinking with the goals of abstinence from drinking and increased marital intimacy. Sam received a score of 45 on the Michigan Alcohol Screening Test (Selzer, 1971) indicating he was well within the range of alcoholic drinking. Jill scored 1 on the same test demonstrating that she was not dependent on alcohol. In addition, Sam was tested using the Alcohol Dependence Data questionnaire (Raistrick, et al., 1983) obtaining a score of 62 indicating a severe dependence on alcohol at pretreatment. Also, Sam reported that he smoked .5 grams of marijuana a day at the onset of therapy and had been previously addicted to codeine.

Sam observed that he had been drinking since he was 18 years old and had tried to quit eight or nine times over a 20 year period. Prior to obtaining experiential systemic marital therapy for alcohol dependency, Sam sought psychiatric help and attended Alcoholics Anonymous (A.A.) but was unable to remain sober. Sam indicated that efforts to treat his dependency on alcohol with psychiatric intervention and membership in A.A. were unhelpful. As a last resort, Sam turned to ExST for assistance. Following 15 sessions of ExST treatment, Sam reported a mild dependence on alcohol and at a follow-up period, three months later, he reported no dependence on alcohol as measured by the ADD (Raistrick et al., 1983) (Appendix H).

The couple experienced a great deal of distance from one another due to Sam's alcoholic drinking, his absence from home, Jill's previous postpartum
depression and both spouses fears of intimacy. Jill was afraid Sam would drink again and this made her tense, nervous and sad. Also, she noted a decline in physical gestures of affection and sexual intimacy. Jill was worried she would lose respect for Sam if he continued drinking. She stated she looked forward to more time together as a family once Sam abstained.

Sam admired Jill's intelligence but had difficulty considering Jill equal to him in the area of decision-making. Sam believed women's roles in marriage were as helpmate to men who were ultimately in charge. Sam found a basis for his beliefs in bible study. Jill revealed a desire to resolve conflict more effectively citing Sam's tendency to leave before she finished her point, dismiss her concerns or throw things at her during arguments. Jill observed that she tended not to discuss her feelings with Sam because he may walk away or the fight could escalate. Sam reported that sometimes he used the couple's arguments as an excuse to drink.

Both Jill and Sam scored within the distressed range when measured on marital satisfaction using the DAS (Spanier, 1976). Jill scored lower (x = 79) than Sam (x = 96) indicating she viewed the marriage to be considerably more distressed. However, at both posttest and follow-up, Jill and Sam's rating of marital adjustment had improved substantially with Sam and Jill scoring 114 and 112 respectively at posttest and 113 and 115 at follow-up (Appendix K). At posttest and follow-up testing occasions both spouses no longer scored within the distressed range but reported increased marital adjustment well within the non-distressed range. In addition, the difference in the spouses pretest scores noted earlier, had greatly diminished at posttest and follow-up.

Sam and Jill reported depressive symptoms at the outset of therapy. When measured on the Beck Depression Inventory (Beck, & Steer, 1987), Jill scored in the mildly depressed range and Sam reported a severe depression.
However, after therapy, both Sam and Jill scored within the normal range and the change was sustained at follow-up three months later.

While Jill reported no psychiatric symptomatology on all measurement occasions, Sam began treatment reporting extreme psychological dysfunction when measured on the SCL-90-R (Derogatis, 1983). After therapy, Sam scored in the normal range reporting no evidence of psychiatric symptomatology. At follow-up, three months later, Sam continued to score just below the normal range (Appendix, I).

In addition, both spouses reported negative self introjects before treatment when measured on the SASB-I (Benjamin, 1974). In particular, Sam experienced himself as low in self-acceptance and self-nurturant behaviour and high in self-hating and self-neglecting behaviour at pretest. However, at posttest and follow-up measurement occasions, Sam indicated that he experienced himself as more self-cherishing and self-enhancing and markedly less self-loathing and self-destroying (Appendix L). Jill's scores indicated diminished self-hating characteristics and greater self-loving behaviours at posttest and follow-up measurement occasions as well (Appendix M).

The couple's enthusiastic public endorsement of the treatment they received and an inspection of the scores obtained on the screening, pretest, posttest and follow-up measures indicated that the clients made significant changes with respect to their personal and marital functioning. The couple reported the cessation of alcoholic drinking and a marked decrease in personal and marital distress at posttest and follow-up measurement occasions. Reports of client and therapist satisfaction with therapy and evidence of marked posttreatment change, demonstrated that the case selected for analysis was representative of therapeutic success and would serve as a critical case exemplar of ExST.
Identification and Description of Relationally Novel Episodes

The successful case of ExST selected for analysis in this study contained eight relationally novel episodes from which two exemplars were chosen for examination. The construct, relational novelty, was chosen as a focus of analysis because it represented the core ExST theoretical concept describing therapeutic change. This section describes the six tenets of relational novelty and the procedure conducted to identify exemplars of the construct for analysis. The section concludes with a synopsis of the episodes selected for examination.

Relational novelty is both a process and an outcome encompassing six tenets (Friesen et al., 1991; Friesen, et al., 1989; Newman, 1991). For the requirements of this research study, all six tenets of relational novelty had to be evident in the episode before the segment could qualify for analysis. Relational novelty is characterized by the following tenets:

1. Therapist and couple collaboration.
2. The intensification of substantive relational themes, relational patterns, narratives or behaviour via therapeutic transactions with self, spouse or the presenting problem.
3. Important experiences, previously out of client conscious awareness emerge in therapy.
4. Clients speak, feel, think and behave atypically rather than speaking, feeling, thinking and behaving in a recurrently characteristic fashion.
5. Clients identify something new about self, their spouse or the presenting problem.
6. Relationally novel episodes follow a general pattern that begins with the facilitation of client narratives or utterances. The therapist then suggests delving into a salient aspect of the narrative or utterance through a therapeutic transaction. The clients consent and the therapist guides them through a deep, intense and novel encounter with self, other or the presenting problem. This encounter ends with a de-intensification during which the therapist may mark a change, congratulate the clients, summarize the encounter or ask the clients for their views of the experience. The therapist encourages clients to talk about the experience or they do so spontaneously.

Three episodes of relational novelty were found to contain evidence of all six tenets. The episodes occurred in sessions #2, #10 and #12 respectively.

Interjudge Agreement

To ensure the segments selected for analysis contained evidence of the construct under investigation, three expert judges rated four episodes of videotaped therapy using the Relational Novelty Identification Form (Appendix F). The scores obtained were compared to the researcher's scores for each episode. The expert judges consisted of two clinicians trained as Experiential Systemic therapists and one of the co-developers of ExST. The training engaged in by the expert judges consisted of lectures on Experiential Systemic Therapy theory and closely supervised field based practice.

In addition, specific training designed to aid judges in identifying relational novelty was conducted as part of this investigation. The specified training consisted of a review of the construct of relational novelty and instruction in the use of the Relational Novelty Identification Form, followed by
an independent rating of a videotape segment of relationally novel marital therapy. The pilot segment was different from the two segments selected for discourse analysis. During training, the researcher and judges compared scores and discussed commonalties and discrepancies between the ratings. After consensus was reached as to the use of the rating measure and the videotape content, the judges independently rated the three selected segments one week later.

Pair wise comparisons were made between the researcher's and the expert judges' scores on a test of relational novelty for the three segments. The index of interjudge agreement for Episode One ranged from 87.2 to 100 percent agreement with the researcher. The index ranged from 97.2 to 100 percent agreement for Episode Two and the judges scored 100 percent agreement with the researcher for Episode Three. The high agreement indexes indicated that there was little discrepancy between the judges and the researcher with respect to the identification of relational novelty in the segments selected for analysis. It is noteworthy that the pair wise comparisons indicated no discrepancy between the researcher's scores and the scores of the co-developer of ExST on the Relational Novelty Identification Form for all episodes.

Initially, three relationally novel episodes drawn from 15 sessions of marital therapy were selected for study. The episodes originated from session #2, #10 and #12 respectively and all three were transcribed in their entirety. Following the comprehensive discourse analysis of the first two change episodes found in session #2 and #10, the analysis was concluded. That is, the first two episodes showed evidence of thematic commonality and based on redundancy criteria (W. Boldt, personal communication, April, 1992), an analysis of a third episode was deemed tautological. Thus, the analyses of two
episodes of relational novelty were sufficient for the provision of an answer to the research question posed in this study. The two relationally novel episodes analyzed in this investigation are described below.

**Synopsis of Episode #1, Session #2**

Episode #1 is approximately 10 minutes in length and has been transcribed and analyzed in its entirety. A transcription of Episode #1 can be found in Appendix N. During this episode, the therapist employed an experiential activity called symbolic externalization of the bottle to promote relational novelty. At the outset of the segment, Sam declared he did not have a drinking problem per se, his problem was keeping the liquor in the bottle. Also, Sam insisted Jill not be involved in decision-making concerning his drinking. Sam wanted to handle his struggles with alcoholic drinking alone to prove to himself that he was not a failure. After reframing Sam's drinking difficulties as partly the result of an alluring bottle, the therapist asked both Jill and Sam where, in the room, they would place a large plastic bottle. The bottle symbolized the presence of alcohol in both Jill and Sam's life. Sam, with Jill's blessing, elected to place the bottle outside the therapy room. Following the removal of alcohol from the room, the therapist intensified Sam's experience of increased relaxation prompted by the departure of alcohol. The therapist's inquiries into Jill's experience of Sam's calm at having removed alcohol from the room led Jill to disclose her feeling of guilt for having stored alcohol for her own use when Sam was attempting to abstain. Also, Jill revealed her fear of Sam returning to alcoholic drinking. In an attempt to assuage her guilt, reduce her fear and act upon Sam's desire to remove alcohol from their lives, Jill suggested they get rid of alcohol together. Sam concurred
having experienced decreased anxiety after removing the bottle from the therapy room.

**Synopsis of Episode #2, Session #10**

Episode #2 is approximately 10 minutes in length and has been transcribed and analyzed in its entirety. A transcription of Episode #2 can be found in Appendix O. In Episode #2, the therapist utilized an experiential technique known as re-enactment. The therapist encouraged the couple to re-enact a fight they had before attending therapy. The room was rearranged to resemble the couple's bedroom and the therapist asked Sam to re-state his exact words to Jill to begin the re-creation of the fight sequence. Sam approached Jill to discuss a financial crisis and received, what he believed to be, a sarcastic comeback from Jill. Jill denied being sarcastic maintaining she was attempting to commiserate with Sam. The therapist forwarded a compromise solution which was later abandoned due to client insistence. The therapist's compromise solution cast Jill as "unintentionally sarcastic" and held Sam responsible for prompting Jill's "unintentional sarcasm" by being inconsiderate. Rather than accept the compromise forwarded, the therapeutic system explored the effects of Sam's desire to believe Jill was sarcastic when she said she was not. The episode concluded with the therapist encouraging Sam to behave differently towards Jill.

The two episodes selected for analysis in this research represented exemplars of relational novelty. To aid in the investigation of this construct, all 15 sessions of therapy, including both Episodes #1 and #2, were captured on videotape. The following section describes the production of the videotape record.
Videotape and Audiotape Production

All 15 sessions of ExST were videotaped as part of TARP procedures with permission from the clients (Appendix V). The videotapes provided the data for the discourse analysis of the therapy construct under investigation. Fifteen sessions of ExST were recorded using a video camera mounted in the corner of the therapy room. A wide angle lense was used to accommodate the room size allowing the therapist and clients to remain in view anywhere in the room. The videotapes were clear, although close-up views of facial expressions were impossible due to the stationary position of the camera. Two sensitive multidirectional microphones captured all sounds in the room. The sound fidelity was excellent with minor moments during which speech was unintelligible. A brief interlude of machinery noise caused by renovations in a neighbouring office interrupted parts of session #2 but the therapist and clients compensated by talking over the interruption.

The transcription of the audio and videotaped data was vital to the conduct of the investigation since the discourse analysis procedure required an accurate text before analysis could proceed. As a result, audiotapes of the videotaped sessions were made and a dictaphone was employed to aid in the transcription of the therapeutic discourse. In addition, all videotapes of the 15 sessions of marital therapy were viewed several times to identify nonverbal cues and provide an overall context for the discourse analysis. The transcription of the verbal, paralinguistic and nonverbal cues was facilitated by the high quality of the video and audio recordings of therapy. The videotapes, audiotapes and transcriptions of therapy were locked in a research office and only the researcher and authorized personnel were given access to the data. The provision of a clear record of the therapy under analysis aided in the
generation of the research results. The next section will outline the method by which the data was analyzed in order to provide an answer to the research question.

Data Analysis

The discourse analysis method employed in this investigation originated with the work of William Labov and David Fanshel in 1977. In their book, *Therapeutic Discourse: Psychotherapy as Conversation*, Labov and Fanshel (1977) pioneered the Comprehensive Discourse Analysis procedure and provided a case example illustrating the application of the method with an individual client complaining of anorexia nervosa. CDA is a method of analysis specifically created to examine naturally occurring therapy discourse.

CDA was created by Labov and Fanshel (1977) in an attempt to offset the methodological limitations observed when the bottom-up model of conversation analysis was employed to explore psychotherapy process. The bottom-up model is characterized by an emphasis on sequencing rules and cognitive linguistic processing as found in turn-taking and adjacency pairs research (Corsaro, 1985). These investigations used adjacency pairs (a series of paired utterances such as questions and answers (Sacks, Schegloff & Jefferson, 1974)) or challenges and defenses (Labov & Fanshel, 1977) to identify the manner in which turn allocations were made between informal conversers (Corsaro, 1985). Little reference was made to participant status or conversational context in this research. A second strand, the top-down model, emphasized general goals, beliefs, events, maxims and rules through which conversers recognize and maintain social interaction and organization over the course of a conversation or within that conversation (Corsaro, 1985). The relationship between the speakers was emphasized in this approach.
Labov and Fanshel (1977) noted that the bottom-up approach to conversation analysis had as its general goal the identification of combinations of single units in order to understand the structure of discourse. The study of sequencing rules began with the smallest units in order to isolate larger structures later. However, the approach did not provide a method of investigating implicit communication or aid in understanding how speech acts perform several functions simultaneously. For these reasons, Labov and Fanshel (1977) observed that a reliance on the study of sequences, such as turn-taking in conversation, presented a limitation when psychotherapeutic conversations were under investigation (Cicourel, 1980). To offset this limitation, Labov and Fanshel (1977) combined the analysis of speech acts (the top-down model) with the analysis of sequencing rules (the bottom-up model) to understand therapeutic conversation as more than an exercise in conversational turn-taking (Russell, 1979).

Labov and Fanshel (1977) observed that speech included a large number of intonations, hesitations, stresses and laughter that provided clues as to the speaker and listener's understanding of what was occurring between them. They also noted the existence of unexpressed social and psychological propositions in many utterances. As a result, Labov and Fanshel reported that conversers understand and respond to each others speech acts at many complex levels of abstraction. Labov and Fanshel maintained that "as we see it now, conversation is not a chain of utterances but rather a matrix of utterances and actions bound together by a web of understandings and reactions" (p. 30).

CDA is recognized as a valuable contribution to clinicians, discourse methodologists, sociologists and investigators of language structure including linguists and conversational analysts (Grimshaw, 1979). Labov and Fanshel's (1977) work has been described by Corsaro (1985) as "the most extensive
substantive application of a discourse model yet to appear in the literature" (p. 183). Todtman (1990) asserted that Labov and Fanshel have authored an outstanding effort which continues to represent "the most detailed and comprehensive analysis of discourse yet accomplished" (p. 44).

Corsaro (1985) highlighted the methodological strengths of the procedure maintaining that it recognizes the importance of working with naturally occurring discourse. CDA also went beyond linguistic or turn-taking structure in formulating discourse rules. Labov and Fanshel's (1977) innovation of expanding the text was considered to be a methodological boon since it moved beyond analyzing isolated utterances. Text expansion tapped both the context in which speech acts existed and their implicit meanings. In addition, the expansion and interaction analysis process was presented in full and all analyst interpretations were open to the scrutiny of readers.

**Cross Sectional Analysis**

Labov and Fanshel (1977) identify two types of discourse relations. These include those united by rules of interpretation and production and those united by sequencing rules. That is, in the former case, surface utterances give clues as to the deeper conversational actions they may perform. In the latter case, actions follow utterances sequentially. The authors suggest that these two relations be combined through cross sectional analysis. This procedure entails the identification of small units for analysis in order to reveal their internal relations. These cross sections are not ends in themselves since questions such as what occurs in therapy or how does change occur in therapy necessitate a longitudinal study of the production and sequencing of verbal interaction.
Labov and Fanshel (1977) chose to identify five episodes of therapy for analysis. They analyzed 15 minutes of a therapy session and confined their comments to segments which were clearly differentiated from one another via a sudden topic shift. However, the issue of segmenting therapy into analyzable units, although practical, has proposed a challenge to change process researchers. Segmenting therapy into units can lead to an incomplete understanding of therapy change process. Nevertheless, the comprehensive and longitudinal nature of Labov and Fanshel's procedure serves to offset this concern. The analysis of the same construct over a complete course of therapy serves to contextualize the segment under consideration. In addition, CDA allows for the influence of both past and future verbal sequences and paralinguistic cues to be included in the analysis of the episode of interest.

A cross sectional analysis of a selected therapy episode requires five steps. These steps include text transcription, text expansion, propositional analysis, interactional analysis and an episode summary.

**Text Transcription**

The words and physical movements of the therapist and clients were captured in the text transcription. The transcription of the physical and verbal discourse was achieved via Jefferson's notation system (Schenkein, 1978) (Appendix G). This system is recognized as useful to microanalysis since it attends closely to paralinguistic cues (Gale, 1989). While other researchers (Gale, 1989; Todtman, 1990) generally avoided the transcription of physical cues, physical movements by the therapist and clients were incorporated into the transcripts in this investigation. The inclusion of physical movement in the transcripts was necessary due to the experiential nature of ExST. In addition,
the analysis of the spoken word was facilitated when videotape data was transcribed.

Two episodes drawn from session #2, and #10 were transcribed using a standard dictaphone with foot pedal and a video cassette recorder. A preliminary transcription was conducted during which the therapist and clients' utterances were recorded in a rudimentary fashion. A second listening sharpened the transcription and a third continued to polish the auditory portion of the transcription process. Once the transcription of the verbal text and paralinguistic cues was complete, the videotapes of the segments were viewed for the purposes of rechecking the verbal text and recording physical cues. The videotape was played in a painstaking frame by frame manner to capture the therapist and clients' movements. When these movements had been recorded, the videotape was played back several frames at a time to check the entire transcription. Physical movements that coincided with speech acts were placed beside these utterances in brackets in the text.

**Paralinguistic cues.**

Pauses and tempo changes are crucial to understanding the implicit themes conveyed in text. Breathiness, high pitched speech, laughter, crying, sighs, suppressed laughter and other paralinguistic phenomena are placed outside the text by Labov and Fanshel (1977). Since paralinguistic cues sometimes contradict explicit speech acts, the interpretation of paralinguistic cues is essential to the study of implicit meanings embedded in the clients words or tones. This interpretation is conducted regularly by therapists and repeatedly made explicit in therapy. However, Labov and Fanshel (1977) recognize the difficulty encountered when transcribers attempt to understand paralinguistic cues. They identify 10 broad meanings associated with
paralinguistic phenomena. These include cues that are meant to convey
tension, tension release, exasperation, mitigation, aggravation, sympathy,
derogation, neutrality, and reinforcement which includes utterances that do not
interrupt the speaker and do not convey highly specific messages (Labov &
Fanshel, 1977). A working knowledge of this general category system allows
for the infusion of implicit and explicit meaning into the text. This functions to
make speech acts coherent to the speaker, listener and the analyst. Labov &
Fanshel (1977) maintain that "if we did not attribute meaning to many of these
paralinguistic cues, we would find that the discourse was incoherent at many
points" (p. 18).

The text episodes analyzed in the current study included paralinguistic
cues in brackets when they present themselves in participant speech. When
past or future sessions were referred to during the analysis of Episode #1 or
#2, the session content referenced was transcribed.

Expansion

Following the separation of speech, paralinguistic cues and nonverbal
movement, the next step in CDA is synthesis. The information gathered thus
far is combined to provide assistance in "understanding the production,
interpretation and sequencing of the utterance in question" (Labov & Fanshel,
1977). Expansions include the following elements:

1. The meaning of the paralinguistic and nonverbal cues is explicated
   in textual terms.

2. References to pronouns, events, other time frames and other
   utterances are made explicit.

3. Factual material is introduced that is presented both before and
   after the utterance from separate parts of the interview.
4. The participants' shared knowledge is explicated as it is derived from the study of the treatment as a whole and written accounts or discussions when available.

Expansions are open-ended and there are no limits as to the possible facts that could be utilized in understanding the utterance. The following example illustrates an expansion from Labov and Fanshel's (1977) work:

**Text:** Client: An-nd so---when---l called her t'day, I said, "Well, when do you plan t'come home?"

**Expansion:** Client: When I called my mother today (Thursday) I actually said, "Well, in regard to the subject which we both know is important and is worrying me, when are you leaving my sister's house where your obligations have already been fulfilled and returning as I am asking you, to a home where your primary obligations are being neglected, since you should do this as head of our household." (p. 160)

According to Cicourel (1980), the expansion model is concerned with:

... the relationship between what is actually said, including paralinguistic and nonverbal activities, the expansions that are part of the researcher's analysis, the attribution of intentions and the way the interaction unfolds because of locally generated conditions and the broader socio-cultural context in which talk is embedded. (p. 111)

The third step in the analysis is the identification of propositions that contribute to the "fabric of the conversational interaction" (Labov & Fanshel, 1977, p. 51). The expanded text provides a context for these propositions.
Propositions

Propositions are defined as recurrent communications that represent what is implicitly being talked about. Recurrent material is explicitly identified in order to reconstruct implicit meanings. There are five types of propositions identified by Labov and Fanshel (1977). These include:

1. Generalized therapy propositions such as "Fred should gain access to his emotions".
2. Psychological propositions such as "Fred experiences anger".
3. Status propositions such as "Fred controls the household".
4. Performance propositions such as "Fred never helps around the house".
5. Characterological propositions such as "Fred is lazy".

These propositions can be linked together or stand separately. For example, Fred never helps around the house because he is lazy or Anna's experience of being unloved is similar to Fred's experience of being unloved. Despite Labov and Fanshel's (1977) identification of five types of propositions, they assert that discourse analysis cannot be undertaken with a predetermined set of propositions. It is the analyst's responsibility to locate recurrent themes in the conversation being studied.

Underlying propositions are not always in the awareness of participants. That is, people may not be conscious of hearing an utterance in the way they did. The manner in which the utterance was heard may be evidenced in their reactions to it (Bilmes, 1985). It also follows that speakers may not be entirely conscious of the meaning with which they infuse a particular utterance. As such, they may share with the listener equal difficulty describing the implicit meanings inherent in their comments. In other words, speakers are not always conscious of what they have said about themselves in their utterances and
listeners are not always consciously aware of what they have heard. The consistent tracing of both explicit and implicit recurrent themes in client speech acts helps the analyst understand how members of the therapeutic system utilize therapy talk as treatment.

**Analysis of Interaction**

The next step in the analysis is "the determination of the actions that are being performed by speakers through their utterances" (Labov & Fanshel, 1977, p. 58). Labov and Fanshel (1977) note how speech serves a social organizing function. As such, interaction is defined as "action which affects (alters or maintains) the relations of the self and others in face-to-face communication" (Labov and Fanshel, 1977, p. 59).

Also, interaction can be defined as the analysis of the meaning of a statement. Labov and Fanshel (1977) maintain that the analysis of interaction provides researchers with an understanding of the differing and co-existing levels of meaning conveyed through discourse. The action of a speech act is what may have been intended either consciously or unconsciously by the speaker when he/she made the utterance. For example, a speech act may be information given as an answer to a request and also be meant to hurt the listener.

The following example of an interaction from Labov and Fanshel's (1977) work illustrates how the client's speech act may reflect upon herself, her mother and her therapist:

The client continues the narrative, and gives information to support her assertion that she carried out the (therapist's) suggestion (to speak directly to people with whom she is having difficulty). The client requests information on the time that her mother intends to come home and thereby requests indirectly that her mother come home . . . (The client is simultaneously
challenging the therapist's role as expert with proof that the therapist's suggestion did not help the client get what she wanted despite her attempt to apply the advice. (The client also challenged) her mother indirectly for not performing her role as head of the household properly, simultaneously admitting her own limitations (and) asserting again that she carried out the therapist's suggestion. (p. 59)

This example of an interactional statement is a summary representing the result of discourse analysis. Upon further inspection, it is noteworthy that both therapist and mother are challenged by the client for not performing their roles properly. The therapist is seen as a giver of defective advice and the client's mother is viewed as a negligent caregiver. Both therapist and mother are construed as unhelpful and neglectful of the client who, in her view, must go it alone.

**Episode Summary**

CDA freezes social interaction into individualized utterances and these "still frames (must be connected) into a moving picture" (Labov & Fanshel, 1977, p. 69). The episode summary provides this reconnection and is utilized in the generation of the study results based on the analyzed episodes. When the episode analysis was complete, the analyst combined the expansions, propositions, and interactions discovered in the text to provide an understanding of therapy change process as it unfolded over the entire episode.

Once the analysis of Episode #1 and #2 was complete, important patterns and themes in the creation of relational novelty became evident. However, it became apparent that the inclusion of the entire analysis of Episode #1 and #2 was too lengthy for inclusion in this document. As a result, illustrative analysis selections were employed to explicate the themes emerging from the analysis.
CHAPTER IV
RESULTS

This chapter focuses on the results of the Comprehensive Discourse Analysis of Episode #1 and Episode #2. Results pertaining to the research question posed in this study will be discussed in two main sections. The first section provides a detailed account of the research findings utilizing illustrative text analysis excerpts to illumine study findings. The second section featured in this chapter provides a summary of the research results.

While the discourse analysis of Episode #1 and #2 was completed in its entirety, the product of the analysis will not be reproduced due to its prohibitive length. Accordingly, text excerpts drawn from the complete analysis will be employed to explicate research findings. While propositions were identified to aid in the formulation of interaction statements, these propositions will not be featured amongst the text excerpts for the purposes of brevity. The complete discourse analysis of Episode #1 and #2 is 165 pages in length and available upon request.

Results of the Comprehensive Discourse Analysis of Episode #1 and Episode #2

The exploration of the results of this study will include a description of an important interactional process discovered in the relationally novel segments selected for analysis. The interactional process present in Episode #1 and Episode #2 was observed to be significant in the creation of relational novelty and may be described as a syncretic change process. The syncretic change process will be defined and delineated in this chapter including an articulation of the two elements of the syncretic change process namely: (a) Initial
disagreement and conflicting belief and practice, and (b) contributions by the therapeutic system to convergence and transformation. The exploration of the first element of the syncretic change process will include attention to disagreement amongst therapeutic system members in both Episode #1 and Episode #2. The delineation of the second element of the syncretic change process will be divided into two parts. These parts include a description of how the influence of intense experiential activity aided the generation of relational novelty and how the provision of a collaborative atmosphere in therapy enabled relational change.

The Syncretic Change Process

The Comprehensive Discourse Analysis of Episode #1 and #2 indicated the presence of an organizing interactional process found to provide the creation of relational novelty with direction and purpose. This organizing process is referred to as a syncretic change process and is characterized by a shift away from disparate belief and practice on the part of therapeutic system members toward less disparate and more intimate relational views and behaviours. Hence, the syncretic change process is characterized by the generation of intimacy by therapeutic system members where initially there existed disparate and distancing beliefs and behaviours that alienated system members.

The syncretic change process provided the promotion of relational novelty with direction and purpose. As such the relational change analyzed in this investigation took the form of movement away from distance oriented patterns of interaction towards intimacy enhancing ways of being. The creation of relational novelty was organized around the enhancement of couple intimacy giving purpose to therapeutic activities that define relational novelty.
Thus, therapeutic activities that characterize relational novelty such as encouraging therapist/couple collaboration, promoting atypical experience, fostering cognitive insight, bringing unacknowledged experience into conscious awareness and evoking substantive relational themes were provided with an intimacy enhancing and distance reducing raison d’etre.

The syncretic change process involved the various therapeutic activities associated with relational novelty to effect couple change. These therapeutic activities promoted couple change in the form of increased intimacy and reduced spousal distance when intense experiential activity and a collaborative therapeutic atmosphere was fostered in therapy. That is, the shift away from disparate or distance oriented exchanges toward increased mutuality was facilitated by relationally novel therapeutic activities that occurred when intense experiential activity was engaged and a collaborative therapeutic atmosphere was encouraged.

The syncretic change process can be divided into two parts that represent different but related aspects of the construct. These parts mark the main qualities characterizing the syncretic change process. These include: (a) Initial disagreement and conflicting belief and practice, followed by (b) therapeutic system contributions to convergence and transformation resulting in increased mutuality and commonalty of belief or practice. The two aspects of the syncretic change process will be explored drawing upon the discourse analysis of Episode #1 and #2.

**Initial Disagreement and Conflicting Belief and Practice**

It was observed in both Episode #1 and #2 that the therapeutic system members held conflicting views regarding the issues of alcohol consumption and spousal supportiveness respectively. In addition, therapeutic system
participants each supported differing methods of remedying the impasse created by disparate views concerning the problematic nature of alcoholic drinking in Episode #1 and the degree of spousal concern offered in Episode #2.

The discourse analysis of Episode #1 uncovered three differing viewpoints and text analysis excerpts will be examined to detail this finding. In Episode #1: The Bottle is Shown the Door, differing opinions regarding the degree to which Sam's alcohol consumption was problematic were encountered when the question of removing alcohol from the home was raised. The following text analysis excerpt encapsulates the disparate views held by members of the therapeutic system and captures Sam's ambivalence regarding the continued consumption of alcohol.

Text: Lines 1-14.

Th: (.hh)Andah ((left hand elevated and rocking)) on the one ((left hand gestures, palm up)) hand it makes it harder for you Sam - that alcohol is in the house ((Jill looks toward Sam))
.hh)and on the other hand ((left arm opening, palm up, right =
[ ]
S: ((weakly)) Yeah

Th: =arm lifting, opening, dropping back to lap)) you think we::ll if I wanted it I'd get it anyway so(.hh)part of you ((left hand raised, fingers bent in rocking motion)) thinks well lets =
[ ]
S: Yeah

Th: =just keep it there ((makes a fist with left hand)) =

Expansion.

I understand that there are two sides to the issue of whether alcohol should be in the house. On one hand, since you have a problem with drinking too much, it is harder for you Sam to be abstinent when alcohol remains handy. I recognize that this statement represents a challenge to you since you have just finished telling me that alcohol in the home is not a problem. I am also aware that Jill believes having alcohol in the house is a problem for you.
On the other hand, I will now include your rationale for keeping alcohol in the house remembering that you have a drinking problem and wish to abstain from drinking alcohol. You believe that if you wanted to drink you would anyway therefore there is a part of you, not all of you, that wants to hang on to alcoholic drinking. I say a part of you because I recognize that I am confronting you with the need to remove alcohol from your home and your life if you are to reach your stated goal of abstinence. I wish to be careful not to alienate you at this early stage of our relationship since I perceive you to be feeling defensive and out of control when discussing the topic of your drinking. I also understand that this is our second session together and I am being careful to reflect your own and Jill’s perspective and mirror your two part struggle with abstinence; Sam wants to stop drinking but he cannot do so yet because he remains committed to alcoholic drinking for the time being.

1. Interaction.

The therapist is attempting to clarify and challenge two of Sam’s incompatible assumptions. Sam declares his wish to abstain from alcohol while claiming alcohol is not a problem for him. The therapist mitigates her challenge by summarizing the two sides of Sam’s dilemma with alcohol and allows him to explain further in the next turn. The therapist perceives Sam to be feeling defensive and out of control when discussing alcohol and makes an effort to summarize Sam’s dilemma without humiliating him. The therapist is also adding credence to Jill’s view that alcohol in the home is a problem for Sam. Hitherto, Jill has been discouraged by Sam from commenting upon his struggles with alcoholism. In this utterance, the therapist encapsulates Sam’s struggle to become sober despite his commitment to alcoholic drinking. In effect, the therapist clarifies and challenges Sam’s statements, adds credence to Jill’s view that alcohol is a problem for Sam, and demonstrates an understanding of Sam’s struggle with alcohol.

In this excerpt, the therapist summarized the therapeutic system’s disagreement noting disparate client beliefs about the appropriate location of alcohol when abstinence was a goal. In the expansion of the therapist’s utterance, the three differing views were made explicit. The three views included: (a) Sam’s opinion that alcohol was not a problem and Jill should not be part of decision-making concerning alcohol or its consumption; (b) Jill’s view that alcohol was a problem for Sam and her reluctant refrain from passing comment on the topic of alcohol; and (c) the therapist’s view that alcohol was a problem for Sam and her belief that Jill be recognized as influential in the decision-making process concerning the whereabouts of alcohol.
Sam's opinion that alcohol was not a problem for him, as identified by the therapist in the previous text excerpt, was an example of a complex and contradictory intrapersonal struggle in which Sam both acknowledged alcohol consumption to be problematic while simultaneously minimizing alcohol's influence in his life. The following discourse analysis excerpt of Sam's response to the therapist's summary (Episode #1, lines 1-14) revealed the complexity of Sam's struggle.

Text: Lines 16-53.

S: Well its the challenge ((makes a fist in front of own face with right hand)) =

[ ]

Th: Yeah

S: its its there its like that ((points toward the bottle)) sitting there ((Jill looks toward bottle while Sam points)) like that really catches my eye - and ah - (.hh) you know - ((shrugs=

[ ]

Th: Yeah ((scratches face, Jill looks toward Sam))

S: shoulders)) it-it's the same sort of thing it-it's benign ((points to bottle and looks toward therapist)) as long as the top's on it. Okay - but when the top's off it and you're=

[ ]

Th: ah huh

S: = pouring it then it's a threat(.hh) and ah ((shakes head)) so I feel as long as I can keep the top on it, it's benign ((points toward bottle)) I can see it - visually(.hh)I can reach out and touch it yet ah - you know that's the challenge ((points at bottle)). There's the challenge there's the(.hh)the mountain you've gotta climb is right there. And that I can't say ((gestures)) it-re it does reinforce me ((points to self)) because I'm saying no to it(.hh)so it builds inside me again ((rolling hand gestures)) I mean I-I as I-um as I went through this last time ((gestures away from self)) I quit h-half a dozen eight times through the course of my life(.hh)and ah:hh things that fuel it like - a the first couple of times I quit(.hh)I could not have it in the house(.hh)and ((rapid hand gestures)) I could not walk into a bar:rt pub or anything and have a pop or have a Perrier or something like that Ijustsimplycouldnottodothatld wouldnotallowmyselftogetintosituation(.hh)where I might be fe-feel compromised(.hh)and ah:.hh now I've gotten ((holds out open hands)) over that ((opens arms, palms up)) step so you know like I-I dunno it-it does well I mean I wouldn't be talking about it if it didn't bother me I guess in the house but ah(.hh)it's sort of=
Expansion.

Well, your depiction of my dilemma makes me want to explain why I keep alcohol in the house. It's a challenge to not drink alcohol when it's in the house. It's in the house and it's like that plastic bottle sitting over there, I really notice that bottle and I'm not quite sure about that bottle being in this room just like I'm not so sure about having alcohol in the house but having the bottle here and in the house is the same sort of thing. I consider it benign, that is it is not threatening to me as long as I can keep the lid on it. So you see, the problem is not the alcohol but keeping the lid on the alcohol. When the lid comes off and I'm pouring it then its a threat, then its dangerous. The challenge is keeping the top on the bottle when its in the house so therefore the alcohol is not a problem for me. It's the fact that the lid comes of it and I pour it that is the problem for me but I'm not bothered by the alcohol being in the house. Even though I can see it and touch it at home the challenge is keeping the top on it and that's the hardest thing for me to do, that's the mountain I have to climb. However, I can't say that having alcohol at home helps me keep the top on but on second thought it does help to have it at home because by saying no to it, not removing the top and not pouring alcohol, I feel in control and less of a failure. Unfortunately, the urge to remove the top and pour the alcohol eventually builds up inside me after awhile and I feel like a failure because alcohol gets the better of me again. I said this last session but I'll say it again even though I find repeating how I have failed to abstain somewhat embarrassing but I'm trying to be honest here. I have tried unsuccessfully to quit drinking six to eight times over the course of my life. The first two times I tried to quit I found that alcohol in the house fueled my desire to take the top off it and pour it as did going to a bar or pub for even a pop or Perrier. I could not trust myself to allow myself to tempt myself in this way and I would not allow myself to get into a situation where I compromised myself by drinking when I knew I shouldn't. I was a real failure then and I was very weak willed. However, now I'm over the stage where I must keep it out of the house and keep myself out of bars even if I order nonalcoholic beverages. You see, I can have alcohol in the house now as well as order nonalcoholic beverages in bars because I'm not as weak as I was, I'm over this step so, well, I'm really not so sure about all this right now because I just described the first two times I tried to quit and I haven't accounted for my four to six recent failures. I think you may be correct in assuming that it does bother me to have alcohol in the house because I have a problem with alcohol that is embodied in getting it, taking the top off it, pouring it and drinking it. I am afraid to admit this because I feel like a failure, I feel weak. I feel powerless to do anything about my drinking, I've tried to control it on my own in the past and my efforts have been unsuccessful. I should be able to do this on my own and the fact that I am in therapy because of my lack of success demonstrates how weak and incompetent I am.

2. Interaction.

In this utterance, Sam is addressing the therapist's challenge by defending having alcohol in the home and attempting to define his problem as not with alcohol but with taking the lid off it and pouring it. He also communicates his sense of failure to the therapist and Jill as he describes his previous struggles with alcohol. Sam eventually notes that the therapist and Jill are correct in assuming that having alcohol in the home bothers him. Sam is reluctant to accept the notion that having alcohol in the home is unwise since it
represents a failure on his part and leads to a sense of incompetency and inadequacy in Sam. He feels embarrassed and afraid of this sense of failure. Admitting that he has a problem with alcohol which he alone cannot solve is a difficult task especially when it is achieved in front of Jill. Sam’s relationship with alcohol appears almost sexual in its metaphoric content. That is, he is having an affair with the substance, is tempted by it and finds himself unable to resist removing its top and imbibing. The therapist's response captures the sexual metaphor existing in Sam’s relationship with alcohol.

Sam struggled with a sense of failure and incompetence when discussing his inconclusive attempts to abstain from alcohol. His desire to be in control and strong as opposed to weak made admitting alcohol was a problem an onerous task. As a result, Sam encountered difficulty reconciling his opposing beliefs. He ambivalently argued against admitting alcohol was a problem while recognizing that he needed help in ending a long-standing addiction.

As well as expressing ambivalence, Sam was adamant that Jill refrain from commenting on his alcohol consumption since her input served to heighten his sense of incompetence with regard to his inability to stop drinking alcohol. Thus, as discovered in the text excerpt below, when Jill ventured to suggest that alcohol be removed from the home, Sam was quick to dissuade her from discussing the subject.

Text: Lines 60-91.

Th: (=clenched hand) can I cope with this?

J: (=thumb gesture) because it's always out of the way ((holds left hand up towards bottle)). It's up in the cupboard way out of the way an' you =

S: Yeah, but we don’t see it

J: (=probably wouldn’t even know it was gone until I got rid ((lowers hand)) of it but then I thought if I did that - ((back and forth gesturing)) without saying anything then I’m ((points =

S: You're interfering you're interfering with m:y
J: =to Sam)) interfering with his way of handling the situation=
   [ ]
S: yeath of handling the situation

J: =((gesturing to self and back and forth)) which has always been he’s
((points to Sam)) always handled it his own way. So that’s why I’ve always
not touched it is because - ((opens =
   [ ]
Th: Uhum

J: =hands, fingers spread)) he wants to do it his way. So::::o we’ll do it that
way

Expansion.

If there is a question of whether Sam can resist the temptations of
alcohol then we should get rid of it outright. I have often thought to myself
that I should take it upon myself to remove the tempter from our home and our
lives. [Therapist: I recognize that I’ve been interrupted and I will relinquish the
rest of my turn to you, Jill]. I’ve even noted how easy it would be because
Sam would not notice since alcohol is always away, up in the cupboard, far,
far away. I must emphasize how far away alcohol is in our home because I
sense Sam may become defensive and feel as though I am attacking him.
[Sam: I’m interjecting here to make it clear that we cannot see the alcohol
because it is kept so far away. This demonstrates that alcohol kept in the
cupboard is less of a problem for me than alcohol kept in view. I am feeling
defensive and like a failure as Jill is talking. I told Jill in the past that I will
handle my problem with alcohol and I have failed to do so]. I am aware Sam is
interjecting here and becoming defensive so I will emphasize how far away
alcohol is in our home because I take great pains to prevent him from feeling
attacked. Sam, since alcohol is not in view, you would probably not even
notice alcohol was gone until I actually removed it and you went to drink it and
it was missing. I have thought about removing alcohol from our home but I
knew if I did remove alcohol surreptitiously I would be being sneaky. [Sam: I’m
interjecting here to tell you that removing alcohol from our house without me
knowing is sneaky. You are interfering with my battle with alcohol and
because I said I would beat alcoholism on my own you are implying that I have
failed in my struggle with alcohol. By saying you want to remove it from the
house you are saying I am a failure and I am becoming quite anxious right now.
I want you to stop saying you are going to remove alcohol from our home, I
want to conquer this myself, my way]. I know I would be interfering with your
way of dealing with alcoholism if I took it upon myself to remove alcohol from
our home. Your way of dealing with the temptations of alcohol has always
been to, I’m thinking better of continuing since Sam, you are becoming agitated
when I discuss my desire to remove alcohol from our home. I will instead
reiterate to the therapist that Sam has always handled alcohol his own way and
that is why I do not broach this topic with him very often and that is why I
don’t throw the alcohol out. Sam gets too defensive, agitated and feels
attacked when I suggest I handle alcohol by getting rid of it. Since he wants to
keep alcohol in the house we do it his way and keep alcohol in the house. I am
resigned to this arrangement in order to keep the peace and Sam’s anxiety and
feelings of failure to a minimum.
4. Interaction.

In this utterance, Jill feels free to broach the topic of removing alcohol from the couple's home and their lives due to the new frame of alcohol-assessor generated by Sam and the therapist. Also, Jill discloses her own desires to be rid of alcohol. It appears that the effects of Sam's drinking on Jill are seldom discussed or acknowledged by Sam. It seems that this type of discussion accentuates Sam's feelings of inadequacy and failure. Jill demonstrates how she copes with Sam's sensitivity by taking great pains to prevent him from feeling attacked. This serves to lessen her opportunities for self disclosure regarding the effects of Sam's drinking. Jill states she is an honest person and despite the pain associated with Sam's drinking, she does not wish to remove alcohol behind Sam's back. Jill indicates that she is resigned to letting Sam handle alcohol on his own and communicates a degree of hopelessness to the therapist. Jill begins the utterance with certainty and enthusiasm, cheered by the evidence of Sam's reduced defensiveness incurred by the new alcohol-as-tempter frame. However, by experiencing Sam's vulnerability, Jill turns to the therapist at the end of the utterance with a measure of despair at the lack of influence she has with respect to Sam's drinking. Jill's speech act broaches her concerns regarding Sam's drinking while assuaging Sam's anxiety. She incorporates Sam's own words into her turn to calm him.

The text excerpt quoted above illustrated the conflicting views held by Sam and Jill regarding the proper location of alcohol in the home. Also, Jill's view that she should cooperate with Sam's desire and refrain from commenting on his alcohol consumption was uncovered in this excerpt. Jill recognized how Sam's tension increased when she suggested removing alcohol. To calm Sam, Jill respected Sam's request stating that if Sam insists she not comment on alcohol consumption or its whereabouts, she will comply. Sam described his insistence that Jill not comment on his alcoholic drinking as "blocking her out" (Episode #1, Line 105). The following text example provides an analysis of Sam's position regarding Jill's involvement in decisions concerning alcohol consumption.

Text: Lines 105-106.

Th: Alright-so ah- ((points finger upward, stands up, picks up bottle and sits down leaving right hand on bottle))

S: I've always blocked her out of my decision making with it. We went through that last time too =
Expansion.

I have always blocked Jill out of my decisions with respect to alcohol as I said in the last session. I emphasize the words blocked and out because I have decided that she should not be involved in any way with my decision to quit drinking. It is important to me that Jill remain outside of that decision since to allow her to influence me would indicate that I was not functioning well in my role as head-of-the-household (Appendix P, Session #8). As the patriarch in the family, it would be a sign of weakness if I was to be swayed by Jill’s desires that I quit drinking. Also, when Jill makes these desires known by crying I feel like a guilty failure because in my role as decision-maker I have failed to make the decision to quit drinking. As a result, I purposely keep Jill out of this and other decisions to reduce my feelings of failure and inadequacy. Now, I mentioned all this the last time we were together in a session and I am quickly reiterating it because I recognize that you wish to move on to a new topic by getting that plastic bottle that I pointed to earlier. However, I want you, therapist and Jill, to know that I make decisions about whether that bottle stays or goes.

10. Interaction.

In this utterance, Sam reiterates his position stating he is in charge of decision-making not Jill. Sam is also communicating to Jill that her previous foray into decision-making represented by her desire to throw the alcohol away was unwelcome. In this utterance, Sam does not agree completely with the therapist’s frame that Jill is a decision-making partner hoping to keep his position as main decision-maker relative to Jill unassailable. The reasons for Sam’s insistence on not sharing authority with respect to alcoholic drinking and general decision making appears to be twofold. Firstly, Sam’s religious upbringing taught him to view women as nurturers of men not decision-makers (Appendix P, Session #8). Secondly, Sam’s sense of worth and identity rests, in part, on being a competent head of household and a competent manager when it comes to alcoholic drinking. Sam’s alcoholic drinking has called this management position into question since alcoholic drinking is not considered a competent activity from a financial and personal view point (e.g., Sam’s abusive and alcoholic father was banished from the family home when Sam was young. His father died alone of alcoholism).

The therapist’s response to Sam’s assertion that Jill be blocked out of decisions centering on alcohol was to reiterate her position regarding Jill’s decision-making status. The therapist attempted to ameliorate the status differential existing between the couple by highlighting both spouses input into decisions concerning alcohol and its whereabouts. The therapist combined Sam’s desire to resist alcohol of his own accord with a joint decision-making
frame in her next turn. In addition, the discourse analysis highlighted the differing perspectives held by Sam and the therapist and Sam’s willingness to begin to entertain the therapist’s viewpoint.


Th: = It’s very - very significant that um - you ah - want a challenge ((leaves hand on bottle)) and - ah that ((removes hand from bottle)) you’ve been in agreement that he ((both hands palms facing move towards Sam pointing)) should be make decisions. You’ve blocked ((right hand glides toward Jill)) her out(.hh) she’s decided it’s your responsibility so together, ((both hands held up palms facing fingers bent, a shake for emphasis)) collaboratively ((hands held together)) you’ve agreed that he’s to make these decisions ((folds hands))

Expansion.

I consider it important that you like the challenge of trying to resist alcohol because I’m going to give you that opportunity soon using this plastic bottle. Also, despite your assertion Sam that you are the sole decision-maker, you both, Jill and Sam, have been in agreement that Sam should make decisions concerning the presence of alcohol in the home. I emphasize your name Sam because I want to make it clear to you that I have heard your concern that I understand that you are the decision-maker. I am listening to you Sam and I have heard what you have said today and last session about being the sole decision-maker. Sam, I recognize that you are the sole decision-maker because you have actively prevented Jill from sharing this position. However, I also know Jill has decided it is your responsibility to deal with alcohol when she refrained from throwing alcohol away without consulting you. So, you both have agreed together and cooperatively that Sam and only Sam is to make decisions with respect to whether alcohol stays or leaves your home.

11. Interaction.

The therapist notes Sam’s fears that his position as head decision-maker is not secure and communicates to both Sam and Jill that she understands he is sole decision-maker. However, she also reiterates her contention that by not throwing the alcohol away without consulting Sam, Jill has been a partner in the decision to let Sam decide whether alcohol should be in the house. The therapist continues to stay with the frame that the couple are joint decision-makers despite Sam’s previous insistence that they are not. Nevertheless, the therapist validates Sam’s contention that he is sole decision-maker regarding alcoholic drinking. The therapist both agrees and disagrees with Sam recognizing he is sole decision-maker while disputing how that came to be. The therapist asserts to both Jill and Sam that Sam was unsuccessful in blocking Jill out since Jill chose to refrain from intervening after careful
consideration of the ramifications of taking matters into her own hands without including Sam. Through the combination of Jill, Sam and the therapist's viewpoints, a frame of joint spousal decision-making is tentatively forwarded.

In this utterance, the therapist began to address an imbalance existing between the couple that centered on an uneven distribution of decision-making influence. The imbalance served to isolate the spouses from one another when Sam insisted he remain unaided in his bid to remain sober. Sam's desire to battle alcoholism alone meant he was unable to access support from Jill in a central area of his life. Sam's insistence that he cope alone with intrapersonal pain represented a pattern of self-seclusion adopted since childhood and as an adult male role expectation (Appendix S, Session #3).

The discourse analysis of Episode #1 revealed the initial disagreement existing between the therapist, Sam and Jill. These differences of opinion regarding the problematic nature of alcohol consumption and the degree to which Jill should be involved in decisions concerning alcohol isolated the spouses from one another. The syncretic change process uncovered in Episode #1 was marked by an initial difference of opinion between therapeutic system members with respect to the issues discussed in therapy. The differences between therapeutic system member's views were such that harmony of opinion was difficult to attain. Thus, before therapy, Sam was unable to end his drinking behaviour, alcohol was kept at home and Jill generally refrained from commenting on the consumption of alcohol and its location.

The discourse analysis of Episode #1 revealed disparate beliefs and practices existing between therapeutic system members. A similar dynamic was uncovered in Episode #2 during the enactment of a pre-session fight. That is, following a morning miscommunication, Sam viewed Jill to be a sarcastic rejector worthy of punishment while Jill viewed herself as commiserating with Sam. At the same time, the therapist believed a compromise solution in which
Sam was perceived as inconsiderate and Jill was cast as "unintentionally sarcastic" could prevail. Text analysis excerpts from Episode #2 will be examined to explore the conflictual beliefs and practices engaged by therapeutic system members. The following text excerpts from Episode #2 reveal the therapeutic system's disparate interpretations and the affective content of the various understandings of the morning dilemma. Sam's interpretation of the morning miscommunication will be explored first followed by Jill's understanding of the couple's argument. Lastly, the therapist's view will be examined as it relates to the couple's differing beliefs and practices regarding spousal support and problem solving.

The discourse analysis of Episode #2 revealed Sam's dismay at what he perceived to be an attack rather than support from Jill. The following excerpt delves into Sam's hurt and the pressure he experienced to perform adequately in his role as head-of-household and provider.

**Text: Lines 4-19.**

S: = Oh, I just, yeah okay, I've just spent an hour going over the books and um ah adding everything up an' trying to shave =

    [  

Th: = Oh

S: =from ((picking at shoe, shifting in chair)) here and put to there and, I mean, we just paid alot of the debt load down this:s last week and I was balancing the cheque book an' an' working out who's getting what an' to finish off because I've only got a couple more payments to make.(.hhh)and ah ((looking up)) I just simply came, I came in an' said good morning to the kids and sat down and I said I hope Broughton flies ((shakes head, looks at therapist)). It'll be, it will be very, it'll be tough the end of this month if it doesn't.(.hhh) And all I got from her was "same old scenario" =

**Expansion.**

Oh you have caught me a bit off guard, let me see how do I answer your question therapist? Yes, okay I know how to explain what happened. You
see, I have just spent an hour, before coming up to talk to Jill, looking at the ledger books trying to balance them. [Th: Balancing the budget sounds like a lot of work and worry, please continue with your recounting of the morning]. I tried to trim some money off certain items in the budget to pay the bills we have. I am uncomfortable with our debts, but we have large debts and we just paid off a big chunk of debt this last week. However, I was balancing the cheque book this morning to juggle which creditor gets what money because I only have two more payments to make before we are out of debt. I'm looking down at the floor right now because I feel embarrassed that I am having trouble paying the bills due to debts incurred and failed business deals. I feel like a failure as a man and as a provider and this contributes to my sense of unworthiness and inadequacy. Anyway, all I did this morning was I came into the bedroom and said "Good morning" to two of our children who were in bed with Jill and I said "I hope the Broughton deal works out because if it doesn't money will be scarce at the end of the month". That's all I said therapist, I was polite, I was up-front and instead of getting the support and comforting I needed at the time, all I got from Jill was a sarcastic response when she said "same old scenario". That really hurt me and I felt rejected by her. I approached her with a problem and I was really worried about the finances, I'm already feeling like a failure and inadequate and her comment made me feel even worse. Jill said that I was a failure and I could be predicted to be a failure with her comment. Jill implied that I was incompetent and as far as I'm concerned this was a slap in the face and a kick to someone who was already down. It was unfair and very painful for me.

2. Interaction.

Sam replies to the therapist’s question in this turn by telling her and Jill about his struggle with the books in the early morning. He implicitly expresses his hurt and feelings of rejection in this utterance but refrains from responding directly to the therapist’s question about his feelings. Sam finds it uncomfortable to disclose his vulnerability in an explicit fashion especially since he perceives Jill to have responded harshly when he approached her with his fears. His brief encapsulation of his sense of inadequacy and worthlessness in the sentence "I hope Broughton flies" refrains from indicating the depth of his despondency. Sam’s sense of embarrassment at having financial difficulties and his notions about how the head of the household should react to stress prevents him from initiating a conversation with Jill based on his fears regarding the finances and his feared role in their delapidated state.

Sam’s uncertainty about his personal competency was revealed in the discourse analysis of Episode #1 and Episode #2. In Episode #1, Sam worried he was inadequate because he could not abstain from alcoholic drinking and in Episode #2 he cited growing debts and business setbacks as threatening his
position as competent head-of-household. The analysis revealed that Sam battled a sense of failure, weakness and incompetence on many fronts leading to a questioning of his personal worth. Failure to conquer alcoholism and land business deals jeopardized Sam's good opinion of his performance in the role of head-of-household and family provider. Sam maintained Jill had sarcastically rejected him the morning he told her about the family's financial troubles. He experienced her as rejecting him on the basis of his poor business performance. Also, Sam's interpretation of Jill's response elicited a sense of inadequacy as revealed in the following text excerpt from the discourse analysis of Episode #2.

Text: Lines 133-161.

S: The rejection, (therapist gives slight nod)) as well umm= [ ]
Th: Yeah

S: =it's there because its's, I mean, ah I'm not going to umm fall back on it, I've just spent four months in rehab for whiplash and then I blew the knee out and I'm not operating 100 percent so things have not been movin'. I came= [ ]
Th: Yeah

S: =back into the business again and ah the first two weeks back= [ ]
Th: yeah ((stands up arms folded across chest, looks at Sam))

S: =I made about $10,000 and(.hhh)it looked like a whole lot more was underway and hasn't come to pass and ah that's::s ((therapist puts hand on her chair)) tough on me.= [ ]
Th: Yeah ((crouches beside Sam's chair))

S: =to you know, I get my hopes up which is something I shouldn't do I should rather ah proceed with the business than meet, than count the money all the time it's hard when you've got creditors= [ ]
Th: Yeah ((nods three times))
S: = that are going well let’s have it.

Expansion.

I feel a lot of rejection from you Jill and [Th: Yes, go ahead] the rejection is there because I take responsibility for the business not doing well. The reason I have not been as successful as I would like to be is because of a variety of physical problems that prevented me from working. I am not trying to make an excuse for my poor business performance by telling you about my physical problems but I have not been as successful with the business because I spent four months away from work to treat my whiplash injury. Then to add to the problem, I re-injured my knee. So you see I have not been functioning at my best and the business has not gone well. [Th: Yes, that is tough on you]. I feel guilty about the lack of success and I believe that a truly successful and worthwhile businessman would not be hampered by physical ailments. Instead, he would rise above them and succeed anyway. I am unable to perform at that level so I am a failure and a disappointment to Jill. I believe I am worthy of rejection on her part because of my poor performance. Actually, I believe that outlining my physical problems as a reason for my poor performance is just making an excuse for the fact that I am woefully inadequate. I am physically and financially compromised. When I returned to the business [Th: Yes, Sam this is really hard on you] I made $10,000 in the first two weeks which is very good and is evidence that I can perform in the business. However, the business deals negotiated after this initial success have not come to fruition and that has been a big loss for me. [Th: I am crouched beside your chair to support you in your disclosure of the tough time you have had. I know it is difficult for you to admit that you are not functioning well so I hope by crouching near to you I can convey my support for your current disclosure]. S: I start to feel really hopeful that I will be successful but I end up feeling very disappointed because the deals fall through. I know I should not get excited about the future prospects for deals that are still being negotiated. However, I get hopeful and count the money I am going to make before I make it because my creditors are requiring me to pay my debts as soon as I have the money. [Th: Yes, I really see how having the creditors breathing down your neck puts a lot of pressure on you]. I have been trying my best to cope with physical injuries that have prevented me from working and when Jill made that sarcastic comment to me I felt rejected by her. Also, I do not feel Jill understood how hard it has been on me lately both financially and physically and that is why she rejected me. I feel like I am trying my best and all I get back from Jill is sarcasm instead of recognition and support.

18. Interaction.

In this utterance, Sam explains to Jill and the therapist that he feels rejected by Jill because he believes he should be performing better in the business. Sam believes that Jill thinks he is a failure and has rejected him for this reason. However, it appears from this utterance that Sam feels like a business failure and rejects himself. He has difficulty with events that are
beyond his control that may be exacting an influence. For example, he blames himself for physical ailments and the recovery time as well as blaming himself for losing business deals yet to be made. Sam's sense of personal responsibility and desire for control extends to those events over which he has little or no influence. Sam measures his self-worth against situations over which he has little or no control. As a result, he often appears inadequate when he measures himself in this manner. Sam believes that he must be in control when it comes to his work and other people's work, his physical body, Jill, the family and his emotions. When Sam does not feel in charge of these arenas of his life he feels worthless. Sam projects his disappointment, self-rejection and sense of worthlessness onto Jill maintaining that it is Jill who is disappointed with him, rejecting him and thinking he is inadequate. By disclosing his inner struggle Sam has offered Jill a glimpse into why she is feeling misunderstood. This added clarification helps Jill express her sense of the misunderstanding between herself and Sam in later utterances.

In this excerpt, Sam revealed his sense of failure and offered an explanation for why Jill's comment "same old scenario" was especially cutting in his view. Sam believed Jill viewed him to be a failure and her remark was designed to express her disapproval of his business prowess. Thus, Jill's remark appeared to confirm Sam's sense of personal inadequacy. The therapist's empathic response to Sam in the next utterance highlighted Sam's implicit experience making his struggles with personal worth explicit.


Th: So, it ((touches Sam's shoulder from crouched position)) sounds as though(.hh)um he's also, ((looks at Jill, rolls right arm in front to herself)) Sam is also feeling rejected and ah and ah he also is feeling bad about himself, ((rolls right arm then rests hand on chest)) he's he knows that he's not operating at 100 percent so(.hh)ah he could say ah ((looks at Jill while rolling hand from chest)) "I'm feeling um not only um disappointed, pressured, I'm feeling rejected(.hh)I'm feeling um unsure of myself right now(.hh)and I'm feeling sad that I'm not operating at ((puts hand in lap, still crouched with arm resting on her chair)) 100 percent and I feel scared 'cause I don't, not sure how we're gonna get through ((looks at Sam, hand at chest)) this this month this mon:th, I'm not sure and sometimes I'm feeling scared and ah when I feel challenged in this way um it touches me at a place where I'm very ((touches arm of chair, continues sitting on floor)) vulnerable ((talking to Jill, Sam looking at floor)), I'm not sure if I'm good enough, touches me in a very deep place(.hh)and ah I feel really vulnerable coming to you and talking to you Jill right now 'cause I'm the breadwinner ((holds hands up around shoulder and neck area, returns hands to lap)) in this family(.hh)right now(.hh)and I-I feel its, the pressure ((sharp hand motions at chest area)) is on me, I know you do alot
((gestures towards Jill)) of work and ah you do your bit, you pu:ll your weight and you support me.(hh)but the pressure is on me right now, I'm feeling pretty vulnerable - ((turns to Sam)) and I'm not sure what you want to add to that?

Expansion.

Okay, I'd like to summarize what you, Sam have just disclosed, to include the sense of pressure and disappointment you felt earlier in the re-enactment. I am crouched beside you Sam and touching your shoulder right now to signal that you have ventured into more emotionally vulnerable territory and I want to reflect this back to you in as caring and as gentle a way as possible. To incorporate this reflection summary into the re-enactment, I am going to pretend to be speaking as Sam addressing Jill. But first, I will address you Jill since you have been listening to Sam so that you may understand his experience of the financial situation and the remark made during the fight. Jill, Sam is feeling rejected by you and he is also feeling worthless because he is not succeeding in the business due to his physical injuries. Sam could say, if he were to express himself using "I" statements and feelings, "I feel disappointed and pressured. I also feel a lack of confidence in myself as a businessman and provider. I am sad that I am physically injured and this is undermining my business performance. I feel frightened that due to my physical difficulties the family will suffer financially and we will not have enough money to pay our bills this month. I am very frightened of this prospect of financial difficulty and I feel very uncertain as to my ability to solve the current crisis. When I feel frightened and unable to cope or fix the problem I feel worthless deep inside my being. I believe I am an inadequate husband, father, provider and businessman. I feel this sense of inadequacy at the core of my being and when I talk about my feelings of inadequacy and worthless with you Jill I feel exposed, raw and vulnerable. I am supposed to be the provider for the family but I am letting you all down. I feel a tremendous burden as the provider especially when I find myself failing at the task and in the role. The family's financial security falls entirely on my shoulders because you are not working outside the home Jill. While I want to recognize that you do a lot of work by looking after the children every day and supporting me as provider I find it a big burden being the sole wage earner. Jill your work as a homemaker makes up for the financial loss caused by your not working for pay and it is a contribution to the entire family's well-being but I still feel loaded down with the responsibility to meet the bill payments and keep the family financially stable. In my role as sole wage earner I feel very vulnerable talking to you because I realize that I am not performing my duties adequately and now the family is having financial difficulties."

Sam, I have tried to encapsulate what you have revealed about yourself and your struggle in this summary. However, I may not have captured all of what you would like to say and you may have something to add to these statements. Please feel free to add anything you wish to this summary of your feelings.


In this utterance, the therapist summarizes and reflects Sam's emotional state at the time of the financial discussion between himself and Jill. The therapist represents Sam's statements in the form of "I" statements attached to feeling words. The therapist uses "I feel" statements to demonstrate how to communicate using this format. In addition, the therapist empathizes with Sam
as well as amplifying and deepening his experience of the financial difficulties. Sam looks at the floor during parts of the therapist's summary indicating his depth of vulnerability. The therapist recognizes that she is reflecting very tender emotions back to Sam as she speaks in his voice and is concerned that he add to what she has summarized if he so desire. The amplifying and deepening of Sam's experience prompts him to regard Jill with a little more compassion as demonstrated in his next utterance.

Sam's experience of inadequacy was highlighted by the therapist in this utterance providing an expanded understanding of his interpretation of Jill's comment and highlighting the affective components underlying his understanding of the morning miscommunication. Sam's view of the morning misunderstanding centered on an interpretation of Jill's remark as a sarcastic rejection which confirmed a sense of inadequacy and incompetence as family provider and head-of-household. The hurt Sam experienced perturbed him to desire revenge.

Text: Lines 394-400.

S: ((hands folded across lap)) I guess may be when I came in this morning I was almost to the same point you are even though I wasn't in tears and I just got slammed in the face maybe this the way I get back at you, I don't know' =

[ ]

J: (hhhh)((wiping tears))

Expansion.

Therapist, I am interrupting your empathic response to Jill's experience of me as hardnosed at the wrong times to explain why it is that I do not care about how Jill feels. Jill, I am unmoved by your sense of aloneness and abandonment. I have a good reason to abandon you Jill because you deserve it. You deserve to be abandoned because I was really upset this morning and I was upset like you are now, I was not crying, but I was very upset. Instead of comforting me like you want me to comfort you now, you attacked me with sarcasm. Since you did not comfort or soothe me this morning I am not going to comfort and soothe you now. You deliberately tried to hurt me and I am punishing you for that now. You are supposed to be the strength in this relationship and you have let me down. When I come to you upset it is important that you help me and if you get so upset that you cannot be supportive, you are worthy of punishment. Your attack upon me this morning was a breach of contract between us and I am extremely hurt and angry at you.
for betraying me. Therefore, I am going to punish you with my withdrawal and lack of care. I am getting revenge by withdrawing my caring from you.

**51. Interaction.**

The therapist's intensification of Jill's isolation through empathy prompts Sam to explain and justify his noncaring attitude towards Jill. According to Sam, Jill has breached the conjugal contract that stipulates that she should comfort, nurture and soothe him when he is upset rather than become upset herself. Jill's breach of contract is a serious violation that warrants punishment with withdrawal of caring and love. Sam believes Jill's lapse in composure caused her to lash out at him and he responds to her in kind. Sam's "eye for an eye, tooth for a tooth" sense of justice precludes, at this point, sympathy for Jill. Sam takes great pains to explain the legitimacy of his claim of breach of contract in this utterance because he is hurt by Jill's alleged sarcasm and he is being faced with his own and Jill's vulnerability. Sam is also candid with the therapist and Jill concerning his desire to seek revenge via hurting and punishing Jill the way he perceived he was hurt and attacked by her.

When disparate views are held steadfastly and conflictual practices employed, marital distance is maintained. Sam genuinely believed Jill had intended to hurt him and endeavoured to exact revenge as a result. However, Jill did not subscribe to Sam's interpretation of her morning comment. Jill's struggle in Episode #2 appeared to center on explaining to Sam, who was hurt, withdrawn and angry, the nature of her intent. The discourse analysis revealed Jill's perspective regarding her comment varied greatly from both the therapist's and Sam's understanding of the couple's dilemma. Jill believed she was commiserating with Sam rather than sarcastically rejecting him when she said "same old scenario" after he approached her with news that money would be scarce at the end of the month. Jill clarified the intent of her remark to Sam explaining she was not rejecting or attacking him. Instead, Jill maintained that she was concerned with the financial difficulties the family was facing. The following text example reveals Jill's attempt to explain her remark as it was uncovered by the discourse analysis.
Text: Lines 242-254.

Th: =going on so it maybe important for you to check out (looks from Jill to Sam, back to Jill) "Hey, Jill I need to talk about something(.hh)could, is this be [ ] Th: =((tips head backwards))

J: =Even the words I said it wasn't ((rubs neck)) intended as a-a crack as you say, it was it was my disappointment in the way things have been going it was and it's not=

O:o ((tips head backwards))

J: =((moves flat left hand in patting motion)) my disappointment of you,=

S: It's the same thing [ ]

J: =it's my disappoint-no it's not! ((puts hand back on lap))

Expansion.

I am interrupting you therapist because you are not understanding what I was saying when I made that remark. You, like Sam, are saying it was sarcastic and it was not. Therapist you are saying that I was unintentionally sarcastic but Sam has misunderstood my words, my words were not sarcastic. I really want you both to understand what I am saying because I am being misunderstood. I did not make a crack, as you call it Sam, because I did not mean to make a crack, I was trying to convey my own disappointment with how the financial deals have been failing lately. By saying "same old scenario" I was saying "it's the same thing every month, we lose prospective business and we don't know if the deals will come through it's a disappointing fact to me that these deals are so unpredictable". [Th: Oh, I get what you meant Jill, you weren't sarcastic at all you were commiserating with Sam, you weren't angry with him or disappointed with him you were disappointed with the uncontrollable and unpredictable nature of the business. I didn't understand that you were not being sarcastic but were disappointed. Also, I didn't see that Sam was projecting his belief about his inadequacy on to you when he felt rejected by your remark. I thought the problem was that you had the financial problems sprung on you when you were unprepared to deal with them. You actually were trying to join with Sam when he came to you and told you he hoped Broughton worked out because if it didn't money would be tight at the end of the month. I completely missed your intent Jill and now I see what you meant when you said "same old scenario"]. J: My comment was not motivated by any disappointment at your performance Sam, I don't blame you for business vissitudes you cannot control, I am disappointed when the business deals fall through just as you are Sam. I am not disappointed with you Sam it is the business let downs that disappoint me. [S: Jill it amounts to the same thing because I run the business and any business failures are my fault so if you are disappointed about the business then you are certainly
disappointed with my performance.] J: It is my disappointment with the business that I am talking about. Hold on a second Sam, no it is not the same thing, I do not hold you responsible for business deals that may or may not be successful. When I am disappointed that a business deal did not go through I am not commenting on your business performance. I am simply disappointed that we didn’t get the deal that’s all.

24. Interaction

Jill is struggling to explain her comment. After the therapist introduces her solution, Jill argues more strenuously for her experience of events. Being unprepared to agree that she was sarcastic, Jill once again asserts that she was disappointed not sarcastic and adds an important understanding to her statements. Jill concludes that Sam believes that disappointment with business let downs is disappointment with him personally. Jill strives to make a distinction between disappointment with business setbacks and disappointment with Sam in her attempt to be understood by both Sam and the therapist. It appears that witnessing Sam’s previous disclosure concerning not being in top performance shape and the therapist’s summary of Sam’s feelings of inadequacy offered Jill insight into why Sam would understand her disappointment to be sarcasm. The combination of Jill’s perseverance in attempting to be understood, her understanding of Sam’s experience, her own experience of disappointment and the refusal to admit to being cruel when she was not compels the therapist to abandon the compromise to which she was attached. Sam disbelieves Jill and equates disappointment with the business with disappointment with him. Sam’s disbelief is based on a genuine experience of equating poor business performance with personal inadequacy and worthlessness. As a result, Sam believes Jill’s disappointment with business setbacks is indicative of Jill’s disappointment with him. Sam was very disappointed with his business performance and before he approached Jill, he probably denigrated himself while balancing the books. Jill’s disappointment confirmed his worst fears; he was inadequate. As a result, Sam continues to be unable to separate Jill’s disappointment with the business from disappointment with him and he maintains his desire to punish Jill. Due to his inability to separate poor business performance from personal inadequacy, Sam requires that Jill be punished so that he can rid himself of feelings of worthlessness and inadequacy. The therapist continues to be left with a dilemma marked by the strength of Sam’s feelings of hurt and betrayal which appear to be based on a misinterpretation of Jill’s words and a difficulty believing Jill’s explanation for her remark. The therapist’s compromise was an attempt to validate Sam’s feelings. However, the compromise failed to account for Jill’s experience of not trying to hurt or betray Sam. Without Jill’s cooperation in adopting the compromise, Sam cannot be persuaded to adopt it as well. The therapist observes the genuine hurt Sam feels but must now include the notion that he is hurt due to a misunderstanding of Jill’s words and his reluctance to give her the benefit of the doubt.
The discourse analysis of Jill's utterance in lines 242-254 above revealed the extent to which the couple disagreed with one another regarding the original interaction. Sam believed Jill was attacking him with sarcasm because, in his view, business failure reflected a lack of personal competence and worth. Nevertheless, business setbacks were not connected to Sam's worth in Jill's opinion. However, Jill explained later in Episode #2 that while she was unhappy when Sam believed his personal worth was connected to his business prowess, she was perturbed by Sam's reluctance to believe her explanation for her remark. Jill clarified her remark asserting that her comment was a form of shorthand communicating her disappointment with the bad financial news. The analysis of the following utterance explores Jill's experience of dismay at the financial setback and her effort to articulate the intent of the remark, "Same old scenario".


Th: And the disappointment is over the sales is not the same as the disappointment in Sam, it's different from (   )

[ ]

J: Well it's more that, I mean I ((sniff, wipes tears, folds kleenex)) I know I hafta learn to deal with things but there have been a few that have been pretty hard(.hhhh)((wipes tears, sobbing)). Sue and Fred's was the worst for me I mean Ryan is the worst for you, so I know how you feel - but my comeback to you was not - ((crying))um an attack at you ((therapist shifts to knees, hands on thighs))(.hhh)((sniff)) - it was um, I guess a quick way of putting into words how I felt that minute ((sobbing)), was that it's, it's hard ((rising tone)) =

Expansion.

Well therapist let me explain I do not feel entirely misunderstood because of Sam's difficulty grasping that I was disappointed in the business not him. It is more accurate to say that I feel misunderstood by Sam because he does not understand how hard the financial setbacks are on me. He also does not understand that I understand how he feels because I feel badly too. Sam says I have to handle the setbacks better but when he says that I feel misunderstood because he does not realize that I cannot just brush off the failures because
they are too painful. I would feel understood if Sam could see that some of the failures are too painful to brush off. Also, I would feel understood if Sam could see that I understand how he feels when deals fall through because I feel just as badly. For example, Sam you say I have to learn to deal better with the failures but you have to admit there have been several failures that have been very hard to bear for both of us. The deal with Sue and Fred was the most painful unsuccessful deal for me and the deal with Ryan was the most painful for you. In conclusion Sam, I want you to know that I know how you feel because I too have felt awful due to the setbacks. Sam, since I understand how badly you feel when the business is unsuccessful because I too have felt upset about it, I would not attack you. I would not attack you with a sarcastic comment when I know how painful the business failures are to you. My comment to you was, from what I have been able to understand to this point, a shorthand statement meant to sum up the desperation I felt at the moment you told me about the possible business setback. I felt desperate because it is difficult to endure the setbacks and the financial losses that are a part of the business cycle. I am crying because I feel so misunderstood by Sam and I feel worried about our financial future this month. I am crying because I am tired of the instability of the business and I am crying because I feel hopeless about the business right now. I am crying because I did not mean to insult you Sam and you do not seem to understand that. You do not understand that I was just reacting to the bad news, I was not trying to attack you when I said "same old scenario".

37. Interaction.

In this utterance, Jill again corrects the therapist. She tells the therapist that she has only partially accounted for Jill's feelings of being misunderstood. Jill expands further on why she is feeling misunderstood and the therapist and Sam learn that the reason Jill feels misunderstood rests on Sam’s interpretation of her being sarcastic when she could not have been sarcastic towards him. Jill is deeply hurt because Sam does not understand that she too feels upset about the broken business deals and since she feels upset about the deals she would not and could not attack him for the failures. Jill feels misjudged by Sam who is assigning her undeserved spiteful qualities. Jill reasons that if Sam understood how hurt she was by the failures he would see how impossible it would be for her to attack him when he was feeling so low. Jill explains to Sam, by way of example, how they both have suffered due to sour deals to underscore how impossible it would be for her to attack him. Jill then endeavours to explain her comment in light of the impossibility of an attack by indicating that the comment was a form of shorthand that summed up her desperation at the bad news. Jill is sobbing during this utterance due to her sense of being harshly judged and misunderstood. She also feels desperate, frightened and tired of the unpredictable business climate. Jill has been able to clarify her remark to Sam and the therapist in this utterance. Jill incorporates the therapist's notion of attack into her statement as she becomes aware of the possibility of Sam feeling attacked by her comment.
Jill disagreed with Sam's view of events by making a distinction between business setbacks and personal worth. In addition, Jill felt misunderstood when Sam believed she was being sarcastic. Jill asserted she could not have been attacking because she empathized with Sam's disappointment with the financial uncertainty.

At the outset of the episode, Sam and Jill's perceptions of the morning interaction were divergent with Sam attesting to Jill's sarcastic and rejecting behaviour and Jill maintaining innocence claiming Sam mistook her quick response for an attack rather than an acknowledgement of disappointment. In addition, the therapist maintained an understanding of the morning interchange which varied from both Jill and Sam's observations. The therapist forwarded a compromise vision of the morning interaction which neither spouse endorsed.

The following text example encapsulates the therapist's viewpoint.

Text: Lines 227-240.

Th: = So, he might assume that anytime is a good time and in fact you'd just woken up and already had the children on your mind and = [ ]
J: yeah, yeah, huh

Th: = ah it may not ((rolls arms, shakes head)) have been a perfect time to let you know ah what's ((touches chest))=
[ ]
J: Yeah it probably wasn't ((scratches head))

Th: = going on so it maybe important for you to check out ((looks from Jill to Sam, back to Jill)) "Hey, Jill I need to talk about something(.hh)could, is this be

Expansion.

Okay Jill, I want to stay focussed on the frame that you were unintentionally sarcastic towards Sam because his timing was off. When you say you are always approachable it makes it appear as if you were intentionally sarcastic. Sam wants to believe you were intentionally sarcastic but I do not
believe you were. I believe if Sam had approached you at a better time you would not have been sarcastic. Let me re-cap the evidence that supports my contention. I believe that if Sam consulted with you prior to discussing an important topic with you, you would not be compelled to answer when you were not ready. If you answer when you are not ready you are more likely to say something that misrepresents your true intentions. You are understanding and open to Sam when he approaches you at the right time, not first thing in the morning when the children are on your mind. Sam assumes that you are ready to talk anytime when in fact you are not ready to talk at anytime. [J: Yes, I understand what you are saying therapist, you could be right, the children were on my mind and I had just woken up]. T: For example, this morning you said that you had just woken up and had the children on your mind making it the wrong time for Sam to discuss the financial pressure he was under. Jill when you have just woken up with the children on your mind this is not the most advantageous time to be approached by Sam to discuss the family’s financial problems. [J: Yes therapist I agree that the time Sam approached me this morning probably was not the best time but I didn’t say "same old scenario" because Sam chose the "wrong" time to talk to me. I was not being sarcastic when I said "same old scenario" and this idea that Sam picked the "wrong" time to talk to me makes it appear that I was sarcastic towards Sam when I was not and I cannot admit I was being sarcastic when I was not. I cannot adopt the idea that I was being sarcastic towards Sam when I was not being sarcastic.] T: So what I am saying is that Sam should approach you first to see if it is a good time to talk to you about something important otherwise you may be unprepared and say something sarcastic that misrepresents you and fails to communicate your caring for Sam. He should say something like "Jill I’d like to get your attention to find out if this is a good time to talk to you about a problem that is bothering me. Would this be the right time or is there another time that would be better?" If Sam does this Jill, you will not say anything sarcastic, Sam will feel heard and you will not have a big fight and lots of distance in your relationship.

23. Interaction.

In this utterance, the therapist is unable to accept Jill's answer to her question regarding the usefulness of an improvement in Sam’s timing such that he checks with Jill before embarking on a discussion of an important topic. Jill maintained that Sam’s timing was not an issue since she considered herself to be approachable. The therapist is attempting to convince Jill and Sam that Sam was negligent in not asking her if it was the right time to talk and Jill was remiss for answering Sam in an albeit unintentionally sarcastic manner. The therapist’s question to Jill about the correctness of her assumption was not designed to elicit disconfirmation from Jill. The therapist was asking Jill to be in agreement with her as opposed to requesting information. When Jill did not concur with the therapist, the therapist attempted to explain the evidence for her assumption and give an example of how Sam could implement the solution to the problem of Jill’s unintentional sarcasm. Although Jill responds during the therapist’s utterance with agreement, she remains unconvinced and in her
next utterance attempts to explain her comment. Neither Sam nor Jill are convinced by the therapist's framing of the morning fight. Sam believes Jill was intentionally sarcastic and Jill asserts she was not being sarcastic at all. The therapist's bid to validate Sam's hurt feelings resulted in the temporary adoption of the belief that Jill was sarcastic when she was not. Jill is requested to adopt a view that the therapist presents as compromise: Jill was sarcastic but unintentionally so. In this way the therapist attempts to reduce Jill's role in Sam's hurt by shifting some of the burden to Sam for his inappropriate timing. The therapist's compromise is unpalatable to Jill who refuses to admit culpability for something she did not do. The suggested compromise is also unacceptable to Sam who continues to want Jill punished for, what he believes to be, her intentionally hurtful remark. The therapist attempts to alter Sam's I-win, you-lose frame by suggesting that Sam wins because Jill was sarcastic and Jill wins because Sam compelled her to be sarcastic due to inappropriate timing. However, the issue could not be resolved by shifting the couple's perspective of the fight since Sam's misunderstanding of Jill's comment is at issue. To address the misunderstanding the therapist will explore the conflict that exists between the couple which includes Sam's misreading of Jill's comment due to a sense of inadequacy. At the same time, the therapist will acknowledge Sam's desire to punish rather than believe Jill.

The different perspectives held by therapeutic system members were encapsulated in a turn-taking sequence in which each member interrupted another to assert an alternate version of events. The following text excerpt explores the therapeutic system members' attempts to influence one another by pressing a particular point of view.

Text: Lines 206-220.

S: =Fiveto, um you know I i-its been on our minds because of the financial setbacks we've just had and I came in and was thinkin' that(.hh)you know, I mean I sha:re the good times with ya an' I felt that you know share some of the bad times too and that's an open relationship and ah(.hh)the crack, and that's all it was was a crack ((looks away from Jill to wall)) - really wasn't

J: Yeah, but it was::n't rea::illy, I mean it's

S: Well it was just a low handed crack as far as I'm (concerned)

Th: It's very important what you've ah said ((touces Sam's arm)) to Jill and it's very important what your adding ((waves hand)) to it now and ah because ((Sam picks at fingers)) she's very receptive and ah she's very caring ((circular
arm motion towards Jill)) of you and ah wants to understand you and ah it may be very important and I’m not sure if this is correct Jill ((motions with arms and shrugs with shoulders)) that when Sam wants to come and talk to you that he check out with you if its a good time, it may be important.

Expansion.

J: Sam I am interrupting your remarks about my intentions when I made the comment this morning to defend myself. Yes, I understand how you could see what I said as a sarcastic remark especially since you were feeling so vulnerable when you approached me but I want you to believe me. The remark I made was not in fact a sarcastic remark, I am telling you the truth right now. I want you to believe me because it is difficult for both of us when there are financial setbacks and I would not be sarcastic to you about these hardships.

S: Jill, I am interrupting your excuse for your sarcastic behaviour because from my point of view your comment was a hit below the belt meant to hurt me and there is no other explanation. You are trying to excuse yourself when you know full well that you aimed to hurt and you succeeded.

Th: I am interrupting you Sam because I want to prevent what I view to be an unproductive fight between you and Jill. Sam you are accusing Jill of being intentionally sarcastic and Jill is denying it and in the mean time, neither of you is feeling understood. Sam what you say about your financial concerns is worth hearing as is the addition you have just made concerning the betrayal you feel due to Jill’s remark. Sam, while Jill’s remark may have hurt you a great deal, Jill is extremely open to hearing about your hurt, she cares a great deal for you and wants to understand you as best she can. Jill has demonstrated this caring and attempt to understand you during this re-enactment. Sam, I do not think Jill was intentionally trying to hurt you because she honestly cares for you, rather I believe that your timing was inconvenient and that is why you ended up fighting instead of discussing the financial situation. Jill, I am not sure if I am correct in assuming that next time Sam wants to talk to you about his worries he would be successful if he asked you ahead of time if you were able to listen and talk to him. Jill, I know you are open to hearing from Sam and this may make it easier for you to respond caringly to him when he approaches you with worries.

21. Interaction

In this series of utterances, Jill and Sam begin to argue about whether Jill intentionally hurt Sam. The argument is defined by a his-word-against-hers-dynamic. Sam wishes to force an admission from Jill regarding her intentionality while Jill appeals to Sam to believe her when she says she did not intend to insult him when the business setbacks upset her. Sam remains unsatisfied and Jill remains unbelieved. The therapist interrupts the couple to end what she perceives to be an unproductive fight in which neither party is feeling understood and for which there is no ready solution. The therapist
wants both Jill and Sam to know that their contributions are worthwhile and not to be discouraged by the others invalidation of their claims. The therapist also indicates to Sam that she believes Jill cares for him but had difficulty expressing this caring because his timing was inappropriate. The therapist attempts to validate Sam's appraisal of Jill's hurtful remark while not supporting that it was intentional. At the same time, the therapist hopes to support Jill in Jill's assertion that she did not intend to hurt Sam. However, the therapist adds that the remark made was hurtful not due to the Jill's callousness but due to the morning circumstances under which it was uttered. In this manner, the therapist attempts to circumvent a situation in which Jill is viewed as an uncaring, callous partner and Sam is an unjustly injured spouse. She also attempts to circumvent the view that Jill is misunderstood by Sam because his feelings are erroneous. The therapist wishes to avoid a situation in which Jill is viewed as callous or Sam is viewed as completely misguided. Sam believes that Jill must be punished for her remarks and he cannot afford to "lose" this argument. If Sam "loses" the argument as he understands it, his fundamental worthlessness is confirmed. If Sam "wins" the argument, Jill is punished and Sam is vindicated in that he is "proven" worthwhile and adequate. It appears that the argument, from Jill's point of view, is less about "winning" or "losing" and more about being believed by Sam. The therapist seems to attempt to guide the couple away from Sam's winner/loser frame to one which acknowledges Sam's hurt while supporting Jill in her claim that she did not intentionally hurt Sam. As a result, the therapist suggests that Sam consult with Jill prior to discussing important topics. If Sam asked Jill if she was amenable to talking this would ensure that Jill could formulate a more caring response to Sam.

Jill finds the therapist's solution to Sam's win/lose frame unappealing since she wants him to believe her motives were genuine and her feelings sincere. Jill wants Sam to believe her and let go of his opinion of her as uncaring. This desire is not satisfied with the therapist's frame since it depicts Jill as hurtful to Sam because she is not at her best in the morning hours. Jill views herself as honest and caring towards Sam. She also views herself as approachable and finds the idea that she is not approachable to be an inaccurate description. Jill finds the notion that she is unapproachable at certain times and uncaring when she is approached during these times untenable.

The analysis of the three turns taken by Jill, Sam and the therapist respectively included the different interpretations each therapy participant made regarding the morning sequence. The discourse analysis of this turn-taking sequence showed Jill attempting to convince Sam of her honestly held conviction that she was not being sarcastic while Sam rejected her explanation maintaining she meant to hurt him. In the third turn, the therapist offered
another explanation for the morning interaction that sought to validate both Sam and Jill’s experience. The therapist promoted a compromise in which Jill was viewed as unintentionally sarcastic and Sam was guilty of bad timing.

Thus, therapeutic system members initially differed with one another with respect to the causes and meaning of the morning fight. Jill understood the fight to be a product of a misunderstanding between herself and Sam while Sam believed the fight to have emanated from Jill’s low opinion of him and her desire to hurt him. The therapist maintained that the fight resulted from Sam’s difficulty in timing his requests for assistance and in Jill’s unpreparedness to meet his requests.

The syncretic change process discovered through the Comprehensive Discourse Analysis of Episode #1 and #2 was shown to originate with conflicting, differing and disparate experiences of a problem or interaction. However, spousal distance, due to the misuse of alcohol and differences of opinion regarding the intent of an incomplete comment, gradually shifted toward more harmonious and consensus oriented couple relations. The convergence of differing belief and practice characterized the second element of the syncretic change process and was accomplished through interactions between members of the therapeutic system. The means by which disparate belief and practice shifted towards increased harmony and mutuality will be described in the next section.

Therapeutic System Contributions to Convergence and Transformation

A second quality intrinsic to the syncretic change process included an account of the therapeutic system’s contributions to the convergence and transformation of disparate belief and practice in the pursuit of increased intimacy. That is, conflicting experiences discovered in Episode #1 and
Episode #2 were eventually transformed allowing for the generation of increased couple commonality and mutuality. This section outlines the means by which disparate beliefs and practices were reconciled by members of the therapeutic system such that the potential for increased harmony and consensus was made possible. The convergence or reconciliation of conflictual views and behaviours was achieved through two intimacy enhancing activities including the employment of intense experiential exercises and the provision of a collaborative therapeutic atmosphere. These activities are discussed below.

**Intense Experiential Activity in Therapy**

The Comprehensive Discourse Analysis of Episodes #1 and #2 revealed the common employment of varying forms of intense experiential activity during each relationally novel episode. ExST theory suggests the purpose of intense experiential activity is "to provide the opportunity and motivation for the client to engage in relational novelty" (Friesen, et al., 1991, p.6). The relationally novel sequences experienced by Sam and Jill during experiential activity in Episode #1 and Episode #2 were characterized by an observed shift away from conflictual beliefs and practices towards more intimate, consensual and harmonious views and behaviours. Intensification strategies that deepened and expanded upon client experiences facilitated the shifts that occurred during experiential exercises in both episodes.

This section will explore the discourse analysis evidence that uncovered the importance of intense experiential activity in the generation of relational novelty. Intense experiential activity is significant in the convergence of disparate belief and practice since it provides an opportunity for intimacy enhancement by employing various tenets of relational novelty to effect a shift away from distance oriented interactions toward more cooperative and
harmonious exchanges. The tenets of relational novelty found to be important in the generation of couple intimacy during intense experiential activity included atypical experiencing, cognitive insightfulness, increased awareness of unacknowledged experience and core theme evocation. This section will describe the experiential activity found in Episode #1 and Episode #2, explore how client experience during experiential exercises was intensified in therapy, and discuss the manner in which relational novelty was promoted through intense experiential activity.

**The Common Engagement of Experiential Technique**

The employment of experiential activity was found to be common to both Episode #1 and Episode #2. For example, in Episode #1, the therapist introduced an experiential activity known as the symbolic evocation or externalization of alcohol (Friesen et al., 1991). In Episode #2, the therapist introduced a re-enactment activity of a morning fight.

During the symbolic evocation of alcohol in Episode #1, the therapist asked the couple where, in the therapy room, they would situate a large plastic bottle meant to represent alcohol. The following text excerpt from Episode #1 illustrates the introduction of this activity.

**Text: Lines 120-129.**

Th: (.hh)Right now - ((lifts bottle, sets it back down and folds hands)) um - alcohol - I guess is in the room fear is in the room fear and apprehension(.hh)and you mentioned ((rolling arms)) =

[ ]

S: Uhum

Th: = a number of things that you ((Sam clears throat)) are feeling scared about(.hh)and um where ((looks at bottle, taps it twice and then looks at Sam and Jill)) would you put this right now in this room? ((holds bottle up))
Expansion.

I am going to move into the present tense now and away from our previous discussion regarding decision-making in the marriage. I'd like to draw your attention to this bottle of alcohol that I'm holding up here. Alcohol is in the room with us and has been all session. Along with alcohol is the fear of drinking it again and the threat you mentioned earlier, Sam, that you would take the top off it and pour it. You feel apprehensive around alcohol because you perceive it to be dangerous to you and your sense of self worth. We know that alcohol bothers you and the presence of this large plastic bottle in therapy has been unnerving. You mentioned earlier that you are afraid of alcohol and like to keep it in view as a means to resist it. [Sam acknowledges the accuracy of the therapist's empathy with a mumbled assent and throat clearing]. You mentioned that you are afraid to go into bars and pubs lest you drink, you are afraid that the urge to drink will build up inside you and that you will fail in your bid to resist alcoholic drinking. You are afraid to remove alcohol from the house because this would feel like a personal failure to you. Also, you are afraid to keep alcohol in the house because you may drink it and this would signal to you that you are a failure. So, given these fears about alcohol being in your presence, where would you put this big bottle of alcohol in the room right now if you were in charge Sam and if you were to comment on alcohol's whereabouts, Jill? I am asking Jill for her opinion regarding alcohol's whereabouts in the therapy room since she makes decisions about alcohol's whereabouts too. Here alcohol is in front of you both, I'm holding it up so that there is no mistake that alcohol is in both your presences, right in front of you. It is not tucked away in a cupboard out of sight. Here it is in full view, fully tempting and fully available. Since alcohol is a tempting member of the household, where does it belong relative to yourselves in this therapy room?

13. Interaction.

The therapist, in this utterance, engages the couple in an experiential activity called symbolic evocation of alcohol. The therapist brings the focus of the session into the here and now and combines Sam's desire to be in charge with the frame that Jill is also responsible for alcohol's whereabouts. The therapist suggests the client's enact their relationships with alcohol as a tangible system member. The therapist also empathizes with Sam's fear of alcohol and his apprehension about being a failure. She also suggests Sam act in his executive role as sole decision-maker with respect to alcohol. The therapist challenges the couple's notion that alcohol is less of a problem because it is in the cupboard and brings the full experience of alcohol's presence into the room. The therapist holds alcohol up as a full participant in the couple's relationship while affirming Sam's decision-making position and Jill's status as co-decision-maker. The therapist intensifies the presence of alcohol in the client's lives by holding the bottle up in the air, tapping it twice and looking at the plastic bottle. The therapist communicates to the couple they have a choice as to the importance and position of alcohol in their lives.
The employment of the symbolic evocation of alcohol as an experiential activity in Episode #1 signaled the beginning of an intensification process designed to perturb atypical behaviour and expand alternatives with respect to alcoholic drinking patterns.

In Episode #2, the experiential re-enactment of a morning fight was introduced to facilitate relational change by intensifying intrapersonal and interpersonal experiences connected to a recurring pattern of couple distance and isolation. The therapist encouraged the couple to re-enter the bedroom as it was re-created in the therapy room to simulate the fight. Having helped the clients arrange the furniture in the room to resemble their bedroom, the therapist embarked upon the re-creation of the fight sequence. The following text analysis excerpt illustrates the initiation of the experiential re-enactment of the fight sequence in Episode #2.

Text: Lines 1-3.

Th: =Yeah, so when you say ((rolling gesture with hands)) I hope that Broughton flies, how are you feeling ((points to body)) towards her? How are you =

Expansion.

Yes, we have just re-arranged the room to look like your bedroom because this morning you had a fight that you have brought in today as an example of how you remain distant and lack intimacy in the relationship. Sam, you tried to discuss your financial position with Jill in the morning when Jill was still in bed. You came to Jill and the first thing you said to her was "I hope the Broughton business deal comes through because if it doesn't money is going to be scarce at the end of the month." Sam, how are you feeling towards Jill right now as you tell her about your concerns over the Broughton deal? How are you at this moment in the bedroom talking to Jill?

1. Interaction.

Having re-arranged the room to simulate their bedroom, the couple and the therapist begin to re-enact the morning fight sequence to perhaps resolve the difficulty and engender more couple intimacy. The therapist has been told
by Sam that he hopes that a business deal comes to fruition because if it does not the family will suffer financially at the end of the month. In this utterance, the therapist asks Sam to address Jill in the present tense as if the morning discussion was occurring now. The purpose of the use of the present tense and the reconstruction of the bedroom in which the fight occurred is to enable the clients to discuss and resolve their differences in as realistic a manner as possible. Also, the present tense focus and simulated bedroom intensify the couple's experience of the fight rather than providing a forum in which they merely talk about their difficulties. The fight chosen for the re-enactment is important since it was recent and encapsulates how distance occurs in the relationship.

Experiential activities such as the re-enactment of a morning fight and the symbolic externalization of alcohol are effective in facilitating relational novelty when client experiences are intensified during the re-enactment or externalization activity (Friesen, et al., 1991). The deepening process is marked by a variety of activities that promote intrapersonal and interpersonal change. The following section describes the components of intensification revealed through the discourse analysis of Episode #1 and Episode #2.

**Components of Intensification**

The intensification process is understood to include the employment of change promoting activities that foster atypical behaviours, thoughts and feelings as well as providing opportunities for new cognitive insight and intrapersonal awareness (Friesen et al., 1991). The change promoting components cited as important to the deepening process include a detailed definition of the specifics of the clients' dilemma as well as the creation of an interaction between clients, parts of self or the symptom. Intensification requires that the therapist maintain a consistent focus on intense here-and-now experience and amplify bodily sensations. Also, during the deepening experience the use of metaphors and symbols is recommended. In addition, the use of empathy to identify underlying emotions is considered important to the intensification process (Friesen et al., 1989). This section delineates the
employment of the six components of intensification revealed in Episode #1 and Episode #2. A discussion of the components enjoying differential usage based on session context and a description of components common to both episodes is undertaken in the following sections.

**Context Dependent Components of Intensification**

The discourse analysis of Episode #1 and Episode #2 revealed that not all six elements of intensification were essential to the deepening process and their usage was contingent upon the nature of the experiential activity being conducted. Indeed, three of the six components including use of a meaningful symbol, the personalization of body states and the employment of empathy to intensify client experience were discovered to be specific to a particular episode. The following section will explore the differential components of intensification discovered to be important in the deepening of experiential activity in both episodes.

**The engagement of a meaningful symbol.**

In Episode #1, a meaningful symbol was utilized and the amplification and personalization of body states was conducted. These aspects of the intensification process were not employed in Episode #2. The following text analyses from Episode #1 capture the therapeutic usage of these facets of the deepening process. In the first illustrative text excerpt drawn from Episode #1, Sam engages a meaningful symbol.

**Text: Lines 291-306.**

S: =But see now ((Jill looks at Sam)) that's really interesting to me because ((points to the right)) that happened and I just got finished saying ((both hands move to the left)) that it doesn't bother me being in the house and seeing it and
that ((points to table for eight seconds)) was a plastic bottle(.hh)!

Th: [ ]

((hushed voice)) Yeh

S: =think the size of it's one thing that really - caught me as well ((drops hands on lap)) the visual size of it 'cause the =

Th: Yeah ((nods))

S: =impact of alcohol in my life(.hh)fer a BOTTLE that's this size ((indicates size)) is about as big as that in the impact ((motions to where bottle once stood)) you know so(.hh)

Expansion.

But therapist, I want you to understand something very important to me. It is very surprising to me that I feel less apprehensive now that alcohol is out of the room since I just finished telling you and Jill that having alcohol in the house is not a problem for me, that it does not tempt me and in fact evokes no negative feelings in me whatsoever. I can't believe a plastic bottle that's not even a real beer bottle could make me so tense. [Th: Yes, I'm listening please continue]. Because the bottle is so big it surprised me, I got nervous because the size of the bottle was so large. In reality, the large plastic bottle represents the actual size of the impact of alcohol on my life. [Th: Yes, I understand and I am listening to what you are telling me about the impact of alcohol in your life]. Up until now, I believed that alcohol did not have as large an impact on my life as it apparently does. You know therapist, you understand, I was probably made tense by the visual size of the bottle rather than alcohol per se.

36. Interaction.

Sam tells both Jill and the therapist that he is surprised to discover that alcohol has such big effect on him. He tells them that he thought alcohol was not a big problem and that seeing the big plastic bottle made him very anxious. This surprised him since the bottle was not a real beer bottle yet it frightened him enough that when he removed it he felt better. Sam is confirming Jill's appraisal that alcohol is a problem for him and that keeping it in the house may not be helpful. However, at the same time, Sam cannot believe that a fake beer bottle could make him so tense and that removing it would make him feel better. He continues to halfheartedly assert that alcohol is not a problem for him because it was the size of the fake bottle that caused him apprehension not the use of it as a symbol of alcohol. Sam goes on to say that alcohol has had a big impact on his life.

In this utterance, Sam observed the symbolic import of the bottle in the therapy room citing its large size to be representative of the impact alcohol has had on
his life. In addition, Sam acknowledged the significance of the large plastic beer bottle marveling at how an obviously fake item can perturb complex and confusing responses.

**Personalizing and amplifying physiological states**

As well as employing a plastic beer bottle to symbolize alcoholic drinking, Sam was requested to become aware of his physical state and personalize his bodily sensations in Episode #1. The following text excerpt captures the use of the client's physiological experience as part of the intensification process.

**Text: Lines 264-266.**

Th: = Okay(.hh)okay(.hh)((continues drawing hand across upper chest)) and if those muscles had a voice - what would they say right now?

**Expansion.**

Alright, great, alright, we're on track here. I'd like to ask you another question now that we are on a roll and in agreement. I want to further explore these relaxed shoulder muscles of yours Sam since you are willing to move along further with the idea that your shoulder muscles have relaxed as a result of the removal of alcohol from the room. Please continue to focus on your shoulders and chest and tell me, if the shoulder and chest muscles could speak to us, you, me and Jill, what do you imagine they would say at this moment?

**32. Interaction.**

The therapist recognizes that Sam has agreed that he is more relaxed without alcohol and takes the opportunity to move further into his experience by giving his body a voice. To accentuate the relaxing effects of alcohol's absence, the therapist encourages Sam's body to speak for itself.

In this text excerpt, Sam was encouraged to personalize his body's experience intensifying an experience of relaxation at the removal of alcohol from the therapy room. The utilization of a meaningful symbol and the personalization of
physiological experience was important to the intensification process undergone in Episode #1.

**Engagement of empathy to access underlying emotion.**

Lastly, an intensification device discovered to have differential usage in Episode #1 and Episode #2 was the engagement of empathy to access underlying emotions during the intensification process. The discourse analyses of the episodes revealed therapist use of varying degrees of empathy ranging from the employment of paraphrasing in Episode #1 to the utilization of advanced empathy in Episode #2. While ExST theory advocates the use of advanced empathy to access underlying emotion (Friesen et al., 1989), the discourse analysis revealed that a lack of advanced empathy did not hamper the deepening process. Indeed, the paraphrasing practiced in Episode #1 enhanced the clients experience and engendered trust in the therapy process setting the stage for deeper exploration in Episode #2. The following text analysis excerpts from both episodes explore the differential use of empathy to intensify client experience.

In Episode #1, the therapist paraphrased client responses to regulate experiential intensity according to client cues. The therapist paraphrased Sam’s observation that something had changed since he removed the bottle from the therapy room. The following utterance analysis illustrates Sam's experience of change.

**Text:** Lines 187-192.

S: U:mm I relax a little bit more you know u:mm - I'm not as = [ ]
Th: ((hushed voice))Yeah ((nods))
S: = tentative l-l mean ((gestures)) already I mean I feel like it-it something has changed ((right hand opens to right)).
Expansion.

Um, let me think about what is going on inside me right now, I am more relaxed you understand and I’m struggling for words to express how I am feeling, I find I am not as anxious as I was, I’m less cautious, defensive and scared as I was when alcohol was in the room. This change from being on my guard with you and alcohol to now feeling less defensive has all happened very quickly. I am surprised by the speed at which my feelings changed after I removed alcohol from the room. I have changed but I’m not quite sure how I have changed except to say that I used to say alcohol’s presence did not bother me but it obviously does bother me very much. My opinion about alcohol’s role in my life has changed just as my feelings of defensiveness, apprehension and anxiety have changed to ones of relaxed calmness as a result of removing alcohol from the room. I don’t think I will be able to have alcohol at home given the stark difference I experience between anxiety about having alcohol in my presence and then calmness after removing it.


Sam is at a loss for words in this utterance since he is unfamiliar with focusing on his inner experiences (Appendix S, Session #3) and with feeling more relaxed as a result of removing alcohol from the room. Sam feels less defensive and cautious with the therapist and Jill now that alcohol is no longer present. He is no longer on his guard and is vulnerable. He says he has changed implying that he is not the same as he was before removing the alcohol and this state is disorienting. Not only is Sam less anxious than he was before, but he begins to admit that alcohol did bother him. Until now, this level of vulnerability was not open to Sam who, for the sake of his sense of self respect, defended his choice to keep alcohol handy. Sam and the therapist have joined together in this utterance with Sam no longer trying to guess what the therapist is "up to". Sam’s increased vulnerability and decreased suspiciousness bodes well for increased intimacy between he and Jill and increased trust between himself and the therapist.

Sam’s experience of lowered apprehension levels revealed in this utterance occurred during his first encounter with intense experiential activity and the intensification process. The therapist’s awareness of Sam’s fears of losing control and his desire to stay one step ahead of the therapist made an advanced empathic response inappropriate. The combination of client readiness and session number (Sam removed the bottle from the therapy office in session #2) provided pacing cues with respect to the regulation of session
intensity. The following text excerpt uncovers the therapist’s reply fashioned to intensify Sam’s experience without frightening him.

**Text: Lines 194-204.**

Th: (left hand gently rolling away from self) So you feel a little more relaxed(.hh)ah not quite as tentative(.hh)and alittle = [ ]
S: Yeah, uhuh

Th: =easier ah in yourself okay ((lowers head and gestures to= [ ] [ ]
S: Uhuh ((nods)) Yep

Th: =her body)) where do you feel that in-in your body? =

**Expansion.**

Th: Please continue staying with your experience of removing alcohol from the room. I would like you to stay focussed on yourself and your sense of relaxation and decreased anxiety, caution, defensiveness and suspiciousness. [S: Yes, I agree with you, therapist that I feel more relaxed]. Th: You notice that you feel calmer, less stressed inside. You feel less wound up and more at home in yourself, your guard does not need to be up when you do not have to resist alcohol anymore. [S: Yes, I concur I do feel less wound up and more relaxed that is quite right, you are entirely correct and understand my experience right now]. Alright, since you are signalling to me that you concur with my appraisal of your internal state, I am going to move further into this experience. I’m looking at my body because I want you to become aware of where you feel this increased easiness in your body? Where would you locate it in your physical body. The experience of removing alcohol from the room is not just an emotional one, it is also a physical experience.

22. Interaction.

The therapist continues to intensify Sam’s experience of removing alcohol from his life and the room by paraphrasing his reactions and asking him to locate his new found relaxation in his body. Sam is willing to engage in this process and feels understood and supported by the therapist thus far. Sam no longer must be on guard and he freely endorses the therapist’s appraisal of his emotional state.

In this utterance, the therapist employed paraphrasing to access Sam’s experience and intensify it at a comfortable rate.
In addition, the therapist employed paraphrasing reflections when intensifying Jill's experience in Episode #1. The following text excerpt illustrates the therapist's regulation of her empathic statements to fit client readiness.

Text: Lines 443-447.

J: =I guess ((holds hands open)) I feel calm

[Yeah ((hands motion downward patting)) so you feel some calm too andah sort of sort of your normal feeling and when you feel calm=

[Yeah]

J: Yeah

Expansion.

Yes, I understand that you feel somewhat calm like Sam and a bit like your normal self, not really feeling much of anything right now [J: Yes, that's what I said but now that you say that I feel calm back to me, I'm beginning to doubt that I really feel that way]. Jill, when you feel calm I wonder what that is like for you right now?

51. Interaction.

The therapist communicates to Jill that her experience is important and that the therapist will accept whatever Jill says about her own experience. The therapist tells Jill what she heard her say using Jill's terminology therein prompting Jill to doubt the validity of her assertion of calm. The therapist's acceptance and validation opens a margin of safety for Jill to both access and express her state in the moment. In addition, the therapist's acceptance of Jill aids Jill in understanding what is being required of her in therapy. That is, Jill learns that her experience is of importance, valid and can be disclosed in the here-and-now.

In this series of turns, the therapist paraphrased Jill's experience of calmness following the removal of alcohol from the room. The therapist used Jill's exact language basing her reflection on Jill's comfort level during the intensification process.

The therapist's efforts to regulate the intensity of session #2 according to client pacing needs demonstrated a respect for client experience aiding future deepening endeavours. For example, the therapist's respectful regulation of session intensity according to client cues in Episode #1
contributed to the engagement of advanced empathy to intensify client experience in Episode #2, session #10. The following text analysis excerpt illustrates the therapist's use of advanced empathy to intensify Jill's in-session experience in Episode #2.


Th: = You don’t - yeah so I understand Jill how sometimes you need to protect ((Jill wipes tears, Sam looking at fingers, moving his fingers)) yourself from getting too close to Sam. Sometimes when you get too close to him you feel really alone, you feel really alone =

Expansion.

Sam you say you do not want to get close to Jill when she is upset and you have said that quite clearly even though you do not want to be thought of as cruel. My interest is in how this, not getting close to Jill when she is upset, affects her. I am addressing Jill now because Sam, you have stated clearly that you will not comfort Jill. As a result Jill, I understand why it is you feel the need to protect yourself from Sam by withdrawing from him. When you talk to Sam about your feelings you feel abandoned by him, he dismisses and avoids hearing what you are trying to say. You keep your distance because it hurts to not be heard or acknowledged. During times when you get close and become vulnerable with Sam he dismisses you and you end up feeling very alone and very isolated. The effect of Sam’s desire not to comfort or listen to you is you are left lonely, alone and isolated.

57. Interaction.

The therapist focusses on the effects of Sam’s distance on Jill when she is upset and intensifies Sam’s painful abandonment of her. Sam’s difficulty with Jill’s hurt defeats and isolates her. Also, the therapist observes the prevention of abandonment and hurt to be a self-protective reason for distance from Sam.

In this utterance, the therapist employed advanced empathy to deepen Jill's underlying affect and underscore the consequences of Sam's distancing behaviour on Jill and the marriage. Also, the therapist utilized advanced empathy in her responses to Sam in Episode #2 intensifying his experience of a core theme of inadequacy and failure. The elaboration of this level of
experience probably would have been impossible and inappropriate in session #2. However, in session #10, Sam was less frightened and more open to deeper self-exploration. The following text analysis excerpt from Episode #2, illustrates the therapist's focus on Sam's lack of personal worth and his sense of inadequacy.


Th: So, it ((touches Sam's shoulder from crouched position)) sounds as though.(hh)um he's also, ((looks at Jill, rolls right arm in front to herself)) Sam is also feeling rejected and ah and ah he also is feeling bad about himself, ((rolls right arm then rests hand on chest)) he's he knows that he's not operating at 100 percent so.(hh)ah he could say ah ((looks at Jill while rolling hand from chest)) "I'm feeling um not only um disappointed, pressured, I'm feeling rejected.(hh)I'm feeling um unsure of myself right now.(hh)and I'm feeling sad that I'm not operating at ((puts hand in lap, still crouched with arm resting on her chair)) 100 percent and I feel scared 'cause I don't, not sure how we're gonna get through ((looks at Sam, hand at chest)) this this month this mon:th, I'm not sure and sometimes I'm feeling scared and ah when I feel challenged in this way um it it touches me at a place where I'm very ((touches arm of chair, continues sitting on floor)) vulnerable ((talking to Jill, Sam looking at floor)), I'm not sure if I'm good enough, touches me in a very deep place.(hh)and ah I feel really vulnerable coming to you and talking to you Jill right now 'cause I'm the breadwinner ((holds hands up around shoulder and neck area, returns hands to lap)) in this family.(hh)right now.(hh)and I-I feel its, the pressure ((sharp hand motions at chest area)) is on me, I know you do alot ((gestures towards Jill)) of work and ah you do your bit, you pu:lI your weight and you support me.(hh)but the pressure is on me right now, I'm feeling pretty vulnerable - ((turns to Sam)) and I'm not sure what you want to add to that?

Expansion.

Okay, I'd like to summarize what you, Sam have just disclosed, to include the sense of pressure and disappointment you felt earlier in the re-enactment. I am crouched beside you Sam and touching your shoulder right now to signal that you have ventured into more emotionally vulnerable territory and I want to reflect this back to you in as caring and as gentle a way as possible. To incorporate this reflection summary into the re-enactment, I am going to pretend to be speaking as Sam addressing Jill. But first, I will address you Jill since you have been listening to Sam so that you may understand his experience of the financial situation and the remark made during the fight. Jill, Sam is feeling rejected by you and he is also feeling worthless because he is not succeeding in the business due to his physical injuries. Sam could say, if he were to express himself using "I" statements and feelings, "I feel disappointed and pressured. I also feel a lack of confidence in myself as a businessman and provider. I am sad that I am physically injured and this is undermining my business performance. I feel frightened that due to my physical difficulties the family will suffer financially and we will not have
enough money to pay our bills this month. I am very frightened of this prospect of financial difficulty and I feel very uncertain as to my ability to solve the current crisis. When I feel frightened and unable to cope or fix the problem I feel worthless deep inside my being. I believe I am an inadequate husband, father, provider and businessman. I feel this sense of inadequacy at the core of my being and when I talk about my feelings of inadequacy and worthless with you Jill I feel exposed, raw and vulnerable. I am supposed to be the provider for the family but I am letting you all down. I feel a tremendous burden as the provider especially when I find myself failing at the task and in the role. The family's financial security falls entirely on my shoulders because you are not working outside the home Jill. While I want to recognize that you do alot of work by looking after the children every day and supporting me as provider I find it a big burden being the sole wage earner. Jill your work as a homemaker makes up for the financial loss caused by your not working for pay and it is a contribution to the entire family's well-being but I still feel loaded down with the responsibility to meet the bill payments and keep the family financially stable. In my role as sole wage earner I feel very vulnerable talking to you because I realize that I am not performing my duties adequately and now the family is having financial difficulties."

Sam, I have tried to encapsulate what you have revealed about yourself and your struggle in this summary. However, I may not have captured all of what you would like to say and you may have something to add to these statements. Please feel free to add anything you wish to this summary of your feelings.


In this utterance, the therapist summarizes and reflects Sam's emotional state at the time of the financial discussion between himself and Jill. The therapist represents Sam's statements in the form of "I" statements attached to feeling words. The therapist uses "I feel" statements to demonstrate how to communicate using this format. In addition, the therapist empathizes with Sam as well as amplifying and deepening his experience of the financial difficulties. Sam looks at the floor during parts of the therapist's summary indicating his depth of vulnerability. The therapist recognizes that she is reflecting very tender emotions back to Sam as she speaks in his voice and is concerned that he add to what she has summarized if he so desire. The amplifying and deepening of Sam's experience prompts him to regard Jill with a little more compassion as demonstrated in his next utterance.

The therapist reflected Sam's vulnerability, fear, sense of inadequacy and failure in her empathic statement. She ventured into a core theme of inadequacy and worthlessness in this utterance. The therapist's empathic reflection was appropriate due to Sam's increasing comfort with deeper levels of self-exposure.

The therapist's use of advanced empathy in Episode #2 was context dependent and reliant on a previously established trusting atmosphere. The
therapist's employment of paraphrasing to intensify client affect in Episode #1 contributed to a respectful therapy climate in which client pacing cues informed therapy. The latitude to utilize advanced empathy to intensify client experience in later sessions was provided through the differential use of empathy in Episode #1 and Episode #2.

Components of the intensification process including the use of meaningful symbols, the personalization of bodily states and the employment of empathy were utilized selectively to intensify experience during experiential activity in the two episodes. In Episode #1, the symbolic representation of alcoholic drinking via a large plastic bottle was meaningful to a client struggling with alcoholism when he found the presence of the replica unnerving. In addition, the therapist focussed on the personalization of the client's physiological experience giving voice to his relaxed body state upon the removal of alcohol from the therapy office. In both episodes, the therapist chose to employ varying degrees of empathy to intensify client experience. In Episode #1, client pacing cues regulated the therapist's choice of empathic statement making paraphrasing an appropriate intensification tool. However, in Episode #2, client comfort made it possible for the therapist to engage advanced empathy to intensify the painful effects of an interpersonal distancing pattern.

**Intensification Components Common to Episode #1 and Episode #2**

While particular components of the intensification process were utilized on a discretionary basis and dependent upon the session context, the discourse analysis of the deepening process in both episodes revealed several Intensification components in common. These components included the creation of interaction between clients and between clients and the symptom.
In addition, the discourse analysis of both episodes revealed the importance of detailing the specifics of client dilemmas as part of the intensification process and finally, the text analysis revealed a common focus on clients' here-and-now experience. The common components of the intensification process will be discussed below.

**Encouraging interaction between clients and clients and symptom.**

The discourse analysis of both Episode #1 and Episode #2 uncovered the creation of two types of therapeutic interaction occurring between spouses in Episode #2, and between clients and the symptom in Episode #1. That is, in Episode #2, the session focussed on spousal interaction and in Episode #1 the experiential activity centered largely on the relationship between the clients and the symptom. In Episode #2, the therapist encouraged the clients to interact with one another as revealed in the following text analysis excerpt.

**Text Line: 268.**

Th: = Can you say this to Sam.

**Expansion.**

Jill would you tell Sam about how hard it is to handle the disappointment you feel when the business suffers setbacks. Sam does not understand what you were trying to say to him this morning and it is best if you address him directly with your explanation for your comment "same old scenario". Sam does not understand that you were not attacking him when you made your comment. He does not understand that you were feeling upset and disappointed with the setbacks when you made the comment.

**26. Interaction.**

The therapist encourages Jill to tell Sam directly that her intent was not to attack him. The therapist requests that Jill inform Sam as to the meaning of her comment which Jill cites to be a shorthand way of conveying her disappointment with the business setbacks. The therapist facilitates couple interaction in this utterance putting an emphasis on the direct communication of affect between spouses.
In this utterance, the therapist initiated spousal interaction to intensify aspects of a marital distancing pattern.

While the therapist encouraged couple interaction in Episode #2, she remained focussed on the relationship existing between the clients and the presenting problem in Episode #1. The following text analysis illustrates the therapist’s interest in exploring each spouse’s relationship to alcoholic drinking via the manipulation of a large plastic bottle. The therapist asked both Sam and Jill to situate alcohol in the room. The text excerpt featured below illustrates the therapist’s focus on Jill’s relationship with alcohol.

**Text: Line 138.**

*Th:* Where would you - put this right now Jill?

**Expansion.**

*Th:* Jill since both you and Sam make decisions about alcohol in the home, I wonder where you would put the bottle at this time? I am specifically asking you this question because the frame of joint decision-making continues to apply to both you and Sam. Also, I am interested in exploring your relationship with the bottle Jill since just as Sam has a relationship with alcoholic drinking, so do you.

**16. Interaction.**

The therapist asked Jill to situate the bottle according to her wishes in this utterance. The therapist communicates to the couple that Jill has decision-making sway with regards to alcohol and she has a particular relationship to alcoholic drinking that is worthy of exploration.

In this question, the therapist oriented therapy discourse toward Jill’s relationship with the bottle creating an interaction between Jill and the symptom.

**Articulation of the specifics of client dilemmas.**

A second intensification component found in both episodes included the articulation of the specifics of the client’s dilemma as a precursor to the
intensification of experiential activity. In particular, at the beginning of Episode #1, the therapist summarized the client's ambivalent relationship with alcohol. As described earlier (Episode #1, Lines 1-14), the therapist observed Sam's desire to abstain from alcoholic drinking and his simultaneous wish to keep alcohol handy reasoning that if he was going to drink he would obtain access to alcohol anyway. In Episode #2, the therapist embarked upon a reconstruction of the setting and utterances that constituted the morning fight. A previously described text analysis excerpt (Episode #2, Lines 1-3), explored the therapist's reconstruction of the couple's bedroom in therapy and her initiation of a detailed re-enactment of the fight sequence.

**Present tense therapy focus.**

The discourse analysis revealed that the therapist maintained a consistent here-and-now focus on the clients' present tense experience during experiential exercises in both episodes. In Episode #1, the therapist maintained a present tense focus on Sam's shift away from apprehension toward increased relaxation once the large bottle was removed from the therapy office. The following text excerpt illustrates the maintenance of a here-and-now experiencing focus in Episode #1.

**Text: Lines 235-237.**

Th: = ((continues shoulder gesture)) So right now your experience is that the apprehension(.hh)ah a few minutes ago a few seconds ago changed to calmness =

**Expansion.**

Sam you have brought a past car accident into your present experience of the bottle being removed from the room to explain why you would be so tense in the shoulder area. However, I would like to focus on your present experience of the contrast between apprehension when alcohol was present and calmness when it was not. This experience happened a few minutes ago.
Actually, I wish to correct my timekeeping to emphasize that your past car accident probably had little to do with your experience of apprehension turning into calmness when alcohol was removed from the room. It was actually a few seconds ago when you noted a change in your body from apprehension to calmness which leads me to believe that removing alcohol from the room results in you feeling calmer. Regardless of the other possible origins of your tension Sam, you feel calmer when alcohol is no longer present.


The therapist responds to Sam's notion that his shoulder and chest tension is due to a car accident rather than alcohol by focussing on the contrast between his bodily states of apprehension and calmness. The therapist's focus on the present tense deepens Sam's experience of the contrast and avoids discussion of the effects of his car accident compared to the effect of alcohol on his anxiety levels. By maintaining a present tense focus on the contrast between apprehension and calmness, the therapist emphasizes the beneficial outcome of calmness rather than dwelling on previous anxiety. The therapist endeavours to steer Sam away from the impossible task of proving himself able to resist alcohol towards a path of least resistance. Experiencing calmness due to the removal of alcohol is preferable to an unending battle of wills in which Sam measures his sense of worth against his ability to resist an irresistible temptor. The therapist also avoids a struggle with Sam over where his tension originates by maintaining a here-and-now focus.

In this utterance, the therapist focussed on Sam's present tense experience refraining from entering into a discussion that downplayed the role alcohol played in his tension levels. Sam found the experience of relaxation upon the removal of alcohol to have a significant impact.

Similarly, in Episode #2, the therapist remained focussed on the here-and-now effects of Sam's distancing behaviour intensifying the isolating consequences of withdrawal. The following text analysis excerpt samples the therapist's present tense intensification effort in Episode #2.


Th: =So you're still feeling the pain from this morning and when =
S: [ ] Yeah
Th:  = Jill ((indicates Jill with left hand)) is being very open with her tears right now you're kind of slamming back at her.

Expansion.

Let me see if I understand what you are saying Sam, right now you continue to feel attacked by Jill who said "same old scenario" in response to you telling her "Broughton better fly". [S: Yes that is the case therapist, I am still hurting from Jill's sarcastic attack on me]. Currently, Jill is very open, vulnerable and desperate. She is sobbing and hurting like you did this morning and your response is to hit her hard with your anger, lack of caring and indifference. Sam even though you understand how Jill is feeling right now because you felt similarly this morning you wish to seek revenge by punishing Jill.

52. Interaction.

In this utterance, the therapist summarizes Sam's position vis a vis revenge against Jill. She also continues to focus on the couple's present tense feelings and behaviours as they occur in the interaction. The therapist observes that even though Sam has experienced a similar sense of desperation, hurt and attack as Jill, he insists on forcefully meting out a vengeful punishment against Jill.

In this utterance, the therapist maintained a here-and-now focus on a relational cycle of hurt and retribution which precluded sympathy, compassion and good will. As such, Sam's sense of hurt and subsequent desire for revenge temporarily sustained couple distance and barred the potential for interpersonal generosity.

Summary

The components of intensification cited in ExST theory were important to the deepening of client experience. However, not all components of intensification were evident in Episode #1 and Episode #2. Although the episodes had several components in common, they also varied with respect to the elements employed to intensify client experience. In particular, the utilization of meaningful symbols, the personalization of bodily states and the use of advanced empathy to deepen experience were not common to both episodes. Nevertheless, both episodes contained a focus on interaction, client here-and-now experience and the specification of client dilemmas. The
employment of various elements of intensification were context dependent determined by session content, client cues and readiness, and session number.

**Intense Experiential Activity and the Syncretic Process**

In addition to describing experiential activity and the components of intensification, the discourse analysis captured how the intensification of client experience during experiential activity aided the syncretic change process. According to ExST theory, the deepening process facilitates relational novelty by fostering atypical behaviours, feelings and thoughts, evoking the essence or substantive relational themes of the client’s issue, bringing important experiences to conscious awareness and promoting new cognitive understandings (Friesen et al., 1991). The discourse analysis of two episodes revealed these aspects of relational novelty to be integral to the syncretic change process in which the couple shifted away from conflictual beliefs and practices towards intimacy, mutuality, and more consensus of opinion and behaviour.

This section delineates the syncretic change process in Episode #1 and Episode #2 highlighting how the four tenets of relational novelty aided the generation of couple intimacy. These tenets include:

1. The facilitation of atypical experience (ATY).
2. The promotion of new cognitive understanding (CU).
3. The bringing of experience into conscious awareness (CA).
4. The evocation of substantive relational themes (SRT).

The tenets of relational novelty will be identified as they occur and recur throughout the following sequential accounts of the intensification of client experience. The tenets will be identified via a code detailing the presence of a tenet of relational novelty during the episode account. For example, when the
evocation of substantive relational themes is noted, the code (SRT) will appear in brackets beside the observation. The codes (ATY), (CU) and (CA) will refer to atypical experiencing, cognitive understanding and conscious awareness respectively.

Sequential accounts of the intensification process engaged in Episode #1 and Episode #2 will be provided in this section to offer a context for couple change, afford a comprehensive understanding of the text and allow for continuity of the therapy story. In addition, sequential accounts of the two episodes will be undertaken in this section to uncover the discourse meaning as it was encountered by the researcher during the analysis process.

The Syncretic Change Process in Episode #1

In Episode #1, the couple's movement away from disparate belief or practice reflected in distance and isolation towards increased mutuality, consensus and partnership was marked by the intensification of the contrast between Sam's states of tension and relaxation and Jill's response to Sam's experience. The intensification of Sam's experience led to Sam's acknowledgement that alcohol was a problem and the perturbation of guilt in Jill. The combination of Sam's recognition of the problematic nature of alcoholic drinking, Jill's desire to contribute to the decision to rid the home of alcohol and her guilt led to a joint decision to remove alcohol from the home. Thus, disparate views regarding alcoholic drinking and Jill's decision-making role in Sam's battle with alcoholism transformed to reflect commonalty of purpose in joint decision-making regarding the location of alcohol. The process whereby conflictual beliefs concerning alcohol and marital decision-making shifted to reflect spousal consensus and a joint decision-making posture was revealed in the discourse analysis of Episode #1.
The purpose of this section is to explore how the intensification of experiential activity promoted couple movement towards increased intimacy. Selected discourse analysis excerpts featured elsewhere in the document but considered pertinent to the discussion of the convergent properties of intense experiential activity will be utilized in this section. The following text analysis inquiry will highlight the tenets of relational novelty that promoted a shift from couple distance to an increased sense of cooperative partnership. The text analysis of Episode #1 will uncover how various tenets of relational novelty including the evocation of substantive relational themes (SRT) and the facilitation of atypical experience (ATY) enhanced the potential for interpersonal intimacy. In addition, the discourse analysis will pinpoint how the promotion of new cognitive understanding (CU) and the bringing of experience into conscious awareness (CA) fostered a shift in spousal distance patterns.

In Episode #1, following Sam’s description of his ambivalent relationship with alcoholic drinking, the therapist introduced an experiential activity identified as the symbolic externalization of alcohol. Upon observing Sam’s ambivalent desire to abstain from drinking alcohol while keeping it handy for consumption, the therapist asked the couple where in the room they would place a large plastic bottle that resembled an oversized bottle of beer. Sam answered the therapist stating he would like to remove alcohol from the room altogether. Jill agreed with Sam claiming that alcohol belonged outside the therapy room door if Sam so desired. The therapist invited Sam to place the bottle outside the therapy office. After removing alcohol from the room with Jill’s blessing, Sam observed an immediate reduction in apprehension representing a departure from his previous understanding of the role alcohol
played in his life. That is, after the therapist asked Sam to comment on the experience elicited when he removed alcohol from the room, he replied that he was surprised to discover that he felt less apprehensive since removing the bottle from the therapy office (ATY). The therapist requested that Sam reflect upon his experience of reduced anxiety intensifying the effects of the experiential exercise as illustrated in the following text example.

Text: Lines 183-185.

Th: So ((flat left hand moving gradually downward)) what's it like Sam to have apprehension levels gone down a bit? ((quiet voice)) What's that like?

Expansion.

I'm going to move further into your experience Sam and I'd like to know what it is like for you, what is happening to you now that your anxiety has lessened. I am using a quiet voice because I wish to move deeper into your experience of removing alcohol from the room. My soothing, calm voice recognizes that this may not be comfortable for you and I wish to support you as we probe further into your experience.

20. Interaction.

The therapist encourages Sam to continue experiencing his reactions to the removal of alcohol from the room. She stresses his name to promote his continued introspection. In addition, the therapist is signaling to the couple that Sam's experience is being probed first. With hushed tones, the therapist encourages Sam in a deeper exploration of his reactions and the soothing quality of the therapist's voice heightens his sense of security. Sam is wary of being overwhelmed by intense experiences and is secure as long as he feels in control. The therapist's voice modulation and tempo are designed to enhance his sense of security while he experiences decreased levels of anxiety at having removed alcohol from the room.

Sam appeared comfortable with the depth of exploration encouraged by the therapist and moved further into his experience in his next turn. In his reply to the therapist's question regarding his experience of lowered apprehension, Sam observed that "something had changed" since he removed alcohol from the therapy office. The following text analysis excerpt presents Sam's reply to the therapist.

S: U::mm I relax a little bit more you know u:mm - I’m not as =

[ ]

Th: ((hushed voice))Yeah ((nods))

S: = tentative I-I mean ((gestures)) already I mean I feel like it-it something has
changed ((right hand opens to right)).

Expansion.

Um, let me think about what is going on inside me right now, I am more
relaxed you understand and I'm struggling for words to express how I am
feeling, I find I am not as anxious as I was, I'm less cautious, defensive and
scared as I was when alcohol was in the room. This change from being on my
guard with you and alcohol to now feeling less defensive has all happened very
quickly. I am surprised by the speed at which my feelings changed after I
removed alcohol from the room. I have changed but I'm not quite sure how I
have changed except to say that I used to say alcohol’s presence did not
bother me but it obviously does bother me very much. My opinion about
alcohol's role in my life has changed just as my feelings of defensiveness,
apprehension and anxiety have changed to ones of relaxed calmness as a result
of removing alcohol from the room. I don’t think I will be able to have alcohol
at home given the stark difference I experience between anxiety about having
alcohol in my presence and then calmness after removing it.


Sam is at a loss for words in this utterance since he is unfamiliar with
focusing on his inner experiences and with feeling more relaxed as a result of
removing alcohol from the room. He feels less defensive and cautious with the
therapist and Jill now that alcohol is no longer present. He is no longer on his
guard and is vulnerable. He says he has changed implying that he is not the
same as he was before removing the alcohol and this state is disorienting. Not
only is Sam less anxious than he was before, but he begins to admit that
alcohol did bother him. Until now, this level of vulnerability was not open to
Sam who, for the sake of his sense of self respect, defended his choice to keep
alcohol handy. Sam and the therapist have joined together in this utterance
with Sam no longer trying to guess what the therapist is "up to". Sam's
increased vulnerability and decreased suspiciousness bodes well for increased
intimacy between he and Jill and increased trust between himself and the
therapist.

Sam's reply to the therapist conveyed the beginnings of an important
intrapersonal awareness. In this utterance, Sam began to become aware of
how alcohol had been causing him undue tension (CA). Also, he reached a
new cognitive understanding which included the realization that alcoholic
drinking may be a bigger problem than first acknowledged (CU).

To continue the intensification process the therapist paraphrased Sam's
feelings of relaxation and tentativeness. The therapist moved to deepen Sam's
experience by requesting that he locate where in his body he noted a sensation
of relaxation, reduced tentativeness and easiness as demonstrated in the
following text analysis excerpt.

Text: Lines 194-204.

Th: ((left hand gently rolling away from self)) So you feel a little more
relaxed(.hh)ah not quite as tentative(.hh)and alittle =
[ ]
S: Yeah, uhuh

Th: =easier ah in yourself okay ((lowers head and gestures to=
[ ]                         [ ]
S: Uhuh ((nods)) Yep

Th: =her body)) where do you feel that in-in your body?=

Expansion.

Th: Please continue staying with your experience of removing alcohol from the
room. I would like you to stay focussed on yourself and your sense of
relaxation and decreased anxiety, caution, defensiveness and suspiciousness.
[S: Yes, I agree with you, therapist that I feel more relaxed]. Th: You notice
that you feel calmer, less stressed inside. You feel less wound up and more at
home in yourself, your guard does not need to be up when you do not have to
resist alcohol anymore. [S: Yes, I concur I do feel less wound up and more
relaxed that is quite right, you are entirely correct and understand my
experience right now]. Alright, since you are signalling to me that you concur
with my appraisal of your internal state, I am going to move further into this
experience. I'm looking at my body because I want you to become aware of
where you feel this increased easiness in your body? Where would you locate
it in your physical body. The experience of removing alcohol from the room is
not just an emotional one, it is also a physical experience.
22. Interaction.

The therapist continues to intensify Sam’s experience of removing alcohol from his life and the room by paraphrasing his reactions and asking him to locate his new found relaxation in his body. He is willing to engage in this process and feels understood and supported by the therapist thus far. Sam no longer must be on guard and he freely endorses the therapist’s appraisal of his emotional state.

The therapist empathized with Sam’s atypical experience of relaxation without alcohol’s presence (ATY). Previously, Sam was unaware that alcohol made him tense and that its absence made him feel calmer (CA).

In response to the therapist’s question regarding the physiological location of relaxation, Sam situated his experience of increased ease in his shoulders as depicted in the text analysis excerpt featured below.

Text: Lines 206-212.

S: =Right across here ((back and forth gestures across shoulders)) =

Th: =Right across there ((back and forth gestures across shoulders)) =

S: =Yeah right across there

Expansion.

S: I feel the relaxation now that alcohol is out of the room across my shoulders. Although this is currently out of my awareness, removing alcohol from the room is like lifting a burden off my shoulders. I feel lighter and easier across the shoulders. Alcohol weighed heavily upon my shoulders and now that the burden has been removed I feel calmer and easier across my shoulders.

Th: I believe you said that you feel more relaxed across the shoulders, in this area of the body, the shoulder area. You feel lighter in the shoulder area since you removed alcohol from the room. I am adopting your words and focussing on your shoulders repeatedly as part of the intensification process. I am highlighting the difference between your previous anxious state and your current sense of calmness to heighten your awareness of the tension alcohol’s presence caused you. The contrast between your previous defensive, anxious state and your current sense of relaxation is worth lingering over. You probably prefer to be relaxed than tense and the experience of calmness is reinforcing in its pleasantness. This is a big change for you and a surprise and I wish to move carefully and slowly. I am aware of your previous defensiveness and I am being careful not to extrapolate too much from your stated experience. I am unsure as to how deeply I can go with my empathic statements since this is our second session together and you fear being out of control and
overwhelmed by unfamiliar experiences. As a result, I study your actual words as an indication of how ready you are to proceed further into your reactions.

S: Yes, you are correct, I feel more relaxed, less suspicious, less defensive and less stressed out across the shoulder area. This pace is comfortable for me, we are not progressing too quickly and I continue to be willing to explore my reactions to putting alcohol outside the door. This level of intensity remains comfortable and up until now your questions and reflections of my inner state have not caused me alarm. You are engaging me at a manageable level of intensity, I do not fear being overwhelmed or out of control at this juncture.

23. Interaction.

In this series of utterances, the therapist and Sam work together to regulate the intensity of the powerful experience of removing alcohol from the room. Sam feels understood and safe so far and the therapist continues to ask him to focus on his internal processes at a comfortable level. He feels relaxed, open and calm while the therapist probes more deeply into the contrast between his previous tension and current calm state. It is important that the therapist aid in the regulation of the intensity of Sam's encounter with his reactions to alcohol's removal lest he fear being overwhelmed by his emotions and bodily sensations. Simultaneously, Sam cues the therapist and regulates the pace of intensification by concurring with her appraisals of his internal state, answering her questions and monitoring the degree to which he discloses his reactions to the removal of alcohol from the room.

The therapist centered her attention on Sam's shoulders to focus on the here-and-now contrast between his previous state of tension as it shifted to one of relaxation at the removal of alcohol from the room (ATY). In addition, the therapist carefully gauged Sam's readiness to enter his experience more deeply by proceeding slowly and adopting his language to describe his experience. Sam's agreement with the therapist's understanding of the physiological location of his relaxation provided the therapist with a cue to further deepen his experiential awareness of calm. Thus, the therapist asked Sam to reflect further on the sensations encountered in his shoulder area in the following text excerpt.

Text: Lines 213-217.

S: = Yeah right across there

Th: You feel easier(.hh)and ah(.hh)((looks downward and continues gesturing across shoulders)) right across there um what's it like ((moves head forward)) inside there ((hushed voice))right across there?
Expansion.

I understand that you agree with my appraisal of the relaxed state of your shoulders and you appear relaxed enough to continue our exploration of your experience of removing alcohol from the room. Sam, you have said you feel lighter, and less tense across your shoulders. I'd like to move a bit further and find out what it is like to feel more relaxed across your shoulders, inside your shoulders, right inside your shoulders. I am aware that I am moving into even more personal and risky territory for you by asking you to expand further on what it is like inside your shoulders. I am hoping to be privy to what is on the inside of you Sam, what is deep within you right now and I recognize that this is a risk. I am speaking in a hushed voice and leaning forward towards you to encourage you to allow me access to your still deeper inner experiences. I am requesting further vulnerability from you Sam as part of your treatment.

24. Interaction.

The therapist asks Sam to move further into his internal experience in this utterance. She summarizes his current experience indicating that she has understood him to this point and encourages him to continue focussing on his own reactions to the experience of removing alcohol from the therapy room. The therapist, moving carefully, asks Sam to disclose what is occurring inside his shoulders. Metaphorically, the therapist is asking Sam to trust her and allow her entry into his internal world. Her hushed tones and forward leaning body stance are an attempt to signal to him that she is respectful and trustworthy. The therapist’s requests for deeper self disclosure demonstrate how to be in therapy to Sam and Jill. In therapy it is considered beneficial to self disclose in a nondefensive fashion and being vulnerable is preferable to being guarded.

In this utterance, the therapist requested that Sam entertain a deepening of his experience promoting the possibility of increased vulnerability. Hitherto, Sam was unaccustomed to open self-disclosure of important personal experience. The intensification process offered him an opportunity to engage in atypical self disclosing behaviours (ATY).

Following a query concerning his relaxed state, Sam indicated that his experience of anxiety in the presence of alcohol changed to calm upon its removal (ATY). Sam's observation that he was calmer once alcohol had been removed from the room provided an experiential challenge to the idea that alcohol was not a problem. Previously, Sam ambivalently characterized his drinking practices as either not at all a problem or very troublesome. The experiential exercise brought Sam's ambivalent intrapersonal struggle with
alcohol to the fore and challenged his belief that alcoholic drinking was not a problem (CU). Sam's encounter with ambivalence and the challenge to his beliefs about alcoholic drinking contributed to increased discomfort as illustrated in the following text analysis excerpt.

**Text: Lines 219-233.**

S: It feels calm right now and that's where it seemed to have =

Th: Uhuh

S: =((continues to indicate shoulder area)) welled up into th-the apprehension was right through here ((drops hands on lap)) =

Th: =((quietly)) Yeah ((nods, gestures to shoulder)) so-

S: =((continues to indicate shoulder area)) welled up into th-the apprehension was right through here ((drops hands on lap)) =

Th: =((quietly)) Yeah ((nods, gestures to shoulder)) so-

S: But then I have been injured there too so you know =

Th: Right

S: =((drops hand on lap)) =

**Expansion.**

My shoulders and chest feel relaxed and calm right now [Th: Yes, I understand] and it is in the shoulder and chest area that the anxiety was located. The anxiety rose into the shoulder and chest area when alcohol was present. [Th: Yes, I understand what you are telling me, the anxiety welled up into your shoulders and chest when alcohol was present]. I'm interrupting you therapist to make you aware of the fact that the shift from apprehension to calmness in my body may not be a big deal since I have sustained injuries in the shoulder and chest area. Tension and anxiety in this area may result from physical injury as opposed to the presence of alcohol in the room. So, alcohol may not be a problem for me, the problem is the injuries I sustained to the shoulder and chest area as the result of a car accident. I have not failed to remain calm around alcohol because the tension I experience is due to a car accident. If I had not had the car accident I would be calm around alcohol and it wouldn't be a problem for me. I am the victim of physical injuries not a weak person who is anxious around alcohol. [Th: Right, I understand you are telling me you think the tension is due to a car accident not alcohol and you want to find a reason other than the presence of alcohol for your tension].

**25. Interaction.**

Sam answers the therapist's question telling her that he feels calm in the shoulder and chest area when alcohol is out of the room. The therapist's question was designed to deepen Sam's experience of the contrast between his bodily state when alcohol is present and when it is not. The contrast between
calmness and apprehension is quite stark in Sam’s experience and in this utterance he struggles to ward off feelings of failure and incompetence as he reflects upon his experience of the contrast. Sam’s solution to the uncomfortable realization that alcohol is a problem for him insofar that it makes him anxious when it is present, is to attach feelings of tension in the shoulders and chest to physical injury. Sam informs Jill and the therapist that he has not failed to be calm around alcohol and control his drinking, rather he is a victim of motor vehicle accident and any tension in the shoulder and chest area is due to his unfortunate accident not his inability to control alcohol. According to Sam, alcohol is not a problem for him and as a result, he is not, as feared, a failure.

Sam regulated the intensity of the experience by developing an alternate hypothesis for why he would be relaxed when alcohol had been removed from the therapy office. The experiential challenge to Sam’s notion that alcohol was not a problem for him prompted the surfacing of his core or substantive relational theme of a sense of inadequacy and worthlessness (SRT). The idea that alcohol was a problem for Sam tapped his anxiety regarding his degree of competence with respect to resisting alcohol. Sam’s previous failures to remain sober became painful evidence of personal weakness and evoked themes of inadequacy and unworthiness (SRT).

The experiential exercise in Episode #1 delved into Sam’s intrapersonal struggle with alcohol and self-worth prompting him to refer to past injury in an attempt to account for the prior existence of shoulder tension. If Sam could demonstrate that his shoulder tension was due to physical injury rather than the presence of alcohol, he could counter the notion that the presence of alcohol caused him apprehension. Thus, Sam could stave off feelings of inadequacy and incompetence.

Nevertheless, in her reply to Sam’s physical injury hypothesis, the therapist sustained the momentum of the deepening process by maintaining a present tense focus and engaging Sam in an atypical exploration of the contrast between his apprehensive and calm states (ATY).
Th: =((continues shoulder gesture)) So right now your experience is that the apprehension ah a few minutes ago a few seconds ago changed to calmness =

Expansion.

Sam you have brought a past car accident into your present experience of the bottle being removed from the room to explain why you would be so tense in the shoulder area. However, I would like to focus on your present experience of the contrast between apprehension when alcohol was present and calmness when it was not. This experience happened a few minutes ago. Actually, I wish to correct my timekeeping to emphasize that your past car accident probably had little to do with your experience of apprehension turning into calmness when alcohol was removed from the room. It was actually a few seconds ago when you noted a change in your body from apprehension to calmness which leads me to believe that removing alcohol from the room results in you feeling calmer. Regardless of the other possible origins of your tension Sam, you feel calmer when alcohol is no longer present.


The therapist responds to Sam's notion that his shoulder and chest tension is due to a car accident rather than alcohol by focussing on the contrast between his bodily states of apprehension and calmness. The therapist's focus on the present tense deepens Sam's experience of the contrast and avoids discussion of the effects of his car accident compared to the effect of alcohol on his anxiety levels. By maintaining a present tense focus on the contrast between apprehension and calmness, the therapist emphasizes the beneficial outcome of calmness rather than dwelling on previous anxiety. The therapist endeavours to steer Sam away from the impossible task of proving himself able to resist alcohol towards a path of least resistance. Experiencing calmness due to the removal of alcohol is preferable to an unending battle of wills in which Sam measures his sense of worth against his ability to resist an irresistible temptor. The therapist also avoids a struggle with Sam over where his tension originates by maintaining a here-and-now focus.

In her reply to Sam's physical injury hypothesis, the therapist maintained a present tense focus on his experience emphasizing the words "right now" and referring to minutes and seconds as measures of the recent as opposed to distant past. In this utterance, the therapist oriented the therapeutic discourse away from an exploration of Sam's tension due to physical injury toward a discussion of how his apprehension changed to calmness. In response, Sam
both agreed with the therapist's appraisal of his current state and attempted to modify the therapist's assessment by altering his observations of his physiological state. In a description of his experience, Sam reduced his sense of relaxation and calm to that of being "settled down" (Episode #1, Line 239). The following text excerpt highlights Sam's continuing struggle with the evocation of a personal conviction that he was inadequate because he was tense in the presence of alcohol (SRT).

Text: Line 239.
S: =Hhm ((nods)) it settled down sure =

Expansion.

Okay, I will agree with you that the anxiety has settled down. The anxiety is not as intense as it was when alcohol was in the room. However, I will not say I am calmer like I did a minute ago. I will only say that the anxiety has decreased which means I still feel tense due to the car accident. Therefore, the decrease in tension is not necessarily due to the removal of alcohol since some tension still exists in my shoulder and chest area. If I still experience some tension when alcohol has been removed then this means alcohol is not a problem for me. I am therefore not a failure. If I was completely calm after alcohol had left the room then I would be a complete failure. Worthwhile people are not calmer when alcohol is absent, I am still a bit tense therefore I am worthwhile.

27. Interaction.

Sam wants to convey to the therapist and to Jill that he is not a failure and he struggles to create a good opinion of himself. He goes so far as to modify his previous assertion that he feels calmer to a less strong position of being settled down. Sam is eager to attain a sense of competence and worth and insists that the therapist account for this desire in her understanding of his experience. He repeatedly emphasizes his desire to view himself as successful and competent and the therapist incorporates the modifications Sam places on his experience into her utterances.

Sam’s response to the therapist in line 239 indicated that although he was in agreement with her regarding the reduction of his anxiety, he minimized the extent to which it had decreased. In the previous utterance, Sam changed his
self description of "calm" (Episode #1, Lines 219-233) to that of a "settled down" experience to ward off a sense of inadequacy and incompetence. If the relaxing effects of the removal of alcohol were downplayed, then Sam could retain the view that alcohol did not bother him. It was important to Sam's sense of self-respect that alcohol not appear to trouble him. If alcohol was identified as being responsible for some of his tension, he believed he would seem incompetent in his battle with alcoholic drinking. Sam's substantive relational theme of inadequacy and worthlessness was evoked during the intensification prompting him to modify his experience of "calm" to a sensation of being "settled down" (SRT).

The therapist recognized Sam's vulnerability and incorporated his minimization into her reflection while continuing to focus on the intensification of his experience as revealed in the following text excerpt.

Text: Lines 241-245.

Th: = ((hushed voice)) Yeah ((nods and continues drawing left hand across shoulders)) okay settled down a bit(.hh)so that calmness and sort of settling down a bit(.hh)do you have any sense of-of ((drawing right hand across shoulders)) the feeling the sensa-sation of that? What's that like? ((right hand rests on chest))

Expansion.

Yes, I understand what you are saying and I want to continue to focus on your bodily experience as I indicate my shoulder area and speak in a hushed voice. I also wish to acknowledge that you have corrected my statement maintaining that you feel settled down. I would like to mitigate that further saying that you have settled down a bit but you are not completely settled since you removed alcohol from the room. You feel calmness as you previously described it and you feel settled down but not too settled down. I do not wish to engage in too much intense expression lest you become overwhelmed so I'm hesitating and struggling for words. What is the sensation of feeling settled down and calm? What is it like, this feeling of being settled down and calm? I'm not sure if I'm being clear and you understand my question Sam.
28. Interaction.

The therapist continues to focus on Sam's present experience of the absence of alcohol and communicates to him that she has understood his desire to maintain a sense of adequacy by incorporating his modifications into her summary of his experience. By including Sam's experience of feeling settled down and adding a further qualifier (i.e., a bit and sort of) to the phrase, the therapist indicates that she understands and listens to Sam. In addition, she tells him that she has heard his statement about feeling calmer and this too is incorporated into the therapy. The therapist is uncertain as to whether her question is clear but her intent is to continue to focus on Sam's experience. She explores the contrast between apprehension and calmness by deepening his experience of the calm state achieved when he removed alcohol from the room.

In this utterance, the therapist continued to respectfully intensify Sam's experience. She entered his world incorporating the mitigation of his sensations while focussing on the present tense intensification of his experience. The therapist accepted and included Sam's thoughts, feelings and physiological sensations as they were reported to her during the intensification process.

The therapist included Sam's mitigation of his experience in her paraphrase summary of the contrast between tension and relaxation following the removal of alcohol from the therapy office. Also, she encouraged atypical self disclosure during the deepening process by requesting that Sam recount his intrapersonal experience (ATY). Sam's reply to the therapist's request revealed his continued intrapersonal trepidation with focussing on how the removal of alcohol from the therapy office perturbed reduced tension as illustrated by the following text analysis excerpt.

Text: Lines 247-252.

S: You mean physically? Yes.

    [ ]

Th: Yeah
Th: ((nods, continues holding hand to chest)) Physically what's it like physically? =

Expansion.

S: Do you, therapist, mean what happens to my physical body when I feel settled down? [Th: Yes, that's what I mean to say, what happens to your body when you feel settled down and calmer?] Yes, I thought so, okay I thought that was what you were trying to say when you asked me what it is like to feel settled down.

Th: Yes, that is what I mean, I mean to ask you what it is like inside you physically when you have settled down? We have discussed your feelings of apprehension and calmness and now I would like to know what the muscles in your chest and shoulder area are doing now that you feel calmer. You said you had a car accident and this made the muscles tense, so now I would like to know what your muscles feel like when alcohol has been removed from the room given that they are already tense from a previous injury?

29. Interaction.

In this turntaking sequence, Sam asks the therapist for clarification of her question by supplying her with the word she was struggling to find. The therapist is open to Sam's help in expressing herself and Sam once again corrects the therapist. In previous utterances, he has corrected and clarified his experience with the therapist and in this turn, he indicates his understanding of the therapist's question by again clarifying her statement. Sam communicates to the therapist that he is listening to her and trying to understand. Sam also tells the therapist that he is in charge, in control and monitoring his therapy carefully. Being one step ahead of the therapist enhances his sense of safety. Sam listens intently to the therapist and monitors her statements for incorrect reflections of his experience and inadequately expressed concepts and questions in an attempt to ward off the feelings of failure which arise due to uncontrollable urges to drink and the need to attend therapy. Helping the therapist express herself makes Sam feel more secure and less vulnerable to feelings of inadequacy and worthlessness.

In her statement, the therapist communicates to Sam that he is accurate in his understanding of her question. She also prompts him to continue experiencing his body in the present tense. The therapist's acceptance of Sam's modifications and clarifications put him at ease enough to entertain the idea that alcohol's absence from the room is related to increased relaxation on his part. The therapist continues to accept clarification and redirection of her statements while maintaining a focus on the current therapeutic activity.

In this utterance, Sam's reply to the therapist's query regarding his experience of feeling "settled down" was made in the form of a question. Sam asked for
clarification from the therapist regarding the type of information she required. His embedded request was both a legitimate request for information and a rhetorical query in that Sam already had the information required to answer the therapist's question (Labov & Fanshel, 1977). Sam appeared to be regulating the intensity of a complex experience which included increased physical relaxation (ATY), heightened feelings of inadequacy (SRT), a new understanding that alcoholic drinking was a bigger problem than previously acknowledged (CU) and a developing awareness that alcohol caused undue tension (CA).

Sam ascertained that the type of data sought by the therapist included disclosure of his physical experience of muscle relaxation. However, he remained perturbed by the experiential challenge posed by the removal of alcohol from the therapy room. As a result, Sam answered the therapist's question regarding his physiological experience by cautiously acknowledging his increased ease as captured in the following text analysis excerpt.

**Text: Lines 254-257.**

S: =U::mm ((shakes head)) the muscles have relaxed th-the ((touches shoulders with bent fingers)) you know right up in here ((drops hands on lap with slapping sound)) y-you know definitely relaxed subsided some

**Expansion.**

Let me think about how I feel physically, my shoulder muscles have relaxed, you understand, therapist, the muscles in my shoulders, inside my shoulders has without a doubt relaxed, the feeling of apprehension has lessened to a certain degree, I have to admit. However, I'm struggling to refrain from concluding that my relaxation is due to the removal of alcohol by mitigating my previous assertion of relaxation to include the experience of some reduction in tension. The tension in my shoulders has subsided to a certain extent but I remain cautious in claiming further calm.

**30. Interaction.**

Sam tells the therapist that he is more relaxed since alcohol has left the room and that his anxiety has subsided to a certain degree. He communicates that he feels secure enough to entertain the notion that he feels tense around
alcohol. The therapist’s acceptance of his experience, her willingness to modify her utterances to reflect her new understanding of Sam and her nondefensive stance engender a greater willingness on Sam’s part to experience this unusual state of relaxation. However, Sam continues to struggle with disruptive competency questions evoked by the idea that he is more relaxed after the removal of alcohol from the room.

In this utterance, Sam told the therapist that his muscles relaxed after he removed alcohol from the office. However, he began to modify the experience due to a desire to preserve his self-esteem. Thus, in her next turn, the therapist overlapped Sam’s utterance to encourage him to continue pursuing atypical behaviours and cognitive understandings including self disclosure (ATY) and the acknowledgement of the problematic nature of alcoholic drinking (CU). The following text excerpt uncovers the therapist’s overlapping turn and her attempt to help Sam engage in relationally novel behaviour.

Text: Lines 259-262.

\[ S:=U:mm ((shakes head)) \text{the muscles have relaxed th-the ((touches shoulders with bent fingers)) you know right up in here ((drops hands on lap with slapping sound)) y-you know definitely relaxed subsided some} \]

\[ \text{Th: So the muscles(.hh)((continues drawing hand across upper chest)) you have a-an awareness that the muscles have relaxed=} \]

\[ S:=Hmhm ((nods)) hhmhm= \]

Expansion.

\[ \text{Th: I am overlapping your statement because I do not want you to modify this experience and backtrack saying you are not as relaxed as you first claimed. I heard you say the tension subsided some and I began to wonder if you would minimize your relaxed state by saying it is merely a reduction in tension not relaxation. As a result, I will quickly echo what you said identifying an awareness that your shoulder muscles have relaxed. These muscles were the same muscles that were injured in the car accident and they have now relaxed when alcohol has been removed from the room.} \]

\[ S: \text{Yes, I agree competely, you have reflected my experience exactly.} \]
31. Interaction.

The therapist overlaps Sam's statement regarding the reduction of tension and anxiety to continue intensifying his experience. She continues emphasizing his relaxed state rather than his previous tension. She quickly echos his statement that he is relaxed keeping the focus on Sam's sense of calm to deter him from modifying or mitigating his utterance. The therapist recognizes that Sam is beginning to adopt the notion that the absence of alcohol increases his sense of relaxation. Sam acknowledges the accuracy of the therapist's statement in his turn and the pair seem to have agreed that he is more relaxed when alcohol is not present.

In Episode #2, the therapist remained focussed on the here-and-now effects of Sam's distancing behaviour on Jill as identified in the following text excerpts. The therapist overlapped Sam's utterance with a paraphrase of his previous statement. In her reflection, the therapist strove to deter Sam from losing sight of the therapeutic gains made when he experienced being more relaxed after alcohol had been removed (ATY). Sam concurred with the therapist's reflection of his experience of muscle relaxation signalling the beginning of consensus regarding the tension inducing nature of alcoholic consumption and the calming effects of its removal.

The growing consensus revealed through the discourse analysis was bolstered by the therapist's persistent pursuit of Sam's here-and-now experience through the intensification process. The agreement reached between the therapist and client in the previous utterances indicated that additional self disclosure was possible and Sam's experience could be further deepened through the personalization of bodily sensations as illustrated in the following text analysis excerpt.

**Text: Lines 264-266.**

Th: =Okay(.hh)okay(.hh)((continues drawing hand across upper chest)) and if those muscles had a voice - what would they say right now?
Expansion.

Alright, great, alright, we're on track here. I'd like to ask you another question now that we are on a roll and in agreement. I want to further explore these relaxed shoulder muscles of yours Sam since you are willing to move along further with the idea that your shoulder muscles have relaxed as a result of the removal of alcohol from the room. Please continue to focus on your shoulders and chest and tell me, if the shoulder and chest muscles could speak to us, you, me and Jill, what do you imagine they would say at this moment?

32. Interaction.

The therapist recognizes that Sam has agreed that he is more relaxed without alcohol and takes the opportunity to move further into his experience by giving his body a voice. To accentuate the relaxing effects of alcohol's absence, the therapist encourages Sam's body to speak for itself.

The therapist's request that Sam's body speak for itself represented a significant risk for him since it had the potential to deepen his experience considerably. His response to the therapist included both his surprise and wariness at being asked such an unusual question. The following text analysis excerpt depicts Sam's tentative answer to the therapist's query.

Text: Lines 268-269.

S: Geeze I don't know - thanks? ((laughs; opens hands and drops on lap)) I don't know =

Expansion.

Geeze, that is a really strange question and I'm not sure where you are going with this. I was feeling kind of on top of this process but asking my muscles what they would say is really weird. I'm getting a bit nervous again because I do not recognize this unorthodox procedure. I am not sure whether I will answer the question correctly and I am also suspicious that this may be a way to trick me. Therapist you could be trying to trick me into admitting that I am crazy or something and that my muscles talk to me. If I answer you, I run the risk of appearing crazy and out of control and I fear I am crazy and out of control sometimes. This would mean I am a crazy failure. However, I am willing to go along with this to a certain extent because despite your unorthodox methods I have felt understood up to now. So, I guess my muscles would thank me for providing them with relief by removing alcohol from the room. It is funny to think of my muscles thanking me and it makes me laugh. I am also nervous and I sometimes laugh when I have been caught
off guard. I'm uncertain as to what you are after, I don't know what you want me to say and I spend a lot of time figuring out the proper way to proceed. So there you go therapist that's about all I can say in answer to your weird question.

33. Interaction.

Sam attempts to respond to the therapist's request that he give his muscles a voice in this utterance. He is somewhat more trusting of the therapist since she has shown a willingness to respect and incorporate his experience into her speech acts. However, he is further challenged by her unusual request. Sam conveys to the therapist that while he may agree with her regarding the reason for his relaxed muscles, he continues to be fearful of being out of control or seeming crazy. He tells the therapist that he second guesses her and wants her to be accepting of him rather than analyzing him. The therapist's question is sufficiently unorthodox that fears of being out of control and inadequacy resurface in this utterance. Sam replies to the therapist's question saying his muscles would probably express gratitude at not being tense anymore. He finds his reply and the question humorous and laughs. Sam tells the therapist he has a sense of humour and that he also laughs when he doesn't know how to respond.

Sam acknowledged that his muscles were grateful when they were given an opportunity to relax once alcohol was removed from the room (ATY).

However, the unusual nature of the personalization request and Sam's growing understanding of the ramifications of relaxed, grateful muscles on his consumption of alcohol (CU) contributed to his caution. Also, Sam's struggle to maintain a sense of competence and adequacy (SRT) despite difficulties remaining abstinent engendered confusion and reticence. Nevertheless, when Sam appeared to dismiss his experience with a second "I don't know" found on line 269 above, the therapist quickly overlapped his utterance beginning a summary of his previous statement.

Text: Lines 270-279.

S: Geeze I don't know - thanks? (laughs; opens hands and drops on lap) I don't know =

Th: (rapid hand rolling gestures) They might say they might say "Geeze I don't
know"(.hh)or or sure 'kay =

[ ]

S: ((laughing)) Yeah ((crosses legs))

Th: =sure((holding open palm out)) or they might say thanks or they might say prob-likely ((nods head)) they'd say both =

S: =((quietly)) Yeah quite possible

Expansion.

Th: If your shoulder muscles had a voice Sam, they may say "Geeze, I don't know what I am supposed to say in answer to such a strange and suspicious question. My muscles are confused, cautious and unsure of what is being required of them right now." They would reply guardly to the question: What would your muscles say right now to you about becoming more relaxed due to the removal of alcohol from the room? [S: Yes, my muscles might say "Geeze, I don't know in response to your question. I laugh because it is very odd to think about my muscles talking and I am becoming uncomfortable. I am uncomfortable because I'm unsure whether I'm answering you correctly and I am on guard wondering if asking my muscles to talk is some kind of psychological test or trick to demonstrate that I am a failure. I feel very cautious and confused as well as amused at this moment]. Th: I am aware that you are unsure as to whether you have answered my question correctly and I am also sensing your discomfort so I would like to encourage you by demonstrating that you have answered the question "correctly" since any answer you offer is the answer to the question. So, sure your muscles may well say "Geeze I don't know, I'm confused and cautious" when asked about what they might say concerning the relaxation they experience since alcohol has been removed from the room. You also said your muscles may say "Thanks for removing the bottle from the room Sam" and this is also another viable answer to the question. Your muscles may say "Geeze, I don't know" or they might say "Thanks" but in all likelihood they would say both. These are viable answers Sam and I have no ulterior motive in asking the question other than to find out what your muscles would say if they could speak now that you have removed alcohol from the room.

S: Well, it is quite possible that if my muscles could speak they would express both my confusion and caution as well as my gratitude that they are more relaxed. I worry about failing to quit drinking and failing to answer the therapist correctly. I also worry about being tricked into admitting I failed thereby experiencing myself as worthless because of my failure to remain sober. I am feeling less apprehensive about your question therapist since once again you have accepted and incorporated everything I have said into your response. This indicates that you are listening and not trying to trick me into admitting I am a failure.
34. Interaction.

In this series of turns, the therapist and Sam reach an understanding that Sam is both confused and appreciative now that alcohol has been removed. Sam tells the therapist that he is frightened by her question and confused by his new found relaxed state. The therapist allays Sam’s fears that she is trying to trick him by incorporating all aspects of his response into her summary. She also accepts that Sam is confused, fearful and grateful now that alcohol has been removed from the room.

The therapist incorporated Sam’s confusion and caution as well as his answer to the question in her paraphrase of his response. She observed that Sam acknowledged his muscles would express both confusion and gratitude following the removal of alcohol from the room. The therapist paraphrased his experience of relaxation recognizing the difficulty Sam encountered when engaging in the intensification process. He quietly agreed with the therapist’s reflection of his confusion and gratitude.

After paraphrasing Sam’s physiological confusion and gratitude, the therapist summarized the outcome of the intensification experience simultaneously recognizing his risk-taking efforts (ATY) during the deepening process.

Text: Lines 281-289.

Th: Yeah.(hh)((left hand moves back and forth across upper chest))
okay.(hh)so I appreciate ((tips left hand towards Sam)) your willingness to to just explore that a bit so that’s important that you notice ((gestures behind her)) when alcohol went outside the door.(hh)((Jill looks at therapist and moves fingers. Therapist draws right hand across chest and looks at Sam)) that you felt calm, there’s less apprehension.(hh)andah that’s easier, more relaxed feeling ((right hand rests on chest)) =

Expansion.

Yes, yes, I recognize my questions were difficult for you Sam and that you felt some fear and I want you to know that I am glad that you are willing to go further into your experience of being more relaxed now that alcohol has left the room. While it is an important part of therapy to delve into questions such as what would your muscles say, how do they feel and what is it like now that they are relaxed, I recognize that these questions are unfamiliar to you and cause you apprehension. I am impressed by your courage to explore your
sensations even though this is uncomfortable for you. So, what is important to your therapeutic progress, Sam, is that you felt calmer, less anxious and more relaxed when alcohol went outside the therapy room door. These feelings of easiness and relaxation are more pleasant and bearable than the previous tension that existed when alcohol was still in the room.

35. Interaction.

The therapist encourages Sam in his exploration of the contrast between anxiety and relaxation when alcohol is absent by indicating to him that he has fulfilled her expectations. The therapist recognizes Sam’s courage in responding to her questions since he continued answering to the best of his ability despite the fear he experienced while responding. The therapist also communicates to Sam that therapy requires that he explore unfamiliar and frightening territory to be successful. This first foray into Sam’s experience of the contrast between calmness and anxiety foreshadows future explorations undertaken by Sam, Jill and the therapist. The therapist also highlights an important moment for Sam summarizing his contrastive experience once he removed alcohol from the room.

Sam’s exploration of his relationship with alcoholic drinking resulted in atypical self disclosure (ATY), the evocation of core themes of inadequacy and worthlessness (SRT), and an expanded awareness and understanding of the tension inducing effects of alcohol (CA) and the problematic nature of alcoholic drinking (CU). Also, Sam experienced how the absence of alcohol provided relaxation, lowered apprehension levels and reduced muscle tension (ATY).

The lack of therapeutic system consensus regarding the problematic nature of alcoholic drinking began to shift during the intensification of Sam’s contrastive experience. That is, he experienced an experiential challenge to his belief that alcohol was not a problem giving additional credence to the notion that the presence of alcohol "bothered" him (CU). Increased therapeutic system commonalty occurred when Sam began to entertain the idea that alcohol was troublesome. This view of his troubles with alcohol corresponded to both the therapist's and Jill's assessment of his difficult relationship with alcohol.

The symbolic externalization of alcohol is an experiential activity requiring clients to explore their relationships with the symptom by interacting
with it (Friesen et al., 1991). Both Sam and Jill had an individual relationship with alcoholic drinking and the therapist tapped their differential experiences via the symbolic evocation activity. Following the intensification of Sam's experience with alcohol, the therapist solicited Jill's response to Sam's removal of alcohol from the room.

Sam's experience of relaxation after removing alcohol from the room had a specific effect on Jill who implicitly disclosed a sense of guilt at having stored alcohol for her own use during Sam's attempts at abstinence. The following text analysis illustrates Jill's response to the therapist’s query regarding her experience of having seen Sam remove alcohol from the room.

Text: Lines 341-349.
S: ((smooths hair))
J: ((moves fingers)) I've always wondered why we keep alcohol in the house when he's not drinking ((flicking away gesture and therapist moves her chair)) I mean okay ((tilts head to right)) I-I still ((holds right hand open on lap)) will have the occasional glass of wine ((therapist nods)) but very rarely ((looks at Sam and Sam moves hand to face)) unless somebuddy else is around =
S: =Hmhmm

Expansion.

S: Smooths hair in preparation for Jill's answer to the therapist's question concerning her reaction to Sam's state of relaxation now that alcohol has been removed.
J: I couldn't figure out why Sam had alcohol in the house when he was not supposed to be drinking. I know part of the reason alcohol stayed in the house was because Sam was unable to stop drinking. But I believe it is not all his fault since we had alcohol at home even though Sam was trying to abstain because I still have the occasional glass of wine. So, we had alcohol in the house so that I could drink it. I feel guilty right now because Sam feels much calmer when alcohol is gone and I kept alcohol around for my own use when I knew he had an alcohol problem. However, although I drink wine very rarely, my alcohol intake increases when I drink with Sam.
S: Yes, I agree that Jill drinks a little unless she drinks with me. I also agree that Jill keeps alcohol around the house for her own consumption.
In her answer to the therapist's question of what it was like for Jill when Sam relaxed after removing alcohol from the room, Jill communicates to the therapist that she feels somewhat guilty about keeping alcohol in the house for her own use. Jill tells the therapist that even though Sam was struggling with abstinence she still had an occasional glass of wine. In this way, Jill tells both Sam and the therapist that she feels partially responsible for Sam's tenseness in the home. However, she attempts to ward off her guilt feelings by emphasizing that she does not require much alcohol and that when she does drink more than a glass of wine it is with Sam. In this way Jill tries to absolve herself of the guilt she feels for Sam's drinking. In addition, she attempts to place responsibility for the alcoholic drinking on Sam by commenting that it is only under his influence that she drinks more than usual implying that it is not her fault he engages in alcoholic drinking. In fact, Jill maintains that Sam has more influence over her drinking habits than she has over his. Jill's utterance is both an admission that she keeps alcohol in the home and an attempt to absolve herself of perceived guilt.

Jill experienced guilt when she understood that alcohol's presence made Sam tense. Previously, Jill stored small amounts of alcohol at home for her own use and consumption. Jill's realization that keeping alcohol for her own purposes conferred jurisdiction over its whereabouts (CA) and the guilt this understanding engendered combined to alter her appraisal of her role in Sam's battle with alcoholism. Plus, early in Episode #1, the notion that Jill was an important decision-maker regarding alcohol (CU) was introduced contributing to a growing sense of partnership in Sam's struggle with alcoholic drinking. The combination of guilt and a sense of decision-making authority with respect to alcoholic drinking offered Jill impetus for change. In the following text excerpt, Jill commented on her ownership of the alcohol in the house. Jill attempted to assuage her guilt feelings by asserting that she stored only small amounts of alcohol for personal use and this should not affect Sam's bid for abstinence.

**Text: Lines 376-385.**

J: Yeah ([rubs face and neck]) but I mean also when you are not drinking there's never a lot there. There's like a little bit = [ ]

Th: So- ([leans forward left hand raised])
J: = ((indicates a little bit with fingers)) of brandy for - baking my cakes and things like that (.hhh) = 

[ ]

Th: So - ((raising left hand towards Jill, leaning forward))

Expansion.

Yes, Sam it is true that you cannot drink alcohol in moderation when you are drinking but what I'm trying to say is that just as there is not alot of alcohol in the house when you are drinking, because you drink it too fast, there is not alot in the house when you are sober. I'd like to say that when you are not drinking I don't have much alcohol in the house so when you are sober it is not my fault that you drink because I really don't keep that much alcohol around, there's just a little bit [Th: I'd like to interrupt here] of brandy for baking. [Th: I'm going to interrupt now because this account of the kinds and quantity of alcohol in your home Jill, has been continuing for quite a while and I believe we have wandered from my original question concerning your reaction to Sam's calmness when alcohol was removed from the room. I would like to return to that question]. J: The brandy for baking is earmarked for baking not for your consumption Sam, so I am not to blame for your drinking. I am feeling guilty that I have alcohol for my use and since you have removed alcohol from the room, Sam, I have become very uncomfortable with the amount of alcohol I have been keeping around the house. I am wondering if I somehow have contributed to your drinking by having alcohol in the house for baking. I feel somewhat guilty now that you have removed alcohol from the room indicating that you want alcohol removed from our home. I worry that the small quantities of alcohol I kept at home have been detrimental to you and I feel like I may have let you down. Sam, you became so calm after removing alcohol from the room and this made me feel guilty because I've been keeping some alcohol around for my own use. I am trying to ask you to tell me that my little bit of brandy and occasional glass of wine did not cause you apprehension when you were legitimately attempting to abstain. I am worried that you were thwarted in your struggle to remain sober by my storing wine and brandy at home. I feel responsible for your levels of tension and alcoholic drinking because I kept alcohol in the home for my own use. I wish you would confirm that my storing brandy and wine did not contribute to your alcoholic drinking, I would feel less guilty and personally liable for your drinking.

44. Interaction.

Jill hopes to absolve herself of guilt stemming from the observation that the storage of alcohol at home caused Sam apprehension. At the same time, Jill is responding to Sam's assertion that she drinks alcohol very quickly with him. Jill maintains that she is not to blame for Sam's drinking when he is committed to drinking, it is when he is attempting sobriety that Jill feels guilty using alcohol for her own needs. Jill attempts to prompt Sam to exonerate her by confirming that her brandy for baking and wine for occasional consumption
did not thwart his efforts to attain sobriety. In this utterance, Jill both declares she is not to blame for Sam's drinking while hoping to assuage her sense of blame for potentially sabotaging Sam's recovery. The therapist is growing restless with Jill and Sam's account of what is consumed and at what rate.

The therapist's question to Jill concerning her reaction to Sam's removal of alcohol from the room elicits a complex response from Jill in which her utterances from line 343 to 383 demonstrate a struggle with feelings of blame and guilt. Jill's experiences parallel Sam's sense of failure and together the couple grapple with burdensome levels of guilt, blame, and failure. Both Jill and Sam assume an acute sense of responsibility for controlling Sam's drinking behaviour which drives each individual's pursuit for absolution. In an effort to salve feelings of blame, guilt and failure, the couple blames each other for Sam's alcoholic drinking and his failure to abstain. In addition, both Sam and Jill wish to be seen as competent and blameless in the eyes of the therapist and as a result they strive to explain to her the complex means by which they both accept blame and attempt to ameliorate it.

Rather than remaining unequivocal in her assertion that she is prevented from throwing alcohol away by Sam's insistence that she not interfere, Jill experiences guilt over having alcohol in the home for her own use. Although Sam prefers Jill refrain from approaching the topic of getting rid of alcohol, Jill questions her own use of alcohol in light of Sam's sobriety. While Jill attempts to dispute her own experience of blameworthiness, she continues to remain guilt ridden. Jill wonders why alcohol is kept in the home when Sam is not drinking and in so doing notes that she uses alcohol for baking and drinking. After noting that the alcohol in the home is for her own use, Jill ponders whether she is partly responsible for Sam's difficulty maintaining sobriety by storing small amounts of alcohol for her own consumption. To reduce her sense of guilt and blame Jill employs seven proofs that should demonstrate her decreased culpability. These include:

1. If alcoholics drink alone and Jill does not drink alone then she is not an alcoholic and since Sam drinks alone he is an alcoholic. If Sam is an alcoholic then it is not Jill's fault that he drinks too much.

2. If Sam will not let Jill throw alcohol away and she wants to throw alcohol away, then she is not to blame for Sam's drinking.

3. If Jill never keeps large amounts of alcohol in the home, then it is not her fault if Sam drinks large amounts of alcohol.

4. If the alcohol Jill uses is for baking and moderate consumption only, then it is not her fault if Sam drinks alcoholic.

5. If Sam is attempting to remain sober, large amounts of alcohol in the home would be detrimental to this pursuit. However, if Jill keeps only small amounts of alcohol at home, then it is not her fault if Sam is unable to abstain.
6. If Jill only drinks a lot of alcohol with Sam, then she is not causing Sam to drink because he has already committed to that course of action.

7. If Sam would concur that small amounts of alcohol do not interfere with his pursuit of sobriety, then Jill would not feel guilty having retained alcohol in the home for her own use.

Sam’s experience of blameworthiness parallels Jill’s and he too engages a series of proofs to reduce this burden. These include:

1. If Jill did not argue with Sam about drinking too much, then he would not drink.

2. If Jill did not interfere with Sam’s drinking behaviour, then he could demonstrate that he can control his drinking.

3. If Jill did not drink quickly with Sam, then he could curb his drinking.

4. If Sam intimidates Jill so that she refrains from commenting on his drinking behaviour, then he demonstrates that he is in control of his alcoholic drinking.

5. If Sam is in control of alcohol then he can remain sober and view himself as a successful person and head-of-household.

Despite their efforts, both Jill and Sam retain their sense of failure and blame. The only recourse appears to be to agree to remove the problematic substance together.

Jill’s sense of guilt, the notion that she decided to allow Sam a sole decision-making role with respect to alcohol and the observation that she stored alcohol for her own use contributed to an increased sense of personal agency. That is, Jill began basing her activities on an appraisal of her own behaviour independent of Sam rather than solely as a response to Sam’s demands (ATY). Jill began to observe that if she kept alcohol for her own use then she had jurisdiction over its location and it was not only up to Sam to dictate its locale (CU). As a result, in the final sequence of Episode #1, Jill suggested that both she and Sam get rid of alcohol together. Jill’s suggestion to Sam is illustrated in the following text excerpt.
Text: Lines 475-485.

J: = Yeah so I'm but as far as what Sam said ((chopping motion with right hand)) I've taken it in ((gestures to self)) andum - I

[ ]

Th: Yeah ((nods))

J: = feel good about ((motions to self with right hand in lap)) - w-what he said because it-I've learnt from it ((opens hands in=

[ ]

Th: Yes

J: = lap, looks at Sam)) I think when we go home we'll - if that's what you want we can just get rid of it=

Expansion.

Yes, therapist, to interrupt the direction in which we are moving (i.e., toward further discussion of my fear and apprehension) it is true that I'm fearful and apprehensive but I want to re-focus on what Sam said about being relaxed after removing alcohol from the room. I want to stick to discussing what Sam said because this is a more familiar focus for me. Also, I want to ensure that the reasons for my feelings of fear and apprehension are not made explicit yet. I am afraid that further discussion of my emotions would make me too vulnerable in relation to Sam at this juncture. In addition, I am afraid of Sam continuing to drink alcoholicly and I want to address a remedy that has come out of what Sam said. I have listened carefully [Th: Yes you have listened very carefully and patiently] to what Sam had to say about feeling calmer now that alcohol is no longer in the room. While I feel apprehensive and fearful, I also feel more hopeful about Sam feeling relaxed now that alcohol has been removed. Sam's calm may mean we should get rid of alcohol. I have learned that Sam feels more relaxed when alcohol is not at home and I have learned that my storing alcohol for my own purposes may not have been helpful to Sam's sobriety. [Th: Yes, continue to tell us what you have learned from seeing Sam remove alcohol from the room and grow calmer]. I think, and I want to be sure this is what you want Sam because I don't want to appear to be interfering, but when we go home after the session today we will get rid of the alcohol, if that is what you really want Sam, we can easily get rid of it from the home. I don't need to keep it for myself and you feel more relaxed so we can just throw the alcohol away, if that's alright with you too.

58. Interaction.

Jill tells the therapist that she does not wish to elaborate further on her feelings of fear and apprehension. Instead, she wishes to discuss the other aspect of her experience, the aspect of self that feels calmer and hopeful now that Sam has said that he wishes to remove alcohol from the room. Jill is cheered by Sam's desire to remove alcohol since this lowers some of her fear
and apprehension concerning his alcoholic drinking. As well as inducing guilt, Sam's removal of alcohol from the room offered Jill some freedom to state her preference regarding the existence of alcohol in the home. Jill is aware that she could be construed as interfering with Sam and his drinking but she suggests that they can get rid of alcohol from home together after the session. Jill originally raised the idea of getting rid of the alcohol at the beginning of the episode but was informed that she was interfering. Following this, Jill became more tentative in her dealings with Sam. However, at this point, she uses what she has learned about Sam's own desire to get rid of the alcohol, her guilt at having stored it, and the joint decision-making frame to make the suggestion that they remove alcohol from their home after the session. In contrast to the first time Jill suggested this course of action, she suggests that they get rid of the alcohol together rather than removing it secretly by herself. Jill keeps alcohol for her own use and this gives her some say over its disposal. In addition, if she shares some of the blame for Sam's lack of abstinence then she can share in the removal of the alcohol from the home. In her original desire to throw the alcohol out, Jill noted that she could do so secretly which implied that the alcohol was for Sam's use not her own. Jill's current desire to join with Sam in removing alcohol from their home is based both on Sam's own initiative to remove it himself, Jill's sense of culpability in keeping it in the home for her own use, and her sense of joint decision-making influence.

Jill's guilt at storing alcohol for her own use (CA), the idea that she was a joint decision-making partner (CU) and her knowledge of Sam's experience of increased relaxation (CU) contributed to her suggestion that together the couple rid the home of alcohol. Jill's proposal to jointly remove alcohol represented a departure from the characteristic manner in which the clients handled alcohol (ATY). Previously, Jill was not permitted to comment on alcoholic drinking and Sam insisted on grappling with the issue alone. However, the experiential activity conducted in Episode #1 contributed to Jill's growing awareness that she had jurisdiction over the whereabouts of alcohol (CA) enabling the initiation of an atypical behavioural sequence in which the spouses joined forces to struggle with alcoholism (ATY). Jill's realization that she had jurisdiction over the location of alcohol (CA) led to questions of personal liability with respect to Sam's lack of abstinent behaviour. She noted that Sam's decision to drink was his own but wondered how her use of alcohol during periods of abstinence may have affected him (CU). Sam experienced increased relaxation when alcohol
was removed from the room prompting Jill to question the effects of her alcohol use on him.

Jill's ownership of the alcohol had important ramifications for Sam's requirement that all matters related to alcohol be considered his domain. That is, once Jill established that it was "her alcohol" that was kept in the home during Sam's periods of abstinence, the legitimacy of his demand that Jill refrain from re-locating alcohol was called into question. In other words, Sam's insistence that Jill keep alcohol handy, ostensibly for her own use, and his claim to sole jurisdiction over Jill's decision to remove or store the substance implied that he had difficulty with alcoholic drinking and his attempts to abstain were fainthearted.

Hence, to appear a competent and adequate manager of alcoholic drinking, Sam had to refrain from preventing Jill's input and attempting to control her decisions regarding alcohol in the home. As a result, Sam's response to Jill's suggestion (i.e., that the couple jointly rid the home of alcohol) was favourable. That is, Sam's expression of confusion and wonder at realizing alcohol was troublesome signified a building sense of harmony and consensus between the couple (ATY). The following text excerpts illustrate a growing sense of mutuality and partnership between Sam and Jill at the end of Episode #1.

Text: Lines 487-490.

S: =(.hh)See again I sit here now an' I say I'm thinkin' that it doesn't bother me ((tilting head to left)) butah it must = [ ]
J: Yeah, yeah
Expansion.

I’m confused, because here I sit thinking again that the alcohol in the home doesn’t make me feel nervous and is not a problem for me but I just removed it from the room and I found that I felt relaxed after doing so. Even though I think alcohol is not a problem for me and doesn’t cause me anxiety, I have proven to myself that it does. Alcohol must make me nervous and it must be a problem for me because I feel relaxed when it is no longer present. [J: Yes, yes, alcohol is definitely a problem for you and you do get nervous around it. I’ve learned from you today that even though you say alcohol is not a problem and it does not make you nervous it does actually make you very uncomfortable and that’s why we should get rid of the alcohol so you can relax at home].

59. Interaction.

Sam responds to Jill's suggestion that they remove alcohol from home together. He tells her he is confused because he still wants to believe that alcohol is not a problem for him. While thinking alcohol does not make him anxious, Sam simultaneously reflects upon his sense of increased relaxation due the removal of alcohol from the room. Sam appears to be thinking out loud as he considers removing alcohol from the home. At first, he wants to retain alcohol in the home and begins to use the familiar reasons for keeping it available. However, Sam is unable to believe that he is not affected by alcohol due to the effects experienced once he removed alcohol from the room. In addition, he can no longer accuse Jill of interfering with his drinking behaviour when he has removed alcohol from the room of his own volition. Nor can he comfortably accuse Jill of interfering with his drinking behaviour after it became clear that edicts regarding the non-removal of alcohol from the home were nonsensical when the alcohol was discovered to be for Jill's use only. That is, bids to demand that Jill continue to store alcohol for her own use on the part of an alcoholicly dependent Sam, highlighted a contradiction in his position. The relationship between Jill continuing to store alcohol and Sam's demand that she do so indicated he was failing in his bid for sobriety by insisting Jill refrain from interfering with his access to her supply. Nevertheless, Sam begins to view Jill as a partner in his struggle with alcoholism rather than a reminder of his failure to remain sober. Sam's rebuttal of his usual reasons for keeping alcohol at home in an answer to Jill's suggestion that they remove alcohol from the home indicates that he no longer resents her input into his drinking behaviour. This fledgling shift bodes well for future sessions in which Jill moves away from the position of second-in-command at home. Also, in this utterance Sam joins with Jill in admitting that alcohol must be a problem and must be anxiety promoting.
J: =But it must do

Expansion.

I agree Sam that alcohol must make you uncomfortable when it is in the home based on what you have said today about feeling more relaxed when alcohol is no longer in the room. I am less nervous about entering into this discussion about your alcoholic drinking since you admit that you have a problem with drinking and you have removed alcohol from the room on your own. I have not interfered with your decision although I happen to agree with it. I feel relieved that you have decided that alcohol bothers you but I also feel some fear and apprehension about whether you will find a way to declare that alcohol doesn't bother you so you can keep it around the house.

60. Interaction.

Jill agrees with Sam's admission that he has a problem with alcohol. She is less tentative in discussing Sam's drinking now that his reaction to her suggestion that they get rid of alcohol is more self-reflective than defensive. Previously, Jill was told not to interfere with his alcoholic drinking. On this occasion, Sam tells her that he thinks he has a problem with drinking rather than responding defensively. This shift encourages Jill to sound more definitive. Jill perceives more latitude for her opinion in the matter of Sam's drinking. Sam's view of Jill's participation in his struggle with alcohol has shifted such that her affirmation of the troublesome nature of alcoholism is not viewed as a confirmation of Sam's failure but rather an acknowledgement of his own conclusions regarding the impact of alcohol.

In this utterance, Sam adopted a nondefensive stance and joined with Jill in recognizing the problematic nature of alcoholic drinking. Sam responded to Jill's proposal that they get rid of alcohol together with an acceptance of her input and an acknowledgement that alcoholic drinking was a difficulty potentially remedied by the removal of alcohol (ATY).

Jill's exploration of her response to Sam's removal of alcohol from the therapy room resulted in a new awareness of personal agency and jurisdiction with respect to the storage of alcohol in the home (CA). Also, the intensification of Jill's experience fostered an understanding that she was a decision-making partner in the relationship and may have some influence with
respect to Sam's bids for abstinence (CU). In addition, Jill's participation in the deepening activity contributed to a sense of personal agency spurring an atypical speech act in which she suggested the couple rid the home of alcohol together (ATY). The intensification of client experience during experiential activity facilitated Jill's assertive participation in the discourse concerning alcohol and its whereabouts and fostered Sam's nondefensive acceptance and acknowledgement of Jill's input (ATY).

**Summary of the Syncretic Change Process in Episode #1**

Sam's acknowledgement of the problematic nature of alcohol and the recognition of the legitimacy of Jill's input into decisions concerning alcoholic drinking were made possible via intense experiential activity. The symbolic externalization of alcohol perturbed atypical behaviour in the form of increased self disclosure, vulnerability, personal agency and spousal partnership. Also, the activity brought the contrast between apprehension, in the presence of alcohol, and relaxation, following the removal of alcohol, into full awareness. In addition, the employment of an intense experiential activity in therapy contributed to the beginning of a shift in Sam's core relational themes of inadequacy and worthlessness. Indeed, Sam's view that he was a failure if he admitted alcohol bothered him and incompetent unless he battled alcohol alone began to shift in Episode #1. That is, Sam began to experience the possibility of a sense of adequacy and worth via the recognition of the problematic nature of alcoholic drinking and the inclusion of Jill's perspective in decisions concerning alcohol.

In Episode #1, the discourse analysis revealed that the intensification of the contrast between Sam's anxious state prior to the removal of alcohol promoted atypical behaviour, evoked and shifted substantive relational themes
and perturbed cognitive understandings and new awarenesses. For example, at the intrapersonal level of the system, Sam recognized alcoholic drinking was a problem (CU) while Jill noted guilt feelings at having stored alcohol for her own use when Sam was abstaining (CA). Also, Jill realized that she had jurisdiction over the location of alcohol since she kept it for baking and personal consumption (CA). In addition, the clients' relationships with the symptom changed when Sam actively removed the bottle from the room rather retaining alcohol for easy access (ATY). Jill endorsed the removal and began experiencing a greater sense of influence and agency regarding the whereabouts of alcohol (ATY). Lastly, at the interpersonal level of the system, Sam and Jill engaged in uncharacteristic levels of self disclosure and began to form a partnership to grapple with Sam's alcoholism (ATY).

Thus, new behaviours (i.e., self disclosure and joint partnership in the removal of alcohol) and new feelings (i.e., relaxation, reduced tension and increased influence) were facilitated during the intense experiential activity conducted in Episode #1. In addition, new cognitions and awarenesses (i.e., alcohol was a problem and using and storing alcohol offered some jurisdiction over it) were observed to emerge in Episode #1. Also, Sam's sense of inadequacy and worthlessness when battling alcoholism alone shifted towards a sense of competence and adequacy when the initial formation of a cohesive couple team to resist alcoholic drinking was introduced in Episode #1 (SRT). The discourse analysis of Episode #1 revealed that increased couple and personal harmony was generated when meaningful therapeutic experiences were actively intensified and paced according to client readiness.
The Syncretic Process in Episode #2

The discourse analysis of Episode #2 revealed the importance of intense experiential activity in the shift away from personal and couple distance towards interpersonal closeness and vulnerability. That is, the shift away from disparate belief and practice reflected in distance and isolation toward increased harmony, partnership and commonalty was marked by the intensification of Sam and Jill's financial worries and the effects of Sam's punitive behaviour on Jill and the relationship.

Text analysis excerpts drawn from Episode #2 will illustrate how the intensification process, described as facilitative of relational novelty (Friesen, et al., 1991), prompted a shift away from disparate belief and practice towards increased mutuality and intimacy. In particular, the discourse analysis will reveal how the intensification of the couple's monetary concerns and Sam's behaviour towards Jill encouraged couple intimacy. The intensification process facilitated the occurrence of relational novelty by offering clients the opportunity to engage in atypical experiencing and develop new cognitive understandings to enhance couple harmony. In addition, the deepening process offered the couple a chance to bring unacknowledged experience into awareness and encounter core or substantive relational themes to promote increased intimacy.

The text analysis excerpts featured in this section highlight how the intensification of experiential activity promoted a shift away from disparate belief and practice towards more consensual ways of being. Analysis excerpts relevant to the discussion of the convergent properties of intense experiential activity will be utilized in this section. Some of the excerpts employed in this section have been utilized elsewhere in the document but are being re-examined as they pertain to intense experiential activity.
The following text analysis inquiry will provide a sequential ordering of the text analysis to highlight the tenets of relational novelty that promoted a shift away from couple distance to an increased sense of nurturance and partnership. The tenets of relational novelty revealed during the sequential account of the syncretic change process in Episode #2 will be identified via codes representing each tenet of relational novelty. The same codes employed in the description of the syncretic change process in Episode #1 will be utilized in this section. That is, the text analysis of Episode #2 will explore how various tenets of relational novelty including the evocation of substantive relational themes (SRT) and the facilitation of atypical experience (ATY) aided increased couple harmony. In addition, the discourse analysis will pinpoint how the promotion of new cognitive understanding (CU) and the bringing of experience into conscious awareness (CA) perturbed a change in couple distance patterns.

In Episode #2, the therapist began an intensification of both Sam and Jill's experience of a morning fight during a re-enactment of the conflict. The original misunderstanding between Sam and Jill was based on a truncated communication sequence in which Sam's utterance, "I hope Broughton flies" (Episode #2, Line 17) belied considerable worry regarding lost business revenues and Jill's response, "Same old scenario" (Episode #2, Line 20) concealed a similar concern. The couple's ambiguous communication style resulted in Sam interpreting Jill's reaction to his news of upcoming financial difficulty as a sarcastic jab at his business competence and performance. Jill explained that what Sam saw as a sarcastic jab was actually a shorthand way of encapsulating the disappointment and worry she experienced upon hearing the bad financial news. Initially, Sam did not believe Jill's explanation for her remark, maintaining that the comment was a sarcastic rejection of him.
Despite Jill's statements to the contrary, Sam believed she was attacking him with her comment and his desire that Jill be punished for rejecting him made clarification of the original misunderstanding difficult. However, the intensification of Sam's upset, fears of personal inadequacy as a businessman and his desire to punish Jill for a perceived rejection aided in the clarification of Jill's comment and the potential for increased mutuality. In addition, the deepening of Jill's response to the business setbacks and the intensification of the effects of Sam's desire for revenge promoted a shift in couple distancing patterns.

The couple's shift away from conflictual belief and practice towards increased harmony and mutuality was initiated when Jill's experience of the couple's misunderstanding was intensified. In the following text excerpt, the therapist summarizes the depth of feeling behind Jill's statement "Same old scenario" adding the observation that Jill was beginning to change a pattern of withdrawal and truncated communication in favour of more open dialogue with Sam (ATY).

**Text: Lines 336-340.**

Th: He didn't hear the feeling (.hh) and now you're letting him know the feeling and ah as you're letting him know he sees yer tears ((Jill moves tissue)) and ah it seems like it cut pretty deep for you ((therapist puts hand to chest)) too, pretty pretty deep and your letting him know.

**Expansion.**

I would like to summarize what you have said and empathize with your experience Jill. It appears that Sam did not understand how disappointed and upset you were feeling when you made your comment to him, Sam did not understand that you were upset not sarcastic. However, you are now making him aware of how painful the setback is for you and you are feeling very vulnerable and exposed right now. You are exposing the hurt you feel at being misunderstood by Sam as well as the hopelessness you experience when you think of the setbacks. Jill, you are crying in front of Sam and demonstrating how upset you are in this way and he has handed you a tissue therein
acknowledging that he sees your tears. Your crying indicates that hearing about the recent setback was like a knife cutting deeply into you, the news of the setback made a very deep cut inside you and you are letting Sam know the degree to which you are hurting.

41. Interaction.

In this utterance, the therapist summarizes and empathizes with Jill's experience. The therapist acknowledges Jill's effort to have Sam understand her remark and feelings about the setbacks. The therapist also acknowledges how hurt Jill is with the setbacks by likening the depth of her hurt to a knife wound. Jill had used the notion that the pain from the setbacks was a deep feeling. The therapist matches the extent of Jill's feelings to her tears and generates an amplifying metaphor that parallels the depth of Jill's pain with the experience of a sharp, painful knife wound. The therapist's empathic amplification intensifies Jill's feelings of sadness and she begins crying again as she further elaborates on her sense of hopelessness and powerlessness over the business difficulties.

The therapist intensified Jill's experience of the bad news while explicitly observing that Jill was engaging in atypical behaviour. By expanding upon her feelings of pain with respect to the financial setbacks, Jill was acting to remain open with her feelings rather than retreating and withdrawing (ATY). Jill was accustomed to remaining silent with respect to her feelings based upon admonishments received as a child (Appendix T, Session #5) and a sense of intimidation when disagreeing with Sam (Appendix Q, Session #4). However, the therapist's use of advanced empathy and the provision of a safe therapeutic context encouraged Jill to elaborate upon her experiences.

The therapist's reflection of Jill's pain prompted Jill to elaborate further upon her sense of powerlessness regarding the many business setbacks faced by both herself and Sam. The therapist's intensification of Jill's feelings enabled Jill to expand upon the helplessness she experienced due to the unsuccessful business deals in the following utterance.

Text: Lines 342-346.

J: ((Sobbing)) Well it's just that we were, we try to get everything sorted out ((wipes eyes with tissue, Sam looking at his hands and moving his fingers)) and there are these setbacks and I jus' and I'm sure Sam feels the same way we jus' wonder why they keep happening ((sobbing, wiping eyes)) =
Expansion.

I am crying so hard and I am so upset because Sam and I try our best to make the business run smoothly and just when we think we have achieved our goal a deal falls through and we are back scrambling to make enough money to finance our expenses to the end of the month. The business setbacks keep coming up and I do not understand why we keep losing business. I am positive that Sam feels the same way as I do, that is we both feel disappointed and bewildered about why we keep making deals that appear to be secure and they just dissolve before our very eyes. I am careful to let Sam know that I am expressing my sense of hopelessness and powerless that I know we share. I want to be sure that Sam knows I am not criticizing him. We just cannot figure out why the deals just keep dissolving over and over again, it feels really hopeless and we are completely powerless to do anything about it. The deals just keep falling through and there is nothing we can do about it.

42. Interaction.

The therapist’s metaphoric amplification of Jill’s upset has prompted Jill to further elucidate her sense of hopelessness and powerlessness in the face of continually dissolving business deals. Jill begins to cry harder as she describes this new level of concern while being careful to communicate to Sam that she is not criticizing him for the lack of control they have over business setbacks.

Jill addressed Sam in this utterance by speaking to the therapist hoping to commiserate with him in his dismay regarding the business difficulties. Jill wished to demonstrate how both she and Sam felt similarly about the business setbacks and her morning comment was an attempt to join him not reject him.

The therapist observed Jill’s attempt to contact Sam and asked him for his response to Jill’s efforts to explain her motives and intentions. Also, the therapist asked Sam to respond to Jill’s attempt to reveal the depth of her upset as illustrated in the following text analysis excerpt.

Text: Lines 348-349.

Th: = Yeah, when you see Jill’s tears Sam, how do you feel ((looks at Sam))? 

Expansion.

Yes, Jill I understand the depth of your hurt right now and I would like to ask Sam about how your hurt is affecting him. As part of the re-enactment I am encouraging you both, Sam and Jill, to share your underlying issues and feelings with respect to the morning fight. I would like to know how you feel
Sam when you see Jill cry so hard? I am wondering what effect Jill's tears of hurt, hopelessness and powerlessness have on you?

43. Interaction.

In this utterance, the therapist acknowledges Jill's pain and draws Sam into the discussion such that he is asked what effect Jill's pain has on him. The therapist is maintaining the process facilitation focus of the re-enactment by asking Sam to remark upon his relationship with Jill at this moment.

In this utterance, the therapist encouraged Sam to interact with Jill asking him to respond to Jill's hurt. By asking Sam and Jill to interact, the therapist engaged process facilitation to enhance the potential for couple intimacy. Process facilitation encourages clients to interact with one another in the presence of the therapist to foster new patterns of relationship. Clients are encouraged to relate spontaneously with one another providing the therapist with the opportunity to become actively involved in client interaction sequences (Friesen et al., 1989). The disclosure of powerful affect in therapy requires heightened vulnerability and the honest expression of pained experience.

Increased vulnerability stemming from the disclosure of underlying affect can enable couple intimacy. Thus, in the utterance analysis featured above, the therapist attempted to include Sam in the discussion of Jill's pained experience. However, Sam's anger and hurt precluded empathy for Jill as revealed in the following text excerpt.

Text: Lines 351-352.

S: It doesn't ((shaking head)) really affect me(hhh)((looks at therapist))

Expansion.

To be perfectly honest therapist, Jill's tears have no affect on me in terms of making me feel compassion for her. I am still very angry about her sarcastic remark and I feel no sympathy whatsoever for Jill right now. I do not believe that Jill was telling me she was upset when she made that remark, I believe she was intentionally trying to hurt me and I remain convinced of that fact. I think Jill should be punished for her sarcastic remark this morning and my lack of sympathy for her is her punishment.
44. Interaction.

When the therapist asks Sam about how he feels when he sees Jill cry, he answers that he feels no compassion or sympathy for Jill. Sam is angry about Jill's sarcastic remark and believes she should be punished for it. He does not believe Jill's explanation for her remark and refuses to include her explanation in his understanding of the morning incident. Sam firmly and honestly believes that Jill is guilty of sarcasm and it appears that his sense of inadequacy precludes giving Jill the benefit of the doubt with respect to her morning remark. Instead, Sam would rather punish Jill with the withdrawal of his caring, compassion and good faith.

Sam’s hurt due to Jill’s response to his financial concerns gave rise to his desire to hurt Jill as much as she had hurt him. Sam withdrew from Jill to punish her. The therapist, in her response to Sam’s withdrawal, expressed surprise at his lack of sympathy for Jill given the earnestness of her upset and vulnerability. The following text analysis excerpt highlights the therapist’s surprise upon hearing that Sam remained unmoved by Jill’s hurt.

Text: Line 354.
Th: It doesn’t affect you?
Expansion.

Sam you are saying that Jill’s tears do not affect you meaning you remain unmoved by her pain. You do not feel sympathy or compassion for Jill even though she has tried to explain her remark to you and tried to note the similarities in both your experiences of the setbacks. It is surprising to me that what Jill has said and her tears do not affect you, how can it be that Jill’s pain does not affect you?

45. Interaction.

Sam has told the therapist that Jill’s pain does not affect him and the therapist is surprised by this admission. She wonders how it can be possible that Sam does not feel sympathy for Jill or joined by her in their disappointment over the setbacks.

The therapist requested Sam explain his lack of compassion for Jill and his desire for revenge in this utterance. Sam responded by reiterating the hurt and rejection he felt due to Jill’s perceived sarcastic remark.
Text: Lines 356-361.

S: No ((looks at wall)). I dunno(.hhh)um um I'm not too pleased with what's taken place the last couple of days granted um but I, I don't want to be hard and cruel ((sniff)) - um I dunno I think you're more set with money ((therapist touches Jill's leg then returns hand to lap)) than I am in that vein and ah I guess I-I I dunno - something that I-((rubs neck)).

Expansion.

No, Jill's tears do not affect me. I know I should feel sympathy and compassion for her but I do not. The reason is that while it is true that I am unhappy with how the business has been failing the last few days I did not like Jill's remark to me when I approached her to discuss the business failures. At the same time that I say I do not feel affected by Jill's tears, I do not want you to think me hard and cruel, therapist. I do not want you to think that I do not have sympathy and compassion for Jill. She made a hurtful, sarcastic comment to me and it is impossible for me to feel compassion for her right now. The most I can say in a sympathetic vein, to show you I am not hard-hearted is that Jill, you are worried about money more than me and that is probably why you made a sarcastic comment to me. You get much too upset about the family finances especially if it causes you to cry this much and make sarcastic comments to me. I think that is about all I can say, I am confused right now because I feel angry with you Jill but I know I should feel compassionate towards you because you are pregnant and upset. I also find myself feeling somewhat helpless and lost when Jill is upset because she is the rudder in the relationship and I depend upon her stability to feel calm myself. When Jill gets upset I want her to stop being upset immediately and that is why I tell her to buck up and stop feeling sad. The last few days have been really difficult for me with the business and I find that when Jill gets upset I encounter my own distress more acutely. When Jill is upset it is as if the boat careens about without the stable rudder and I fear all will be lost.

46. Interaction.

In this utterance, Sam attempts to explain how it is possible that he feels unaffected by Jill's tears. He acknowledges that he has been upset about the poor business showing as has Jill but that she is more upset than he. While Sam is angry with Jill, he appears to indicate that he does not feel comfortable with his lack of demonstrable compassion for her. At the same time, Sam is still feeling the sting of Jill's allegedly sarcastic comment. To balance these two competing agendas, Sam concludes that Jill made the sarcastic comment due to her overly emotional state, not as an entirely cold hearted attack on him. In addition, Sam hopes to persuade Jill to stop feeling upset because her upset jeopardizes her role as stable rudder. Sam needs Jill's stability to feel safe. When Jill becomes upset, Sam feels helpless, lost and frightened and as a result he attempts to block Jill's expression of her distress. Simultaneously, due to Jill's upset, Sam is becoming aware of how acutely distressed he feels about the business failures and this awareness is extremely uncomfortable for him.
In this utterance, Sam revealed his discomfort with Jill's upset as well as a growing confusion as to Jill's intent when she said "same old scenario." While feeling uneasy about appearing hardhearted, Sam continued to find it difficult to believe Jill was not attacking him with her remark. Sam told Jill in a halting manner, that her upset was caused by undue concern with monetary matters highlighting how his compassion would be ineffective in helping Jill overcome her upset. Sam reasoned that since Jill was overly concerned with money, his sympathy would not be of any assistance to her even if he could be supportive. Sam observed that he could not be empathic because Jill had been sarcastic and he continued to feel rejected and attacked. The therapist noted Sam's confusion and halted phrasing in her reply. To encourage continued exploration of the couple's relationship, the therapist reflected Sam's disorientation in the following analyzed utterance.

Text: Lines 363-367.

Th: It sounds like your struggling for words right now =
((Jill wipes her nose))
S: =Yeah ((scratches back of neck and between shoulder blades)) =

Expansion.

Th: I notice you appear a bit confused right now Sam as you struggle for words to express how it is that you feel unaffected by Jill's tears. I am interested in what you have to say and I appreciate that you are having difficulty saying it at this moment. I would like you to know that I do not judge you negatively for not being affected by Jill's tears because I believe you are being perfectly honest with Jill and myself and I am sincerely interested in your experience right now.

S: Yes, I am having difficulty expressing myself right now because I feel confused. I thought I was intentionally attacked by Jill and I wanted to punish her but I am now wondering about the accuracy of my reaction to her. I may have misconstrued what Jill said because I have trouble seeing the hurt side of her. It scares me when she gets upset so I prefer to see her as cold, hard, calculating and in control rather than hurt, vulnerable and lost. I feel very uncomfortable facing both my need for Jill's strength and my own sense of worthlessness and inadequacy. Also, I think I should feel sympathy for Jill but my feelings of anger and desire to punish her are very strong. Mostly, I believe
Jill was trying to hurt me with her remark this morning and that is why it is hard for me to be compassionate towards her right now.

47. Interaction.

The therapist conveys to Sam that she does not judge him negatively for his honesty concerning his reaction to Jill's tears. As demonstrated in later text, Sam is confused because he is becoming aware of his need for Jill's stability. Sam prefers to view Jill as calculating rather than vulnerable because at least if she is cold hearted she is still in control and the strength in the relationship. At the same time, Sam is confused because he realizes he would like to punish Jill for her remark and by association her vulnerability. In addition, Sam acknowledges that he too is distressed by the financial situation but finds Jill's upset raises the acute nature of his distress to his awareness. To avoid the loss of Jill as the strength in the relationship and to avoid facing his sense of worthlessness and inadequacy, Sam attempts to dissuade Jill from the expression of her distress by telling her to buck up and handle the setbacks without upset.

Confusion stemming from a myriad of different factors combined to disorient Sam. First, Sam felt hurt, attacked and rejected by Jill making him angry and desirous of revenge. In addition, Sam experienced concerns about the business and his performance as a businessman more acutely when Jill was upset. Sam encountered the weight of feelings of failure and helplessness brought to the fore by Jill's expression of hurt. In addition, Sam had difficulty coping with Jill's upset fearing he would lose her as stable relationship rudder if she became too vulnerable.

The intensification of Jill's pain meant that her experience was available to Sam prompting him to begin to re-think his interpretation of Jill's upset and her remark, "same old scenario." The intensification process in Episode #2 served to value Jill's experience previously muted by childhood admonishment (Appendix T, Session #5) and dismissed by Sam when fighting would escalate. Jill's atypical self disclosure despite a long-standing pattern of retreat marked an important intrapersonal and interpersonal shift (ATY). Jill's atypical behaviour during the re-enactment activity provided the couple with an opportunity for enhanced mutuality, vulnerability and partnership. In addition,
Jill's openness brought Sam's desire to protect himself from Jill's pain into his awareness (CA) as observed by the therapist in the following utterance.

Text: Lines 369-376.

Th: = And you're saying ah when you see Jill's tears um you kind of move into your ((Sam brings hand down to lap)) head 'cause you wanna protect yourself from feeling pain and and Jill is showing =

[ ______ ]

S: That's probably what it is

Th: your tears ((gestures towards Jill with left hand, looks back and forth between clients)) and she feels kind of alone here

Expansion.

Sam let me see if I understand what you are saying to Jill. It appears that when you see Jill crying you begin to want to avoid feeling the pain of Jill's upset. You also want to avoid your own hurt at seeing the business deals dissolve so you use your logical faculties to make sense of why Jill is feeling upset. In this way, you shield yourself from feeling upset about Jill and the business. [S: Yes, I agree, I am probably shielding myself from feeling the distress of the dissolved business deals and protecting myself from feeling Jill's hurt when I tell her to stop feeling upset.] However, Jill is crying very hard right now and being very vulnerable and when you protect yourself from feeling upset about Jill's upset or the business, Jill probably feels alone and isolated from you.

48. Interaction.

In this utterance the therapist attempts to clarify the source of Sam's confusion centering her understanding on his desire to protect himself from feelings of distress by employing his logical faculties. Sam dismisses and blocks Jill's expression of emotion by withdrawing caring and telling Jill she is overly concerned with money and mishandles setbacks. Sam feels vulnerable when Jill is no longer functioning as the strength or rudder in the relationship. Jill's vulnerability intensifies his sense of worthlessness and inadequacy propelling him to dismiss, block, threaten, punish and abandon Jill rather than focus on his fears.

Sam agreed with the therapist's appraisal of his unconscious desire to shield himself from Jill's hurt (CA). In addition, the therapist's observation of Sam's withdrawal from Jill prompted her to observe that Sam's desire to protect himself from Jill's pain left Jill alone with her tears (CU).

Thus, the morning fight provided an encapsulation of how emotional distance was sustained and maintained in the marriage. The therapist's
observation that Jill felt "kind of alone here" (Line 376) served as a further intensification of Jill's experience. Sam's self-protective shield had painful consequences for Jill and altered the degree to which intimacy was possible in the marriage. Jill's response to the therapist's empathy indicated that she experienced Sam's shield as rejecting and uncaring as revealed in the text excerpt featured below.

Text:  Lines 378-384.

J: sobbing, wiping eyes)) Well, it just comes across as being hardnosed, you ((Jill always ((flattened left hand makes sharp downward =

Th: [ ] Yes

J: = gestures)) come across hardnosed at the wrong times =

Expansion.

I feel alone Sam because when you tell me to stop being upset you seem hardnosed, cruel, unsympathetic and impatient. [Th: Yes, you feel hurt when you see Sam being hardened and cruel when you are upset, Jill]. Sam, I am crying because it hurts me when you appear not to care about how I am and you respond uncaringly to me. When I feel upset about something Sam, you respond by being threatening, uncompromising and dismissive. When I am upset I need you to be comforting and soothing rather than impatient and hardened.

49. Interaction.

When Sam uses distancing behaviors to avoid experiencing his own and Jill's hurt, the effect is the neglect and abandonment of Jill. Jill summarizes Sam's unempathic response to her as his being hardened harkening back to his description of himself as not wanting to sound hardened and cruel. Sam appears uncaring to Jill when he tries to prevent her from expressing emotions. Jill identifies Sam's characteristic response to her hurt as unsupportive. The therapist, sitting close to Jill, continues to offer subtle encouragement to Jill in Jill's desire to be heard by Sam.

Jill sobbed audibly throughout this utterance and as revealed in the interaction statement, the therapist's reference to Jill's aloneness in the marriage had
connections to her core theme of abandonment (SRT). Formerly, silence, retreat and peacekeeping behaviour staved off fears of abandonment in Jill's family of origin and in her marriage to Sam. However, Jill's continued expression of her thoughts and feelings during the re-enactment interrupted her peacekeeping pattern (ATY) perturbing Sam's anxiety, sense of inadequacy (SRT) and helplessness. The intensification of the couple's experience prevented either spouse from successfully adopting familiar interaction patterns characterized by angry withdrawal, self-protective retreat and couple distance (ATY). The therapist reflected Jill's core or substantive relational theme of abandonment in her empathic response to Jill in the next utterance.


Th: =So you're feeling abandoned right now - you're feeling alone with your tears (Sam moves fingers) Sam is saying it doesn't=

J: ((sniff, wiping eyes and nose))

Th: =affect him, you feel

Expansion.

Jill you are feeling abandoned by Sam at this moment because he is saying that how you feel does not have any bearing on him or his behaviour. Sam is saying your feelings do not matter to him right now and as a result you feel alienated and alone with your tears of hurt and sadness. Sam is telling you that how you feel has no impact or influence on him. As a result you feel isolated and cut-off.

50. Interaction.

The therapist empathizes with Jill in her current state. In addition, the therapist intensifies the effects of Sam's indifference on Jill. The therapist notes that Jill feels abandoned, isolated and alone when Sam responds to her in a rigid, uncaring and controlling manner. Sam asserts that he is justified in being unaffected by Jill's tears because she has let him down in her role as relationship rudder (Episode #2, Lines 443-451). Jill's deviation from her invincible rudder role and Sam's experience of inadequacy have culminated in a sense of injustice and a desire for retribution.
The therapist intensified Jill's substantive relational theme of abandonment with this utterance perturbing her to enter a prolonged period of crying (SRT). Jill's tears prompted Sam to become consciously aware of his fears of her vulnerability and his concerns that Jill's upset would jeopardize the relationship (CA). Also, while Jill sobbed, Sam encountered his desire to punish her and distance himself from her via withdrawal of care, advice-giving behaviour and the attribution of manipulative intent to her tears. The following text excerpt reveals Sam's acknowledgement of his desire to punish Jill and exact revenge.

Text: Lines 394-400.

S: (hands folded across lap) I guess may be when I came in this morning I was almost to the same point you are even though I wasn't in tears and I just got slammed in the face maybe this the way I get back at you, I don't know=

J: [ ]

(hhhh)((wiping tears))

Expansion.

Therapist, I am interrupting your empathic response to Jill's experience of me as hardnosed at the wrong times to explain why it is that I do not care about how Jill feels. Jill, I am unmoved by your sense of aloneness and abandonment. I have a good reason to abandon you Jill because you deserve it. You deserve to be abandoned because I was really upset this morning and I was upset like you are now, I was not crying, but I was very upset. Instead of comforting me like you want me to comfort you now, you attacked me with sarcasm. Since you did not comfort or soothe me this morning I am not going to comfort and soothe you now. You deliberately tried to hurt me and I am punishing you for that now. You are supposed to be the strength in this relationship and you have let me down. When I come to you upset it is important that you help me and if you get so upset that you cannot be supportive, you are worthy of punishment. Your attack upon me this morning was a breach of contract between us and I am extremely hurt and angry at you for betraying me. Therefore, I am going to punish you with my withdrawal and lack of care. I am getting revenge by withdrawing my caring from you.

51. Interaction.

The therapist's empathic intensification of Jill's isolation prompts Sam to explain and justify his noncaring attitude towards her. According to Sam, Jill
has breached the conjugal contract that stipulates that she should comfort, nurture and soothe Sam when he is upset rather than become upset herself. Jill's breach of contract is a serious violation that warrants punishment with withdrawal of caring and love. Sam believes Jill's lapse in composure caused her to lash out at him and he responds to her in kind. Sam's "eye for an eye, tooth for a tooth" sense of justice precludes, at this point, sympathy for Jill. Sam takes great pains to explain the legitimacy of his claim of breach of contract in this utterance because he is hurt by Jill's alleged sarcasm and he is being faced with his own and Jill's vulnerability. Sam is also candid with the therapist and Jill concerning his desire to seek revenge via hurting and punishing Jill the way he perceived he was hurt and attacked by her.

In this utterance, Sam acted to maintain the distance experienced by the couple occasioned by the morning fight. Sam observed that both he and Jill felt distress at the bad financial situation. However, he believed that instead of comforting him, Jill lashed out with sarcasm. Sam reasoned that if Jill attacked him when he was vulnerable she should receive similar treatment when she was vulnerable. Sam believed that since he felt as bad as Jill but received a sarcastic jab instead of support, he could not be expected to offer Jill caring or comfort. In lieu of sarcasm as a rejection strategy, Sam engaged withdrawal of caring to retaliate. Sam cited Jill's sarcastic rejection of him to be the same as his withdrawal from her therein justifying his behaviour, sustaining marital distance and delaying clarification of the original misunderstanding. In her response to Sam, the therapist reflected both Sam's hurt desire for revenge as well as the distancing consequences of a vengeful course of action.


Th: =So you're still feeling the pain from this morning and when= [ ]
S: Yeah

Th: =Jill ((indicates Jill with left hand)) is being very open with her tears right now you're kindof slamming back at her.

Expansion.

Let me see if I understand what you are saying Sam, right now you continue to feel attacked by Jill who said "same old scenario" in response to
you telling her "Broughton better fly". [S: Yes that is the case therapist, I am still hurting from Jill's sarcastic attack on me]. Currently, Jill is very open, vulnerable and desperate. She is sobbing and hurting like you did this morning and your response is to hit her hard with your anger, lack of caring and indifference. Sam even though you understand how Jill is feeling right now because you felt similarly this morning you wish to seek revenge by punishing Jill.

**52. Interaction.**

In this utterance, the therapist summarizes Sam's position vis-a-vis revenge against Jill and focuses on present tense ongoing interaction. The therapist observes that even though Sam has experienced a similar sense of desperation, hurt and attack as Jill, he insists on forcefully meting out a vengeful punishment against Jill for her breach of contract.

The therapist reflected Sam's hurt and desire for revenge while highlighting an ethical concern with purposive punishment directed at an obviously injured party. The therapist observed that when Jill was vulnerable, Sam continued to hurt her while remaining cognizant of the depth of her upset. As demonstrated in the following utterance analysis excerpt, Sam concurred with the therapist's reflection of his pain, desire for revenge and observations regarding the questionable morality of his vengeful stance (CU).

**Text: Lines 409-413.**

S: Probably that's what I'm doing yeah.  
Th: [ ] Oh  
J: ((sobbing))

**Expansion.**

Yes therapist, it is more than likely that I am seeking revenge against Jill while personally knowing the extent of her pain. I do not want to agree with you wholeheartedly because I did not initially understand that what I was saying was that I am punishing Jill while being aware of how hurt she is. This sounds very cruel and I do not want to seem cruel to you therapist, it makes me feel guilty. However, I am honest and it does appear that I am vengefully punishing Jill while remaining cognizant of her openness, vulnerability and hurt as I am meting out my punishment.

**53. Interaction.**

In this utterance, Sam acknowledges the accuracy of the therapist's observation that his "eye for an eye, tooth for a tooth" sense of justice
precludes empathy for Jill. Sam did not wish to acknowledge that he must suspend empathy for Jill to effect his punishment. He observes that this may appear to be cruel and he is uncomfortable with the characterization of himself as cruel. The intensification of the moral significance of purposely hurting another to inflict pain while understanding the full effects of these actions prompted Sam to feel uncomfortable.

The therapist’s reflections upon the moral significance of Sam’s behaviour prompted him to feel guilty since the relationship between Jill’s continued hurt and his punitive withdrawal was becoming clearer. However, Sam attempted to find temporary relief from uncomfortable feelings of uncertainty, inadequacy, worry and guilt emerging with Jill’s upset and tears by theorizing about the most effective way to deal with business setbacks. The following text analysis excerpt illustrates Sam’s relief seeking utterance.

Text: Lines 415-425.

S: You see I see the setbacks as stepping stones to the (go) ahead ((looks at therapist)) and that’s the way I try to look =
 [ ]
J:((sniffling))

S: =at it I mean it’s just a matter of you pick yourself =
 [ ]
Th: Yeah

S: =up you get ((shakes head, therapist looks at Jill)) back on track and you take that first step again =

Expansion.

Therapist, I feel guilty that I am punishing Jill when she is obviously very distressed and in need of comforting and the benefit of my doubt. When I feel guilty I attempt to discount Jill’s claim to my sympathy to offset my guilt feelings. As a result, I will again explain to you and Jill how I see setbacks as not worth emotional upset because setbacks are merely the means to future success. Since setbacks are not worth emotional upset, they should not cause Jill to attack me which further supports my claim that I was illegitimately attacked by Jill. Therefore, I should not have to comfort Jill over setbacks that should not upset her. Nor should I be expected to forgive her for a sarcastic remark born of undue upset. Nor should I be expected to comfort Jill when she has become illegitimately upset and attacked me in the process. Thus, it is plain that I am not guilty of being cruelly punitive towards Jill because she should not be upset about the setbacks, she should support her husband not attack him and she should not expect comfort when she has breached our conjugal contract by being vulnerable and not supportive. I have a legitimate right to my indifference and punitive actions and my advice to you Jill is don’t
be upset, don’t take setbacks so hard and get on with life like I do. I do not want to feel guilty anymore nor do I want to be convinced that you were not being sarcastic when you made your remark this morning. Jill, I want to punish you in a guilt and remorse free manner and I do not want this course of correction to be altered by excuses and claims of extenuating circumstances. If we can follow this course of action I can successfully avoid feeling guilty, inadequate and worthless. As long as I remain punitive and distant from Jill I will hold inadequacy and worthlessness at bay. If Jill can accept these terms we can probably continue the relationship without further discussion of the morning incident.

54. Interaction.

In this utterance Sam repeats a pattern in which he attempts to stave off guilt feelings and painful thoughts and feelings by discounting Jill’s experience. He attempts to demonstrate that her claim to upset is false because becoming upset over setbacks is unnecessary. In addition, Sam hopes to bolster his assertion that he has been wronged by claiming Jill breached the conjugal contract. Jill’s vulnerability represents a serious challenge to what Sam has believed to be familiar and appropriate behaviour for her. In effect, Jill demonstrates that she is unable to fulfill Sam’s expectations for her role and duties and abide by the terms laid down in the contract. Sam’s expectations of Jill are considerable in that she is expected to be the rudder and strength in the relationship. As relationship rudder, Jill bears responsibility for the stability of the relationship which requires her to be unfailingly supportive of Sam and capable of withstanding withdrawal. Sam provides an elaborate proof delineating why he is not guilty of cruelty towards Jill by outlining how she is deserving of punishment based on her illegitimate upset (i.e., setbacks are not cause for upset) and subsequent attack on him. Sam is unwilling to consider Jill’s explanation for her remark since believing her version of events requires Sam to encounter feelings of inadequacy, face the manner in which he has been treating Jill and entertain a change in spousal roles. By advising Jill to pull herself together, Sam hopes to bring the interaction to a close such that Jill discontinues her tearful explanation of her words and intentions. Jill is sobbing and extremely vulnerable during Sam’s renewed attempt to curb her expression of feelings. At home, Sam’s advice-giving behaviour may have resulted in a suspension of Jill’s attempts to influence matters. However, the therapist persists in making Sam’s behaviour explicit in her next turn thereby preventing a return to the status quo.

In this utterance, Sam revealed his continued desire for what he considered to be justifiable revenge based on the hurtful consequences of the early morning fight. In addition, Sam’s difficulty with his own and Jill’s upset was evident in this excerpt. Sam’s complex response to the therapist’s observation that he was purposely hurting Jill despite knowledge of her pain revealed his avoidance of both his own and Jill’s painful experience.
For example, Sam feared Jill's upset because it contributed to an awareness of his own despair (CA). The discourse analysis of Episode #2 revealed that both the therapist and Sam observed that Jill's crying was an uncomfortable reminder of Sam's own unshed tears regarding the family's financial difficulties (Episode #2, Lines 369-376). In addition, Jill's expression of painful affect perturbed deep discomfort in Sam. Sam's substantive relational theme of inadequacy was evoked when he suffered business setbacks (SRT) and from Sam's perspective, his inadequacy was confirmed if Jill showed signs of upset due to business difficulties.

Also, Sam avoided Jill's upset when it arose because her distress appeared to threaten the stability of the marriage. Jill's role as steady rudder was jeopardized when she became upset causing Sam concern regarding the effects of her vulnerability on the relationship. Accordingly, Sam attempted to curb Jill's expression of her experience by offering advice and implicitly questioning the legitimacy of her claim to upset.

Sam's advice to Jill regarding how to think about setbacks so as to avoid the emotional upset they engendered was based upon a desire to reduce the intensity of a discussion that evoked his core theme of inadequacy and threatened the security of the marriage. However, the therapist maintained a here-and-now focus on Sam's behaviour centering on the effect of his advice-giving utterance on couple intimacy as indicated in the following text excerpt.

Text: Lines 427-429.

Th: =So you don't want to get close to her right now, you wanna [ ]
J: (sobbing)
Expansion.

Sam, at present, you do not want to comfort Jill or let go of your commitment to viewing her negatively. You would rather continue punishing her despite her appeal to you for understanding. You would rather continue distancing behaviours such as advice-giving than view Jill as sympathetic and worthy of serious consideration. You would rather view Jill as purposely hurtful than reconsider your rendition of the morning events. You want to maintain the current distance between yourself and Jill despite the cruelty of this pursuit. You want to remain distant and hope that Jill will suspend her quest for understanding enabling you to keep your inadequacy and guilt feelings at bay. You do not want closeness with Jill because it would mean treating her warmly and compassionately, it would mean you would have to share the role of rudder in the relationship and it would mean you would have to believe Jill and face your painful view of self. Also, increased closeness with Jill would mean giving up the unbalanced distribution of decision-making authority in the relationship. Jill would be credited with 50% of the control as evident, in this instance, by your willingness to take her experiences and explanations seriously and your willingness to incorporate Jill’s clarifications into your account of the morning fight. However, Sam you do not want increased intimacy with Jill right now.

55. Interaction.

The therapist intensifies the substance of Sam’s utterance such that it is made clear that he is choosing to remain distant from Jill. The prospect of treating Jill as an equal partner, sharing the responsibility for nurturing the relationship, treating her with compassion, taking her seriously and her thoughts into account and facing his own pain are more than Sam is willing to do at this point. The therapist’s observation serves to continue the intensification of what is occurring between Sam and Jill. Rather than enabling Sam’s hoped for return to the status quo, (i.e., the avoidance of pain and the maintenance of Jill as nurturant rudder) the therapist continues to intensify the interaction. Jill is probably unable, at this point, to continue pursuing her view with Sam and would probably withdraw in anguish at home. Sam’s efforts to control Jill and legitimize his punitive actions could have the effect of intimidating Jill, draining her of her desire to continue contradicting him. Sam is probably relatively successful in keeping Jill from pursuing her grievances with him at home due to his use of advice giving, withdrawal of caring and threat of physical intimidation (e.g., throwing his dinner at her and employing aggressive play (Appendix Q, Session #4 and #6). There probably comes a point when Jill gives up trying to be heard, understood and cared for by Sam out of fatigue, fear of reprisal and frustration. At this juncture, Jill may experience herself as abandonable, a common theme in her life. In this instance, the therapist continues a here-and-now to intensification of Sam’s actions such that their effects on Jill and the marriage continue to be accessible. By making Sam’s attempts to abandon Jill explicit, the therapist endeavours to alter a familiar distance inducing interaction pattern.
In this utterance, the therapist commented on the interpersonal function of Sam's advice-giving statement. That is, Sam's advice-giving behaviour revealed a desire to distance himself from Jill. Sam's punitive distancing behaviour was connected to his lack of self-worth in that he attempted to ensure a sense of personal adequacy by maintaining Jill in the role of sarcastic rejector. If Jill was shown to have been attacking Sam and therefore in error, then the view that he was an inadequate provider would also be in error. That is, if Jill was wrong in attacking Sam for incompetence then he would be competent because Jill wrongly rejected him. Thus, punitive withdrawal from Jill kept Sam's sense of inadequacy at bay since punishing her meant that she was wrong and he was an adequate provider after all.

Prior to entering therapy, Sam employed a variety of methods to ensure dignity and self-respect including the hard-nosed government of self and others and a tendency to numb, control, dismiss and mute painful experience via alcohol and drug abuse. In addition, to assure peace, interpersonal contact and prevent abandonment, Jill suspended the expression of personal experience and retreated. The therapist's intensification of Jill's hurt in a safe context allowed both Jill and Sam to engage in an atypical interaction that had the potential to increase mutuality and couple intimacy. Rather than retreat, Jill continued her tearful quest to be understood by Sam (ATY). While Jill attempted to be understood by Sam, he struggled to incorporate her explanation into his understanding of the morning miscommunication (ATY). In addition, the intensification of Sam and Jill's experience of the morning fight and the effects of his behaviour and outlook on Jill evoked core relational themes of inadequacy and worthlessness in Sam and fears of abandonment in Jill (SRT). The deepening of underlying feelings associated with these themes fostered a potential shift, in Sam's case, towards an increased sense of worth
and adequacy, and in Jill's case, an experience of self as acceptable and lovable (SRT, ATY).

The intensification of the effects of distance maintaining beliefs and practices in the marriage appeared to aid the generation of intimacy when the impact of Sam's desire not to get close to Jill was explored. That is, the exploration of Sam's punitive withdrawal and Jill's protective distancing response brought the intimacy reducing effects of withdrawal of caring into sharp relief (CU). The following text analysis excerpt illustrates the therapist's intensification of Jill's desire to keep distant from Sam to protect herself from abandonment and further hurt.


Th: = You don't - yeah so I understand Jill how sometimes you need to protect ((Jill wipes tears, Sam looking at fingers, moving his fingers)) yourself from getting too close to Sam. Sometimes when you get too close to him you feel really alone, you feel really alone =

Expansion.

Sam you say you do not want to get close to Jill when she is upset and you have said that quite clearly even though you do not want to be thought of as cruel. My interest is in how this, not getting close to Jill when she is upset, affects her. I am addressing Jill now because Sam, you have stated clearly that you will not comfort Jill. As a result Jill, I understand why it is you feel the need to protect yourself from Sam by withdrawing from him. When you talk to Sam about your feelings you feel abandoned by him, he dismisses and avoids hearing what you are trying to say. You keep your distance because it hurts to not be heard or acknowledged. During times when you get close and become vulnerable with Sam he dismisses you and you end up feeling very alone and very isolated. The effect of Sam's desire not to comfort or listen to you is you are left lonely, alone and isolated.

57. Interaction.

The therapist focusses on the effects of Sam's distance on Jill when she is upset and intensifies Sam's painful abandonment of her. Sam's difficulty with Jill's hurt defeats and isolates her. Also, the therapist observes the
prevention of abandonment and hurt to be a self-protective reason for distance from Sam.

The techniques of self-protection utilized by Jill to defend against impending abandonment included retreat and the suspension of self-expression. Prior to therapy, Jill obtained security through a peace-keeping role which relied upon propitiation and cautious self-expression to be effective. For example, Jill refrained from commenting on Sam's alcohol abuse when he was sober preferring to let "sleeping dogs lie" (Appendix R, Session #1). Also, Sam had come close to leaving the relationship (Appendix R, Session #1) and sometimes threatened to leave the marriage when disagreements occurred (Appendix Q, Session #4) contributing to Jill's childhood predisposition to retreat to stave off fears of abandonment (Appendix T, Session #5).

Jill's ability to remain vulnerable during the re-enactment and allow herself to cry deeply reflected an important shift (ATY) since, on previous occasions, she would remain apart having failed to be understood by Sam. The depth of Jill's vulnerability during the re-enactment was noteworthy. Several factors including Jill's need to protect herself from Sam, her predisposition to surrender and retreat and Sam's employment of avoidance and control strategies to manage painful situations made Jill's self disclosure difficult. Indeed, the analysis of Jill's paralinguistic reply to the therapist's empathic acknowledgement of her need for self-protection reveals the depth of her exposure and pain in Episode #2.

**Text: Lines 441.**

J: = ((sobbing, sniffing)) =

**Expansion.**

It is true, I am very much alone right now. I realize I am alone a great deal in the marriage and Sam does not seem to care. I am exhausted trying to get him to understand my point of view, my feelings and my motivations. All I
have left are my tears. I have nothing left to say, in my vulnerability I have been abandoned and dismissed by Sam. I feel utterly alone and utterly defeated.

58. Interaction.

Jill has been crying since she told Sam that her experience of him was that he was hard-nosed and unsympathetic. Jill’s only verbalizations have been sniffs and sobs. Her crying increases in intensity when the therapist amplifies Sam’s stance and explores the effects of his stance on Jill. For example, Jill cries more intensely when the therapist notes that Sam is trying to exact revenge and does not want to get close to her. Jill cries harder when the isolating effects of Sam’s behaviours are made explicit by the therapist. Jill’s despair, communicated by her crying, centers on Sam’s hardened reaction to her when she is vulnerable. His reaction reduces Jill to tears and renders her desire to be heard, understood and comforted hopeless in her eyes. Jill is drained, aware of a great deal of hopelessness and helplessness. The therapist’s intensification of Sam’s response to Jill’s vulnerability has brought these deleterious effects to the fore.

Jill’s increased sobbing due to the therapist’s observation that she was alone in the marriage perturbed a new awareness for Sam as well as renewing his desire for distance from Jill. In the following text analysis excerpt, Sam becomes aware of the reason he is uncomfortable with Jill’s expression of painful affect and why he finds it difficult to comfort her (CA).


S: =I think that the reason, part of the reason why I don’t like getting closer is that I’m seeing the vulnerable side of her which I don’t like seeing because she is the rudder, the =

[ ]

Th: (.hhh){(continues looking at Jill while Sam looks at therapist)}

S: =((looking at therapist)) catalyst or the you know the strength in the relationship =

Expansion.

When I think about why I do not want to be close to Jill right now, I conclude that part of the reason is I do not want her to be vulnerable and I am uncomfortable with her vulnerability. One of the other reasons I do not want to be close to Jill right now is that I continue to feel injured by her sarcasm and to comfort her would make it seem that she had not wronged me. My view of Jill’s comment being intentionally sarcastic must prevail so that I can maintain my sense of adequacy, worthiness and control. The reason for my seemingly uncaring attitude rests on Jill’s role as rudder in this relationship. I depend on Jill for support and back-up and when she is vulnerable she cannot function in this role. Jill is the strength in this relationship and the catalyst in that she is
the heart of the relationship. If Jill ceases to function due to emotional upset then I fear the relationship will cease to be because Jill is instrumental in the existence of the marriage. I cannot comfort her because to acknowledge her vulnerability would jeopardize the relationship as I know it.

59. Interaction.

In this utterance Sam attempts to explain why it is he cannot comfort Jill. He continues to maintain the distance from Jill he requires for comfort. He claims that since Jill is instrumental in keeping the relationship whole, comforting her in her upset would jeopardize the relationship. To Sam, Jill’s upset is a threat to the continuation of the marriage as he knows it. He does not want to comfort Jill because he cannot afford to lose Jill as relationship rudder or lose Jill’s offence of intentional sarcasm as his means of obtaining adequacy. The therapist continues intensifying the effects of Sam’s distance and inability to comfort Jill in her next utterance.

While Sam reported an important awareness into the reasons for his difficulty with Jill’s upset, he simultaneously maintained distance between himself and Jill. As well as providing an important personal awareness, Sam’s insightful analysis of the reasons for his distance promoting behaviours performed an avoidance function. Sam’s analysis of the reasons for his behaviour helped him avoid Jill’s ongoing pained experience and circumvented recognition of the effects of his punitive actions. In her response to Sam’s insight the therapist intensified the effects of his need for Jill to be relationship rudder.


Th: =((looking at Jill)) Yeah, so means that Jill has to feel alone with her pain (((turns to look at Sam)) - ((voice very quiet)) yeah - yeah - yeah

J: ((sobbing))

Expansion.

Yes, Sam I understand that you require Jill to be strong in the relationship so that you can feel supported and continue day to day. However, when Jill is required to remain in that role to the exclusion of other options for behaviour, she is forced to feel and be alone with her pain and despair. Jill is forced to live alone in the relationship when you need her to be strong even when she is not feeling particularly strong. Yes, I see yes, I see, yes, I see this can be a very lonely, isolated and desolate marriage for Jill. [J: I feel desolate
and without recourse when Sam will not listen to me, responds harshly, and dismisses my attempts to expand my role in the marriage.]

60. Interaction.

The therapist amplifies the effects of Sam's insistence that Jill remain strong and supportive in the relationship. The therapist identifies the painful loneliness Jill experiences when forced to cope alone with her hurt and despair. At the same time, it is expected by Sam that she be ready to help him cope with his hurt. The therapist recognizes the desolate place Jill often occupies in the marriage and highlights this to both spouses. Jill's response is to cry harder and Sam analytically acknowledges her desolation.

The therapist intensified Sam's distancing behaviour maintaining a present tense focus on the effects of his role expectations and punitive behaviours on Jill. The therapist sustained the intensification of Jill's experience of Sam's distancing activities to promote an atypical pattern of couple interaction. The intensified interaction was structured such that a shift occurred in which Sam could not avoid or dismiss Jill's feelings, thoughts and explanations while Jill refrained from suspending her quest for understanding and retreating (ATY). The intensification of the couple's distance pattern and the prevention of a return to familiar interaction styles of dismissive and surrendering behaviour prohibited the discussion concerning the morning misunderstanding from meeting a premature and unresolved end (ATY). The intensification of the detrimental effects of Jill's assignment to the relationship rudder role helped Sam understand the depth of her isolation (CU) as illustrated in the following text analysis excerpt.

Text: Lines 459-460.

S: ((quiet voice)) Interesting ((looks from therapist to table next to him))

Expansion.

Therapist what you are saying about Jill being required to live alone with her despair is true and you make an interesting point. It is interesting because I never thought about what it would be like to be the rudder in the relationship and be expected to be strong for everyone else and not get support. I am understating the importance of what you have just pointed out to me because I
feel uncomfortable imagining how alone Jill must feel as the sole supporter of the family. I feel somewhat ashamed about assigning Jill such a lonely existence and for this reason I cannot continue looking you in the eye therapist.

61. Interaction.

Through the therapist's intensification of the effects of Sam's distancing behaviour on Jill, he reluctantly begins to realize that Jill was being required to exist in an untenable situation. Sam looks down and away from the therapist appearing to experience some embarrassment during this utterance. Rather than initiate another explanation of why he is correct in his punishment of Jill, Sam appears to pause having heard the therapist's message to consider the effects of his behaviour on Jill. Sam's pause indicates a willingness to temporarily consider the deleterious effects of his punitive and withdrawing behaviour on Jill.

Sam learned something new about himself and his spouse during the intensification of the effects of his distancing behaviour. Sam realized that the role of family rudder may be a lonely one for Jill since it required her to nurture and support family members without reciprocation (CU).

The following text analysis excerpt depicts the therapist's continued intensification of the import of Sam's new understanding and her recognition that the intensification process raised uncomfortable issues. In addition, the therapist encouraged Sam to believe Jill wanted to commiserate with him rather than attack him as illustrated below.


Th: ((quiet voice)) Yes, and it's not only interesting ((looks at Jill)) it's very significant and ah it's wonderful ((Jill moving her kleenex)) that you can, that you can see that it's worth looking at. I'm impressed that you're willing to look at that and to give it some thought because ((looks at Jill, motions toward her)) Jill is is joining you and sharing her pain with you.

J: ((sobbing))

Expansion.

Yes Sam I think it is interesting that Jill is alone with her pain but I believe that to be an understatement. The fact that Jill is left alone with her hurt because you are uncomfortable with her vulnerability is very important to the level of intimacy between you and Jill. Jill is required to protect herself from you Sam and in so doing she must handle her despair alone. I have highlighted the effects on Jill of your reluctance to care for her when she is upset and I am glad that you understand how your abandonment of Jill in her
pain is worth questioning. I recognize that it is not easy for you to look at how your distancing behaviour affects Jill and I wish to acknowledge that you are willing to give your withdrawal of support from Jill some thought. I am glad you are willing to look at your abandonment of Jill because, during the re-enactment, Jill was willing to try to understand your hurt and share her own with you. Consequently, Jill would like to be understood and heard by you and now your willingness to think about the loneliness of the rudder role is an important step in drawing closer to Jill.

62. Interaction.

In this utterance, the therapist observes that Sam pauses to think about Jill’s loneliness in the marriage. She also notes that Sam continues to struggle with the effects of his punitive abandonment on Jill and his difficulty with her vulnerable expression of emotional upset. The therapist recognizes that it is difficult for Sam to face his behaviour and Jill’s pain. The therapist appears somewhat relieved that Sam has shown an initial willingness to consider the effects of his withdrawing behaviour on Jill without rebutting her claim to upset. The intensification of the effects of Sam’s punitive and withdrawing statements was painful for Jill. Jill sobbed during Sam’s struggle to understand the effects of his abandoning behaviour. Through the intensification of the effects of Sam’s behaviour, the therapist offered him time to think about his avoiding and controlling relational style and assumptions. For example, when Sam offered Jill advice about how to handle financial setbacks, the therapist highlighted Sam’s implicit relational desire to maintain distance and refrain from drawing emotionally closer to Jill. When Sam told Jill and the therapist that he did not want to be emotionally close to Jill, the therapist focussed on the isolating effects of his distancing behaviour. Also, the therapist praised Sam’s initial foray into considering the effects of his abandonment on Jill as beneficial to Jill who remained atypically open to Sam in an attempt to be understood by him.

In this utterance, the therapist began to summarize the work of the session anticipating the end of the therapy hour. The therapist highlighted the intimacy generating function of Jill’s vulnerable self disclosure (ATY). The clinician noted that Jill “joined” (Line 467) with Sam by expressing her pain. In addition, the therapist affirmed Sam’s struggle to recognize the isolating effects of his behaviour on Jill (CU) as important to the couple’s “joining process”.

In her next utterance, the therapist continued to summarize the important intimacy enhancing elements emerging from the re-enactment activity. In particular, the therapist observed the commonalities between Jill and Sam’s experience noting that Jill had been atypically vulnerable and Sam had found her vulnerability uncomfortable. The text analysis excerpt featured below
captures the therapist's continued summary of the intimacy generating aspects of the re-enactment including Jill's atypical openness and Sam's disclosure of his fear of her vulnerability (ATY).

**Text: Lines 472-480.**

Th: It seems like you're both disappointed and ah she's sharing her vulnerable side which means she's ((motions towards Jill)) taking a big risk to be spontaneous and to be very open and honest with you and right now ((motions towards Sam)) it's it's too scary for you to...

S: It's the same thing, I used to get the tears over alcohol ((shaking head)) and I used to do the same thing I would withdraw=

**Expansion.**

Th: Sam, it appears to me that both you and Jill are disappointed with the business setbacks and even though you say you are not as disturbed as Jill by the setbacks, you are distressed nonetheless. When Jill feels the distress of the setbacks she shares that with you and shows you her vulnerable side. Jill is taking a big risk when she shows you her vulnerable side. She is being spontaneous and not censoring her behaviour and reactions and she is being very transparent, honest and trusting with you. Part of Jill's goal in coming to therapy was to become more open and spontaneous and this is what she is attempting to enact with you now. Unfortunately, Sam you find Jill's openness too frightening to address so you withdraw from Jill in a variety of ways including dismissing her and punishing her with abandonment.

S: I am interrupting you therapist to say that you may think that Jill is being newly spontaneous and open with me by crying but these tears are old hat. Jill used to turn on the tears when I was drinking and I did what I do now when I see the usual tears, I withdraw to get away from such unwarranted crying. So, it is not that I am afraid to address Jill's tears or her reason for crying it is just that I am accustomed to Jill crying to get my sympathy for questionable causes such as my alcoholic drinking. Right now, Jill is crying because she says she has gotten too upset over the financial setbacks and wants me to feel sorry for her. Jill is not fooling me with these tears, she tried to use them in the past when I was drinking and she's trying to use them on me now. She just wants to get me feeling sorry for her so that I will do what she wants me to do like stop drinking, which I already did, or believe her when she says she was not being sarcastic when she actually was being sarcastic. I withdraw so that Jill will not seem to be in control of me. Jill may be the rudder of the ship but I am the captain and if I were to comfort Jill and recognize her hurt I fear I would no longer be captain of the ship, I would no longer be adequate and worthwhile
and I would no longer remain in my familiar role with Jill. Therapist, I cannot afford to relinquish my view of Jill as sarcastic due to unnecessary and manipulative crying; there is too much at stake.

63. Interaction.

The therapist continues to build on the notion that Jill is being open and spontaneous with Sam. The therapist highlights the fact that Sam feels upset about the setbacks as does Jill and this forms a basis of understanding between them. Also, she notes that Sam is afraid of Jill's vulnerability in an effort to further deepen and explore his previous statement regarding his interest in the effects of his behaviour on Jill. However, Sam interrupts the therapist's prompt claiming that Jill is using her tears to control him. He claims Jill tried to control his drinking behaviour with tears and she is again trying to control him with the same device. Sam's explanation for Jill's tears serves as an argument against the legitimacy of Jill's hurt and a justification for his withdrawal. Sam's explanation for Jill's tears as calculated and manipulative parallels his understanding of Jill's morning remark as intentionally sarcastic. When the therapist touched on Sam's fear of Jill's vulnerability his anxiety increased preturbing him to struggle to re-instate Jill as unflappable rudder. By discounting Jill's hurt once more and insisting on viewing her as calculating and manipulative, Sam shields himself from responsibility for the abandonment of Jill. He also protects himself from focusing on his sense of inadequacy. Sam is frightened by Jill's vulnerability since to acknowledge it rocks the foundation of what Sam has come to rely upon to sustain him. Sam requires Jill to be an unflappable rudder so that he can continue as ship captain. To Sam, Jill's vulnerability reminds him of his own and the reminder is intolerable. If Sam acknowledges, empathizes and comforts Jill, he simultaneously acknowledges that she did not purposely mean to hurt him which in turn confirms, in his mind, that he is an inadequate and incompetent businessman. In addition, Sam would consider himself to be weak if he were to "fall" for Jill's tears and allow himself to be manipulated. Layers of intrapersonal pain and an adherence to rigid sex roles confine Sam to a narrow band of behavioural and perceptive possibilities at this juncture.

In this series of two turns, the therapist focussed on the couple's common experience of upset due to financial setbacks, Jill's uncharacteristic depth of self disclosure and Sam's fears of Jill's vulnerability. However, the therapist's summary was interrupted by Sam who continued to distance himself from Jill by attributing manipulative intent to her expression of feeling.

The difference in viewpoint between the therapist and Sam was clarified in this interchange when Sam asserted that Jill's tears were calculated and self-
serving. The therapist however, understood Jill's vulnerability to be a courageous, honest and spontaneous expression of her core experience and an attempt to share that experience with Sam. In his utterance, Sam observed that he interacted with Jill according to a set of assumptions founded upon prior tearful exchanges concerning alcoholic drinking (CU). Previously, Sam practiced withdrawal from Jill believing her to be attempting to control his drinking using crying as a guilt and inadequacy inducing technique. Hence, Sam assumed that crying on Jill's part was an attempt to manipulate him and the tears she was shedding during the re-enactment were a pretense and not credible.

Believing Jill's tears to be opportunistic, Sam withdrew thereby reducing the potential for intimacy and mutuality in the marriage and increasing Jill's isolation. Nevertheless, in her reply to Sam, the therapist continued focussing on Jill's benevolent motivations, the sincerity of her vulnerable disclosure and her quest for Sam's understanding. The therapist acknowledged Sam's efforts to be vulnerable during the re-enactment, stressed the common experiences shared by the couple and challenged Sam to behave differently towards Jill.

Text: Lines 481-512.

Th: = Yeah, so maybe you're still in that pattern ((rotating arm)) of withdrawing from the tears because in the past ah the tears were to do with alcohol, now the tears are to do with ((hands moving, left hand touches chest)) very real core of who Jill is and her willingness to share herself ((Jill moving kleenex)) with you and it right now ((looks at Sam)) you don't want to come close to her but are willing to look at that as something very interesting(.hhh)and the challenge when you leave here will be - to - ((raises hand, continues looking back and forth between clients)) deal with that because Jill ((touches Jill's knee)) does not feel safe right now she shared a very deep part of herself and it ((looking back and forth between clients)) hasn't been(.hh)something that's felt safe to do so she may choose to withdraw, she may choose to withdraw ((looking at Jill)) - or ((rolling gesture to Jill)) she may choose to keep doing this with you in-in sharing her vulnerability ((Sam continuing to look intently at therapist)) with you she's really honouring ((Jill wipes nose)) who you are,
she's honouring you deeply and you've also shared your vulnerability ((gesturing towards Sam)) with us. Telling her of when you came to the bedroom(.hhh)you talked about the financial si-si-tuation you let her know this morning, that in here, that it's not just disappointment it's also the pressure and rejection and pain and fear and ah ((Sam scratches nose)) it-it triggers you to point where you feel vulnerable in your self esteem especially when you're not 100 percent ((Jill moving kleenex, therapist rolling hand)). So you've shared your vulnerability with her and she's shared hers' with you and ah ((indicating Sam with her hand and looking at him)) in the past there was a pattern where there were tears it was usually to do with alcohol so you would withdraw(.hh)so now there's a chance to do something different ((rolling left hand)). And I wonder what you'd like to do that's different right now?

Expansion.

Yes, I understand that perhaps you are still behaving in the old manner of withdrawing when Jill cried about your alcoholism. However, the tears Jill sheds do not have anything to do with your drinking and are not an attempt to manipulate you. The difference between Jill's tears in this session and her tears on previous occasions is the level of vulnerability and disclosure reached by Jill. Jill is exceptionally vulnerable to you right now and she may be protecting and censoring herself less today than ever before and that makes this situation different from the situation in which you withdrew from Jill before. In fact, right now, Jill's tears are a product of Jill revealing herself to you such that she shares her despair and feelings of abandonment with you. Jill's tears arise from a deep, profound place within her being. Jill experiences a great deal of despair and alienation due to your withdrawal and abandonment of her. You are unwilling to comfort Jill or end your withdrawal but at the same time you are concerned enough about your behaviour to re-consider it in a measured way. We are going to end the session soon and I am looking into the future as I say this because the problem for you Sam is you are going to have to think hard about the effects of abandoning Jill when you leave here today. Sam, you are going to have to make a change in your abandoning, withdrawing and controlling behaviour towards Jill because Jill does not feel safe with you. Jill feels threatened, unsafe and rejected. She has disclosed her sense of desolation, despair and loneliness to you today and that has not traditionally been safe to do. It appears that it is still unsafe for Jill to reveal deep aspects of herself to you when you threaten, invalidate, dismiss and discount her. Sam, it is important for you to know that as a result of your behaviour towards her, Jill may decide to withdraw from you, Jill may decide to protect herself from you and stay away from you emotionally. On the other hand, Jill may continue to try to prompt you to understand her and have compassion for her. If Jill continues to share her vulnerability with you Sam, I want you to know that when she discloses her deepest hurts and pain, it is no trivial matter. When Jill discloses herself to you she is recognizing that as her spouse you are one of the closest people to her and you are the person with whom she should feel comfortable revealing her innermost feelings. Jill is allowing you to see her when she is most vulnerable and is entrusting you with
a profound part of her being. It is important that you realize this Sam, that when you reject or abandon Jill you are betraying an almost sacred trust between you. Also Sam, you have entrusted a part of yourself to Jill during the session and I wish to recognize this disclosure as well. Sam you told both Jill and I of what happened when you came into the bedroom full of disappointment about the financial situation. Sam, you went further in your disclosure during the session revealing how hard the pressure was on you and how rejected you felt when Jill said "same old scenario". You shared your fear of the creditors and unpaid bills and the pain you experience when business deals go sour. Sam you also noted how physical ailments and unsuccessful business deals perturb a sense of inadequacy and worthlessness that undermines your confidence. Sam you have shared your vulnerabilities with Jill and Jill has shared her vulnerabilities with you and this type of discussion can promote an open, caring relationship between spouses. In the past, Sam, you withdrew from Jill when she cried about the hurt your drinking caused her. However, the current discussion of each others vulnerabilities is unlike previous discussions and there exists now an opportunity to change your usual withdraw/abandon behaviour pattern Sam. Sam you do not have to continue withdrawing from Jill since you have already been vulnerable with her. Jill feels unsafe with you and your therapy goals include more marital intimacy. Perhaps you would like to do something else besides withdraw from Jill at this time. Perhaps you wish to change this old pattern of withdrawal today. Sam, what would you like to do that represents a shift in your old style of interacting with Jill given her current desolation and despair?

64. Interaction.

The therapist is aware of the impending end of the session and she begins to summarize the session including the disclosures made by both Sam and Jill as well as the hurtful effects of Sam's withdrawal on Jill. The therapist highlights Sam's old pattern of withdrawal from Jill over his alcoholism as different from his current withdrawal from her. The therapist does not agree with Sam's opinion that Jill's current tears are a manipulation. Instead, the therapist notes that Jill's tears are a manifestation of a profound sense of desolation at the core of her being. At first, it appears that the therapist is making a distinction between Jill's past manipulative tears and her current genuine ones. However, closer inspection reveals that the therapist is not making a distinction between manipulative tears and genuine ones, rather she is remarking on a difference in degree of depth of disclosure. The therapist surmises that Jill's tears concerning Sam's drinking were a product of considerable upset but she assumes that Jill reached an even deeper level of disclosure and vulnerability in the session when she conveyed her sense of aloneness and abandonment to Sam. The therapist impresses upon Sam the fact that Jill's disclosures and vulnerability are a sacred trust that was betrayed when he punitively withdrew from her in her time of need. However, the therapist takes pains to acknowledge that Sam is willing to thoughtfully investigate his behaviour further even if he is unwilling to comfort to Jill. The therapist also comments on Sam's vulnerability in the form of his sense of
inadequacy and worthlessness as revealed earlier in the session. She notes that both Sam and Jill have disclosed some of their innermost fears and hurts and harkens back to Sam's typical pattern of withdrawal challenging him to change his usual way of being.

The therapist's response to Sam's belief that Jill was manipulating him was to intensify the importance of her disclosure to the creation of marital intimacy. Jill shared a core part of her being with Sam and this was highlighted in the therapist's utterance. In addition, the therapist recognized that Sam shared his vulnerability (ATY) with both herself and Jill disclosing a sense of inadequacy (SRT) and failure when unable to meet business and financial goals. At the end of the speech act, the therapist invited Sam to shift away from typical distancing patterns of interaction towards a potentially more intimate way of being with Jill.

The therapist's request to Sam that he consider doing something "that's different right now" (Line 512) represented an invitation to him to alter his view of Jill and his behaviour towards her. In response, Sam chose to approach Jill nonverbally (ATY) as illustrated in the following text excerpt.

Text: Lines 514-523.

((pause, Sam claps hand lightly, looks at Jill))
((Sam leans over and hugs Jill))
S: I love you honey. (I really do)
    [   ]
J:    ((sniff))
((couple continues embracing, therapist stands up, moves to other side of room and looks away))

Expansion.

((S: The therapist has asked me what I would like to do that is different from my usual pattern of withdrawal from Jill. I think I would like to give Jill a hug because she feels so bad. It may be true that Jill has really tried to trust me with her pain and I have let her down so far. It is true that I have stopped drinking and Jill is not crying because I am drinking. Maybe she is not trying to manipulate me right now, maybe she is really upset and I have misunderstood her. Perhaps Jill is in need of some reassurance that I care for her because I
have been very distant throughout the session. Yeah, I better give Jill a hug, that is what I will do, things are going to be okay between us.))  Jill, I really do care for you and I want you to know that I love you very much. We have both been very disappointed about the financial setbacks. I have been harsh during this session and I want you to know that I care about you. ((Th: This is a tender moment between Jill and Sam and I would like to signal my respect for their privacy by moving to the other side of the room and refraining from watching them while they embrace)).

65. Interaction.

Sam acts nonverbally upon the therapist’s request to respond to Jill without withdrawing by hugging her. It appears that he resists his impulse to pull away from Jill and hugs her anyway. Sam conveys in the hug that he wants to join with Jill and indicates that he understands that the financial setbacks hurt her as well as him. Sam acknowledges that there does not have to be a winner and a loser when he crosses over to hug Jill. Sam wants Jill to know he cares about her and he accompanies his affectionate gesture with words to that effect. Also, Sam is attempting to reassure Jill not only of his love for her but that somehow the family will make it through the current financial crisis. Sam’s gesture is significant in light of the win/lose paradigm upon which he based his relations with Jill. Sam symbolically crosses over to Jill’s "side" thereby being at her side to comfort and reassure her.

Sam’s previous understanding of male/female relations was rigid in that the woman’s role in marriage was to nurture the man and the man’s role in marriage was to make decisions alone concerning the family’s welfare. Role fluidity allowing for female decision-making and male nurturing was formerly unimaginable. Nevertheless, Sam displayed a foray into a nurturing role when he reached out to Jill to effect a significant departure from his prior harsh and angry withdrawal. Sam’s sense of worth was found more in being caring towards Jill than in maintaining a punitive stance during this moment. Sam’s hug is particularly remarkable when his previous subscription to societal messages warning against nurturing are taken into account. To hug Jill, Sam had to refrain from adopting retaliatory methods of conflict resolution, forego rigid role prescriptions, and find a sense of worth in intimacy rather than avoidance and control. To hug Jill, Sam had to take Jill seriously as a potential ally and friend, put aside his fear of losing her as rudder, and accept that he had been hurting her. Sam had to trust that the relationship would not disintegrate if he were to be different with Jill. He also had to trust that he would not disintegrate if he were to behave differently towards her.

Rather than respond with a distancing statement, Sam decided to approach Jill with a hug representing an initial shift away from withdrawing, avoiding and controlling behaviours towards more nurturing, caring and accepting practices (ATY). Sam’s willingness to believe Jill and take her concerns seriously (ATY)
and Jill's willingness to remain available to Sam (ATY) contributed to increased mutuality. The intensification process employed by the therapist offered Jill the opportunity to experience herself as meriting care rather than abandonment when expressing her feelings, views and desires (SRT) and helped Sam find a sense of worth in comforting Jill (SRT).

Summary of the Syncretic Change Process in Episode #2

The discourse analysis of Episode #2 uncovered an intensification of the couple's disappointment regarding the financial setbacks and a deepening of the painful effects of Sam's punitive withdrawal from Jill. The intensification of client experience during the re-enactment prompted atypical interpersonal behaviour, new awareness and cognitive understanding as well as a change in the couple's core relational themes. In particular, Sam shifted his behaviour towards Jill away from a punitive, invalidating and withdrawing stance towards a more compassionate and affectionate posture (ATY). Also, Jill remained open and vulnerable to Sam refraining from retreating or suspending self-expression during the re-enactment (ATY). Jill's willingness, with the aid of the therapist, to remain open to Sam rather than retreat was an important risk since she generally suspended self-expression to protect against abandonment. The intensification process consistently focussed on Jill's here-and-now experience in a safe context encouraging her to pursue her desire for care and understanding despite potential retaliatory abandonment or rejection. The intensification of the effects of Sam's beliefs and actions upon Jill served to validate her experience and urged Sam to take her concerns seriously (ATY). In addition, the complex process whereby Sam retained a sense of personal well-being through distance, control and revenge was challenged during the intensification. Sam's atypical response to hug Jill when she was upset
marked a major shift away from prescriptive roles towards more equitable and companionable couple relations (ATY).

In addition, a significant intrapersonal awareness and various cognitive understandings occurred in Episode #2. For example, an awareness, previously out of Sam's consciousness, was reported during the intensification process. The awareness included Sam’s realization that he required Jill to be a strong relationship rudder, supportive of others but without need of support herself. Also, Sam experienced an important cognitive understanding regarding the isolating effects of his withdrawal of caring. He believed Jill was manipulative rather than sincere and calculating rather than vulnerable enabling him to punitively distance himself from her. However, at the end of the episode, Sam appeared to believe Jill's explanation for her comment viewing her with less suspicion. Sam was able to understand how alienated and alone Jill was in the relationship (CU) which contributed to his formulation of an affectionate rather than punitive response (ATY).

Sam's affectionate gesture characterized both a literal and a figurative shift in his relationship with himself and Jill. To reach out to Jill, Sam relinquished his desire for vengeance (ATY) and found a sense of worthiness and adequacy in nurturant behaviour (SRT). Also, when Sam comforted Jill, his gesture signaled a recognition that she could no longer play the unflagging rudder role and she may be in need of reassurance and care herself (CU).

Lastly, the intensification process evoked the couple's core or substantive relational themes. Sam's themes included a sense of inadequacy and unworthiness while Jill experienced herself as being abandonable. Nevertheless, the clients' themes began to shift at the end of Episode #2 with Jill beginning to have a sense of herself as a lovable and valued partner and Sam beginning to experience a sense of adequacy and worth via sobriety and
nurturing behaviour. The discourse analysis of Episode #2 showed that increased couple intimacy and personal peace was facilitated when significant experiences in therapy were consistently intensified.

**Provision of a Collaborative Therapeutic Atmosphere**

The discourse analysis of Episode #1 and Episode #2 revealed a second element of convergence essential to the development of intimacy during the syncretic change process. The promotion of a collaborative atmosphere in therapy was found to contribute to a shift away from relational distance towards increased couple mutuality. Thus, an important tenet of relational novelty termed, therapist and couple collaboration contributed to the convergence of disparate belief and practice since couple change required the provision of an accepting, encouraging, trusting, respectful and caring therapy environment.

The tenet of therapist and client collaboration is a central guiding principle in ExST theory and practice and is defined according to two influential factors. These factors include the co-development of the therapeutic venture by all members of the therapeutic system and the assumption of joint therapist/client responsibility for the therapeutic venture. Firstly, the co-development of the therapeutic venture by clients and therapist requires entrance into the clients' worlds by accepting their experience and employing their language, cadence and metaphors to enhance the opportunity for mutual trust, respect and caring (Friesen, et al., 1989). Secondly, according to ExST theory, the therapist and clients share ownership of therapy and assume responsibility for therapy activity in the development of the therapy story and the generation of mutual trust (Friesen et al., 1989).
The following section will be divided into two parts to explore the provision of a collaborative therapy environment as it contributes to the convergence of disparate belief and practice during the syncretic change process. First, the section will uncover how the co-development of therapy, as a safe, respectful and caring context, was facilitated by therapist entrance into client experience. Second, the section will delve into the issue of client and therapist joint ownership of therapy as part of the generation of couple trust, mutuality and intimacy.

Co-developing Therapy by Entering the Clients' Worlds

The discourse analysis of both Episode #1 and #2 revealed that the therapist entered the clients' worlds by accepting their experiences, using their language style and co-developing therapy with them. The following section will highlight the co-development of the therapy story such that a collaborative therapy environment was fostered. Text excerpts from both episodes will be employed to illustrate the creation of a collaborative therapy context.

In Episode #1, the therapist's acceptance of Jill's experience, the employment of her language forms and the co-development of the therapy venture aided in the provision of a cooperative and collaborative forum for intrapersonal and interpersonal change. In particular, the therapist's genuine interest in Jill's experiential response to Sam's calm upon removing alcohol from the room contributed to a collaborative therapy atmosphere. That is, in response to the therapist's question concerning her experience of Sam's new found calm, Jill initially believed she felt calm and relaxed just as Sam did when alcohol had been removed from the room. The following text analysis excerpt illustrates Jill's response.
Text: Lines 436-442.

J: Um - I feel ((Sam sniffs and turns toward Jill )) um normal really I'm just ((rapid rolling gestures towards self)) taking it in the calm =

Th: Okay

J: =I guess ((holds hands open)) I feel calm

Expansion.

J: I'm not sure how I feel therapist, I notice Sam is looking at me waiting for me to say how I feel and I guess I am simply normal, not feeling much of anything, I'm just observing how Sam feels calm and not reflecting on how I feel just taking in Sam's experience of calm. [Th: What you are saying is you feel normal Jill and that's good to know so you are answering the question from your own experience which is what I hope you will do in therapy. I accept whatever emotional or bodily felt experience you choose to disclose.] It is risky for me to tell you how I feel because this makes me vulnerable and being vulnerable around Sam is not always safe. It is safer to take his cue as to how he may like me to feel because I'm less likely to raise Sam's ire if his anxiety and defensiveness remain low. When Sam feels like he is in control he is less threatened so I know for certain that Sam feels calm so I'll say I'm calm too. Yes, I'm calm like Sam.

50. Interaction.

In this utterance Jill reveals her unfamiliarity with disclosing her feelings and the riskiness of this behaviour. Jill normally remains focussed on Sam's state to guard against upsetting him. She sometimes suspends her own feelings to stave off abandonment. The prevention of abandonment and hurt requires Jill study and learn as much as possible about Sam's emotional condition. This pattern first asserted itself in Jill's family of origin when Jill was silenced as a child (Appendix T, Session #5). The therapist's insistence that Jill reflect upon and disclose her experience is risky, unfamiliar territory. However, the therapist's encouraging words and total acceptance of what Jill has to say about her emotions and bodily sensations creates a margin of safety for Jill to notice her own state and discover that it is different from Sam's condition. This margin of safety is created by the therapist's validating words and presence.

In this utterance, Jill observed a sense of calm that paralleled Sam's experience of relaxation.

The therapist's reply to Jill's observation of calm employed Jill's language forms. The therapist noted that Jill felt "normal" (Line 436) and "calm" (Line 438) and utilized her specific use of language to develop the therapy story. Thus, the therapist accepted, entered and intensified Jill's
experience making it possible for her to focus on herself. In the following text excerpt, the therapist responded to Jill's observation of personal relaxation by adopting her exact terminology.

**Text: Lines 443-447.**

\[ J: \text{=} I\text{ guess (}holds\ hands\ open\text{)} \ I\text{ feel calm} \]
\[ Th: \text{Yeah (}hands\ motion\ downward\ patting\text{)} \ so\ you\ feel\ some\ calm\ too\ andah\ sort\ of\ sort\ of\ your\ normal\ feeling\ and\ when\ you\ feel\ calm=} \]
\[ J: \text{Yeah} \]

**Expansion.**

Yes, I understand that you feel somewhat calm like Sam and a bit like your normal self, not really feeling much of anything right now [J: Yes, that's what I said but now that you say that I feel calm back to me, I'm beginning to doubt that I really feel that way]. Jill, when you feel calm I wonder what that is like for you right now?

**51. Interaction.**

The therapist communicates to Jill that her experience is important and that the therapist will accept whatever she says about her own experience. The therapist tells Jill what she heard her say using her terminology therein prompting Jill to doubt the validity of her assertion of calm. The therapist’s acceptance and validation opens a margin of safety for Jill to both access and express her state in the moment. In addition, the therapist’s acceptance of Jill aids her in understanding what is being required of her in therapy. That is, Jill learns that her experience is of importance, valid and can be disclosed in the here-and-now.

The therapist’s acceptance of Jill’s experience contributed to a deepening of her affective state such that she began to identify a dramatically different intrapersonal state from the one she first reported. The following text analysis excerpt highlights Jill’s growing sense of safety and familiarity with focussing on and expressing her thoughts and feelings. In addition, the text excerpt illumines Jill’s role in the co-development of the therapy story. She initiates a shift in therapy focus away from her experience of a sense of calm towards the recognition of an underlying apprehension in the following text example.

J: Actually I say I ((wriggles fingers)) I feel calm I'm pickin' at my fingers I'm not ((laughing, looking at Sam)) really as calm - as I think I am -

Expansion.

I'm interrupting you therapist to say that I understand you are interested in my experience right now and I realize that although I say I'm calm, this is not the case because I'm picking at my fingers which tells me I'm not calm. I'm looking at Sam right now and laughing a bit nervously because I'm not sure how he is going to react to my saying I'm not calm. Also, I am telling you Sam that I am not in a calm state which makes me more vulnerable than when I was simply learning about you. I have been thinking that I should be calm like Sam but I'm not calm at all. When I feel encouraged and safer I am able to notice my emotional and bodily states.

52. Interaction.

As requested by the clinician, Jill reveals her awareness of her present experience. Jill corrects her own assertion saying rather than feeling calm, she is nervous. She notes both the risk of this admission and the irony inherent in the contrast between what she actually feels and what she thinks she should feel. Jill also checks with Sam to see how he will react to her differential emotional and physical status. Jill feels a modicum of safety inclining her to focus on her own experience. Jill's candid admission indicates that she believed she should feel calm like Sam but she does not. Jill tells Sam that she feels different from him while checking on the relative safety of this departure from her usual behaviour.

Hitherto, Jill was inclined to modify her experience and opinion to aid in the reduction of Sam's anxiety. Previously, Jill remained largely in agreement with Sam to stave off the possibility of punitive consequences based on differences of opinion. However, the therapist's enquiry into and acceptance of Jill's unique experience offered her the opportunity to report sensations which differed from those forwarded by Sam. The therapist's acceptance of Jill's experience was highlighted in her reply to Jill as illustrated in the following text analysis excerpt.

Text: Lines 452-460.

Th: (.hh)So there's - s' part of you ((smiles, holds left hand to shade forehead, Sam uncrosses leg)) part of you that ah takes another perspective
That says "hey just wait a minute =

J:

Yeah

Th: = ((wriggles fingers, joking tone of voice)) notice what I'm doing with my fingers here"

Expansion.

That's interesting, there is a part of you Jill that has a different viewpoint. [J: Yes that is correct]. This part wants you to slow down a bit and not assume you are calm when you are actually picking the skin off your fingers. This part wants you to notice you are picking at your fingers, that you are not relaxed and in fact you are quite anxious right now. I share the wry humour with which you approach the fact that you have been saying you are calm while anxiously picking the skin off your fingers.

53. Interaction.

In this utterance, the therapist observes the two aspects of Jill, the calm aspect and the aspect that is anxious now that Sam is relaxed when alcohol is out of the room. The therapist validates both these aspects giving credence to both as important in Jill's experience. The therapist also reflects Jill's wry laughter concerning the contrast between her actual nervous state and her stated calm condition.

In this utterance, the therapist reflected Jill's growing awareness of apprehension and engaged playfully with her by sharing in her somewhat black humour concerning the contrast between her calm and apprehensive states.

Following the therapist's summary, Jill focussed on her feelings of fear and agitation and engaged Sam in a discussion concerning her anxiety. The therapist's acceptance of Jill's world encouraged her to explore her thoughts and feelings deeply and disclose the full complexity of her experience. In addition, the therapist's incorporation of Jill's language and experience into her reflections and her accepting entry into Jill's world aided Jill's partnership in the collaborative venture. Thus, Jill's role in the co-development of the therapy endeavour was to introduce a new aspect of her experience (i.e., apprehension) and include Sam in her disclosure. The following text excerpt illustrates Jill's elaboration of her experience and her invitation to Sam to note her apprehension.
Text: Lines 461-465.

Th: = ((wriggles fingers, joking tone of voice)) notice what I'm doing with my fingers here"

J: I notice what I did last week I'd picked at my skin? here? ((picks at wrist, points to hand and looks at Sam)) and I-I was all red? ((Sam chuckles and therapist nods head)) so I mean

Expansion.

I picked at my skin last week too, so I was very anxious last week during our first session Sam, do you see how I picked at my skin, see how nervous I was last week and see how nervous I am this week. See, look here Sam, I was all red here on my wrist from picking at my skin because I was so anxious, so I am not as calm as I said I was today and I was very anxious last week too. Do you see how nervous I am Sam? I want you to know that I feel fearful around you Sam and I cannot say this directly but I want you to notice my reddened wrists because I want you to know I am fearful of you and your drinking. I want you to stop drinking but I can't tell you this because I am frightened of you, you tell me not to interfere so I'll show you my irritated skin. [Sam chuckles ironically in acknowledgement of Jill's anxiety and the therapist nods her head to say she understands Jill was very anxious last week and this week too].

54. Interaction.

The therapist's focus on Jill's fingers prompts her to expand further on what her fingers have been doing for the last two sessions. Jill tells Sam that she is quite anxious in therapy to the point where she has picked off the skin on her wrist. It is important to Jill that Sam actually see the damage she has been doing to herself due to her anxiety in the sessions. She points to the places where she picked at herself and indicates her wrist and hand as sites made red with irritation. Jill uses a rising inflection to indicate that she wants Sam to see the damage. The tone of her request that he see her wrist and hand includes the grim humour with which she noted the contrast between feeling anxious rather than calm. Her rising inflections also demonstrate both an attempt to join with Sam who disclosed that he felt anxious when alcohol was in the room and a desire that he understand that his actions are causing her considerable anxiety. Rather than tell Sam directly that his drinking and intimidating behaviour are sources of fear, Jill points to her damaged hands as a meta-communication regarding the effect of Sam's behaviour.

The margin of safety generated by the therapist's interest, encouragement and acceptance of Jill's experience allowed Jill latitude to tap her fear and apprehension. The co-development of the therapy story required the therapist to remain open to Jill's experience so she could explore it fully. Together, Jill
and the therapist discovered that Jill was not only feeling calm and normal but she was also feeling fearful and apprehensive.

Text: Lines 467-468.

Th: So there's some ((rolling right hand)) fear and apprehension for you

Expansion.

Let me interject here Jill, you feel some fear and apprehension right now like Sam did earlier. The fear and apprehension I noted existing in the room earlier continues to be present for you but not for Sam. You feel anxious and afraid in the sessions, so much so, that you pick your fingers, wrist and hand until they are reddened.

55. Interaction.

The therapist empathizes with Jill saying that her finger and wrist picking behaviour indicates that she is fearful and apprehensive. The therapist conveys to Jill that she understands she is saying that she is anxious when she recounts how she picks her fingers until they are red. The reason for Jill's apprehension in both the first and second sessions is related to Sam's potential for intimidation revealed later in Session #4 (Appendix Q, Session #4) and his alcoholic drinking. Also, as revealed earlier in the session, Jill noted feelings of guilt concerning storing alcohol for her own use when Sam was attempting sobriety and this may add to her sense of apprehension.

The therapist empathized with Jill in this utterance observing that her finger and wrist picking behaviour indicated a degree of fear and apprehension on Jill's part. In response, to the therapist's empathic statement, Jill confirmed that she felt frightened and anxious as illustrated in the following text analysis excerpt.

Text: Lines 469-471.

J: Yeah ((nods three times)) there is =

Expansion.

Yes, you have that right therapist, I feel a great deal of fear and apprehension right now. I am afraid to talk about my feelings with Sam because I feel frightened by him and I show him the damage I do to myself by picking myself sore because I want you both to know how anxious I am right now. In addition, talking about myself rather than studying Sam makes me
anxious. Also, I'm afraid Sam will drink again and I'm finding the threat of his continued alcoholic drinking to be anxiety provoking. I also feel anxious because I feel guilty about storing and using alcohol for my own purposes when Sam has been abstaining. However, I am beginning to reach the limits of my ability to continue delving into my fear and the reasons for it since discussing myself or my feelings is both an unfamiliar and sometimes maritally risky behaviour.

56. Interaction.

Jill confirms to the therapist that her skin picking behaviour is a manifestation of her fear and apprehension. Jill does not elaborate further and changes the focus from herself to Sam in her next utterance. This indicates that the reasons for the fear and apprehension are not to be explicitly revealed to the therapist or Sam at this time. However, Jill's emphatic nodding, repetition of phrases and acknowledgement of the therapist's accuracy demonstrate that she feels understood. Jill does not want to continue exploring her fearful emotions and wishes, for the time being, to remain indirect in her communication to Sam regarding his frightening behaviour and alcoholic drinking. Jill also indicates that she does not want to focus on her guilty feelings or her apprehension at this time. Jill has reached the limits of her ability to remain vulnerable and clearly signals to the therapist that she does not wish to move further. She has engaged in new and risky behaviour and has gone as far as is comfortable. Jill does not wish to make her fear of Sam and Sam's drinking any more explicit than to acknowledge that she felt fear and apprehension in the last two therapy sessions.

In this utterance, Jill offered a confirmation of the accuracy of the therapist's reflection regarding her skin-picking behaviour. However, Jill's utterance provided the therapist with an indication that Jill had reached the limits of her comfort with the disclosure of her inner experience. Nevertheless, Jill had ventured further than usual into the expression of her experience marking the beginning of a shift towards increased self-expression and disclosure. The co-development of the therapy venture required a safe context, acceptance and encouragement of unfamiliar experience and respect for client pacing and readiness. The therapist's respectful entry into Jill's world facilitated Jill's self-expression. In addition, the therapist's understanding and acceptance aided Jill's forays into unfamiliar intrapersonal and interpersonal territory expanding the potential for increased intimacy with self and others.

The discourse analysis of Episode #1 and Episode #2 revealed the co-development of the therapy venture to be similar in both episodes. Indeed, in
Episode #2, the therapist entered the clients' experience by adopting similar language, observing client cues and participating in the co-development of therapy. For example, in the following text excerpt drawn from Episode #2, the therapist conveyed to Sam her genuine interest in his experience and its importance to the therapy change process.

Text: Lines 21-30.

Th: =So, ((motioning towards Sam with left hand, tilting hand back and forth)) before we move on I'd just like to slow this right down 'cause it's very important what your saying right now. (.hhh)It's very important what's going on for you right ((pointing to self)) now you spent an hour with the books ((moves chair around towards Sam, gestures with hands then folds them))(.hhh) trying to figure things out, shift things around, ((Sam bites nails)) wondering how maybe you can't make the payments and wondering how your going to manage. That's a whole hour in the early morning with the books =

Expansion.

Sam, you have recounted how you had been working on the books and how Jill reacted to your desire to discuss the finances and I'd like us to go back to the beginning when you said that you had spent an hour with the books. It is very important that we look at what was happening inside you when you were looking at the books for an hour. What you are telling myself and Jill about yourself and your worry with the books is very important to understanding yourself. In the process of intensification it is important to focus on your feelings, thoughts and behaviours Sam and to do this I would like to move slowly and cover all the levels of your experience that you encountered. Sam you have been trying without success to figure out how to balance the books, you've been afraid that you won't be able to make the payments and worse, you have been worried about how the family is going to manage given the financial crisis. Now, that's a whole hour, a long hour of worry and fear while trying to balance the budget. This situation was very worrisome and difficult for you.

3. Interaction.

In this utterance, the therapist asks Sam to slow down so that he can contemplate all the levels of his experience before he moves onto the hurt caused by Jill's remark. The therapist believes that the totality of Sam's experience is important and she reflects back to him his desperate attempts to salvage the budget. The therapist encourages Sam to move more deeply into his sense of worry and futility by incorporating his communication style and empathizing with his feelings. Also, the therapist emphasizes the dire consequences of a lack of funds and underscores the amount of time Sam was devoting to finding a solution to the problem. By intensifying Sam's experience the therapist prompts Sam to express his anxiety by biting his nails and elaborating on the time it took to balance the books.
In this utterance, the therapist moved her chair nearer to Sam signaling her personal valuing of his experience, desire to listen closely to what he had to say and respect for him as a co-developer of the therapy story. The use of "we" and "I" pronouns to describe what was occurring in the therapy room conveyed the therapist’s participant status as co-developer of the therapy venture. The therapist included herself in Sam’s story saying “before we move on” (Line 22) and noted her personal preference to move slowly to ensure that Sam’s experience was fully explored and understood. As well as functioning as a participant by including herself in the therapeutic venture, the therapist acted as guide to the therapy change process. That is, therapy change required the in-depth exploration of Sam’s experience and a rapid account of his dilemma could have prevented the intensification of his experience. Acting as a guide to personal and marital change, the therapist requested that Sam proceed slowly when recounting his experience for the dual purpose of meeting therapy goals and ensuring the therapist’s understanding of his situation.

The text analysis examples drawn from Episode #1 and Episode #2 illustrated the therapist’s entry into the clients’ worlds and the deepening and valuing of their experience. The therapist acted as participant and guide moving into client experience by respectfully accepting the totality of client thought, feeling and behaviour. The therapy was co-developed when the client’s language and all aspects of the client’s world were explored, acknowledged and reflected in the therapeutic milieu. The safety to explore new behaviour in the form of atypical self disclosure was achieved through the gentle, slow and consistent inclusion of all client experience.
Joint Ownership and Shared Responsibility for the Therapeutic Venture

As articulated in the previous section, the discourse analysis of Episode #1 and Episode #2 uncovered the collaborative co-development of the therapy story based upon client and therapist participation and interaction. The provision of a collaborative atmosphere in therapy necessitated the co-development of the therapy venture via the employment of client language, the incorporation of the totality of client experience into therapy, the adoption of a participant-guide therapist stance and the pacing of activities according to client cues.

In this section, the discourse analysis findings pertaining to the second factor important to therapist and client collaboration will be detailed. That is, according to ExST theory the generation of a collaborative therapy environment also involved client and therapist partnership such that "client and therapist share ownership of the therapeutic venture and jointly assume responsibility for the activities (Friesen et al., 1991, p.12). However, the discourse analysis of Episode #1 and Episode #2 revealed that the creation of a collaborative therapy context via the co-development of the therapy story did not necessarily infer joint therapist/client ownership of the therapy process in the form of shared responsibility for therapy activity. That is, the discourse analysis of Episode #1 and Episode #2 uncovered the centrality and importance of the therapist's guiding role in the co-development of the therapy story. For example, the therapist's role in the co-development of the therapy venture was crucial in that her active use of encouragement and acceptance promoted client self-disclosure and client self-disclosure coupled with therapist acceptance, respect and guidance shaped the therapy story.

The centrality of the therapist in the development of the therapy story assigned the clinician proportionately more responsibility for the therapy
process than was assigned the clients. As such, the therapist assumed disproportionate responsibility for the generation of opportunities for intimacy in therapy. The guiding aspect of the participant-guide role characterized by therapist employment of "clinical wisdom while remaining committed to the spirit of cooperation in this deeply human activity" (Friesen et al., 1991, p.13) was discovered to be influential in the generation of intimacy. This section is devoted to the exploration of the therapist’s guiding function informed by her clinical theory, wisdom and experience to aid in the convergence of disparate belief and practice.

The discourse analysis revealed that the therapist’s guiding role required her to cooperatively influence the course of therapy while remaining sensitive and accountable to her clients, co-developing the therapy story by changing her focus when re-directed by clients and offering alternate and new opportunities for novel behaviour. The guide role incorporated two interconnected meta-assumptions including: (a) The assumption of disproportionate therapist expertise, and (b) a client-based permission to act as process guide during therapy.

These meta-assumptions were conveyed to study participants, in part, through TARP promotional literature that described the nature and calibre of the therapy delivered. A pamphlet entitled "The Alcohol Recovery Project" (Appendix U) was available to all TARP clients. The pamphlet noted the innovative treatment protocol, the aim of the project, the quality of the therapists and the selection requirements for client participation in the study. The pamphlet cited ExST as "a new, creative approach to helping couples and individuals with alcohol-related problems" noting the treatment was "developed especially for people struggling with alcohol dependency." The TARP literature stated, under the heading "The Aim", that the project strove to "offer couples
and individuals an opportunity to obtain relief from alcohol problems. . . " In addition, the pamphlet described the TARP clinicians, under the heading "The Therapists", as "carefully chosen and trained" offering a "high quality service...ensured through ongoing clinical supervision." TARP literature contributed to an assumption of clinical expertise by advertising the advent of a new therapy designed to help couples and individuals obtain relief from alcohol problems. In addition, the promotional literature noted that ExST was delivered by competent, trained professionals who were expressly educated to aid people in their struggles with alcohol related problems. Thus, the therapist and clients assumed the therapist had greater expertise than the clients in the field of couple recovery from alcoholism.

The assumption of disproportionate expertise implied therapist responsibility for guiding therapy such that an accepting, safe, respectful, caring and change maximizing therapeutic environment was established and maintained. The assumptions underlying the therapist's role as guide provided her with tacit permission to actively engage her clinical abilities for the purpose of enabling couple change. The discourse analysis of Episode #1 and Episode #2 revealed that the therapist acted upon the assumption of disproportionate expertise by: (a) Maintaining a consistent focus on the present tense during sessions and conducting activities according to client cues, as well as (b) employing her clinical expertise to guide the therapy sessions in an ethical fashion.

Present Tense Focus and Accommodating Client Cues

The therapist's employment of her clinical abilities on behalf of the clients during intense experiential activity occasioned her to maintain a consistent focus on the client's here-and-now experiencing while conducting
the session according to client cues. The following text examples, drawn from Episode #1, illumine the therapist's guiding function with respect to maintaining a here-and-now focus while accommodating client cues. Several text excerpts employed in this section were featured earlier in Chapter 4 but are being explored again to reveal another important level of meaning discovered in the therapy discourse.

The text excerpt provided below begins a significant turn-taking sequence in which Sam moves away from present tense experiencing and the therapist acts to re-establish a here-and-now therapy focus. Sam shifted away from present tense experiencing towards the introduction of a past experience to identify a reason, other than the presence of alcohol, for his tension.

**Text: Lines 219-233.**

S: It feels calm right now and that's where it seemed to have=

Th: Uhuh

S: ((continues to indicate shoulder area)) welled up into th-the apprehension was right through here ((drops hands on lap))=

Th: ((quietly)) Yeah ((nods, gestures [to shoulder]) so-

S: ((gestures to shoulders)) But then I have been injured there too so you know=

Th: Right

S: ((drops hand on lap))=

**Expansion.**

My shoulders and chest feel relaxed and calm right now [Th: Yes, I understand] and it is in the shoulder and chest area that the anxiety was located. The anxiety rose into the shoulder and chest area when alcohol was present. [Th: Yes, I understand what you are telling me, the anxiety welled up into your shoulders and chest when alcohol was present]. I'm interrupting you therapist to make you aware of the fact that the shift from apprehension to calmness in my body may not be a big deal since I have sustained injuries in the shoulder and chest area. Tension and anxiety in this area may result from physical injury as opposed to the presence of alcohol in the room. So, alcohol may not be a problem for me, the problem is the injuries I sustained to the
shoulder and chest area as the result of a car accident. I have not failed to remain calm around alcohol because the tension I experience is due to a car accident. If I had not had the car accident I would be calm around alcohol and it wouldn't be a problem for me. I am the victim of physical injuries not a weak person who is anxious around alcohol. [Th: Right, I understand you are telling me you think the tension is due to a car accident not alcohol and you want to find a reason other than the presence of alcohol for your tension].

25. Interaction.

Sam answers the therapist's question telling her that he feels calm in the shoulder and chest area when alcohol is out of the room. The therapist's question is designed to deepen Sam's experience of the contrast between his bodily state when alcohol is present and when it is not. The contrast between calmness and apprehension is quite stark in Sam's experience and in this utterance he struggles to ward off feelings of failure and incompetence as he reflects upon his experience of the contrast. Sam's solution to the uncomfortable realization that alcohol is a problem for him insofar that it makes him anxious when it is present, is to associate feelings of tension in the shoulders and chest to physical injury. Sam informs Jill and the therapist that he has not failed to be calm around alcohol and control his drinking, rather he is a victim of motor vehicle accident and any tension in the shoulder and chest area is due to his unfortunate accident not his inability to control alcoholic drinking. According to Sam, alcohol is not a problem for him and as a result, he is not, as feared, a failure.

Sam forwarded the idea that the reason for his anxiety was a previous car accident rather than the presence of alcohol. Sam's allusion to the past as an explanation for his shoulder tension had the potential to reduce the intensity of his experience of the contrast between tension and relaxation upon the removal of alcohol from the therapy office. However, the therapist, in her role as process guide, endeavoured to sustain the intensity of Sam's experience by maintaining a present tense focus on the contrast between apprehension and calm upon the removal of alcohol from the room. The following text excerpt illustrates the therapist's focus on Sam's here-and-now experience in therapy.


Th: = (continues shoulder gesture) So right now your experience is that the apprehension(.hh)ah a few minutes ago a few seconds ago changed to calmness =
Expansion.

Sam you have brought a past car accident into your present experience of the bottle being removed from the room to explain why you would be so tense in the shoulder area. However, I would like to focus on your present experience of the contrast between apprehension when alcohol was present and calmness when it was not. This experience happened a few minutes ago. Actually, I wish to correct my timekeeping to emphasize that your past car accident probably had little to do with your experience of apprehension turning into calmness when alcohol was removed from the room. It was actually a few seconds ago when you noted a change in your body from apprehension to calmness which leads me to believe that removing alcohol from the room results in you feeling calmer. Regardless of the other possible origins of your tension Sam, you feel calmer when alcohol is no longer present.


The therapist responds to Sam’s notion that his shoulder and chest tension is due to a car accident rather than alcohol by focussing on the contrast between his bodily states of apprehension and calmness. The therapist’s focus on the present tense deepens Sam’s experience of the contrast and avoids discussion of the effects of his car accident compared to the effect of alcohol on his anxiety levels. By maintaining a present tense focus on the contrast between apprehension and calmness, the therapist emphasizes the beneficial outcome of calmness rather than dwelling on previous anxiety. The therapist endeavours to steer Sam away from the impossible task of proving himself able to resist alcohol towards a path of least resistance. Experiencing calmness due to the removal of alcohol is preferable to an unending battle of wills in which Sam measures his sense of worth against his ability to resist an irresistible temptor. The therapist also avoids a struggle with Sam over where his tension originates by maintaining a here-and-now focus.

As a guide to the therapy process, the therapist maintained a therapy focus on what she deemed to be helpful to Sam in his bid to ameliorate alcoholic drinking. The therapist highlighted Sam’s present tense contrastive experience rather than centering on a past car accident. By underscoring Sam’s here-and-now contrastive experience, the therapist opted not to delve into a comparison between muscle tension caused by a car accident and muscle tension caused by alcoholic drinking behaviour. In his response to the therapist’s contrastive reflection of his experience, Sam agreed with her appraisal of his relaxed state.
Text: Line 239.

S: =Hmhm ((nods)) it settled down sure =

Expansion.

Okay, I will agree with you that the anxiety has settled down. The anxiety is not as intense as it was when alcohol was in the room. However, I will not say I am calmer like I did a minute ago. I will only say that the anxiety has decreased which means I still feel tense due to the car accident. Therefore, the decrease in tension is not necessarily due to the removal of alcohol since some tension still exists in my shoulder and chest area. If I still experience some tension when alcohol has been removed then this means alcohol is not a problem for me. I am therefore not a failure. If I was completely calm after alcohol had left the room then I would be a complete failure. Worthwhile people are not calmer when alcohol is absent, I am still a bit tense therefore I am worthwhile.

27. Interaction.

Sam wants to convey to the therapist and to Jill that he is not a failure and he struggles to create a good opinion of himself. He goes so far as to modify his previous assertion that he feels calmer to a less strong position of being settled down. Sam is eager to attain a sense of competence and worth and insists that the therapist account for this desire in her understanding of his experience. He repeatedly emphasizes his desire to view himself as successful and competent and the therapist incorporates the modifications Sam places on his experience into her utterances.

Sam agreed with the therapist regarding the quality of his relaxed state while modifying the degree to which he was relaxed. That is, Sam's sense of relaxation after the removal of alcohol changed in degree from "calm" (Episode #1, line 219) to "settled down" (Episode #1, line 239) after he began to reflect upon the consequences of reduced tension at the removal of alcohol. If Sam's tension reduced after the removal of alcohol from the room, then he had a problem with alcohol. The idea that he had a problem with alcohol threatened Sam's self esteem prompting him to downplay any reduction of tension associated with the removal of alcohol from the therapy office.
Sam's desire to maintain a sense of self-respect while he grappled with alcoholic drinking provided a cue for the therapist to incorporate the totality of Sam's response into her understanding of his utterance. However, Sam's fears of losing personal worth did not deter the therapist from her focus on the here-and-now intensification of his experience of the removal of alcohol from the therapy room. The therapist continued the intensification process while respectfully incorporating Sam's efforts to maintain his dignity as illustrated in the following text excerpt.

Text: Lines 241-245.

Th: =((hushed voice)) Yeah ((nods and continues drawing left hand across shoulders)) okay settled down a bit(.hh)so that calmness and sort of settling down a bit(.hh)do you have any sense of-of ((drawing right hand across shoulders)) the feeling the sensa-sation of that? What's that like? ((right hand rests on chest))

Expansion.

Yes, I understand what you are saying and I want to continue to focus on your bodily experience as I indicate my shoulder area and speak in a hushed voice. I also wish to acknowledge that you have corrected my statement maintaining that you feel settled down. I would like to mitigate that further saying that you have settled down a bit but you are not completely settled since you removed alcohol from the room. You feel calmness as you previously described it and you feel settled down but not too settled down. I do not wish to engage in too much intense expression lest you become overwhelmed so I'm hesitating and struggling for words. What is the sensation of feeling settled down and calm? What is it like, this feeling of being settled down and calm? I'm not sure if I'm being clear and you understand my question Sam.

28. Interaction.

The therapist continues to focus on Sam's present experience of the absence of alcohol and communicates to him that she has understood his desire to maintain a sense of adequacy by incorporating his modifications into her summary of his experience. By including Sam's experience of feeling settled down and adding a further qualifier (i.e., a bit and sort of) to the phrase, the therapist indicates that she understands and listens. In addition, she tells Sam that she has heard his statement that he feels calmer and this too is
incorporated into the therapy. The therapist is uncertain as to whether her question is clear but her intent is to continue Sam’s focus on his experience. She explores the contrast between apprehension and calmness by deepening Sam’s experience of the calm state achieved when he removed alcohol from the room.

The therapist was aware of Sam’s vulnerability at this juncture and she employed her guide role to include all of his experience while continuing to have faith in his ability to participate in an intensification exercise. The therapist recognized that she was gently requesting an anxious client to slowly move further into a potentially frightening experience. The guide role required the therapist to accommodate Sam’s pacing needs while maintaining a commitment to change through intensification.

The importance of the therapist’s guiding function as it pertained to the maintenance of a here-and-now therapy focus was discovered to be present in both Episode #1 and Episode #2. In Episode #2, attention to present tense experiencing through the incorporation of the totality of client experience enabled a sense of mutual trust to grow between the therapist, Sam and Jill. Sam’s belief that the therapist was a caring resource allowed for increased candor on the part of both Sam and the therapist. The following text excerpts, drawn from Episode #2, explore the therapist’s here-and-now experiential focus and Sam’s increased comfort and acceptance of the therapist’s observations. Several of the excerpts featured below were employed elsewhere in Chapter Four. Once again, a different level of meaning regarding the therapist’s guiding function can be observed in the following utterances making their repetition useful for in-depth exploration of important aspects of the therapist’s role in therapy.

In Episode #2, the therapist remained oriented to the present tense effects of Sam’s behaviour on Jill and the marriage. That is, the therapist remained interested in the distancing effects of Sam’s utterances. The
following text analysis excerpt highlights one of Sam’s withdrawal oriented statements.

Text: Lines 415-425.

S: You see I see the setbacks as stepping stones to the (go) ahead ((looks at therapist)) and that’s the way I try to look =

J:((sniffling))

S: =at it I mean it’s just a matter of you pick yourself =

Th: Yeah

S: =up you get ((shakes head, therapist looks at Jill)) back on track and you take that first step again =

Expansion.

Therapist, I feel guilty that I am punishing Jill when she is obviously very distressed and in need of comforting and the benefit of my doubt. When I feel guilty I attempt to discount Jill’s claim to my sympathy to offset my guilt feelings. As a result, I will again explain to you and Jill how I see setbacks as not worth emotional upset because setbacks are merely the means to future success. Since setbacks are not worth emotional upset, they should not cause Jill to attack me which further supports my claim that I was illegitimately attacked by Jill. Therefore, I should not have to comfort Jill over setbacks that should not upset her. Nor should I be expected to forgive her for a sarcastic remark born of undue upset. Nor should I be expected to comfort Jill when she has become illegitimately upset and attacked me in the process. Thus, it is plain that I am not guilty of being cruelly punitive towards Jill because she should not be upset about the setbacks, she should support her husband not attack him and she should not expect comfort when she has breached our conjugal contract by being vulnerable and not supportive. I have a legitimate right to my indifference and punitive actions and my advice to you Jill is don’t be upset, don’t take setbacks so hard and get on with life like I do. I do not want to feel guilty anymore nor do I want to be convinced that you were not being sarcastic when you made your remark this morning. Jill, I want to punish you in a guilt and remorse free manner and I do not want this course of correction to be altered by excuses and claims of extenuating circumstances. If we can follow this course of action I can successfully avoid feeling guilty, inadequate and worthless. As long as I remain punitive and distant from Jill I will hold these extremely unpleasant sensations at bay. If Jill can accept these terms we can probably continue the relationship without further discussion of the morning incident.

54. Interaction.

In this utterance Sam repeats a pattern in which he attempts to stave off guilt feelings and painful thoughts and feelings by discounting Jill’s experience. He attempts to demonstrate that her claim to upset is false because becoming
upset over setbacks is unnecessary. In addition, Sam hopes to bolster his claim that he has been wronged by claiming Jill breached the conjugal contract. Jill's vulnerability represents a serious challenge to what Sam has believed to be familiar and appropriate behaviour for Jill. In effect, Jill demonstrates that she is unable to fulfill Sam's expectations for her role and duties and abide by the terms laid down in the contract. Sam provides an elaborate proof delineating why he is not guilty of cruelty towards Jill by outlining how she is deserving of punishment based on her illegitimate upset (i.e., setbacks are not cause for upset) and subsequent attack on him. Sam is unwilling to consider Jill's explanation for her remark since believing her version of events requires Sam to encounter feelings of inadequacy, face the manner in which he has been treating Jill and entertain a change in spousal roles. By advising Jill to pull herself together, Sam hopes to bring the interaction to a close such that Jill discontinues her tearful explanation of her words and intentions. Jill is sobbing and extremely vulnerable during Sam's renewed attempt to curb her expression of feelings. At home, Sam's advice-giving may have resulted in a suspension of Jill's attempts to influence matters. However, the therapist persists in making Sam's behaviour explicit in her next turn thereby preventing a return to the status quo.

Sam made an advice-giving utterance about the merits of seeing setbacks as stepping stones after acknowledging that he was exacting revenge by "slamming back at her (Jill)" with angry withdrawal (Episode #2, Line 407). Sam's advice-giving utterance had the potential to reduce the intensity of the effects of his here-and-now behaviour. However, the therapist maintained a steady focus on the present tense import of Sam's advice to Jill by commenting on the in-the-moment function of his behaviour. As process guide, the therapist articulated her observation of the function of Sam's behaviour, maintained an emphasis on a present tense focus and nurtured her intensification agenda as illustrated in the following text excerpt.

Text: Lines 427-429.

Th: =So you don't want to get close to her right now, you wanna [ ]
J: ((sobbing))

Expansion.

Sam, at present, you do not want to comfort Jill or let go of your commitment to viewing her negatively. You would rather continue punishing her despite her appeal to you for understanding. You would rather continue
distancing behaviours such as advice-giving than view Jill as sympathetic and worthy of serious consideration. You would rather view Jill as purposely hurtful than reconsider your rendition of the morning events. You want to maintain the current distance between yourself and Jill despite the cruelty of this pursuit. You want to remain distant and hope that Jill will suspend her quest for understanding enabling you to keep your inadequacy and guilt feelings at bay. You do not want closeness with Jill because it would mean treating her warmly and compassionately, it would mean you would have to share the role of rudder in the relationship and it would mean you would have to believe Jill and face your painful view of self. Also, increased closeness with Jill would mean giving up the unbalanced distribution of decision-making authority in the relationship. Jill would be credited with 50% of the control as evident, in this instance, by your willingness to take her experiences and explanations seriously and your willingness to incorporate Jill’s clarifications into your account of the morning fight. However, Sam you do not want increased intimacy with Jill right now.

55. Interaction.

The therapist intensifies the substance of Sam’s utterance such that it is made clear that he is choosing to remain distant from Jill. The prospect of treating Jill as an equal partner, sharing the responsibility for nurturing the relationship, treating her with compassion, taking her seriously and her thoughts into account and facing his own pain are more than Sam is willing to do at this point. The therapist’s observation serves to continue the intensification of what is occurring between Sam and Jill. Rather than enabling Sam’s hoped for return to the status quo, (i.e., the avoidance of pain and the maintenance of Jill as nurturant rudder) the therapist continues to intensify the interaction. Jill is probably unable, at this point, to continue pursuing her view with Sam and would probably withdraw in anguish at home. Sam’s efforts to control Jill and legitimize his punitive actions could have the effect of intimidating her, draining her of her desire to continue contradicting him. Sam is probably relatively successful in keeping Jill from pursuing her grievances with him at home due to his use of advice giving, withdrawal of caring and threat of physical intimidation (e.g., throwing his dinner at her and employing aggressive play (Appendix Q, Session #4 and #6). There probably comes a point when Jill gives up trying to be heard, understood and cared for by Sam out of fatigue, fear of reprisal and frustration. At this juncture, Jill may experience herself as abandonable, a common theme in her life. In this instance, the therapist continues a here-and-now to intensify Sam’s actions such that their effects on Jill and the marriage continue to be accessible. By making Sam’s attempts to abandon Jill explicit, the therapist endeavours to alter a familiar distance inducing interaction pattern.

The therapist’s ease with Sam and Sam’s trust in the therapist made what could have been a brusque intensification of in-session behaviour in an earlier
session, a candid therapist/client exchange later in therapy. The therapist's guiding role required her to monitor client cues to accommodate the strength of the therapeutic relationship when formulating questions, reflections and observations during therapy. Generally, earlier intensification statements were more tentative while in later sessions, the therapist engaged in less mitigation during her observations and reflections. For example, in session #10, from which Episode #2 was drawn, the therapist felt sufficiently confident regarding the strength of her trusting relationship with Sam to move more quickly when intensifying his in-session behaviour.

The therapist's role as collaborative guide required her to remain open and sensitive to client experience while pursuing a clinically and theoretically grounded therapy agenda to promote relational change. The role of therapy process guide was rooted in the assumption of disproportionate clinical expertise and the provision of permission to act upon that expertise. Hence, as part of the intensification process in both Episode #1 and Episode #2, the therapist consistently maintained a present tense focus on client experiencing. The sensitive conduct of the intensification process allowed for an increase in trust as therapy progressed. The monitoring of client cues, the incorporation of the totality of client experience and an ability to gauge the strength of the therapeutic relationship during the intensification process were found to be important features of the collaborative guide role.

Ethical Therapy Practice

As detailed in the previous section, the significance of the therapist's role in the provision of a collaborative therapy atmosphere was revealed when the clinician consistently maintained a present tense therapy focus and monitored client cues during the intensification process. A second indicator of
the importance of the therapist’s role in the generation of a collaborative and
intimacy enhancing therapy environment was the practitioner’s employment of
ethical therapy practices. In particular, the therapist acted as process guide to
(a) respect client disagreement and change the therapy agenda, and (b) provide
intimacy enhancing opportunities during couple interactions that impeded
intrapersonal and interpersonal well-being. This section outlines how the
resolution of therapist/client differences and therapist involvement in potentially
detrimental couple interactions revealed the ethical import of the therapist guide
role.

Respecting client disagreement and changing the therapy agenda.

The discourse analysis revealed the therapist’s role as process guide to be significant in the generation of a collaborative therapy context capable of contributing to the promotion of couple intimacy. The process guide role required the therapist to consider client disagreement and change the therapy agenda in response to client dissent. Hence, the therapist’s role as process guide (inferred from the assumption of greater clinical expertise) conferred disproportionate responsibility for the therapy process upon the clinician imbuing the therapist’s role with ethical significance. The following section will focus on the therapist’s response to client disagreement with the direction of therapy.

In Episode #2, the therapist forwarded a compromise solution designed to validate both Sam and Jill’s experience by suggesting that Jill was unintentionally sarcastic and Sam needed better timing when attempting to discuss difficult issues with Jill. The therapist asked Jill, "I’m not sure if this is correct Jill that when Sam wants to come and talk to you that he check out with you if it is a good time" (Episode #2, lines 217-220). The compromise
suggested by the therapist required Jill's endorsement before being adopted and was predicated on the notion that Jill needed advance warning before being consulted on important matters. However, Jill took issue with the idea that she was somewhat difficult to approach. In the following text excerpt, Jill replies to the therapist's suggested compromise by asserting that the therapist is mistaken in identifying her and not Sam as difficult to approach.

Text: Lines 222-225.

J: Well, usually with me anytime I'll ((moving fingers, motions towards self, therapist leans forward)) ac::cept any informat-if anything it's Sam ((motions towards Sam)) that you hafta check out whether or not it's a good time =

Expansion.

Therapist, you are asking me if you are correct in assuming that I would want Sam to check with me as to whether I was amenable to discussing important issues with him before he begins the discussion. The idea that there is a right time to approach me about important topics and a wrong time to approach me with important topics is erroneous because I am generally always approachable and interested in discussing important topics with Sam. I am quite willing to engage in any kind of discussion and that is the kind of person I am. On the other hand, Sam is difficult to approach and I often have to be careful about when, where and how I broach important topics with him. I have to check him out to see if he is ready and able to hear what I have to say. So, you see therapist you are wrong because it is not me who is difficult to approach and needs to be consulted before discussing matters, it is Sam who is difficult to approach.

22. Interaction.

Jill responds to the therapist's question regarding her assumption that Jill needs to be consulted prior to the discussion of important topics. Jill informs the therapist that her assumption is erroneous and it is Sam who requires the consultation. Jill describes to the therapist the need to be careful about when, where and how she addresses Sam concerning important topics. Also, Jill is attempting to correct the depiction of herself as sometimes difficult to approach and hard to talk to. She wants the therapist to know that she is approachable and it is Sam who requires prior consultation.

In this utterance, Jill disagreed with the therapist's notion that she was difficult to approach and refused to endorse the compromise solution. Jill maintained
that Sam did not need to ascertain her readiness before consulting her with respect to important topics. Nevertheless, Jill’s assertion that she was easy to approach and never unintentionally sarcastic differed from the therapist’s view making the compromise solution untenable. In her reply to Jill, the therapist pressed the compromise solution agenda indicating an initial difficulty with accepting Jill’s unwillingness to endorse the compromise. The following excerpt illustrates the therapist’s pursuit of a compromise agenda.

Text: Lines 227-240.

Th: =So, he might assume that anytime is a good time and in fact you’d just woken up and already had the children on your mind and =
        |
J:    yeah, yeah, huh
Th: =ah it may not ((rolls arms, shakes head)) have been a perfect time to let you know ah what’s ((touches chest))=
        |
J:    |
Th:    Yeah it probably wasn’t ((scratches head))

Th: =going on so it maybe important for you to check out ((looks from Jill to Sam, back to Jill)) "Hey, Jill I need to talk about something(.hh)could, is this be

Expansion.

Okay Jill, I want to stay focussed on the frame that you were unintentionally sarcastic towards Sam because his timing was off. When you say you are always approachable it makes it appear as if you were intentionally sarcastic. Sam wants to believe you were intentionally sarcastic but I do not believe you were. I believe if Sam had approached you at a better time you would not have been sarcastic. Let me re-cap the evidence that supports my contention. I believe that if Sam consulted with you prior to discussing an important topic with you, you would not be compelled to answer when you were not ready. If you answer when you are not ready you are more likely to say something that misrepresents your true intentions. You are understanding and open to Sam when he approaches you at the right time, not first thing in the morning when the children are on your mind. Sam assumes that you are ready to talk anytime when in fact you are not ready to talk at anytime. [J: Yes, I understand what you are saying therapist, you could be right, the children were on my mind and I had just woken up]. T: For example, this
morning you said that you had just woken up and had the children on your mind making it the wrong time for Sam to discuss the financial pressure he was under. Jill when you have just woken up with the children on your mind this is not the most advantageous time to be approached by Sam to discuss the family's financial problems. [J: Yes therapist I agree that the time Sam approached me this morning probably was not the best time but I didn't say "same old scenario" because Sam chose the "wrong" time to talk to me. I was not being sarcastic when I said "same old scenario" and this idea that Sam picked the "wrong" time to talk to me makes it appear that I was sarcastic towards Sam when I was not and I cannot admit I was being sarcastic when I was not. I cannot adopt the idea that I was being sarcastic towards Sam when I was not being sarcastic.] T: So what I am saying is that Sam should approach you first to see if it is a good time to talk to you about something important otherwise you may be unprepared and say something sarcastic that misrepresents you and fails to communicate your caring for Sam. He should say something like "Jill I'd like to get your attention to find out if this is a good time to talk to you about a problem that is bothering me. Would this be the right time or is there another time that would be better?" If Sam does this Jill, you will not say anything sarcastic, Sam will feel heard and you will not have a big fight and lots of distance in your relationship.

23. Interaction.

In this utterance, the therapist is unable to accept Jill's answer to her question regarding the usefulness of an improvement in Sam's timing such that he checks with Jill before embarking on a discussion of an important topic. Jill maintained that Sam's timing was not an issue since she considered herself to be approachable. The therapist is attempting to convince Jill and Sam that Sam was negligent in not asking her if it was the right time to talk and Jill was remiss for answering Sam in an albeit unintentionally sarcastic manner. The therapist's question to Jill about the correctness of her assumption was not designed to elicit disconfirmation from Jill. The therapist was asking Jill to be in agreement with her as opposed to requesting information. When Jill did not concur with the therapist, the therapist attempted to explain the evidence for her assumption and give an example of how Sam could implement the solution to the problem of Jill's unintentional sarcasm. Although Jill responds during the therapist's utterance with agreement, she remains unconvinced and in her next utterance attempts to explain her comment. Neither Sam nor Jill are convinced by the therapist's framing of the morning fight. Sam believes Jill was intentionally sarcastic and Jill asserts she was not being sarcastic at all. The therapist's bid to validate Sam's hurt feelings resulted in her temporary adoption of the belief that Jill was sarcastic when she was not. Jill is requested to adopt a view that the therapist presents as compromise: Jill was sarcastic but unintentionally so. In this way the therapist attempts to reduce Jill's role in Sam's hurt by shifting some of the burden to Sam for his inappropriate timing. The therapist's compromise is unpalatable to Jill who refuses to admit culpability for something she did not do. The suggested compromise is also unacceptable to Sam who continues to want Jill punished
for, what he believes to be, her intentionally hurtful remark. The therapist attempts to alter Sam's I-win, you-lose frame by suggesting that Sam wins because Jill was sarcastic and Jill wins because Sam compelled her to be sarcastic due to inappropriate timing. However, the issue could not be resolved by shifting the couple's perspective of the fight since Sam's misunderstanding of Jill's comment is at issue. To address the misunderstanding, the therapist will explore the conflict that exists between the couple which includes Sam's misreading of Jill's comment due to a sense of inadequacy. At the same time, the therapist will acknowledge Sam's desire to punish rather than believe Jill.

The therapist's initial difficulty in accepting Jill's disagreement with the compromise solution and her attempt to persuade Jill to adopt the compromise represented a potential departure from the collaborative guide role. The pursuit of a therapy agenda whether it be a compromise solution or an intensification exercise is part of the guiding function found in the ExST therapist's role as indicated by the discourse analysis of Episode #1 and Episode #2. However, the manner in which the agenda was pursued appeared to be important to the provision and maintenance of a collaborative atmosphere. The discourse analysis revealed therapist respect for client feedback decreased the potential for coercive therapy practice and according to ExST theory, "coercive behaviour on the part of the therapist is antithetical to collaboration" (Friesen et al., 1989, p.73.). When a therapy agenda is pursued sensitively and respectfully, therapy is more readily collaborative.

For example, in Episode #2, the therapist relinquished her attempted solution at Jill's insistence. In the text excerpt featured below, Jill interrupted the therapist's example of how to implement the compromise solution explaining that her morning comment was due to disappointment with the financial difficulties not an example of unintentional sarcasm towards Sam. The following text analysis excerpts explore Jill's explanation for her remark, and the therapist's realization that the compromise solution was inadequate. Also, as uncovered in the following text excerpts, the therapist began to
understand that Sam was mistaken in his belief that his business performance was being critically assessed by Jill.

**Text: Lines 242-254.**

*Th:* =going on so it maybe important for you to check out ((looks from Jill to Sam, back to Jill)) "Hey, Jill I need to talk about something(h.h)could, is this be

*J:* Even the words I said it wasn't ((rubs neck)) intended as a-a crack as you say, it was it was my disappointment in the way things have been going it was and it's not=

*Th:*

*O:o* ((tips head backwards))

*J:* =((moves flat left hand in patting motion)) my disappointment of you,=

*S:

*It's the same thing

*J:* =it's my disappoint-no it's not! ((puts hand back on lap))

**Expansion.**

I am interrupting you therapist because you are not understanding what I was saying when I made that remark. You, like Sam, are saying it was sarcastic and it was not. Therapist you are saying that I was unintentionally sarcastic but Sam has misunderstood my words, my words were not sarcastic. I really want you both to understand what I am saying because I am being misunderstood. I did not make a crack as you call it Sam, because I did not mean to make a crack, I was trying to convey my own disappointment with how the financial deals have been failing lately. By saying "same old scenario" I was saying "it's the same thing every month, we lose prospective business and we don't know if the deals will come through it's a disappointing fact to me that these deals are so unpredictable". [Th: Oh, I get what you meant Jill, you weren't sarcastic at all you were commiserating with Sam, you weren't angry with him or disappointed with him you were disappointed with the uncontrollable and unpredictable nature of the business. I didn't understand that you were not being sarcastic but were disappointed. Also, I didn't see that Sam was projecting his belief about his inadequacy on to you when he felt rejected by your remark. I thought the problem was that you had the financial problems sprung on you when you were unprepared to deal with them. You actually were trying to join with Sam when he came to you and told you he hoped Broughton worked out because if it didn't money would be tight at the end of the month. I completely missed your intent Jill and now I see what you meant when you said "same old scenario"]. *J:* My comment was not motivated by any disappointment at your performance Sam, I don't blame you
for business vissitudes you cannot control, I am disappointed when the business deals fall through just as you are Sam. I am not disappointed with you Sam it is the business let downs that disappoint me. [S: Jill it amounts to the same thing because I run the business and any business failures are my fault so if you are disappointed about the business then you are certainly disappointed with my performance.] J: It is my disappointment with the business that I am talking about. Hold on a second Sam, no it is not the same thing, I do not hold you responsible for business deals that may or may not be successful. When I am disappointed that a business deal did not go through I am not commenting on your business performance. I am simply disappointed that we didn't get the deal that's all.

24. Interaction.

Jill is struggling to explain her comment. After the therapist introduces her solution, Jill argues more strenuously for her experience of events. Being unprepared to agree that she was sarcastic, Jill once again asserts that she was disappointed not sarcastic and adds an important understanding to her statements. Jill concludes that Sam believes that disappointment with business let downs, is disappointment with him personally. Jill strives to make a distinction between disappointment with business setbacks and disappointment with Sam in her attempt to be understood by both Sam and the therapist. It appears that witnessing Sam's previous disclosure concerning not being in top performance shape and the therapist's summary of Sam's feelings of inadequacy offered Jill insight into why Sam would understand her disappointment to be sarcasm. The combination of Jill's perseverance in attempting to be understood, her understanding of Sam's experience, her own experience of disappointment and the refusal to admit to being cruel when she was not compels the therapist to abandon the compromise to which she was attached. Sam disbelieves Jill and equates disappointment with the business with disappointment with him. Sam's disbelief is based on a genuine experience of equating poor business performance with personal inadequacy and worthlessness. As a result, Sam believes Jill's disappointment with business setbacks is indicative of her disappointment with him. Sam was very disappointed with his business performance and before he approached Jill, he probably denigrated himself while balancing the books. Jill's disappointment confirmed his worst fears; he was inadequate. As a result, Sam continues to be unable to separate Jill's disappointment with the business from disappointment with him and he maintains his desire to punish Jill. Due to his inability to separate poor business performance from personal inadequacy, Sam requires that Jill be punished so that he can rid himself of feelings of worthlessness and inadequacy. The therapist continues to be left with a dilemma marked by the strength of Sam's feelings of hurt and betrayal which appear based on a misinterpretation of Jill's words and a difficulty believing Jill's explanation for her remark. The therapist's compromise was an attempt to validate Sam's feelings. However, the compromise failed to account for Jill's experience of not trying to hurt or betray Sam. Without Jill's cooperation in adopting the compromise, Sam cannot be persuaded to adopt it as well. The
therapist observes the genuine hurt Sam feels but must now include the notion that Sam is hurt due to a misunderstanding of Jill's words and his reluctance to give her the benefit of the doubt.

The therapist's increased understanding of the complexity of the dilemma faced by Sam and Jill was revealed in the previous analysis when the therapist tipped her head back and said "O:o" (Episode #2, Line 246) signaling a new realization. Having understood and considered Jill's exception to the compromise solution, the therapist was faced with an important choice. The choice presented to the therapist was to continue persuading or cajoling Jill to adopt the compromise or account for Jill's experience by changing her agenda. The choice facing the therapist demonstrated her proportionately greater influence and responsibility in the therapeutic relationship. Whether to continue persuading a dissenting client to adopt the therapist's agenda or change the agenda to better address the client's concerns was an important ethical choice open to the therapist. The decision to accept or reject client disagreements with the therapy direction was made by the therapist in her guide role infusing it with social and moral responsibility. When the therapist chose to consider Jill's dissenting voice and change her agenda she demonstrated an ethical and clinically responsible use of the process guide role.

The therapist elected to relinquish her compromise agenda due to Jill's insistence and the realization that the solution forwarded was limited in its utility. Since neither client endorsed the compromise it was unhelpful in decreasing couple distance or increasing spousal intimacy. The therapist's decision to abandon the compromise solution as ineffectual left the therapy agenda momentarily in question. The discourse analysis of Episode #2 revealed the therapist's struggle to identify how to proceed once the compromise solution was abandoned. The following text analysis excerpt illumines the therapist's quandary.
Text: Line 256.

Th: For him it is the same thing ((points to Sam)).

Expansion.

Jill, even though you say you separate your disappointment with the business from disappointment with Sam, Sam does not do that. Sam views your disappointment with the business to be your disappointment with him. Sam’s hurt is genuine and while based on a misreading of your words and intentions, he is earnest in his pain. This leaves me with a dilemma because as marital therapist I believe I am supposed to validate both client’s feelings and not take sides. Jill your comment several turns ago indicating that you were unprepared for Sam to approach you because you had just awoken, provided me with the idea that Sam had ill-timed the conversation and an improvement in his timing would preclude his being met with unintentionally sarcastic comments from you. However, over the course of the re-enactment you have come to identify two important factors about your own feelings and experience of the fight. First, you feel disappointed with the business let downs and your comment was not a result of being unprepared to discuss the family’s financial position in the early morning. Second, although you were disappointed with the unpredictable nature of the business, you were not disappointed with Sam. Jill, you have clarified two important points but I am still unsure as to how to deal with Sam’s hurt and incorporate the information that has come to light.

25. Interaction.

Jill has become much clearer as to the feelings and purposes of her remark and has communicated her new awareness to the therapist. Previously, the therapist believed the conflict could be resolved if Sam’s timing improved providing Jill with a better opportunity to respond in a supportive manner. The therapist’s favoured hypothesis led her to suggest a pre-mature solution to the couple’s conflict. The compromise solution was unacceptable and in this utterance, the therapist struggles to generate an alternate therapy agenda. The therapist’s comment to Jill about the earnestness of Sam’s sense of betrayal indicates her struggle with the loss of the compromise solution for the couple. The therapist’s struggle is short lived since she asks if Jill can speak directly to Sam about his misunderstanding in the next turn. Thus, the therapist encourages the continuation of the re-enactment as it begins to cover new territory including Jill’s experience of being misunderstood by Sam. A discussion concerning the misunderstanding would probably have been impossible at home because Sam left the room angrily before Jill had an opportunity to explain herself. In addition, Sam’s hurt and desire to punish Jill precluded him from either listening to Jill’s explanations or believing them. However, the therapist’s revised therapy agenda highlighted a discussion of the couple’s misunderstanding interrupting Sam’s withdrawal and Jill’s retreat response offering the couple an opportunity to explore their difficulties more completely.

In this utterance, the therapist grappled with how best to proceed in guiding the clients toward enhanced intimacy once the compromise solution was no
longer viable. However, when the therapist adopted a new agenda, as revealed by the following discourse analysis excerpt from Episode #2, the therapy began to address Jill’s sense of being misunderstood and Sam’s difficulty believing Jill.

Text: 258-270.

J: =Well, to me it’s not, it’s my disappointment of the way the =
[                         ]
Th: To you its not ((motions to Jill))

J: =business is it’s my - - my um ability of not being able to
[                         ]
Th: Yeah ((moves from sitting on floor beside Sam’s chair to sitting on floor beside Jill’s chair))
J: han:dle=

Th: =Can you say this to Sam.
J: =er my w:ay of not being able to han:dle - the um - ((therapist glances over shoulder)) the disappointment.

Expansion.

Well therapist, it may be that Sam thinks that when I am disappointed with the business I am disappointed with him but that is not how I see or experience my disappointment. I am disappointed with how the business is going not with Sam. [Th: Jill to you your disappointment with the business is not disappointment with Sam even though that is the way Sam sees it]. I am struggling to explain my remarks because I was confused earlier when Sam accused me of intentionally hurting him. I knew I did not intentionally try to hurt him and previously I had thought my words came out quickly because I had just woken up. But I realize now that I was also feeling really disappointed when Sam told me about the financial problems. [Th: Yes, I understand what you mean now Jill and I want to encourage you to continue clarifying your remark and the accompanying feelings]. In effect, my remark was my disappointed reaction to the business problems and it came out in a short quick sentence because I do not handle the disappointment well. I was having a hard time with the bad news not with Sam's performance.

Th: Jill would you tell Sam about how hard it is to handle the disappointment you feel when the business suffers setbacks. Sam does not understand what you were trying to say to him this morning and it is best if you address him directly with your explanation for your comment, "Same old scenario". Sam does not understand that you were not attacking him when you made your comment. He does not understand that you were feeling upset and disappointed with the setbacks when you made the comment.

J: Oh, okay I should say this to Sam. Sam my remark, "Same old scenario", was an indication of how upset I was over the business let downs
and it demonstrated how difficult it is for me to handle the disappointment. I am not very good at weathering the business uncertainty and the unpredictable money situation. It upsets me quite a bit.


In this series of interjections and turns Jill continues to clarify the difference between the way she views her comment and the way Sam views her comment. Jill points out to the therapist that because Sam sees her comment his way and is hurt by it does not mean her experience of her remark is any less valid. Jill insists that her feelings and experiences be taken into account in the discussion about her remark. The therapist responds to Jill's insistence that her experience be understood by attending closely to Jill. The therapist sits on the floor next to Jill's chair and encourages her to speak to Sam. The therapist encourages Jill to tell Sam directly that her intent was not to attack him. The therapist requests that Jill inform Sam as to the meaning of her comment which Jill cites to be a shorthand way of conveying her disappointment with the business setbacks. The therapist facilitates couple interaction in this utterance putting an emphasis on the direct communication of affect between spouses. Jill conveys to the therapist and Sam that the bad news is upsetting and disappointing to both herself and Sam. Jill notes that her remark was an indication of how hard it is for her to handle the financial setbacks inherent in the business. The therapist changes her approach in the session from promoting a compromise solution to facilitating the clarification of Jill's remark. The therapist utilizes ongoing couple interaction to stress the effects of Sam's disbelief and desire to punish Jill on the couple's potential for intimacy.

In the excerpt featured above, the therapist suggested Jill address Sam regarding his misunderstanding of her comment, "same old scenario." The therapist shifted the therapy focus away from the compromise agenda marking the beginning of an exploration of Sam's misunderstanding of Jill in the latter part of the episode. Thus, the therapist explored Sam's difficulty with believing Jill and his desire to punish her as well as the effects this dynamic had on Jill and the marriage. It is possible that if the therapist had not relinquished her compromise agenda in favour of a new focus at client insistence, the session activity may not have prompted novel couple interaction.

By incorporating client dissent and altering the therapy direction, the therapist acted as an influential guide in addressing the reduction of intimacy in Sam and Jill's relationship. Sam and Jill's feelings were difficult for them to access and express leading them to communicate via shorthand speech
patterns. The shorthand communications were incomplete and as a result more likely to be misinterpreted and misunderstood. Once a misunderstanding occurred it was exacerbated by punitive withdrawal and protective retreat responses making clarification of the misinterpretation difficult. Through the ethical employment of the guide role, the therapist aided in the generation of increased marital intimacy by encouraging the direct expression of affect, the clarification of spousal misunderstanding and the recognition of the effects of punitive withdrawal on intimacy in the relationship.

**Introducing intimacy enhancing spousal interaction.**

As therapy guide, the therapist employed her participant observations to further a rendition of therapy events that promoted couple intimacy rather than alienation. The therapist’s disproportionate responsibility for the therapy process infused her guide role with moral import disposing her to respond in a proactive manner when observing spousal interactions that could hamper intrapersonal well-being and interpersonal mutuality.

The discourse analysis of Episode #1 and Episode #2, revealed the therapist’s active involvement in spousal interactions that impeded psychological and marital robustness. For example, in Episode #1, the therapist sought to include Jill in decision-making regarding the whereabouts of alcohol in the home. However, Sam believed family decision-making was chiefly in the husband’s domain (Appendix P, Session #8) and, based partly on this belief, he strove to prevent Jill from exercising decision-making authority over the location of alcohol. The therapist, noting the asymmetrical allocation of decision-making authority in the marriage, began to explore the clients’ decision-making roles in Episode #1. In the following text analysis excerpt, Sam highlights how he prevented Jill from making decisions about alcohol.
Expanding on the last session, I've always blocked Jill out of my decision making with respect to alcohol. I have always blocked Jill out of my decision making with respect to alcohol as I said in the last session. I emphasize the words blocked and out because I have decided that she should not be involved in any way with my decision to quit drinking. It is important to me that Jill remain outside of that decision since to allow her to influence me would indicate that I was not functioning well in my role as head-of-the-household (Appendix P, Session #8). As the patriarch in the family, it would be a sign of weakness if I was to be swayed by Jill's desires that I quit drinking. Also, when Jill makes these desires known by crying I feel like a guilty failure because in my role as decision-maker I have failed to make the decision to quit drinking. As a result, I purposely keep Jill out of this and other decisions to reduce my feelings of failure and inadequacy. Now, I mentioned all this the last time we were together in a session and I am quickly reiterating it because I recognize that you wish to move onto a new topic by getting that plastic bottle that I pointed to earlier. However, I want you, therapist and Jill, to know that I make decisions about whether that bottle stays or goes.

10. Interaction.

In this utterance, Sam reiterates his position stating he is in charge of decision-making not Jill. Sam is also communicating to Jill that her previous foray into decision-making represented by her desire to throw the alcohol away was unwelcome. In this utterance, Sam does not agree completely with the therapist's frame that Jill is a decision-making partner hoping to keep his position as main decision-maker relative to Jill unassailable. The reasons for Sam's insistence on not sharing authority with respect to alcoholic drinking and general decision making appears to be twofold. Firstly, Sam's religious upbringing taught him to view women as nurturers of men not decision-makers (Appendix P, Session #8). Secondly, Sam's sense of worth and identity rests, in part, on being a competent head of household and a competent manager when it comes to alcoholic drinking. Sam's alcoholic drinking has called this management position into question since alcoholic drinking is not considered a competent activity from a financial and personal view point (e.g., Sam's abusive and alcoholic father was banished from the family home when Sam was young. His father died alone of alcoholism).

Sam's efforts to block Jill out of decision-making regarding alcoholic drinking
represented an attempt to maintain a sense of self-respect despite being unable to remain sober. Sam’s prevention of Jill’s input also reflected his beliefs concerning appropriate male/female roles in marriage. In addition, when Sam prohibited Jill from participating in decision-making concerning alcohol, he relied upon a familiar childhood strategy of overcoming difficulties by struggling alone. Sam’s desire to grapple with painful issues alone and avoid joint partnership with Jill contributed to couple distance. The therapist recognized the importance of collaboration and joint partnership in the amelioration of alcoholic drinking, in family decision-making and couple intimacy. As a result, she highlighted aspects of the couple’s decision-making process that contributed to spousal parity as illustrated in the text excerpt featured below.


Th: =It’s very - very significant that um - you ah - want a challenge ((leaves hand on bottle)) and - ah that ((removes hand from bottle)) you’ve been in agreement that he ((both hands palms facing move towards Sam pointing)) should be-make decisions. You’ve blocked ((right hand glides toward Jill)) her out(.hh) she’s decided it’s your responsibility so together, ((both hands held up palms facing fingers bent, a shake for emphasis)) collaboratively ((hands held together)) you’ve agreed that he’s to make these decisions ((folds hands))

Expansion.

I consider it important that you like the challenge of trying to resist alcohol because I’m going to give you that opportunity soon using this plastic bottle. Also, despite your assertion Sam that you are the sole decision-maker, you both, Jill and Sam, have been in agreement that Sam should make decisions concerning the presence of alcohol in the home. I emphasize your name Sam because I want to make it clear to you that I have heard your concern that I understand that you are the decision-maker. I am listening to you Sam and I have heard what you have said today and last session about being the sole decision-maker. Sam, I recognize that you are the sole decision-maker because you have actively prevented Jill from sharing this position. However, I also know Jill has decided it is your responsibility to deal with alcohol when she refrained from throwing alcohol away without consulting you. So, you both have agreed together and cooperatively that Sam and only Sam is to make decisions with respect to whether alcohol stays of leaves your home.
11. Interaction.

The therapist notes Sam's fears that his position as head decision-maker is not secure and communicates to both Sam and Jill that she understands he is sole decision-maker. However, she also reiterates her contention that by not throwing the alcohol away without consulting Sam, Jill has been a partner in the decision to let Sam decide whether alcohol should be in the house. The therapist continues to stay with the frame that the couple are joint decision-makers despite Sam's previous insistence that they are not. Nevertheless, the therapist validates Sam's contention that he is sole decision-maker regarding alcoholic drinking. The therapist both agrees and disagrees with Sam recognizing he is sole decision-maker while disputing how that came to be. The therapist asserts to both Jill and Sam that Sam was unsuccessful in blocking Jill out since she chose to refrain from intervening after careful consideration of the ramifications of taking matters into her own hands without including Sam. Through the combination of Jill, Sam and the therapist's viewpoints, a frame of joint spousal decision-making is tentatively forwarded.

In this utterance, the therapist observed that, if they chose, both Sam and Jill could alter or maintain the location of alcohol in the home without consultation. However, in supporting joint partnership, a consultative process was emphasized in which Jill refrained from removing alcohol from the home to respect Sam's wishes. Jill's decision not to throw alcohol away was based on a cooperative principle that precluded independent decision-making concerning matters of couple or family importance.

The therapist's focus on collaboration in the distribution of decision-making authority implicitly called the legitimacy of Sam's belief regarding his decision-making predominance into question. That is, if Jill decided to allow Sam more decision-making influence, then he was not the sole or main decision-maker in the relationship. The introduction of the notion that Jill decided to allow Sam differential decision-making status opened the way for Jill's continued input in important decisions, called her status as "49% decision-making authority" into question, encouraged a sense of increased agency and influence in Jill, and increased the possibility of joint partnership in the marriage. For example, in Episode #1, Jill realized she had jurisdiction over
the location of alcohol because she sometimes kept it handy for her own use when baking (Episode #1, Lines 376-383). Hitherto, Jill understood alcohol in the home to be solely Sam's domain. However, during the intensification of her response to Sam's new found calm at the removal of alcohol from the room, Jill realized that both she and Sam had jurisdiction regarding the whereabouts of alcohol in the home. This awareness contributed to her suggestion, at the end of the episode, that the couple remove alcohol from the home together. While Jill could legitimately discontinue using alcohol for baking and remove it from the shelf without consulting Sam, the principle of joint decision-making precluded unilateral action on important issues. The therapist employed the guide role to influence the allocation of decision-making authority by highlighting joint partnership in the marriage. Joint spousal partnership had the potential to enhance marital intimacy such that spouses included each other in important decisions and were not alone when coping with difficult issues.

In addition, the therapist's guiding role, imbued with moral significance, prompted a pro-active therapist response to potentially harmful spousal interactions in Episode #2. In Episode #2, the therapist intensified the effects of Sam's punitive behaviours on Jill and the couple's relationship as well as encouraging Jill to express her feelings rather than suspend them or retreat. Thus, the therapist's ethical predisposition to respond to detrimental spousal interactions and encourage the expression of previously undervalued client experience was highlighted. The following text excerpts illustrate the therapist's employment of the guide role to conduct ethically responsible therapy. The excerpts featured below were explored elsewhere in Chapter Four but are re-examined in this section to reveal the significance of the therapist's guide role in the facilitation of intimacy enhancing spousal
interactions. The therapist, acting as process guide, underscored the effects of Sam's behaviour on Jill and highlighted the importance of her pained experience to pinpoint the ramifications of punitive withdrawal on Jill and the relationship. In the following text excerpt, the therapist intensified Jill's pained experience, valued her viewpoint and brought it forward as relevant, serious and worthy of Sam's attention.


Th: =So you're feeling abandoned right now - you're feeling alone with your tears (Sam moves fingers) Sam is saying it doesn't =

J: ((sniff, wiping eyes and nose))

Th: =affect him, you feel

Expansion.

Jill you are feeling abandoned by Sam at this moment because he is saying that how you feel does not have any bearing on him or his behaviour. Sam is saying your feelings do not matter and as a result you feel alienated and alone with your tears of hurt and sadness. Sam is telling you that how you feel has no impact or influence on him and makes no difference to him. As a result you feel isolated and cut-off.

50. Interaction.

The therapist empathizes with Jill in her current situation. In addition, the therapist intensifies the effects of Sam's indifference on Jill. The therapist notes that Jill feels abandoned, isolated and alone when Sam responds to her in a rigid, uncaring and controlling manner. Sam's sense of inadequacy and a fear of Jill's vulnerability combine with his desire for control and his rigid beliefs about men's and women's roles to create distance between the couple. Sam's expectations of Jill are considerable in that while being accorded 49% of the decision-making authority in the marriage compared to Sam's 51% share of authority (Appendix P, session #8), Jill is expected to be the rudder and strength in the relationship. In addition, as relationship rudder, Jill bears responsibility for the stability of the relationship requiring her to be unerringly supportive of Sam and capable of withstanding withdrawal. Sam asserts that he is justified in being unaffected by Jill's tears because she has let him down in her role as relationship rudder. Jill's deviation from her invincible role and Sam's resulting experience of inadequacy have culminated in a sense of injustice and a desire for retribution.

In this utterance, the therapist brought Jill's experience of Sam's punitive withdrawal to the fore by placing an emphasis on her pain in therapy. The
therapist communicated to Sam that Jill's hurt was related to his withdrawal and in so doing prevented Sam from dismissing Jill's experience. When the therapist valued Jill's experience it became noteworthy and difficult to discount. By intensifying Jill's experience, the therapist accentuated the importance of her thoughts and feelings to the well-being of the relationship. Also, the therapist implicitly signaled to Sam that for marital satisfaction to occur, it would be advisable to value Jill's expression of hurt and her efforts to disclose her vulnerability. In addition, highlighting Jill's experience in therapy offered her freedom to express herself without muting her voice or being dismissed. Jill's tearful expression of her experience was an unfamiliar and atypical behavior. Jill generally avoided disclosing the depth of her emotional experience for protective purposes.

While the therapist employed the guide role to value undervalued client experience, she also intensified the effects of Sam's punitive withdrawal on Jill and the relationship. Thus, the therapist facilitated spousal well-being by ameliorating harmful interactions involving the punitive withdrawal of care and attention and the dismissal of spousal feedback and self disclosure. The therapist utilized her position as process guide to underscore the effects of Sam's withdrawal highlighting the ramifications distance had on Jill and the potential for intimacy in the marriage. The following text excerpt illustrates the therapist's intensification of Jill's affect and her observation that when Sam punitively withdraws from Jill, she is compelled to retreat to protect herself.


Th: =You don't - yeah so I understand Jill how sometimes you need to protect ((Jill wipes tears, Sam looking at fingers, moving his fingers)) yourself from getting too close to Sam. Sometimes when you get too close to him you feel really alone, you feel really alone=
**Expansion.**

Sam you say you do not want to get close to Jill when she is upset and you have said that quite clearly even though you do not want to be thought of as cruel. My interest is in how this, not getting close to Jill when she is upset, affects her. I am addressing Jill now because Sam, you have stated clearly that you will not comfort Jill. As a result Jill, I understand why it is you feel the need to protect yourself from Sam by withdrawing from him. When you talk to Sam about your feelings you feel abandoned by him, he dismisses and avoids hearing what you are trying to say. You keep your distance because it hurts to not be heard or acknowledged. During times when you get close and become vulnerable with Sam he dismisses you and you end up feeling very alone and very isolated. The effect of Sam’s desire not to comfort or listen to you is you are left lonely, alone and isolated.

**57. Interaction.**

The therapist focusses on the effects of Sam's distance on Jill when she is upset and intensifies Sam's painful abandonment of Jill. Sam’s difficulty with Jill’s hurt defeats and isolates her. Also, the therapist observes the prevention of abandonment and hurt to be a self-protective reason for distance from Sam.

In this utterance the therapist engaged in the present tense exploration of an intimacy hampering interaction to enhance spousal awareness of the hurtful effects of punitive behaviours and beliefs. Sam’s desire to punitively distance himself from Jill resulted in Jill feeling alone, unsafe and in need of protection. Thus, punitive withdrawal behaviour reduced the potential for spousal intimacy by eliciting self-protective responses.

As well as prizing undervalued client experience and highlighting the effects of punitive withdrawal behaviour on couple intimacy, the therapist employed the guide role to offset potentially detrimental constructions of spousal behaviour. For example, in Episode #2, the therapist utilized her observations of client process to support the perception that Jill’s crying behaviour was an invitation for intimacy rather than an attempt to manipulate Sam. The following text analysis excerpts reveal Sam’s construction of Jill’s behaviour and the therapist’s support for an alternate viewpoint. The text
excerpt featured below uncovers Sam's and the therapist's disparate views regarding Jill's behaviour. The therapist noted Jill was open and honest with her vulnerability while Sam believed she was using her tears to evoke sympathy.

Text: Lines 472-480.

Th: It seems like you're both disappointed and ah she's sharing her vulnerable side which means she's ((motions towards Jill)) taking a big risk to be spontaneous and to be very open and honest with you and right now ((motions towards Sam)) it's it's too scary for you to

S: It's the same thing, I used to get the tears over alcohol ((shaking head)) and I used to do the same thing I would withdraw =

Expansion.

Th: Sam, it appears to me that both you and Jill are disappointed with the business setbacks and even though you say you are not as disturbed as Jill by the setbacks, you are distressed nonetheless. When Jill feels the distress of the setbacks she shares that with you and shows you her vulnerable side. Jill is taking a big risk when she shows you her vulnerable side. She is being spontaneous and not censoring her behaviour and reactions and she is being very transparent, honest and trusting with you. Part of Jill's goal in coming to therapy was to become more open and spontaneous and this is what she is attempting to enact with you now. Unfortunately, Sam you find Jill's openness too frightening to address so you withdraw from Jill in a variety of ways including dismissing her and punishing her with abandonment.

S: I am interrupting you therapist to say that you may think that Jill is being newly spontaneous and open with me by crying but these tears are old hat. Jill used to turn on the tears when I was drinking and I did what I do now when I see the usual tears, I withdraw to get away from such unwarranted crying. So, it is not that I am afraid to address Jill's tears or her reason for crying it is just that I am accustomed to Jill crying to get my sympathy for questionable causes such as my alcoholic drinking. Right now, Jill is crying because she says she has gotten too upset over the financial setbacks and wants me to feel sorry for her. Jill is not fooling me with these tears, she tried to use them in the past when I was drinking and she's trying to use them on me now. She just wants to get me feeling sorry for her so that I will do what she wants me to do like stop drinking, which I already did, or believe her when she says she was not being sarcastic when she actually was being sarcastic. I withdraw so that Jill will not seem to be in control of me. Jill may be the rudder of the ship but I am
the captain and if I were to comfort Jill and recognize her hurt I fear I would no longer be captain of the ship, I would no longer be adequate and worthwhile and I would no longer remain in my familiar role with Jill. Therapist, I cannot afford to relinquish my view of Jill as sarcastic due to unnecessary and manipulative crying; there is too much at stake.

63. Interaction.

The therapist continues to build on the notion that Jill is being open and spontaneous with Sam. The therapist highlights the fact that Sam feels upset about the setbacks as does Jill and this forms a basis of understanding between them. Also, she notes that Sam is afraid of Jill's vulnerability in an effort to further deepen and explore Sam's previous statement regarding his interest in the effects of his behaviour on Jill. However, Sam interrupts the therapist's prompt claiming that Jill is using her tears to control him. He claims Jill tried to control his drinking behaviour with tears and she is again trying to control him with the same device. Sam's explanation for Jill's tears serves as an argument against the legitimacy of her hurt and a justification for Sam's withdrawal. Sam's explanation for Jill's tears as calculated and manipulative parallels his understanding of her remark as intentionally sarcastic. When the therapist touched on Sam's fear of Jill's vulnerability his anxiety increased preturbing him to struggle to re-instate her as unflappable rudder. By discounting Jill's hurt once more and insisting on viewing her as calculating and manipulative, Sam shields himself from responsibility for the abandonment of Jill. He also protects himself from focussing on his sense of inadequacy. Sam is frightened of Jill's vulnerability since to acknowledge it rocks the foundation of what Sam has come to rely upon to sustain him. Sam requires Jill to be an unflappable rudder so that he can continue as ship captain. To Sam, Jill's vulnerability reminds him of his own and the reminder is intolerable. If Sam acknowledges, empathizes and comforts Jill, he simultaneously acknowledges that Jill did not purposely mean to hurt him which in turn confirms, in his mind, that he is an inadequate and incompetent businessman. In addition, Sam would consider himself to be weak if he were to "fall" for Jill's tears and allow himself to be manipulated. Layers of intrapersonal pain and an adherence to rigid sex roles confine Sam to a narrow band of behavioural and perceptive possibilities at this juncture.

Sam's construing of Jill's tears as manipulative had the potential to impede the couple's bid for increased intimacy. If crying remained evidence of manipulative intent rather than an invitation to intimacy, couple mutuality, partnership and affinity was improbable. The following text excerpt illustrates the therapist's reply to Sam as she offers an alternate construction of the meaning of Jill's tears.
Text: Lines 481-512.

Th: = Yeah, so maybe you’re still in that pattern ((rotating arm)) of withdrawing from the tears because in the past ah the tears were to do with alcohol, now the tears are to do with ((hands moving, left hand touches chest)) very real core of who Jill is and her willingness to share herself ((Jill moving kleenex)) with you and it right now ((looks at Sam)) you don’t want to come close to her but are willing to look at that as something very interesting(.hhh)and the challenge when you leave here will be - to - ((raises hand, continues looking back and forth between clients)) deal with that because Jill ((touches Jill’s knee)) does not feel safe right now she shared a very deep part of herself and it ((looking back and forth between clients)) hasn’t been(.hh)something that’s felt safe to do so she may choose to withdraw, she may choose to withdraw ((looking at Jill)) - or ((rolling gesture to Jill)) she may choose to keep doing this with you in-in sharing her vulnerability ((Sam continuing to look intently at therapist)) with you she’s really honouring ((Jill wipes nose)) who you are, she’s honouring you deeply and you’ve also shared your vulnerability ((gesturing towards Sam)) with us. Telling her of when you came to the bedroom(.hhh)you talked about the financial sii-ituation you let her know this morning, that in here, that it’s not just disappointment it’s also the pressure and rejection and pain and fear and ah ((Sam scratches nose)) it-it triggers you to point where you feel vulnerable in your self esteem especially when you’re not 100 percent ((Jill moving kleenex, therapist rolling hand)). So you’ve shared your vulnerability with her and she’s shared hers’ with you and ah ((indicating Sam with her hand and looking at him)) in the past there was a pattern where there were tears it was usually to do with alcohol so you would withdraw(.hh)so now there’s a chance to do something different ((rolling left hand)). And I wonder what you’d like to do that’s different right now?

Expansion.

Yes, I understand that perhaps you are still behaving in the old manner of withdrawing when Jill cried about your alcoholism. However, the tears Jill sheds do not have anything to do with your drinking and are not an attempt to manipulate you. The difference between Jill’s tears in this session and her tears on previous occasions is the level of vulnerability and disclosure reached by Jill. Jill is exceptionally vulnerable to you right now and she may be protecting and censoring herself less today than ever before and that makes this situation different from the situation in which you withdrew from Jill before. In fact, right now, Jill’s tears are a product of Jill revealing herself to you such that she shares her despair and feelings of abandonment with you. Jill’s tears arise from a deep, profound place within her being. Jill experiences a great deal of despair and alienation due to your withdrawal and abandonment of her. You are unwilling to comfort Jill or end your withdrawal but at the same time you are concerned enough about your behaviour to re-consider it in a measured way. We are going to end the session soon and I am looking into the future as I say this because the problem for you Sam is you are going to
have to think hard about the effects of abandoning Jill when you leave here today. Sam, you are going to have to make a change in your abandoning, withdrawing and controlling behaviour towards Jill because Jill does not feel safe with you. Jill feels threatened, unsafe and rejected. She has disclosed her sense of desolation, despair and loneliness to you today and that has not traditionally been safe to do. It appears that it is still unsafe for Jill to reveal deep aspects of herself to you when you threaten, invalidate, dismiss and discount her. Sam, it is important for you to know that as a result of your behaviour towards her, Jill may decide to withdraw from you, Jill may decide to protect herself from you and stay away from you emotionally. On the other hand, Jill may continue to try to prompt you to understand her and have compassion for her. If Jill continues to share her vulnerability with you Sam, I want you to know that when she discloses her deepest hurts and pain, it is no trivial matter. When Jill discloses herself to you she is recognizing that as her spouse you are one of the closest people to her and you are the person with whom she should feel comfortable revealing her innermost feelings. Jill is allowing you to see her when she is most vulnerable and is entrusting you with a profound part of her being. It is important that you realize this Sam, that when you reject or abandon Jill you are betraying an almost sacred trust between you. Also Sam, you have entrusted a part of yourself to Jill during the session and I wish to recognize this disclosure as well. Sam you told both Jill and I of what happened when you came into the bedroom full of disappointment about the financial situation. Sam, you went further in your disclosure during the session revealing how hard the pressure was on you and how rejected you felt when Jill said "same old scenario". You shared your fear of the creditors and unpaid bills and the pain you experience when business deals go sour. Sam you also noted how physical ailments and unsuccessful business deals perturb a sense of inadequacy and worthlessness that undermines your confidence. Sam you have shared your vulnerabilities with Jill and Jill has shared her vulnerabilities with you and this type of discussion can promote an open, caring relationship between spouses. In the past, Sam, you withdrew from Jill when she cried about the hurt your drinking caused her. However, the current discussion of each others vulnerabilities is unlike previous discussions and there exists now an opportunity to change your usual withdraw/abandon behaviour pattern Sam. Sam you do not have to continue withdrawing from Jill since you have already been vulnerable with her. Jill feels unsafe with you and your therapy goals include more marital intimacy. Perhaps you would like to do something else besides withdraw from Jill at this time. Perhaps you wish to change this old pattern of withdrawal today. Sam, what would you like to do that represents a shift in your old style of interacting with Jill given her current desolation and despair?

64. Interaction.

The therapist is aware of the impending end of the session and she begins to summarize the session including the disclosures made by both Sam and Jill as well as the hurtful effects of Sam's withdrawal on Jill. The therapist highlights Sam's old pattern of withdrawal from Jill over his alcoholism as
different from his current withdrawal from her. The therapist does not agree with Sam's opinion that Jill's current tears are a manipulation. Instead, the therapist notes that Jill's tears are a manifestation of a profound sense of desolation at the core of her being. At first, it appears that the therapist is making a distinction between Jill's past manipulative tears and her current genuine ones. However, closer inspection reveals that the therapist is not making a distinction between manipulative tears and genuine ones, rather she is remarking on a difference in degree of depth of disclosure. The therapist surmises that Jill's tears concerning Sam's drinking were a product of considerable upset but she assumes that Jill reached an even deeper level of disclosure and vulnerability in the session when she conveyed her sense of aloneness and abandonment to Sam. The therapist impresses upon Sam the fact that Jill's disclosures and vulnerability are a sacred trust that was betrayed when he punitively withdrew from her in her time of need. However, the therapist takes pains to acknowledge that Sam is willing to thoughtfully investigate his behaviour further even if he is unwilling to comfort to Jill. The therapist also comments on Sam's vulnerability in the form of his sense of inadequacy and worthlessness as revealed earlier in the session. She notes that both Sam and Jill have disclosed some of their innermost fears and hurts and harkens back to Sam's typical pattern of withdrawal challenging him to change his usual way of being.

In this utterance, the therapist shared her experience of Jill's tears as a profound honouring of Sam, an atypical foray into deep emotional expression and an act of courage. The therapist observed that Sam's perception of Jill's tears as manipulative made Jill feel unsafe jeopardizing her well-being and reducing the degree of closeness possible in the marriage. Also, the therapist recognized that both Sam and Jill had been vulnerable during the session indicating that this type of disclosure was important to the generation of couple intimacy.

In sum, disproportionate responsibility for the ethical conduct of the therapy venture prompted therapist involvement in the amelioration of asymmetrical couple decision-making processes and clinical intercession during interactions that impeded intrapersonal and interpersonal well-being. For example, in Episode #1, the therapist emphasized joint partnership rather than an asymmetrical distribution of couple decision-making authority. In Episode #2, the assumption of disproportionate expertise and the permission to act on
that expertise imbued the guide role with responsibility for valuing previously marginalized client experience, responding pro-actively when harmful constructions of spousal behaviour were forwarded and focussing on the intrapersonal and interpersonal ramifications of punitive and vengeful behaviours.

Thus, as a therapeutic guide, the clinician employed her observations to provide an intimacy enhancing understanding of spousal vulnerability and to comment on the effects of withdrawal on couple closeness. In addition, the therapist outlined the relational ramifications of a lack of spousal safety and emphasized joint partnership. Also, as part of her guide role, the clinician acted to value undervalued client experience and offered opportunities for change in unsatisfactory interaction patterns.

A collaborative therapeutic atmosphere was revealed to be important to the convergence of disparate belief and practice. The convergence of conflictual perspectives and activities necessitated the co-development of the therapy venture such that clients' worlds were entered respectfully using their language style, cues and experience. In addition, the therapist's collaborative guide role was found to be important in the generation of intimacy. That is, disparate and detrimental spousal interactions and constructions of behaviour required pro-active therapeutic responses to offset impediments to mutuality and intimacy. The therapist's inclination towards active intercession when witnessing potentially harmful spousal interactions infused the collaborative guide role with moral and ethical responsibility. Hence, the disproportionate responsibility intrinsic to the collaborative guide role aided the generation of spousal mutuality by affording the therapist permission and ethical impetus to address potentially detrimental client beliefs and practices.
Summary of the Results of the Comprehensive Discourse Analysis of Episode #1 and Episode #2

The results of the discourse analysis of Episode #1 and Episode #2 will be summarized in this section.

The Syncretic Change Process

The Comprehensive Discourse Analysis of Episode #1 and Episode #2 revealed that the means by which therapist and clients influenced the creation of relational novelty was through an interactional process termed the syncretic change process. This study found that the syncretic change process organized the creation of relational novelty giving it an intimacy enhancing and distance reducing therapeutic purpose. The syncretic change process is characterized by a shift away from conflicting belief and practice towards increased couple commonality and mutuality. In essence, the syncretic change process refers to the generation of intimacy by therapeutic system members where initially there existed disparate beliefs and behaviour that served to isolate system members.

The syncretic change process constitutes two parts representing different but related aspects of the same construct. These two elements include: (a) Initial disagreement and conflicting belief and practice which (b) transforms via therapeutic system efforts, to reflect increased mutuality and commonality of belief and practice in the relationship.

First, the discourse analysis of both episodes revealed the existence of disparate beliefs and practices concerning issues of alcohol consumption and storage and spousal supportiveness respectively. In Episode #1, therapeutic system members encountered disagreement concerning the troublesome nature of alcoholic drinking and the degree to which Jill should be involved in decision-making concerning alcohol consumption and storage. In Episode #2, conflict
was observed between therapeutic system members regarding the resolution of a morning miscommunication.

The second element important to the syncretic change process was concerned with the reconciliation of conflictual beliefs and practices. The discourse analysis revealed that the convergence of differing viewpoints and behaviours was made possible through two intimacy enhancing activities including the employment of intense experiential exercises and the provision of a collaborative therapeutic atmosphere. These two activities involved various tenets of relational novelty to effect a shift away from distance oriented interactions toward more cooperative and harmonious exchanges. The tenets of relational novelty employed during the syncretic shift included: Encouraging therapist and couple collaboration, facilitating atypical experience, promoting cognitive insight, bringing unacknowledged experience into awareness and evoking core relational themes. Accordingly, the shift away from distance oriented exchanges toward increased mutuality was facilitated by the aforementioned therapeutic processes when intense experiential activity was engaged and a collaborative therapeutic atmosphere was encouraged.

**Intense Experiential Activity**

The study of Episode #1 and Episode #2 revealed the common engagement of experiential technique and the intimacy enhancing importance of the intensification of client experience. The intensification of client experience during experiential exercises was observed in both episodes and found to be integral to the creation of intimacy oriented relational novelty.

Six components of intensification previously articulated in ExST theory were found to be helpful to the deepening of client experience (Friesen et al.,
Four of the components were common to both episodes. These included:

1. Providing a detailed definition of the specifics of the clients' dilemma.
2. Creating an interaction between clients or between clients and the symptom.
3. Maintaining a present tense focus during sequences of intense client experiencing.
4. Employing varying degrees of empathy ranging from paraphrasing to advanced empathy to access underlying feeling on a context dependent basis.

The utilization of an additional two components of intensification was found to be contingent upon the nature of the experiential activity conducted. These components included:

1. Utilizing meaningful metaphors and symbols.
2. Personalizing and amplifying physiological states.

The intensification of client experience was essential in the generation of intimacy promoting relational novelty since it was through the deepening process that atypical experience, cognitive understanding, intrapersonal awareness and core relational themes were evoked.

**Intense experiential activity and the syncretic change process.**

In addition to capturing the importance of experiential activity and the components of intensification in the generation of couple intimacy, the discourse analysis revealed how the intensification of client experience during experiential activity aided the syncretic change process in both Episode #1 and Episode #2. The means by which intense experiential activity enabled the
convergence of disparate belief and practice was through the facilitation of four tenets of relational novelty including:

1. Atypical experiencing during which clients are encouraged to speak, feel, think and behave atypically rather than speaking, feeling, thinking or behaving in a recurrently characteristic fashion.

2. Cognitive understanding resulting in new learnings and insights about self, spouse or the presenting problem.

3. Increased awareness such that previously unacknowledged experience is brought into consciousness.

4. The evocation of substantive relational themes.

The four tenets of relational novelty listed above, fostered enhanced couple intimacy when facilitated by intense experiential activity during the syncretic change process. Intimacy oriented relational novelty encouraged clients to engage in distance reducing interactions as well as harmony promoting insights and awarenesses. Also, clients experienced a shift in previously isolating core themes when intimacy oriented relational novelty occurred.

The Provision of a Collaborative Therapeutic Environment

The provision of a collaborative therapeutic environment was found to foster a shift away from couple distance toward increased mutuality. Therapist and client collaboration is an important tenet of relational novelty which, when given an intimacy oriented purpose, facilitated the creation of couple harmony and mutuality. The provision of a collaborative therapy environment enabled relational change when the therapy venture was co-developed by therapist and clients and the therapist engaged in the ethical employment of her guide role.
Co-developing the therapy story.

In co-developing the therapy venture with clients, the therapist entered clients' worlds by accepting their experiences, using their language style and encouraging clients to actively shape therapy. The therapist expressed genuine interest in clients' worlds and adopted client terminology in her reflections of client experience. Entering client worlds through the use of client language forms increased client safety and prompted self disclosure. Indeed, unexpected client revelations that steered therapy towards relevant exploration of client issues occurred when therapeutic safety and interest was ensured. As well, in co-developing the therapy venture with clients, the therapist maintained an appreciation of client efforts to negotiate new intrapersonal and interpersonal territory. The therapist remained aware of the difficulty encountered when core relational themes were evoked and atypical thoughts, feelings and behaviours were entertained.

In co-developing the therapy story, the therapist engaged playfully with clients highlighting her participant role in the therapy process. Also, the therapist employed both nonverbal and verbal behaviour to convey her empathic participant status in the therapeutic relationship. The therapist moved her chair closer to distressed clients and utilized "we" and "I" pronouns to include herself in the therapy process. The therapist's acceptance of the clients' worlds through the reflection of the entirety of client experience and the employment of her caring participant role enabled increased couple intimacy by fostering client safety and prompting client vulnerability.

Ethical employment of the guide role.

While the role of therapist as process participant was observed in the study of Episode #1 and Episode #2, the clinician's guiding function was also
noted. Although ExST theory asserts that the clients and therapist assume joint responsibility for therapy activities (Friesen et al., 1991), the discourse analysis revealed disproportionate therapist centrality in the co-development of the therapy venture. As such, the therapist assumed disproportionate responsibility for the generation of opportunities for intimacy in therapy. The therapist's guiding function was predicated on two interconnected meta-assumptions established at the outset of therapy. These included: (a) The assumption of disproportionate therapist expertise and, (b) a client-based permission to act as process guide during therapy. The discourse analysis of the two episodes revealed that the therapist acted upon the assumption of disproportionate expertise by maintaining a consistent focus on the present tense during sessions, conducting activities according to client cues and employing her clinical expertise to facilitate therapy sessions in an ethical fashion.

In particular, the therapist acted as process guide in considering client disagreement and altering the therapy agenda in response to client dissent. Accordingly, the therapist’s role in the promotion of couple intimacy was imbued with ethical significance. In addition, the therapist’s decision to accept or reject client disagreements with the therapy direction infused the role with social and moral responsibility.

The therapist's employment of the guide role promoted couple intimacy rather than relational distance when she responded in a proactive manner upon observing spousal interactions that could hamper intrapersonal and interpersonal well-being. Active therapist involvement in couple interaction sequences included: (a) the reflection of client affect, (b) the fostering of client disclosure, (c) the provision of alternate understandings of observed client interaction and, (d) the identification of the ramifications of client behaviour.
The therapist underscored the harmful effects of certain behaviours on the individual and the relationship. In particular, she noted how vengeful and punitive behaviours resulted in a lack of spousal safety and a need for retreat and self-protection. Also, the therapist acted as ethical process guide to aid in the amelioration of the asymmetrical allocation of influence in the relationship. Therapist promotion of parity, joint partnership and consultation aided in the enhancement of intimacy and the reduction of couple isolation and alienation. As well, the therapist prized undervalued client experience bringing it into prominence as worthy of consideration in the pursuit of couple intimacy.

The results of this study will be discussed in the next chapter. In particular, the findings will be examined as they pertain to ExST theory and the larger body of research considered in the literature review.
CHAPTER V
DISCUSSION

This chapter provides a discussion of the theoretical implications of the study results for ExST theory including a brief synopsis of the research findings. In addition, the research results are linked to the larger body of literature and situated in the current knowledge base. The chapter concludes with a delineation of the limits of the investigation and an account of future research directions based on this study.

Implications of the Study Results to EXST Theory

This section is concerned with the theoretical implications of the research findings. The section will focus on the identification of syncretic relational novelty as a subtype of relational novelty. Additionally, the tasks associated with the generation of syncretic relational novelty and the manner in which these tasks contribute to the support, refinement and expansion of ExST theory will be articulated.

Syncretic Relational Novelty

The purpose of this study was to contribute to ExST theory via an in-depth analysis of naturally occurring therapy discourse. ExST has been shown to be an effective individual and couple treatment for alcohol dependency (Grigg, 1994). However, little research has focussed on how change occurs in ExST. Consequently, this study aimed to contribute to the continuing development of the ExST theory of change through an examination of the manner in which change was co-created by the members of the therapeutic system.
As such, this investigation sought to answer the following research question: How do members of the therapeutic system both explicitly and implicitly influence the creation of relationally novel episodes at the intrapersonal, interpersonal and symptomatic levels of the system over the course of 15 sessions of a successful case of Experiential Systemic Therapy for the treatment of alcohol abuse?

The means by which the therapeutic system influenced the creation of relational novelty was through the syncretic change process. The syncretic change process is characterized by movement away from distance oriented beliefs and behaviours towards intimacy enhancing beliefs and practices. The therapeutic system employed intense experiential activity and provided for the generation of a collaborative therapeutic environment to effect a shift away from disparate belief and practice toward increased couple harmony and mutuality.

During the employment of intense experiential activity various tenets of relational novelty were instrumental in the generation of a syncretic shift. Accordingly, atypical experiencing, cognitive understanding, enhanced awareness and the evocation of substantive relational themes were employed to enhance couple opportunities for intimacy. Additionally, therapist and couple collaboration was observed to be important in the pursuit of couple mutuality and partnership. In particular, two aspects of therapist/couple collaboration found to be helpful in the creation of a syncretic shift were the co-development of the therapy venture and the engagement of ethical therapy practices such as pro-active responding during spousal interactions that threatened client well-being and prizing undervalued client experience.

Thus, the syncretic change process provides the creation of relational novelty with intimacy enhancing and distance reducing purpose. Relational
novelty was described in ExST theory as a general change construct comprised of six tenets. These tenets include therapist/couple collaboration, atypical interaction, cognitive insight, increased awareness, the perturbation of core relational themes and a description of the relationally novel pattern (Friesen et al., 1989). The tenets of relational novelty were articulated in ExST writings with no reference to their purpose or direction. The findings of this study indicate that relational novelty is a broad descriptor of therapeutic change and the construct can be expanded to include a change sub-type. Hence, relational novelty was found to include a subtype called syncretic relational novelty. This finding was based on the observation that the generation of couple change had a particular focus centering on the promotion of spousal intimacy.

Intimacy oriented or syncretic relational novelty represents one type of relational novelty in which couple harmony, consensus, mutuality and partnership is valued and promoted. Hitherto, relational novelty was considered in general terms with emphasis placed on its global characteristics. This study identified the existence of a particular type of change predicated upon the reduction of couple distance, isolation and alienation in favour of relational cooperation, nurturance and safety.

As a result, ExST theory can be expanded to include the notion of types of relational novelty beginning with the inclusion of syncretic relational novelty in its lexicon. Syncretic relational novelty refers to the promotion of intimacy in relationships where distance and isolation prevail. The therapeutic system utilized a variety of tasks to pursue syncretic relational novelty. These tasks are described below.
Tasks Associated With Syncretic Relational Novelty

The perturbation of couple intimacy required the employment of intense experiential activity and the provision of a collaborative therapy environment. The utilization of intense experiential activity and the promotion of a collaborative therapy environment required particular tasks by the therapeutic system. This section will detail the therapeutic system tasks associated with these elements and connect these tasks to relevant ExST theory.

Therapeutic System Tasks Relating to Intense Experiential Activity

To achieve the convergence of disparate belief and practice observed in Episode #1 and Episode #2, the therapeutic system engaged a variety of tasks during intense experiential activity that fostered intimacy oriented relational novelty. These tasks included the introduction of intense experiential activity, the therapeutic involvement of the components of intensification and the regulation of the intensification process.

The introduction of intense experiential activity.

According to ExST theory, action-oriented activities are helpful in evoking alternative ways of being (Friesen et al., 1991). ExST theorists state:

We believe that the enhancement of experience will lead to the addition of novelty in the domain of the client's perceived possibilities for feeling, thought and action and will open vistas of potential for clients to find their own new solutions to their problems (Friesen et al., 1991, p.34).

Hence, ExST theory suggests that the aim of intense experiential activity is "to provide the opportunity and motivation for the client to engage in relational novelty" (Friesen et al., 1991, p.6). The findings of this study lend support to the notion that action-oriented activities enhanced via the
intensification process offer clients a chance to engage in novel behaviour. Indeed, the introduction of intense experiential activity was observed to perturb atypical client experience, evoke substantive relational themes, encourage cognitive insight and bring unacknowledged experience into conscious awareness. In addition, this research revealed that the provision of intense experiential exercises that challenged and transformed client belief and behaviour were important to the convergence of disparate belief and practice. Hence, intense experiential activity contributed to the generation of a syncretic couple shift away from isolation and distance towards increased intimacy.

**Components of intensification.**

The enhancement of experiential activity through the intensification process was cited as integral to the generation of relational novelty (Friesen et al., 1991). Accordingly, the intensification process deepens client experience to promote atypical behaviour, thought and feeling as well as provide opportunities for new cognitive insight and intrapersonal awareness (Friesen et al., 1991). ExST theory delineates six important components of the intensification process designed to deepen client experience and foster change (Friesen et al., 1989).

This research study observed that the intensification of client experience involved the utilization of the six components of intensification during experiential activity. The components of intensification noted in this study included detailing specifics of client concerns to ensure a complete understanding of the issue (Friesen et al., 1989). A full description of the specifics of the client difficulty aided in the re-creation of the dilemma during Episode #1 and Episode #2.
A second component of intensification, found to be present in the relationally novel sequences analyzed in this study, was concerned with encouraging active interaction between clients and between clients and the symptom. The inclusion of all therapeutic system members during experiential activity was an important contributor to couple intimacy. For example, when underlying emotion was articulated during interactions between clients or clients and the symptom, self disclosure, vulnerability and increased trust and understanding was possible.

A third component of intensification included the employment of varying forms of empathy from paraphrasing to advanced empathy to access underlying emotion thereby facilitating client self disclosure and deep experiencing. According to ExST theory, the exploration of underlying emotion "may result in intensifying the experience" (Friesen, et al., 1989, p. 36).

Fourthly, as cited in ExST theory, the utilization of a meaningful symbol aided in the intensification process. For example, in Episode #1, Sam engaged a large plastic bottle as a relevant representation of alcoholic drinking. This symbol was a powerful representation as indicated by Sam's report of increased tension at the presence of the bottle and his experience of decreased apprehension upon removing the symbol from the therapy room. Couple intimacy had the potential of being enhanced when Sam had an intense encounter with the impact alcohol had on his anxiety levels. Sam observed a contrast between personal relaxation and tension based on the absence or presence of alcohol thereby confirming Jill's contention that alcohol consumption was problematic for Sam.

Fifth, the amplification and personalization of physiological states (Friesen et al., 1989) facilitated the intensification process and couple intimacy. In Episode #1, the therapist asked Sam to focus on the area of his body in
which he noted his new found sense of relaxation upon the removal of alcohol. Sam identified the reduction of tension as being notable in the shoulder region and when requested to give voice to these relaxed muscles (personalization), Sam indicated they felt grateful and cautious. The amplification and personalization of Sam’s physiological states contributed to his acknowledgement of the problematic nature of alcohol storage and consumption.

A sixth component of intensification, observed through the discourse analysis of Episode #1 and Episode #2, included the maintenance of a present tense focus via empathic reflections of client experience and direct questioning during the deepening process (Friesen et al., 1989). The maintenance of a here-and-now focus on all aspects of client experience was discovered to be important in the provision of intimacy oriented relational novelty.

While ExST theory indicates that "a variety of methods may be used to deepen experience" (Friesen et al., 1989, p. 34), this statement only hints at the context dependent nature of the differential use of the various components of intensification. Accordingly, ExST theory could be refined to include an understanding of the context dependent aspects of the deepening process. In particular, the research findings indicated that not all six elements of intensification were essential to the deepening process and their usage was contingent upon the nature of the experiential activity being employed.

Indeed, three of the six components including use of a meaningful symbol, the personalization of physiological states and the utilization of empathy to intensify client experience were discovered to be specific to a particular episode. For example, in Episode #1 the symbolic evocation of alcoholic drinking was facilitated through the use of a large plastic bottle. The replica contributed to the intensification of the client’s struggle with alcoholism.
In addition, the therapist conducted an in-depth exploration of the client's physiological state and employed paraphrasing responses rather than advanced empathy to deepen client experience in Episode #1.

Nevertheless, the discourse analysis of Episode #1 and Episode #2, revealed several intensification components in common. These included the creation of an interaction between clients and between clients and the symptom, the detailing of the specifics of client dilemmas and the common focus on clients' here-and-now experience. The components common to Episode #1 and Episode #2 appear to transcend technique remaining applicable in situations where experiential activity may vary.

However, the use of symbol in therapy seems to be related to technique based interactions that center on the symbolic evocation of alcohol or expressive transactions employing artistic venues. While detailing specifics of client dilemmas, responding empathically, creating interactions in therapy and focussing on present tense experience may be employed during most action-oriented methods, the use of symbol in therapy is specific to techniques centering on the use of objects representing client issues.

Interestingly, the personalization of body states was found to exist in Episode #1 in concert with the use of symbol. It is possible to speculate that the personalization of physiological states may involve the objectification of various parts of the body. The process of objectifying body parts and processes involves clients with their physiology as a representation of internal states and client issues. For example, in Episode #1, the therapist asks Sam what his shoulder muscles would "say" about his new found relaxation upon the removal of alcohol from the room. Sam responds saying his muscles would be cautiously grateful. If Sam's shoulders are considered akin to a symbol
representing Sam's relationship with the decision to end alcoholic drinking, the "comments" made by the relaxed muscles illustrated Sam's growing awareness that the cessation of alcoholic drinking would be met with trepidation and some gratitude. That is, Sam began to observe that the cessation of alcoholic consumption would be both beneficial and difficult. Also, Sam's physiological reaction to the absence of alcohol indicated that increased personal peace could be found in a recognition of the problematic nature of alcoholic drinking and a decision to end a dependency on alcohol.

**The regulation of the intensification process.**

In discussions concerning the use of experiential activity and the intensification process, ExST theory emphasizes the significance of deepening client experience, the importance of action-oriented methods, and the centrality of the components of intensification (Friesen, et al., 1989). However, the usefulness of regulating the intensity of deep experiential activity remains unmentioned in ExST theory. The discourse analysis of Episode #1 and Episode #2 revealed the presence of therapist efforts to regulate the intensity of experiential activity according to client readiness, comfort and session number or therapy phase.

Earlier therapy sessions required a more tentative, slower and less intense approach to deepening client experience when compared to the more direct intensification activity possible during later sessions. Client trust in the therapist and the therapy process increased throughout therapy with this approach. The therapist regulated the experiential intensity of an exercise by fashioning the intensity of her inquiries and empathic responses according to client comfort levels and degree of client agreement with her reflections.
Although ExST theory advocates the use of advance empathy to access underlying emotion (Friesen et al., 1989) the discourse analysis revealed that a lack of advanced empathy did not hamper the deepening process. It appeared that the paraphrasing practiced in Episode #1 enhanced the clients experience and engendered trust in the therapy process enabling deeper exploration in Episode #2. The differential use of varying degrees of empathy was based upon sensitivity to client cues. Thus, the regulation of experiential intensity via sensitive empathic responding was helpful in ensuring appropriate levels of experiencing paced according to client readiness and session number.

Clients employed a variety of devices signalling comfort level and readiness during experiential activity. These devices included vague self disclosure, reference to past events during discussions concerning present tense experience, and "Yes, but" statements and embedded requests in response to intense therapist queries and empathic reflections. In addition, efforts to modify or minimize self report data during the intensification process may signal client reticence and a desire to decrease the depth of the experience.

**Therapeutic System Tasks Relating To The Provision of a Collaborative Therapeutic Environment**

To achieve the convergence of disparate belief and practice observed in Episode #1 and Episode #2, the therapeutic system was involved in the collaborative shaping of the therapy venture and the employment of responsible therapy practices. Intimacy oriented or syncretic relational novelty was facilitated when the therapeutic system co-developed the therapy venture and engaged in ethical therapy practices.
The co-development of the therapy venture.

According to ExST theory, the co-development of the therapy venture requires the therapist to "actively honour the client's world and selectively adopt their language" (Friesen et al., 1991, p. 12). In addition, ExST theory places a premium on embracing client experience describing this process as the validation of client experience as genuine and important (Friesen et al., 1989). A recognition that "no one narrative fits the wide spectrum of clients who participate in therapy" (Friesen et al., 1991, p. 12) contributes to the emphasis on the co-development of the therapy venture.

This study found that efforts were made to co-develop the therapy venture in both Episode #1 and Episode #2. As such, the therapist entered clients' worlds using their language and incorporating the totality of their experience. Clients were actively encouraged to shape therapy when the therapist demonstrated genuine interest in client experience and included all client experience whether it be fear, ambivalence or dissension. In addition, the therapist maintained an explicit appreciation of client efforts to explore new intrapersonal and interpersonal territory. ExST theory explicitly articulates the importance of recognizing client efforts indicating that "therapists should recognize the symbolic gesture made by people who come to a professional for help and acknowledge their courage in facing their difficulties" (Friesen et al, 1989, p. 52).

An important aspect of the collaborative co-development of the therapeutic venture articulated in ExST theory is the notion that "the therapist is part of the therapeutic system, not a distant observer or someone doing something to other people. . . . Therapists do not pretend to be experts outside the system being worked on, but rather see themselves as legitimate members of the therapeutic system (Friesen et al., 1989, p. 74). The
therapist's participant status was overtly recognized in her use of "we" and "I" pronouns in Episode #1 and Episode #2. The use of self-inclusive terms established the therapist's participation in the therapeutic venture.

**The engagement of ethical therapy practices.**

ExST theory posits that the generation of a collaborative therapy atmosphere involved client and therapist partnership such that "client and therapist share ownership of the therapeutic venture and jointly assume responsibility for the activities (Friesen et al., 1991, p. 12). However, this study revealed that therapist/client ownership of therapy did not infer shared responsibility for therapy activity. That is, the discourse analysis revealed both the therapist's participant role and the centrality of her guide role during the provision of a collaborative therapy environment.

The study found the therapist to be proportionately more responsible for the therapy process than the clients. Hence, within the framework of syncretic relational novelty, the therapist assumed disproportionate responsibility for the generation of opportunities for intimacy in therapy. The process guide role afforded the therapist was based upon two inter-connected meta-assumptions related to the implicit content of TARP promotional literature. These meta-assumptions include: (a) The assumption of disproportionate therapist expertise, and (b) a client-based permission to act as process guide during therapy.

The two aforementioned meta-assumptions were most in evidence when the therapist maintained a present tense therapy focus, accommodated client cues and employed the guide role to engage in ethically responsible therapy practices. The discourse analysis of Episode #1 and Episode #2 uncovered the therapist's consistent and sensitive re-establishment of a present tense focus
according to an assessment of the strength of the therapeutic relationship. In addition, the study revealed how the assumption of disproportionate clinical expertise and client-based permission to act on this assumption afforded the therapist the opportunity to employ ethically responsible therapy practice. The therapist activities related to ethical therapy practice included: (a) the consideration of client disagreement with the therapy agenda and the alteration of the session direction in direct response to client cues, (b) the promotion of increased couple intimacy through proactive responding to spousal interactions that impede intrapersonal and interpersonal well-being, (c) the promotion of couple parity, joint partnership, consultation and the amelioration of asymmetrical influence in the relationship, and (d) the valuation of minimized and marginalized client experience in the pursuit of couple intimacy.

ExST theory establishes a fertile environment for non-coercive, ethical and collaborative therapy practice. For example, ExST theory considers it morally wrong to coerce clients and "coercive behaviour on the part of the therapist is antithetical to collaboration" (Friesen et al., 1989, p. 73). ExST theory emphasizes the collaborative rather than expert therapy stance (Friesen et al., 1991) preparing the clinician for changing the therapy agenda when requested by clients. Also, ExST theory provides clinicians with the tools to intervene in spousal interactions that impede well-being. In particular, the intensification of experiential activity is posited as influential in the transformation of interpersonal patterns which limit client creativity, adaptability and spontaneity (Friesen et al., 1989). In short, ExST theory lays the foundation for ethical therapy practice and the ethical conduct of the process guide role.

Nevertheless, the study findings may be employed to further expand ExST in relation to the therapist guide role itself. It appears that while ExST
theory provides the foundation for the therapist's role in guiding therapy, it refrains from acknowledging the responsibility afforded therapists via the assumption of disproportionate expertise and a client based permission to act on that assumption. Currently, the definition of collaboration in therapy de-emphasizes the therapist's guiding function to differentiate the theory from models that advocate technical approaches to clients, advice or teaching models and strategic therapies. Similarly, ExST highlights the therapist's participant function to differentiate it from models that emphasize therapist neutrality. ExST theorists appear to struggle with the proportion of responsibility taken by participant-observer therapists who enter an "I-Thou encounter which involves mutual trust, respect and caring" (Friesen et al., 1991, p. 31) between therapists and clients. It has been noted that when the therapist's disproportionate responsibility for the therapy process has been de-emphasized in other couple and family therapy models, a "lack of moral clarity in the stance of the therapist" can result (Goldner, 1993, p. 159). The results of this study may aid ExST theorists in combining the therapist's clinical wisdom with the pursuit of collaboration without de-emphasizing the therapist's responsibility for the therapeutic process.

The therapist's ethical conduct of therapy in the form of proactive responses to potentially harmful spousal interactions, an emphasis on fostering couple joint decision-making and inclusion of marginalized client experience has significant implications for ExST theory with respect to its thinking concerning gender issues in heterosexual couples therapy. Also, the research findings centering on the therapist's consideration of client disagreement with the therapy direction and her subsequent alteration of the session agenda uncovered a potential addition to ExST's systems theory underpinnings. The
following sections will articulate the implications of these findings for ExST theory regarding its treatment of gender issues in therapy.

**Gender Issues in Heterosexual Couples Therapy**

The single case study presented in this research revealed how aspects of gender-oriented socialization potentially impeded the growth of intimacy between the spouses. It was observed that particular societally and familial based messages concerning appropriate male/female behaviour served to contribute to a decrease in the couple's opportunities for closeness. These intimacy decreasing messages focussed on male solitariness and ascendancy and female inferiority and lack of influence. Also, the discourse analysis uncovered evidence of emotional and physical intimidation in the relationship giving rise to important considerations regarding the expansion of ExST theory. The following section will articulate how these gender specific findings contribute to ExST theory.

**Gender-Oriented Socialization and Couple Intimacy**

The discourse analysis revealed a myriad of factors influential in the creation of a relational atmosphere in which intimacy was difficult. For example, intrapersonal, interpersonal, familial and socio-cultural factors hampered marital intimacy such that a morning miscommunication, featured in Episode #2, sparked the escalation of spousal distance, mistrust and hurt. Originally, the couple's predisposition to discomfort with expressing painful thoughts and emotions obscured their messages of worry and support to one another. Sam's comment to Jill, "I hope Broughton flies" (Episode #2, line 17) and Jill's response to Sam, "Same old scenario" (Episode #2, line 20) concealed unacknowledged disappointment, worry, concern, a sense of failure
and inadequacy and an attempt at commiseration. Nevertheless, avoidance of expressing painful experience was familiar to both Sam and Jill.

Jill was silenced as a child in a home where grieving her mother's death was disallowed and later considered disloyal by an insecure stepmother. Jill learned to become silent to keep the peace and avoid admonishment. Sam grew up in a home where he was required to be self-sufficient. Surviving physical abuse and a convulsive medical condition required Sam to be self-reliant. In addition, both Jill and Sam found self-expression difficult due to socio-cultural messages concerning appropriate male/female behaviour. Jill was discouraged from pursuing her schooling when made to leave school to work after being told girls did not need higher education (Appendix T, Session #5). The combination of being silenced as a child (Appendix T, Session #5) and being told her educational aspirations were inappropriate contributed to Jill experiencing herself as not being taken seriously. Having learned that she had little influence and that conflict with her stepmother was physically and emotionally dangerous, Jill suspended self-expression and retreated. Similarly, Sam's self-reliance was supported by socio-cultural messages requiring boys and men to "go it alone", avoid the expression of pain and refrain from becoming vulnerable or weak. Sam's "lone male" identity precluded the expression of painful affect (Appendix S, Session #3).

Hence, family of origin issues and socio-cultural prescriptions for appropriate male/female behaviour acted to render the expression of painful experience uncomfortable and relatively rare for both spouses. As a result, the couple's initial terse exchange was made possible by familial and socio-cultural factors present in the couple's history. The expression of mutual worry and concern regarding the family finances was rendered improbable by the couple's
truncated communication style leaving the meaning of the exchange open to spousal interpretation.

In this case, Sam interpreted Jill's comment to be a sarcastic rejection of him and evidence of her poor opinion of his business prowess occasioning an angry and punitive withdrawal. Sam's angry withdrawal of caring and Jill's reflexive and protective response coupled with Sam's low self esteem and diminutive view of women made the clarification of the misunderstanding difficult. Once again several intrapersonal, interpersonal, familial and socio-cultural factors served to support an exacerbation of the couple's difficulty sharing painful thoughts and emotions.

For example, Sam believed he was inadequate and unworthy due to his failure to abstain from alcoholic drinking, difficulties with the business, his familial background and restrictive socio-cultural messages regarding appropriate male behaviour. Repeated beatings as a child, a lack of parental support, parental neglect, and severe paternal alcoholism suggested to Sam that he was not worth caring for (Bowlby, 1988). In addition, socio-cultural messages that suggested men should succeed no matter the odds, that men should be in control, independent and rise and fall on their own merit served to limit Sam's capacity to seek assistance. In addition, these views of masculinity heightened a sense of personal inadequacy, worthlessness and incompetence when factors beyond Sam's control impeded successful execution of his breadwinner role. Sam's lack of self esteem stemming from familial and socio-cultural sources contributed to his angry and vengeful withdrawal from Jill.

Also, familial and socio-cultural elements combined to contribute to Sam's punitive behaviour towards Jill. Sam had experienced the use of physical violence and emotional neglect to cope with interpersonal difficulty and his religious training taught that women's inferiority to men was God
ordained, natural and conclusive (Appendix P, session, #8). The use of emotional withdrawal, substance abuse and physical intimidation to cope with stressors and conflict was a part of Sam's childhood environment. Also, Sam's biblically based views of the superiority of men over women led to a conclusion that women were to be taken less seriously than were men. Thus, the combination of a sense of personal inadequacy and worthlessness, a belief in male superiority, a willingness to engage emotional withdrawal and physical intimidation to counter differing viewpoints (Appendix Q, Session #4; Appendix Q, Session #6) made the possibility of clarifying the misunderstanding ensuing from an initial couple difficulty with self-expression increasingly remote.

Jill's retreating response to Sam's punitive withdrawal had a protective function based on a perceived threat from Sam and past interactions with family of origin members. Jill would withdraw from Sam to end a possible fight escalation which could be emotionally or physically harmful. Thus, Jill's opinion regarding Sam's interpretation of her comment was muted to avoid further confrontation. Jill protected herself in a similar manner in her family of origin, remaining silent to avoid emotional or physical danger and keep the peace. In addition, Jill's sense of lack of influence stemming from familial and socio-cultural sources dovetailed with Sam's biblical beliefs regarding women's inferiority and lack of influence relative to men. Thus, in the initial interaction, the clarification of Sam's comment to Jill and the meaning of Jill's reply was postponed by a complex myriad of factors including discomfort with emotional expression and vulnerability, low self-esteem, adherence to sex role stereotypes, the use of emotional and physical intimidation to counter disagreement and reflexive self-protective response behaviour.

As indicated above, the importance of familial and socio-cultural factors when promoting syncretic change processes came to light through the
discourse analysis. That is, this study observed particular familial and socio-cultural messages that impinged upon couple satisfaction and the potential for intimacy. These messages included:

(1) "Girls do not need schooling". This message undermined Jill's sense of personal agency.

(2) "Boys and men must go-it-alone". This message undermined Sam's ability to request help and form interdependent partnerships.

(3) "Men should succeed and be in control at all times". This message created a climate in which Sam felt inadequate and incompetent when experiencing personal or business difficulties.

(4) "Women are inferior to men by biblical standards". This message prohibited Sam from taking Jill seriously and contributed to Jill's lack of influence in the marriage.

(5) "Emotional withdrawal, substance abuse and physical intimidation are helpful tools to use in coping with stressors and conflict". This message undermined spousal affiliation and partnership as well as being psychologically and physiologically harmful.

By making familial and socio-cultural messages such as these explicit, therapists can begin to address detrimental belief systems and observe their intimacy reducing qualities.

A concern with promoting awareness of the role played by socio-cultural factors in therapy exists in ExST writings. That is, ExST theory refers to the significance of socio-cultural elements of client experience when describing the principle of ecological assessment (Friesen et al., 1989). An ecological
assessment of client difficulties is considered helpful in engaging clients and making therapy relevant to clients' lives (Friesen et al., 1989). ExST theorists write:

This assessment includes gaining an understanding of the individual, couple, family and, community context (including work, school, medical services and the police) as well as the societal/political/cultural systems and the environmental context within which the subsystem members operate. (Friesen et al., 1989, p. 9)

Hence, this study supports the continued monitoring of socio-cultural factors during the therapeutic process. However, ExST theory may be refined to alert therapists to remain aware of gender specific difficulties arising in social/political/cultural systems. A heightened therapist awareness of the societal pressures and implicit messages brought to bear on both men and women and how these pressures and messages contribute to couple dissatisfaction and a lack of intimacy could be encouraged in ExST theory. Also, a theory-based encouragement of therapist awareness regarding the debilitating effects of certain types of gender specific socialization on men would be helpful to clinicians. ExST theory alludes to the impact of detrimental aspects of male socialization on men (see page 58 of this document) but further expansion of this issue is required to aid ExST therapists in their bid to understand and work with men in heterosexual relationships.

**Emotional and Physical Intimidation in Heterosexual Relationships**

The discourse analysis revealed that Sam's emotionally and physically intimidating behaviours towards Jill and his beliefs about her inferiority were related to familial and socio-cultural factors. This finding pointed to a need for
ExST theory to address issues of female marginalization and intimidation in heterosexual relationships. Indeed, the observation that the ethical therapist intercedes in couple interactions that impede intrapersonal and interpersonal well-being and prizes marginalized experience was based on the analysis of the husband's behaviour toward his wife. Distancing and dismissive statements, ascriptions of asymmetrical influence, negative constructions of behaviour and desires for revenge were present in Sam's interactions with Jill. The therapist's use of intensification to highlight Sam's desire to remain punitive and distant and the clinician's focus on Jill's pained response aided in the valuing of Jill's previously discounted experience. The therapist's valuation of Jill's tears as a genuine expression of her pained core rather than an attempt at manipulation further highlighted the significance of the therapist's bids to prize Jill's experience and influence potentially harmful interactions. Also, the clinician's emphasis on spousal equality despite Sam's assertion of a 51%-49% split in decision-making authority underscored her proactive response to potentially harmful spousal beliefs and interactions.

The therapist's use of intensification to highlight cause and effect interactions, her prizing of previously marginalized experience and her valuation of egalitarianism in relationships mark three important clinical responses to observed interaction sequences that involve the devaluing and emotional and physical intimidation of a woman in therapy. Thus, ExST could explicitly recognize the factors, processes and issues involved in the event that a wife is marginalized and intimidated by her husband in therapy. ExST theory could highlight the therapist's role in assessing, recognizing and intervening therapeutically in these situations. Also, the explicit acknowledgement of the benefits of egalitarianism in relationships and the means by which therapist's can contribute to gender equality may be introduced into ExST theory.
Although, ExST theory has yet to articulate how to work with violence against women, the model includes a perspective on wife abuse that describes violence as being the responsibility of the offender and subscribes to informational recursivity theory (Cottone & Greenwell, 1992) to account for interaction patterns that recognize individual responsibility for behaviour (see page 47 and page 51 of this document). The research findings pertaining to Sam's emotionally and physically intimidating behaviours and his beliefs about Jill's inferiority support the continued exploration in ExST theory of issues related to wife abuse. The expansion of ExST theory to include the creation of a treatment protocol for wife assault and the continued development of informational recursivity theory as a theoretical rationale for understanding personal responsibility and initiative in abusive cause and effect sequences would be particularly helpful to clinicians.

**Informational Recursivity Theory**

The discourse analysis of Episode #2 revealed that the therapist changed the session agenda following client disagreement with the therapy direction. Thus, the clinician appeared to shift away from a compromise solution in which Jill was seen to be instrumental in fostering Sam's hurt by being unintentionally sarcastic and Sam was seen to have contributed to Jill's sarcasm by approaching her at an inconvenient time. The resolution of the conflict was for Jill to be given more time and warning to enable her to respond nurturantly towards Sam and for Sam to provide her with the time to do this. Jill required more time to consider Sam's needs and it was therefore in Sam's best interests to provide her with that time. However, this solution did not take into account two important but diverse spousal experiences. First, Jill was not being sarcastic, she was trying to commiserate with Sam and second,
Sam genuinely believed Jill intentionally set out to hurt him. As a result, distance remained between Sam and Jill. Nevertheless, later in the episode, the therapist altered her compromise agenda due to client insistence. In response to client insistence, the therapist employed process facilitation and intensification to explore the spouse’s diverse experiences. Process facilitation refers to the direct involvement of clients with one another during which the therapist actively intervenes in the exchange commenting upon ongoing, recursive client processes (Friesen et al., 1989).

The theoretical notions underlying the therapist’s compromise solution conform to premises found in systemic thinking which postulate that spouses are mutually influential and cause and effect framings of interactional sequences are inconsistent with systemic philosophy (Becvar & Becvar, 1988). That is, spouses are seen to influence one another such that one person cannot act in a particular manner without the other person’s implicit or explicit permission (Becvar & Becvar, 1988). The compromise solution forwarded by the therapist was grounded in these notions with both spouses seen to be equally responsible for the interaction that took place that morning.

Although ExST theory cites systems theorists like Becvar & Becvar (1988), the writings omit discussion of the mutual interaction and mutual influence aspects of systems thinking (Friesen et al., 1989). Instead, emphasis is placed on the systemic concern with "the relationship of some whole consisting of interacting parts in interaction with its environment" (Friesen, et al., p. 22). This view does not account for the possibility of differential influence between interacting parts and the possibility of cause and effect sequences of interaction.

While ExST theory remains vague in its treatment of the notion of mutual influence and cause and effect sequences, the therapist in the present study
put mutual influence theory into practice in Episode #2 when she forwarded the compromise solution. However, the therapist altered the therapy direction due to client insistence when the compromise solution did not address spousal concerns or experiences. The therapist altered the therapy agenda away from one in which both spouses were held equally responsible for the morning interaction to a therapy direction that favoured a cause and effect understanding of couple dynamics with a focus on personal initiative and responsibility. Through the use of process facilitation, the therapist ascertained that Sam misunderstood Jill’s clumsy attempt to commiserate with him and angrily sought vengeance for a perceived wrong. Sam's desire for revenge and punitive behaviours contributed to Jill's self-protective retreat highlighting the importance of developing theory that can track cause and effect sequences, ascribe individual responsibility and initiative during potentially harmful interactions and account for differential influence in systems. Based on the cause and effect observation that Sam's vengeful actions hurt Jill, the therapist invited Sam to "do something different" rather than continue to perceive Jill as manipulative and punitively withdraw. Thus, responsibility for initiating a change in the interaction pattern was placed upon Sam in recognition of his particular role in the conflict.

ExST theory adopted the notion of informational recursivity theory (Cottone & Greenwell, 1992) to begin to address cause and effect sequences of interaction and the need for frameworks that recognize individual responsibility in interactions with others. According to ExST theory, the notion of informational recursivity can be utilized to aid therapists in understanding problematic couple interaction patterns prior to and during therapeutic activities designed to encourage relational novelty. Informational recursivity describes cause and effect sequences of behaviour in which the behaviour of one spouse
serves as information influencing the behaviour of the other. As such the notion of informational recursivity has the potential of re-introducing the idea of personal responsibility and accountability for one's actions as opposed to obfuscating who does what to whom.

The obfuscation of cause and effect sequences between spouses was made possible through the creation of a false dichotomy between circularity and linearity (Cottone & Greenwell, 1992). This dichotomy can be described as one in which linearity connotes cause and effect sequences and circularity connotes mutual interaction and mutual influence such that one person cannot dominate another without that person's consent (Becvar & Becvar, 1988). However, cause and effect sequences can occur in a circular fashion without implying equality or complicity where there is none. The notion of informational recursivity partially addresses the need for theory that accounts for descriptions of people's reactions and actions with respect to one another without removing personal responsibility and individual initiative from the equation.

In sum, the continued application and development of informational recursivity theory can be helpful to clinicians especially when practitioners encounter cause and effect interactions and therapeutic situations in which differential spousal influence exists. From this vantage point, informational recursivity theory could be particularly helpful in aiding in the development of a treatment protocol for wife abuse. Wife abuse can be explicitly addressed through notions forwarded in informational recursivity theory that highlight the effects of abuse on wives and hold husbands responsible for their actions. Not obfuscating the husband's responsibility and the wife's pain may aid in the generation of therapist interventions and begin to address the intimacy destroying aspects of intimidating interactions.
Summary

The findings of this single case study research contributed to the continued development of ExST theory by revealing the existence of a particular type of relational novelty namely syncetic relational novelty. The discovery of syncetic relational novelty and the means by which it was facilitated in therapy offered an opportunity to support, refine and expand ExST theory. ExST theory was supported in its formulation of the significance of intense experiential activity in generating relational change and its articulation of the six components of intensification important to the deepening process. While the significance of the six components of intensification noted in ExST writings was supported in this study, the utilization of the six methods of intensification were revealed to be context dependent heralding a necessary refinement to ExST theory. This refinement includes the acknowledgement that all six components of intensification are not essential to the deepening process and may be employed on a context dependent basis during therapy. In addition, ExST theory may be expanded to include the recommendation that experiential intensity be regulated according to client readiness cues and session number or therapy phase.

Also, the study established support for ExST writings concerning the co-development of the therapy venture via the adoption of client language structures and the incorporation of the totality of client experience. Also, this research identified the importance of the therapist's participatory role underscored in ExST theory.

As well as supporting current articulations of aspects of ExST theory and highlighting areas in need of refinement, the study indicated the need for the expansion of ExST in several important areas. In particular, the study results point to the need for an expanded articulation of gender issues in ExST theory.
Specifically, the inclusion of a recognition of certain aspects of male/female socialization which reduce the potential for intimacy in heterosexual couples needs to be addressed in ExST thinking. Furthermore, an acknowledgement of the negative socio-cultural pressures on men and the role these pressures play in impeding intimacy would be helpful to clinicians in their work with husbands in heterosexual partnerships. This study also highlighted the need for an assessment and treatment protocol for ExST therapist's working with husband's who believe their wives to be inferior and who employ emotional and physical intimidation in their relationships. As well, it is recommended that ExST theory continue the development of informational recursivity theory (Cottone and Greenwell, 1992) to lend theoretical support and direction to therapists who work with husbands who abuse their wives.

Study Links to the Literature

The following section situates this research study in the current literature regarding couple and family therapy process research. Accordingly, the study findings will be integrated with previous research endeavours to expand the knowledge base in the area of family and couple therapy process.

In the main, the therapy context in which this research study provides the most application is with the clinical genre encompassing experiential therapies. The following discussion will synthesize the findings of this study with the results of studies aimed at understanding experiential therapy. An articulation of where this study and previous research efforts intersect will be undertaken. A discussion of the specific contributions this study makes to the field of couple and family therapy process with a particular emphasis on experientially oriented therapy will be provided.
The findings of this study add to several of the conclusions made in other research endeavours including findings pertaining to intensification or deepening experience, therapist/client collaboration, the importance of experiential activity and attention to gender issues in therapy process research. In addition, the study results add to current understandings regarding experiential couple therapy process by identifying the importance of syncretic or intimacy oriented relational change, documenting the qualities of the intensification process and highlighting the centrality of the therapist guide role.

**Intensification or Deepening Experience**

Several researchers highlighted the importance of the intensification or deepening process to marital satisfaction, intimacy, acceptance of problematic states and the conduct of experiential activities (Dechenne, 1973; Dubberley-Habich, 1992; Johnson & Greenberg, 1988; Wiebe, 1993). The study featured here concurs with the literature in underscoring the importance of deepening experience during experiential activity to contribute to increased client affiliation, self-disclosure and spousal acceptance (Johnson & Greenberg, 1988). Indeed, the research highlighted the importance of client vulnerability and self-disclosure as contributors to the generation of in-session relational change lending some support to Dechenne’s (1973) contention that deep experiencing in therapy was related to increased marital health and more constructive and less structure bound relationships. In addition, this study noted how deep in-session experiencing was given an intimacy enhancing purpose when intensification was employed to foster joint partnership, highlight the effects of hostile, dominant and coercive behaviours and encourage vulnerable self-expression. These findings correspond to Johnson and Greenberg’s (1988) results indicating that deep experiencing facilitated client
"softening" which was related to successful therapeutic outcome and fewer blaming, dominating and coercive spousal interactions. Johnson and Greenberg (1988) and Dubberley-Habich (1992) both observed that deepening client experience facilitated affective exploration and disclosure of painful emotion. This finding was noted in the current study during in-session intense experiencing.

In addition, Wiebe (1993) observed how the intensity of deepened client experience was regulated through the use of humour, validation, topic changes, cognitive analyses of affective phenomena and therapist pacing according to client cues. A similar notation was made in the present study including the observation that the therapist modulated her empathic responses to decrease or increase the intensity of client experiencing dependent upon client cues and therapy phase. Client cues employed to determine experiential pacing included vague self disclosure, reference to past events during a focus on here-and-now experiencing, "yes but" statements, embedded requests and minimizations of self report data.

**Therapist/Client Collaboration**

The drawbacks of a noncollaborative therapeutic stance were documented by Patterson and Forgatch (1985) and by Gale (1989). Specifically, Patterson and Forgatch (1985) noted that teaching and confronting therapist behaviours elicited client resistance giving rise to the observation that an expert therapist stance when undertaking parent training may decrease the clinician's ability to aid the client. Similarly, Gale's (1989) analysis revealed that the Solution Oriented Therapy approach of "ignoring the listener" engendered client disagreement and an ensuing struggle between the therapist and the client for input into the direction of therapy. The aim of
decreased interpersonal distance symbolized by the letting go of an extra-marital affair (Gale, 1989) and improved parenting skills (Patterson & Forgatch, 1985) may have been hampered by the therapist's confrontational instructor and unyielding expert stance in therapy.

The study featured in this dissertation noted the importance of taking a participatory, collaborative stance in therapy including a willingness to change the therapy agenda when encountering client disagreement. The purpose of the provision of this type of collaborative atmosphere was to contribute to the generation of increased couple intimacy and to facilitate effective couple interaction patterns.

The significance of the collaborative therapist stance was noted by Dubberley-Habich (1992) and Wiebe (1992) with emphasis placed on the collaborative therapist's participatory role in therapy and her employment of the collaborative role to incorporate the totality of client experience into the therapeutic story. The validation of client strengths was also observed to be a technique employed by a collaboratively oriented therapist (Wiebe, 1993). The present study uncovered the importance of collaboration in the context of successful experiential therapy with a special emphasis on therapist participation and adoption of the client's world in therapy. In addition, the principle of collaboration offered the clinician a theory driven rationale for acknowledging client dissent and altering the therapy agenda in response.

**Gender Issues in Heterosexual Couples Therapy**

The influence of gender issues in heterosexual couples therapy was alluded to by Wiebe (1993) who along with Maltz and Borker (1982) acknowledged the importance of recognizing the gender context as significant in therapeutic transactions between men and women. In particular, Wiebe
(1993) noted how the therapist elevated the wife's status in the relationship by encouraging her role in decisions concerning alcohol, its consumption and its storage. In addition, Wiebe (1993) observed that the woman was dismissed by her husband in an intimidating fashion when attempting to engage in joint decision-making activity. The findings of this study expand upon Wiebe's (1993) efforts to account for gender issues in therapy by recognizing the role played by male/female socialization on the potential for couple intimacy. As a result, specific recommendations were made suggesting ExST theorists continue work on expanding theory concerning negative socio-cultural pressures on men as well as developing a protocol for working with wife abuse.

As well as pioneering discussion of gender issues in couples therapy process research with Wiebe (1993), the study featured in this document made some important contributions to other aspects of experiential therapy theory. For example, the discovery of the importance of intimacy oriented relational change as part of the intensification process, the centrality of the therapist's guide role in experiential therapy and a description of the qualities of the intensification process itself increased understanding of the processes important to experiential therapy theory.

**Syncretic Relational Novelty**

Both Dechenne (1973) and Johnson and Greenberg (1988) commented upon the intimacy enhancing effects of deep experiencing. These authors described couples who engaged in deep experiencing as affiliative, constructive, capable of personal and affective disclosure, less rigid, hostile and coercive than couples who did not engage in deep experiencing (Dechenne, 1973; Johnson & Greenberg, 1988). Marital satisfaction and successful
therapeutic outcome were found to be related to intense experiencing and experiential therapy (Dechenne, 1973; Johnson & Greenberg, 1988). Thus, the notion that deep experiencing offers a means of generating increased couple intimacy received some empirical support. However, none of the research projects investigating experiential therapy commented upon the overarching theoretical utility of this finding. As a result, the current study findings with respect to syncretic relational novelty represent an initial attempt to address the process of intimacy enhancement in experiential couples therapy. That is, syncretic relational novelty provides a framework for understanding the shift that occurs when couples move from distance oriented interactions to intimacy enhancing exchanges. The concept offers a potential explanatory system for observations of couple "softening" in EFT and gives various therapeutic activities including the engagement of experiential activity such as ritual, symbolic externalization and two-chair work intimacy enhancing purpose. Further work is required to ascertain the applicability of syncretic relational novelty to other experiential therapies. However, the syncretic change process described in this research may offer a springboard to developing a common language for explaining experiential therapy process as it contributes to the generation of couple intimacy and harmony.

**The Centrality of the Therapist Guide Role**

Therapist activities including "teaching" (Patterson & Forgatch, 1985), "ignoring" (Gale, 1989), "collaborating and participating" (Dubberley-Habich, 1992; Wiebe, 1993), "organizing" (Turner, 1972) and "stimulating and supporting" (Postner et al., 1971) are well documented in the therapy process literature. However, commentary on the therapist's guiding function including the clinician's disproportionate responsibility for the therapy process is lacking
in therapy process research. The findings of this study include the notion that the therapist enters into a non-neutral relationship with the clients in which the clinician is fully a participant and proportionately more responsible than the clients for the process. The ExST therapist is a collaborative guide whose role is founded, partly, upon the dual themes of the assumption of disproportionate expertise and the client-based authority to act upon this expertise.

It is hoped that a recognition of therapist expertise and the resulting ethical responsibilities encountered when engaging experiential activity will aid in the continued development of client-sensitive experiential therapy. Also, the notions presented in this study concerning implicit meta-assumptions associated with the conduct of therapy may contribute to further therapy process research that centers on or accounts for therapist responsibility and influence in clinical practice.

**Qualities of the Intensification Process**

Students of ExST have lamented the lack of direction offered in the ExST manual describing "how to" intensify client experience (Friesen et al., 1989). The results of this study not only lend support to ExST theory in its description of the methods of intensifying experience but also offer examples to interested clinicians of how the intensification process can be conducted in therapy. This study along with the research of Wiebe (1993) and Dubberley-Habich (1992) provides a service to clinicians interested in case example descriptions of various therapeutic processes and techniques. Case study research using discourse analysis methodologies provides a rich opportunity for the study of therapy technique unavailable when quantitative methods that codify therapy activity are employed (i.e, Johnson & Greenberg, 1988).
Limits of the Study

This section is concerned with the limits of the present study including a discussion of the generalizability of this investigation and the potential threats to internal validity existing in this research endeavour.

Generalizability

To aid in the discussion of the generalizability of this study, this section will review the central issues involved when the external validity of single case therapy change process research is considered. The synopsis of issues in external validity will be followed by commentary on the application of these concerns to this research project.

External validity refers to establishing whether the results of the investigation can be generalized beyond the case studied to broader theory (Yin, 1989). This requires the clear articulation of analyzable theory and a well-defined research question, design and study method. The current investigation is detailed in its design and method so that applied theory may be reviewed, refined and expanded. In this study, external validity is increased through the explicit delineation of pertinent theory. Theory building requires a clear statement of the current state of the theory under scrutiny and a detailed and logical analysis of its application in order to add to knowledge.

According to Yin (1989) "the appropriately developed theory also is the level at which the generalization of the case study results will occur" (p. 38). This is termed analytic generalization as opposed to statistical generalization. In statistical generalization, inferences are made regarding a population on the basis of the data collected from a representative sample. Yin (1989) asserts that it is erroneous to apply statistical generalization to the results of case studies. Cases are not sampling units and have not been chosen to be
representative of a population. Case studies are selected on the basis of how well they reflect a given theory under review.

Analytic generalizability is achieved when previously developed theory is compared with the results of the case study. If similar cases are investigated later and are shown to support the theory then replication has been achieved. This process parallels the replication efforts made in experimental and quasi-experimental research endeavours.

The research presented in this dissertation is a single critical case study aimed to illumine aspects of ExST theory. In particular, this study was concerned with how relational novelty was generated by therapist and clients in successful ExST couples therapy. As a result, the development of construct validity was important to the generalizability of this study. The exacting articulation and identification of pertinent ExST theory contributed to external validity by ensuring that the study findings related to the theory topic of investigation. In addition, the employment of a rigorous method of analysis (CDA), further strengthened the analytical generalizability claims made in this study. Thus, the development of construct validity entailed the utilization of measures that truly captured the concepts under study (Yin, 1989).

In the present study, a successful case of ExST couple's therapy was selected on the basis of therapist and client report and the completion of a standardized measurement protocol. The self-report data and information garnered from the questionnaire package indicated a positive therapeutic outcome in which the cessation of alcoholic drinking and increased intrapersonal and interpersonal satisfaction was realized. Of particular interest in this study was the change construct called relational novelty. The construct was identified in each episode selected for analysis by expert judges trained in ExST. Thus, the study results can be generalized only to ExST theory as it
pertains to successful couple's therapy. However, since ExST belongs to the broader field of experiential therapies, the study results may be generalized to experiential therapy theory in the area of intensification or deepening of experience. Nevertheless, the study results cannot be generalized to other therapy theories. In addition, the findings presented here are based on an analysis of successful couple's therapy and make no direct comment on theory related to the dynamics involved in unsuccessful ExST couple's therapy.

**Internal Validity**

Internal validity is a concern for research endeavours where causal or explanatory inferences are made. This study revealed two elements considered to be contributors to a syncretic couple shift in therapy. These elements included the introduction of intense experiential activity and the provision of a collaborative environment. The articulation of these factors represents an attempt to both explain and describe how convergence of disparate couple belief and practice occurs. This finding reflects an effort to identify a relationship between the two aforementioned elements of convergence and the generation of syncretic relational novelty in this case study. However, it is reasonable to believe that other factors also may have contributed to the syncretic shift observed in this investigation. The possibility of additional explanations for the syncretic phenomena observed in this study leads to a discussion of three potential threats to internal validity. These threats include factors relating to analyst interpretations, segmenting therapy process and proximal versus large "O" outcome.

**Analyst Interpretation versus Participant Report**

It could be argued that understanding how change is created in-session may best be achieved by asking participants rather than inferring from pre-
selected change moments. In this study, the researcher selected change episodes for analysis and then inferred from a discourse analysis of client and therapist utterances how relational novelty was generated. Thus, it could be argued that what the analyst viewed as important to the creation of change may not be shared by clients or therapist.

However, this concern neglects to account for the fact that both methods, client/therapist retrospective interview and CDA, rely upon the client and therapist version of events. It is the format that is different. For example, CDA uses tapes of clients and therapists engaged in therapy while interview procedures use tapes of clients and therapists talking about previously conducted therapy. In both cases, therapy participants' views concerning their therapy are employed either during the therapy (CDA) or after it (retrospective interview) and then interpreted by researchers to understand the nature of therapeutic change. In both cases, a researcher is required to make sense of the data by remaining faithful to it. For the purposes of this study, the appeal of CDA was it afforded the opportunity to study change while it was occurring as opposed to a retrospective view of the creation of change. Nevertheless, neither method is considered superior in its ability to inform since they garner different types of information to be synthesized and interpreted by researchers. Finally, the choice of method is governed by the research question being posed. Thus, a question about client/therapist retrospective views on the co-creation of change is different from a question concerning the manner in which change is co-created by clients and therapist in naturally occurring therapy. Both questions require the use of different research methods to offer a worthy answer.

However, as stated earlier, analyst's are required to make sense of data garnered from either research method. The study is limited by the analyst's
interpretations of the text as well grounded as the interpretations may be. Something may be missed, something may be explained clumsily for want of adequate descriptors, something may be over or under emphasized from various readers' viewpoints both now and in the future. Indeed, the analyst may re-read the analysis several years from now and want to change aspects of it. Notwithstanding these limits to awareness and understanding, the goal of hermeneutical work is to provide ones best effort at the time one made the effort rather than attempt to capture an inalienable truth. Consensus amongst readers that an interpretation is satisfactory is wrought by agreement with the essence of the argument, its internal logic and flow and its adherence to the text from whence it originated.

Accordingly, the reader will recognize the analysis as valid or reject it as being superficial based on the logic of the argument made by the analyst as well as the reader's own experience and the advent of new information existing beyond the bounds of the initial research investigation (Katz, 1983).

**Segmenting Therapy Process**

This study sought to explore a theoretical construct called relational novelty. The isolation of this construct for investigative purposes necessitated the segmentation of therapy into relationally novel "episodes". The means by which segmenting therapy process offers a threat to internal validity is through the potential omission of subject matter pertinent to the research inquiry. The segmenting process (although necessary in answering the research question and ensuring construct validity) can lead to oversights when the research scope is narrowed. Thus, segmenting therapy may reduce the analyst's ability to account for the potential plethora of factors existing to explain a given phenomenon.
However, the CDA procedure was designed to account for as much of the therapy discourse as possible (Labov & Fanshel, 1977). CDA relies upon the incorporation of past and future discourse to generate interactional statements aimed at understanding how discourse participants influence each other. As a result, episodes of relational novelty analyzed in this study include as much relevant data as possible from the entire 15 sessions of therapy.

**Proximal Versus Large "O" Outcome**

This study delved into the manner in which change was co-created by clients and therapist in the context of successful marital therapy. The relationally novel moments selected for analysis represent proximal outcomes. That is, there is a distinction to be made between proximal and large "O" outcome. Proximal outcome refers to in-session and immediate post-session change that appears directly related to session content. Large "O" outcome refers to changes noted at the end of a course of therapy and at follow-up that may be related to the culmination of proximal shifts and between session phenomenon. It could be that the series of proximal changes which occurred in the analyzed therapy contributed to the large "O" success but this study cannot address this question. In this study, proximal change was analyzed in the context of large "O" success to understand how proximal change was co-created by the therapeutic system. This study's contribution to an expanding understanding of ExST therapeutic change was to investigate the nature of proximal change in a successful case of ExST couple's marital therapy and to postulate how this change occurred. Nevertheless, the relationship between proximal and large "O" outcome is of interest to change process researchers and further research would be required to link relationally novel episodes to large "O" therapeutic success.
Future Research Directions

Potter and Wetherell (1987) note that salient process research studies should give rise to new problems and areas of interest. The present research study results generated a variety of new research pursuits. The problems highlighted by this investigation center mainly on theoretical and methodological concerns. For example, from a theoretical viewpoint, a question arises regarding the possible existence of additional types of relational novelty besides syncretic relational novelty discovered in this research study. Also, future research projects may focus on the discovery of important factors associated with the convergence of disparate belief and practice in addition to those pinpointed in this study.

Questions concerning the applicability of the notion of syncretic change to other therapies is of interest to theoreticians and practitioners. In addition, the recommendation that ExST formulate a protocol for working with wife abuse underscored an important discourse analysis research area in which client strategies of intimidation and control are documented and therapist responses observed. In a similar vein, negative implicit socio-cultural messages regarding appropriate masculine behaviour could be located in the discourse and categorized enabling therapists and theorists to identify pressures on men that threaten their intrapersonal and interpersonal well-being.

This study examined therapeutic discourse in the context of successful therapy. The investigation of ineffective change processes in the context of unsuccessful therapy may lead to the continued illumination of factors involved in syncretic relational novelty when unsuccessful client discourse is analyzed.

A methodological question arising from this study centers on a comparison between two or more different analyst interpretations of the same segment of therapy discourse. A study designed to answer this type of
question would document thematic similarities and differences between the analysts' interpretations of the text. For example, it has been observed by this researcher, on an informal basis, that the expansion, proposition and interactional statements made by different students studying the same transcript are thematically similar, varying mainly in depth of analysis.
REFERENCES


Grimshaw, A. D. (1979). What's been done-when all's been said? Contemporary Sociology, 8, 170-176.


APPENDIX A

INTRAPERSONAL PATTERNS OF RELATIONSHIP
Joe: Hurt, frightened, needing of care aspect of self.
Sue: Hurt, frightened, needing of care aspect of self.

Joe: Powerless aspect of self feels put upon by guilty aspect and gets angry at hurt aspect.
Sue: Helpless aspect of self feels blamed and gets angry at hurt aspect.

Joe: Guilt ridden, shamed aspect of self invalidates hurt aspect of self.
Sue: Self blaming aspect of self in validates hurt aspect.

Substantive Relational Themes: Unlovableness and Self-Abandonment
APPENDIX B

INTERPERSONAL PATTERNS OF RELATIONSHIP
Joe is verbally and physically abusive towards Sue. He is afraid Sue does not care for him, feels powerless over this and explodes.

Sue is distrustful, has seen this before. She is frightened and angry and keeps Joe at arms length. She desperately wants it to be real but remains unconvinced due to past experience. The pressure builds between the couple.

Sue becomes angry threatens to leave and/or retaliates. She is frightened of Joe, afraid he does not care and feels like a failure.

Joe is remorseful and attentive after hitting Sue. He feels guilty, ashamed undeserving of Sue’s love and tries to make amends.

Substantive Relational Themes: Unlovableness and Self-Abandonment
APPENDIX C

ENVIRONMENTAL PATTERNS OF RELATIONSHIP
* Men are violent towards women.
  Women bear the brunt of this violence.

Men feel isolated, frustrated and alienated.
Women feel isolated, alienated and frustrated.

Culture promotes violence as a way to solve problems.

Men struggle with how to be intimate with each other and women.
Women do not feel safe in the streets or at home and feel invalidated.

Substantive Relational Theme: Alienation

* Please note that this pattern is representative of a general trend and does not apply to all men and all women all of the time.
APPENDIX D

A COMPOSITE OF THE THREE PATTERNS OF RELATIONSHIP
* Please note that this pattern is representative of a general trend and does not apply to all men and all women all of the time.
APPENDIX E

THERAPIST COMPETENCY FORM
Please answer the following questions, based on the information you have about this therapist's conduct in this experiential systemic therapy session in The Alcohol Recovery Project.

1. In this session, how close does the therapist come to emulating your concept of the principles of experiential systemic therapy?

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Completely unlike
emulation

Somewhat like
emulation

Completely matches emulation

This item is meant to measure your impression of the therapist over the course of the entire session.

2. In this session, how close does the therapist come to emulating your concept of the appropriate selection of techniques in this therapeutic circumstance?

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Completely unlike
emulation

Somewhat like
emulation

Completely matches emulation

This item is meant to measure your opinion regarding the appropriateness of what the therapist did in the session considering issues such as timing, client receptiveness, fit in the therapeutic mandate.
3. In this session, how close does the therapist come to emulating your concept of the skillful implementation and utilization of techniques?

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<td>Completely unlike</td>
<td>Somewhat like</td>
<td>Completely matches</td>
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<td>emulation</td>
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This item is designed to measure your assessment of how well the therapist used techniques towards the ends of the therapeutic mandate. Principle issues of concern in this item are the smoothness of introduction, rationale provided to contextualize tasks, appropriate level of therapeutic intensification of experience and the systemic connection of the activity to the client's relational context.

4. In this session, how close does the therapist come to emulating your concept of being in an experiential systemic therapeutic relationship with the client(s)?

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This item is meant to measure your view on the degree to which the therapist assumed an interpersonal stance congruent with the collaborative, warm, empathic, open, spontaneous, respectful and sincere and developmental attributes seen as central to experiential systemic therapy.

5. If you were conducting an Outcome study in experiential systemic therapy, how comfortable would you be in selecting this therapist to participate at this time (assuming this session is typical)?

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<tbody>
<tr>
<td>extremely uncomfortable</td>
<td>ambivalent</td>
<td>extremely comfortable</td>
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This item is meant to measure the degree to which you endorse this therapists conduct as being an acceptable representation of experiential systemic therapy.

6. How rigidly entrenched did you feel this client was to work with in this session?

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<td>not entrenched</td>
<td>moderately entrenched</td>
<td>extremely entrenched</td>
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This item is meant to measure your assessment of the degree difficulty and challenged the therapist was faced with in working with this client.

7. How productive was this session in moving towards the goals of the therapy?

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<tr>
<td>not productive</td>
<td>somewhat productive</td>
<td>optimally productive</td>
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This item is meant to measure your impression of the quality of the session in terms of accomplishing the therapeutic mandate.
APPENDIX F

RELATIONAL NOVELTY IDENTIFICATION FORM
RELATIONAL NOVELTY IDENTIFICATION FORM

A. Therapist and Couple Collaboration

1. Empathy: Was the therapist empathetic towards the clients (e.g., she/he sensitively and imaginatively entered the clients' worlds)?
   
   YES   NO

2. Rapport: Did the therapist and clients get along?
   
   YES   NO

3. Warmth: Did the therapist convey warmth?
   
   YES   NO

4. Genuine Involvement: Was the therapist involved with the clients?
   
   YES   NO

5. Non-judgemental: Did the therapist convey positive regard for the clients' personhood?
   
   YES   NO

6. Joint venture: Was the therapy a joint venture between therapist and clients and did they work together to explore therapeutic issues?
   
   YES   NO

7. Intrusion: Did the therapist intrude upon the clients with his/her own life story, ideas or values?
   
   YES   NO

8. Coercion: Was the therapist coercive in his/her dealings with the clients?
   
   YES   NO

9. Dependency: Did the therapist foster undue dependency?
   
   YES   NO

10. Incorporate client language: Did the therapist incorporate the clients' language and experience into the episode?
    
    YES   NO

11. Safety: Was there a sense of safety in the therapeutic context?
    
    YES   NO
12. Acknowledgement and affirmation: Did the therapist acknowledge and affirm the clients' feelings, thoughts and actions?

YES    NO

13. Commitment: Did the therapist commit him/herself to help the clients to the fullest extent possible?

YES    NO

14. Open to experience: Was the therapist open to his/her own experience (e.g., shares humanness, demystifies role, builds collaboration)?

YES    NO

15. Flexibility and adaptability: Did the therapist adapt to the clients' style (e.g., open to new information, readiness to grow with the clients)?

YES    NO

16. Sense of mutuality: Did the therapist build a sense of mutuality by using terms such as "we" and "us"?

YES    NO

17. Negotiating therapy content: Did the therapist discuss session activities in such a way as to ensure an opportunity for client input?

YES    NO

B. Intensification

18. Symbolic qualities: Did the therapist show evidence of having listened and understood the metaphoric significance of gestures and other symbolic communication?

YES    NO

19. Deepening, enhancing and broadening experience: Did the therapist increase the clients' awareness of current feelings, perceptions and physical states?

YES    NO

20. Action oriented: Did the therapist use action oriented activities as a means of intensifying experience?

YES    NO

21. Novelty and playfulness: Did the therapist provide a context of novelty and playfulness in therapy?

YES    NO
22. Relational substance of experience: Did the therapist focus on the relational substance of experience (e.g., rejection, dominance, subjugation, loss, attack, isolation, fear, withdrawal, trust)?

   YES          NO

23. Use of language: Did the therapist use concrete, explicit, detailed, metaphorical and pictorial language as a means of deepening experience?

   YES          NO

24. Underlying emotions: Did the therapist identify underlying emotions such as fear, rejection, hopelessness and powerlessness?

   YES          NO

25. Detailing certain aspects: Did the therapist and clients explain the exact aspects of the situation (e.g., who was present, personal thoughts and feelings, and bodily sensations of each person in the situation)?

   YES          NO

26. Amplifying bodily aspects of experience: Did therapist intensify bodily aspects of experience (e.g., asking clients to identify bodily experiences, repeat statements or give voice to body parts or sensations)?

   YES          NO

27. Accurate empathy: Was the therapist accurate in his/her reflections of the clients' feelings, thinking and behaviour?

   YES          NO

C. Atypical Processes

28. Focus on current dynamics: Did the therapist focus on the clients' overt or covert here and now issues (e.g., interpersonal and intrapersonal conflict)?

   YES          NO

29. Focus on transition: Did the therapist focus on the clients' current transition from one way of being to another?

   YES          NO

30. Novel patterns: Did the therapist assist the clients in developing and enacting alternative patterns of behaviour, thought and feelings (e.g., ways of being in relationship with self, spouse or presenting problem)?

   YES          NO
D. Identification of Novelty

31. Identification of novelty: Did the clients identify something new about self, their spouse or the presenting problem (e.g., statements such as I never said, did or knew that before now)?

   YES  NO

E. Systemic Hypothesis

32. Relational Hypothesis: Did the therapist show evidence of recognizing the connections between the problem and clients' relationships with self, spouse, presenting problem or environmental context?

   YES  NO

33. Systemic Focus: Did the therapist maintain a focus on the clients' relationships with self, spouse, presenting problem or environmental context (e.g., a focus on expectations, feelings, thoughts regarding their relationships)?

   YES  NO

F. Relationally Novel Sequence

34. The therapist suggested delving into a salient aspect of the clients narratives or utterances.

   YES  NO

35. The clients consented (either explicitly or implicitly) to the exploration of their narratives.

   YES  NO

36. The therapist guided the clients through a deep, intense and novel encounter with self, spouse or the presenting problem.

   YES  NO

37. The encounter ended with a de-intensification during which the therapist marked a change, congratulated the clients, summarized the segment or asked the clients for their views.

   YES  NO

38. The therapist encouraged the clients to talk about the experience or they did so spontaneously.

   YES  NO
39. Overview: Overall, would you consider this episode to be an example of relational novelty?

   YES       NO
APPENDIX G

JEFFERSON'S NOTATION SYSTEM
The following explanation of transcript notation was drawn from Jefferson's notation system (Schenkein, 1978):

1. The point where overlapping utterances stop overlapping is marked with a single right-hand bracket:

   Tom:  I used to smoke a lot more than this
         [ ]
   Bob:  'I see

2. When there is no interval between adjacent utterances, the second being latched immediately to the first (without overlapping it), the utterances are linked together with equal signs:

   Tom:  I used to smoke a lot =
   Bob:  = He thinks he's real tough

3. The equal signs are also used to link different parts of a single speaker's utterance when those parts compromise a continuous flow of speech that have been separated to different lines by transcript design, accommodating an intervening interruption:

   Tom:  I used to smoke a lot more than this =
         [ ]
   Bob:  You used to smoke
   Tom:  = but I never inhaled the smoke

4. A short untimed pause within an utterance is indicated by a dash:

   Dee:  Umm - my mother will be right in

5. Untimed intervals heard between utterances are described within double parentheses and inserted where they occur:

   Rex:  Are you ready to order ((pause))
   Pam:  Yes thank you we are

6. A colon indicates an extension of the sound or syllable it follows:

   Ron:  What ha:ppened to you
   and more colons prolong the stretch:

   Mae:  I ju::ss can't come
   Tim:  I'm so::: sorry re:::ally I am

7. A period indicates a stopping fall in tone, not necessarily the end of a sentence.
8. A comma indicates a continuing intonation, not necessarily between clauses of sentences.

9. A question mark indicates a rising inflection, not necessarily a question.

10. An exclamation point indicates an animated tone, not necessarily an exclamation.

11. Emphasis is indicated by varieties of italics, the larger the italics the greater is the relative local stress:

   Ann: It happens to be mine
   Ben: It's not either yours it's mine
   Ann: I DON'T KNOW WHY YOU'RE SO HARD ON THIS

12. Audible aspirations (hhh) and inhalations (.hhh) are inserted in the speech where they occur.

13. Double brackets are used to enclose a description of some phenomenon the transcriptionist does not want to wrestle with. These can be vocalizations that are not, for example, spelled gracefully or recognizably:

   Tom: I used to ((cough)) smoke alot
   or other details of the conversational scene:
   Jan: This is just delicious
   *((telephone rings))*
   Kim: I'll get it

   or various characterizations of the talk:
   Ron: *((in falsetto *)) I can do it now
   Max: *((whispered *)) He'll never do it

   or to indicate physical movement (this notation has been added to Jefferson's notation system to accommodate physical movements):

   Tom: I used to ((points finger at cigarettes)) smoke a lot

14. Items enclosed within single brackets are in doubt, as in:

   Ted: I ('spose I'm not)

15. When single brackets are empty, no hearing could be achieved for the string of talk or item in question:

   Todd: My ( ) catching (Schenkein, 1978, pp. xii-xv)
APPENDIX H
ALCOHOL DEPENDENCE DATA QUESTIONNAIRE
Alcohol Dependence Data Questionnaire

ADDQ Score

Severe Dependence
Moderate Dependence
Mild Dependence

Pre-test Post-test Follow-up
Measurement Occasion
APPENDIX I

SYMPTOM CHECKLIST 90 REVISED
SCL-90-R Global Severity Index

GSI Scores

- Symptomatic Range
- Normal Range

Pre-test  Post-test  Follow-up
Measurement Occasion

- Sam
- Jill
APPENDIX J

BECK DEPRESSION INVENTORY
Beck Depression Inventory

BDI Score

25
20
15
10
5
0

Pre-test  Post-test  Follow-up
Measurement Occasion

Moderate-Severe Depression
Mid-Moderate Depression
Normal Range

Sam
Jill
APPENDIX K

DYADIC ADJUSTMENT SCALE
Dyadic Adjustment Scale

DAS Score

- Normal Range
- Distressed Range

Pre-test  Post-test  Follow-up
Measurement Occasion

Sam
Jill
APPENDIX L

STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOUR, SAM
Structural Analysis of Social Behaviour (Sam)

**SASB Cluster Score**

Cluster Number

Measurement Occasion
- Pre-test - Post-test - Follow-up

**CLUSTER NUMBER KEY**

1 = SPONTANEOUS SELF  
2 = SELF-ACCEPTING & EXPLORING  
3 = SELF-NOURISHING & CHERISHING  
4 = SELF-PROTECTING & ENHANCING  
5 = SELF-MONITORING & RESTRAINING  
6 = SELF-INDICTING & OPPRESSING  
7 = SELF-REJECTING & DESTROYING  
8 = DAYDREAMING & SELF-NEGLECTING
APPENDIX M

STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOUR, JILL
Structural Analysis of Social Behaviour (Jill)

SASB Cluster Score

Measurement Occasion
- Pre-test → Post-test → Follow-up

<table>
<thead>
<tr>
<th>Cluster Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SPONTANEOUS SELF</td>
</tr>
<tr>
<td>2</td>
<td>SELF-ACCEPTING &amp; EXPLORING</td>
</tr>
<tr>
<td>3</td>
<td>SELF-NOURISHING &amp; CHERISHING</td>
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<tr>
<td>4</td>
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<td>SELF-REJECTING &amp; DESTROYING</td>
</tr>
<tr>
<td>8</td>
<td>DAYDREAMING &amp; SELF-NEGLECTING</td>
</tr>
</tbody>
</table>
APPENDIX N

TRANSCRIPTION OF EPISODE #1: THE BOTTLE IS SHOWN THE DOOR
Th: (.hh)Andah ((left hand elevated and rocking)) on the one
((left hand gestures, palm up)) hand it makes it harder for you
Sam - that alcohol is in the house ((Jill looks toward Sam))
(.hh)and on the other hand ((left arm opening, palm up, right=
[ ])
S: ((weakly)) Yeah
Th: =arm lifting, opening, dropping back to lap)) you think
we::11 if I wanted it I'd get it anyway ((hh)part of you ((left
hand raised, fingers bent in rocking motion)) thinks well lets=
[ ]
S: =just keep it there ((makes a fist with left hand))=
S: =Well its the challenge ((makes a fist in front of own face
with right hand))=
[ ]
Th: Yeah
S: =its= its there its like that ((points toward the bottle))
sitting there ((Jill looks toward bottle while Sam points)) like
that really catches my eye - and ah - (.hh) you know - ((shrugs=
[ ])
Th: Yeah ((scratches face, Jill looks toward Sam))
S: =shoulders)) it-it's the same sort of thing it-it's benign
((points to bottle and looks toward therapist)) as long as the
top's on it. Okay - but when the top's off it and you're=
[ ]
Th: ah huh
S: = pouring it then it's a threat(.hh) and ah ((shakes head)) so
I feel as long as I can keep the top on it, it's benign ((points
toward bottle)) I can see it - vi-visually(.hh)I can reach out
and touch it yet ah - you know that's the challenge ((points at
bottle)). There's the challenge there's the(.hh)the mountain
you've gotta climb is right there. And that I can't say
((gestures)) it-re it does reinforce me ((points to self))
because I'm saying no to it(.hh)so it builds inside me again
((rolling hand gestures)) I mean l-l as l-um we went through this
last time ((gestures away from self)) I quit h-half a dozen eight
times through the course of my life(.hh)and ah:hh things that
fuel it like - a the first couple of times I quit(.hh)I could not
have it in the house(.hh) and ((rapid hand gestures)) I could not
walk into a bar:r pub or anything and have a pop or have a
Perrier or something like that I just simply could not do that I
wouldnotallowmyselftogetintosituation(.hh)where I might be fe-
feel compromised(.hh) and ah:hh now I've gotten ((holds out open
hands) over that ((opens arms, palms up)) step so you know like
l-l dunno it-it does well I mean I wouldn't be talking about it
if it didn't bother me I guess in the house but ah(.hh)it's sort
of=
Th: =It's part of ((raised right arm, fingers bent hand rocking))
part-partly it's a challenge partly its a tea:ss ((holds up=
    Yeah)
S:
Th: =clenched hand)) can I cope with this?
    [  
J: =We should get rid of it then. ((Sam scratches
neck)) I have often thought of getting rid of it - ((outward=
[  
Th: =an'--
J: =thumb gesture)) because it's always out of the way ((holds
left hand up towards bottle)). It's up in the cupboard wa:y out
of the way an' you=
    [  
S: =Yeah, but we
don't - see: e it
J: =probably wouldn't even know it was gone until I got rid
((lowers hand)) of it but then I thought if I did that - ((back
and forth gesturing)) without saying anything then I'm ((points=
[  
S: =You're interfering you're interfering with m:y
J: =to Sam)) interfering with his way of hand:ling the situation=
    [  
S: =yeah of handling the situation
J: =((gesturing to self and back and forth)) which has always
been he's ((points to Sam)) always handled it his own way. So
that's why I've always not touched it is because - ((opens=
[  
Th: =Uhum
J: =hands, fingers spread)) he wants to do it his way. So:
we'll do it that way
S: Which (((therapist gestures)) apparently has not always worked
but (((laughs)))
[  
J: =Yeah but it has worked for quite a while
[  
Th: So - you've left it for him to do?=
S: =Yeah
Th: Alright-so ah- ((points finger upward, stands up, picks up
bottle and sits down leaving right hand on bottle))
S: =I've always blocked her out of my decision
making with it. We went through that last time too=


Th: It's very - very significant that um - you ah - want a challenge ((leaves hand on bottle)) and - ah that ((removes hand from bottle)) you've been in agreement that he ((both hands palms facing move towards Sam pointing)) should be - make decisions. You've blocked ((right hand glides toward Jill)) her out (.hh) she's decided it's your responsibility so together, ((both hands held up palms facing fingers bent, a shake for emphasis)) collaboratively ((hands held together)) you've agreed that he's to make these decisions ((folds hands))

S: Hmhm

Th: (.hh) Right now - ((lifts bottle, sets it back down and folds hands)) um - alcohol - I guess is in the room fear is in the room fear and apprehension (.hh) and you mentioned ((rolling arms))=

S: [ ]

Th: = a number of things that you ((Sam clears throat)) are feeling scared about (.hh) and um where ((looks at bottle, taps it twice and then looks at Sam and Jill)) would you put this right now in this room? ((holds bottle up))

S: ((emphatically quiet voice)) Outside the door.

Th: You'd like it outside the door? ((continues to hold bottle up))

S: (.hh) Yeah ((scratches head and smoothes hair))

Th: Where would you - put this right now Jill?

J: Well because he wants it outside the door outside the door =

S: [ ] ((chuckles))

Th: = So you would put it outside the door. Would you put it outside the door please? ((puts bottle on the floor and looks down))

S: ((quiet voice)) Sure ((picks up bottle and puts it outside the door)).

Th: Thank you ((scratches nose, tucks hair behind ears and puts notepad on table, tucks hair behind ears again and leans forward))

S: ((sits down and folds arms over chest))

Th: Now it's gone - at the moment - ((backs of hands held high gesturing behind herself)) you want it outside the door and=

S: Hm it's interesting, yeah
Th: =that's - that's really important((folds hand)). Now that it's not here - ((fist crosses chest and gestures toward door)) um, I'm-I ((outward gesturing)) want to ask you to um to let me know wh-what's that like for you? ((looks from Jill to Sam))

J: ((looks at Sam))

(( four second pause))

S: I feel less apprehensive to be frank with you ah that's interesting that's why I sat down th-that's interesting 'cause I noticed it went down in me((.hh)ah when I first walked in and saw it - something triggered inside me and - ah-ah you know it really caught my attention. Really caught my attention. I thought it was a little unusual to have it in here((.hh)((rolling gesture towards therapist)) but I mean p-part of the therapy and everything else ((slaps thighs)) it is to see the reaction granted((.hh)but ahm apprehension levels have gone down ((holds out open hands))

Th: So ((flat left hand moving gradually downward)) what's it like Sam to have apprehension levels gone down a bit? ((quiet voice)) What's that like?

S: U:mm I relax a little bit more you know u:mm - I'm not as=[ ]

Th: ((hushed voice))Yeah ((nods))

S: =tentative I-1 mean ((gestures)) already I mean I feel like it-it something has changed ((right hand opens to right)).

Th: ((left hand gently rolling away from self)) So you feel a little more relaxed(.hh)ah not quite as tentative(.hh)and alittle= [ ]

S: Yeah, uhuh

Th: =easier ah in yourself okay ((lowers head and gestures to= [ ]

S: Uhuh ((nods)) Yep

Th: =her body)) where do you feel that in-in your body?= 205

S: =Right across here ((back and forth gestures across shoulders))=

Th: =Right across there ((back and forth gestures across shoulders))=

S: =Yeah right across there [212

Th: You feel easier(.hh)and ah(.hh)((looks downward and continues gesturing across shoulders)) right across there um
what's it like ((moves head forward)) inside there ((hushed voice)) right across there?

S: It feels calm right now and that's where it seemed to have= [ ]

Th: Uhuh

S:=((continues to indicate shoulder area)) welled up into th-the apprehension was right through here ((drops hands on lap))=

Th:=(((quietly)) Yeah ((nods, gestures to shoulder)) so-

S: ((gestures to shoulders)) But then I have been injured there too so you know=

Th: Right

S: =((drops hand on lap))=

Th:=((continues shoulder gesture)) So right now your experience

is that the apprehension(.hh)ah a few minutes ago a few seconds

ago changed to calmness=

S: =Hmhm ((nods)) it settled down sure=

Th:=((hushed voice)) Yeah ((nods and continues drawing left hand

across shoulders)) okay settled down a bit(.hh)so that calmness

and sort of settling down a bit(.hh)do you have any sense of-of

((drawing right hand across shoulders)) the feeling the sensa-
sation of that? What's that like? ((right hand rests on chest))

S: You mean physically? Yes.

[ ]

Th: Yeah

S: =U::mm ((shakes head)) the muscles have relaxed th-the

((touches shoulders with bent fingers)) you know right up in here

((drops hands on lap with slapping sound)) y-you know definitely

relaxed subsided some

[ ]

Th: So the muscles(.hh)((continues drawing hand across upper chest)) you have a-an awareness that the muscles have relaxed=

S: =Hmhm ((nods)) hhmhm=

Th: =Okay(.hh)okay(.hh)((continues drawing hand across upper chest)) and if those muscles had a voice - what would they say right now?

S: Geeze I don't know - thanks? ((laughs; opens hands and drops on lap)) I don't know=
Th: (rapid hand rolling gestures) They might say they might say "Geeze I don't know" (.hh) or or sure 'kay=

S: (laughing) Yeah ((crosses legs))

Th: =sure((holding open palm out)) or they might say thanks or they might say prob-likely ((nods head)) they'd say both=

S: =((quietly)) Yeah quite possible

Th: Yeah (.hh) (left hand moves back and forth across upper chest) okay (.hh) so I appreciate ((tips left hand towards Sam)) your willingness to to just explore that a bit so that's important that you notice ((gestures behind her)) when alcohol went outside the door (.hh) ((Jill looks at therapist and moves fingers. Therapist draws right hand across chest and looks at Sam)) that you felt calm, there's less apprehension (.hh) and ah that's easier, more relaxed feeling ((right hand rests on chest))=

S: =But see now ((Jill looks at Sam)) that's really interesting to me because ((points to the right)) that happened and I just got finished saying ((both hands move to the left)) that it doesn't bother me being in the house and seeing it and that ((points to table for eight seconds)) was a plastic bottle (.hh)!

Th: ((hushed voice)) Yeh

S: =think the size of it's one thing that really — caught me as well ((drops hands on lap)) the visual size of it 'cause the=

Th: Yeah ((nods))

S: =impact of alcohol in my life (.hh) for a BOTTLE that's this size ((indicates size)) is about as big as that in the impact ((motions to where bottle once stood)) you know so (.hh)

Th: Sure ((several head nods)) sure an' I appreciate ((gestures to her head)) your willingness to analyze (.hh) ((touches head with left hand)) and ah what I'm what I'm noticing is that um ((left hand waving in front of chest)) — you ((nodding at Sam)) were willing (.hh) and you may need to take a bit of time off ((rolling arm gestures)) right now and you can do that inside yourself or (.hh) 'ah I ((waves left=)

S: Sure ((rubs his neck))

Th: =hand to side of head) remember last week that (.hh) you wanted to you were here to talk about your feelings ((open hand gesture)) and yet (.hh) ah it seems important that you take some time off for yourself (.hh) and so we're sort of ((long back and forth gestures)) go in and out of feelings (.hh) and ah you=

[ ]
S: Hmhm ((nods))

Th: =((gestures to Sam)) can be in charge of that process (.hh).
So ((looks toward Jill and continues with gesturing to chest and shoulders)) Jill what's it like for you? That ah Sam is saying ah after alcohol went out the door ((motions to door, continues drawing right hand across chest))(.hh) that he's saying that ah for him the experience was (.hh) a relaxing and easy letting go a bit ah ah sor' of less=

J: Well he seems less -

Th: =apprehension calming for him (.hh) ((right hand returns to lap)) [ ]

J: Yeah

S: ((smoothes hair))

J: ((moves fingers)) I've always wondered why - we keep alcohol in the house when - he's not drinking ((flicking away gesture and therapist moves her chair)) I mean okay ((tilts head to right)) I-I still ((holds right hand open on lap)) will have the occasional glass of wine ((therapist nods)) but very rarely ((looks at Sam and Sam moves hand to face)) unless somebody else is around=

S: =Hmhm

J: In fact -((leans back and opens hands)) never ((holding both hands open on lap with fingers apart)) - I never drink on my own ((Jill's hands lay open on her lap)) or - uu:mm things like=

S: ((clears throat))

J: =that so (.hh) uu:mm - but I've stopped wondering about that as well because ((therapist leans toward Jill)) Sam has always reinforced ((rolling hand gestures)) that it doesn't matter ((Sam shifts position)) leave it there. And we never have alot ((holds open hands on lap)) I mean you know we've got a bottle of - well=

Th: Yeah [ ]

S: I usually drink it too fast

J: =yeah ((looks at Sam, hands on lap with left hand opening and moving towards Sam)) y-you=

S: =We'll bring a bottle home and it will be gone in that night basically=

J: =Yeah ((rubs face and neck)) but I mean also when you are not drinking there's never a lot there. There's like a little bit=
Th: (leans forward left hand raised))

So-

J: =((indicates a little bit with fingers)) of brandy for -
baking my cakes and things like that(.hhh)=

Th: So - ((raising left hand towards Jill, leaning forward))

Th: Yeah ((gestures to and from mouth)) so you're filling me in
with some of the details(.hh)andah ((rotating hand gesture))
letting me know that ahm ((fingers move as if in dialogue)) it's
easy to get into a discussion about how much you ha::d or what
you did with ii::t n' how quickly it went and kind of easy

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J: (leans forward left hand raised))

So-

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Th: Yeah ((gestures to and from mouth)) so you're filling me in
with some of the details(.hh)andah ((rotating hand gesture))
letting me know that ahm ((fingers move as if in dialogue)) it's
easy to get into a discussion about how much you ha::d or what
you did with ii::t n' how quickly it went and kind of easy

J: (leans forward left hand raised))

So-

Th: Yeah ((gestures to and from mouth)) so you're filling me in
with some of the details(.hh)andah ((rotating hand gesture))
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J: (leans forward left hand raised))

So-

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with some of the details(.hh)andah ((rotating hand gesture))
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easy to get into a discussion about how much you ha::d or what
you did with ii::t n' how quickly it went and kind of easy

J: (leans forward left hand raised))

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Th: Yeah ((gestures to and from mouth)) so you're filling me in
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you did with ii::t n' how quickly it went and kind of easy

J: (leans forward left hand raised))

So-

Th: Yeah ((gestures to and from mouth)) so you're filling me in
with some of the details(.hh)andah ((rotating hand gesture))
letting me know that ahm ((fingers move as if in dialogue)) it's
easy to get into a discussion about how much you ha::d or what
you did with ii::t n' how quickly it went and kind of easy

J: (leans forward left hand raised))

So-
Th: Ah how do you feel inside? ((draws left hand down torso twice))

J: Um - I feel ((Sam sniffs and turns toward Jill)) um normal really I'm just ((rapid rolling gestures towards self)) taking it in the calm = ]

Th: Okay

J: =I guess ((holds hands open)) I feel calm [ ]

Th: Yeah ((hands motion downward patting)) so you feel some calm too andah sort of sort of your normal feeling and when you feel calm = ]

J: [ Actually I say I ((wriggles fingers)) I feel calm I'm pickin' at my fingers I'm not ((laughing, looking at Sam)) really as calm - as I think I am - [ ]

Th: (.hh) So there's - s' part of you ((smiles, holds left hand to shade forehead, Sam uncrosses leg)) part of you that ah takes another perspective that says "h::ey just wa:it a min::ute=" [ ]

J: Yeah

Th: =((wriggles fingers, joking tone of voice)) notice what I'm doing with my fingers here" [ ]

J: I notice what I did last week I'd picked at my skin? here? ((picks at wrist, points to hand and looks at Sam)) and I-I was all red? ((Sam chuckles and therapist nods head)) so I mean

Th: So there's some ((rolling right hand)) fear and apprehension for you [ ]

J: ((nods three times)) there is, there is= Th: =Okay(.hh)=

J: =Yeah so I'm but as far as what Sam said ((chopping motion with right hand)) I've taken it in ((gestures to self)) andum - I [ ]

Th: Yeah ((nods))

J: =Feel good about ((motions to self with right hand in lap)) - w-what he said because it-I've learnt from it ((opens hands in= [ ]

Th: Yes

J: =lap, looks at Sam)) I think when we go home we'll - if that's what you want we can just get rid of it=
S:. (hh) See again I sit here now an' I say I'm thinkin' that it doesn't bother me (tilting head to left) but ah it must do

J: Yeah, yeah
APPENDIX O

TRANSCRIPTION OF EPISODE #2: THE MORNING FIGHT
Th: =Yeah, so when you say ((rolling gesture with hands)) I hope that Broughton flies, how are you feeling ((points to body)) towards her? How are you=

S: = Oh, I just, yeah okay, I've just spent an hour going over the books and um ah adding everything up an' trying to shave=

[ ]

Th: = Oh

S: = from ((picking at shoe, shifting in chair)) here and put to there and, I mean, we just paid alot of the debt load down this: s last week and I was balancing the cheque book an' an' working out who's getting what an' to finish off because I've only got a couple more payments to make (.hhh) and ah ((looking up)) I just simply came, I came in an' said good morning to the kids and sat down and I said I hope Broughton flies ((shakes head, looks at therapist)). It'll be, it will be very, it'll be tough the end of this month if it doesn't (.hhh) And all I got from her was "same old scenario"=

Th: =So, ((motioning towards Sam with left hand, tilting hand back and forth)) before we move on I'd just like to slow this right down 'cause it's very important what your saying right now. (.hhh) It's very important what's going on for you right ((points to self)) now you spent an hour with the books ((moves chair around toward Sam, gestures with hands then folds them))(.hhh) trying to figure things out, shift things around, ((Sam bites nails)) wondering how maybe you can't make the payments and wondering how your going to manage. That's a whole hour in the early morning with the books=

S: =That's two more, ((picks at shoe)) more than two mornings in a row now=

Th: =Two mornings in a row. Jill doesn't notice, ((looks at Jill and motions with outstretched arm towards her)) she's asleep she's jus' just woken up and already the children are on her mind ((Sam scratches head adjusts glasses, rests head on hand)). She doesn't know this, ((looks at Sam)) all she knows she knows is that ((claps)) all of a sudden ((looking back and forth between Sam and Jill, sharp downward motion with hands)) you're sitting on the bed there. So, I'm ((leans towards Jill rolling hands)) wondering Jill if you can remember, 'member last week we did a role reversal, you put yourself in Sam's shoes, ((Sam raises head, drops hand, looks at therapist)) I invited you to do that when you left here from time to time during the week if you, if you were willing (.hhh) What, ((left arm motion away from self towards Jill)) if you put yourself-self in his shoes right now,. (.hhh) as we are sort of going over what happened this morning ((Sam looks down)) can you look at him and imagine how he's feeling as he's telling you about (.hhh) Brought-Broughton may not fly, ((quiet voice)) don't quite know how we're going to manage
things, maybe tight. Can you imagine what's—his experience is?

Put yourself in his shoes=

J: =Yeah, I know how he mus' ((moves hands))=

Th: =Can you tell him how he feels.

J: I know that, I mean, for hard work and everything (.hhh)=

[ Can you tell

him how he feels?]

J: =and the and the disappointment=

Th: =So, you feel disappointed ((looking at Jill waves right hand

towards Sam)).

J: Well, I think he feels disappointed=

Th: =Can you tell him "you feel disappointed"=

J: =You feel disappointed ((Sam picking at his pants)) an: :d

i: =t's u: m, when everything looked so good things aren't

looking so good - an: :d um ((Sam scratches face, rests head on

hand)) -- if Broughton doesn't fly ((opens hands on lap)) then

it's going to be quite tight if it does then it'll be not so bad=

Th: =Yeah, great and(.hhh)when things are quite ((Sam moves hand
to chin, looks at Jill)) tight ((motions toward Sam)), how do you

think Sam feels?=

J: =Oh, alot of pressure=

Th: =Can you tell him you feel(.hhh)you feel=

[ the pressure]

J:

Th: =you feel disappointed ((Sam looks at nails)). Yeah, I

noticed he nodded when you said that(.hhh)you feel really

((looking back and forth between Sam and Jill)) pressured - Sam.

S: Mmmmm.

Th: Yeah, and ah what can you say to Jill now?

S: Broughton better fly ((looks at nails, chuckles, puts hand
down, looks at therapist, pulls on crossed leg)).

Th: Yeah, yeah and I notice that you laugh.

J: Even as he said it ((sharp motion towards Sam, therapist

looks at Jill)) I understood what he was saying but I think, I

was expressing my disappointment in the way things had gone ((Sam

looks up at blackboard on the wall))).
Th: (.hh)Oh, so he felt rejected ((circular motions with left arm towards Jill)).
J: Yeah, huhh.
Th: So, he didn't hear that you understood him and now ((Sam looks down wall then down at floor)) we hear ((therapist motions toward Jill circling arm towards herself)) that you understand how he, well we know that but in this conversation as we re-enact ((therapist rotating right arm)) this he ((left arm comes across body to indicate Sam)) felt heard and I noticed that when you said ((gestures toward Jill)) "you feel pressured" that he ((rests hand on chest, nods four times)) nodded=
J: =Yeah.
Th: And I think that maybe you felt understood - a little bit
S: Muhh ((moves head side to side))
Th: And ah, I also want to ah invite you Sam to tell Jill what else ((Sam looks ar floor)) you're feeling besides disappointment and pressure. Can you tell Jill what else you're feeling? 'Cause this is major, this is something today that's major you have to cope with.
S: Ahumm
Th: The rejection, ((therapist gives slight nod)) as well umm=
S: Yeah
Th:
S: =it's there because it's, I mean, ah I'm not going to umm fall back on it, I've just spent four months in rehab for whiplash and then I blew the knee out and I'm not operating 100 percent so things have not been movin'. I came=
Th: Yeah
S: =back into the business again and ah the first two weeks back=
Th: yeah ((stands up arms folded across chest, looks at Sam))
S: =I made about $10,000 and(.hhh)it looked like a whole lot more was underway and hasn't come to pass and ah that's:
(therapist puts hand on her chair)) tough on me.=
Th: Yeah ((crouches beside Sam's chair))
S: =to you know, I get my hopes up which is something I shouldn't do I should rather ah proceed with the business than meet, than count the money all the time it's hard when you've got creditors=
Th: Yeah ((nods three times))
S: =that are going well let's have it.
Th: So, it ((touches Sam's shoulder from crouched position))
sounds as though(.hh)um he's also, ((looks at Jill, rolls right
arm in front to herself)) Sam is also feeling rejected and ah and
ah he also is feeling bad about himself, ((rolls right arm then
rests hand on chest)) he's he knows that he's not operating at
100 percent so(.hh)ah he could say ah ((looks at Jill while
rolling hand from chest)) "I'm feeling um not only um
disappointed, pressured, I'm feeling rejected(.hh)I'm feeling um
unsure of myself right now(.hh)and I'm feeling sad that I'm not
operating at ((puts hand in lap, still crouched with arm resting
on her chair)) 100 percent and I feel scared 'cause I don't, not
sure how we're gonna get through ((looks at Sam, hand at chest))
this this month this month, I'm not sure and sometimes I'm
feeling scared and ah when I feel challenged in this way um it it
touches me at a place where I'm very ((touches arm of chair,
continues sitting on floor)) vulnerable ((talking to Jill, Sam
looking at floor)), I'm not sure if I'm good enough, touches me
in a very deep place(.hh)and ah I feel really vulnerable coming
to you and talking to you Jill right now 'cause I'm the
breadwinner ((holds hands up around shoulder and neck area,
returns hands to lap)) in this family(.hh)right now(.hh)and I-l
feel its, the pressure ((sharp hand motions at chest area)) is on
me, I know you do alot ((gestures towards Jill)) of work and ah
you do your bit, you pu:ll your weight and you support me(.hh)but
the pressure is on me right now, I'm feeling pretty vulnerable -
((turns to Sam)) and I'm not sure what you want to add to that?

S: ((looking at Jill)) Well, I think that I've um, I mean, um -
my timing probably was not right this morning but I mean I was
((therapist looks over shoulder, Sam glances to where she is
looking)) wide awake(.hh)an=

Th: Yeah

S: =had 3 or 4 cups of coffee in me and ah what time is it?=

Th: Yeah

S: =Fiveto, um you know I i-its been on our minds because of the
financial setbacks we've just had and I came in and was thinkin'
that(.hh)you know, I mean I share the good times with ya an' I
felt that you know share some of the bad times too and that's an
open relationship and ah(.hh)the crack, and that's all it was
a crack ((looks away from Jill to wall)) - really wasn't

J: Yeah, but it was::n't rea::lly, I mean it's

S: Well it was just a low handed

Th: It's very important what you've ah said

((touches Sam's arm)) to Jill and it's very important what your
adding ((waves hand)) to it now and ah because ((Sam picks at
fingers)) she's very receptive and ah she's very caring
((circular arm motion towards Jill)) of you and ah wants to understand you and ah it may be very important and i'm not sure if this is correct Jill ((motions with arms and shrugs with shoulders)) that when Sam wants to come and talk to you that he check out with you if its a good time, it may be important.

J: Well, usually with me anytime I'll ((moving fingers, motions towards self, therapist leans forward)) accept any informat-if anything it's Sam ((motions towards Sam)) that you hafta check out whether or not it's a good time=

Th: =So, he might assume that anytime is a good time and in fact you'd just woken up and already had the children on your mind and=

J: yeah, yeah, huh

Th: =ah it may not ((rolls arms, shakes head)) have been a perfect time to let you know ah what's ((touches chest))=

J: Yeah it probably wasn't ((scratches head))

Th: =going on so it maybe important for you to check out ((looks from Jill to Sam, back to Jill)) "Hey, Jill I need to talk about something(.hh)could, is this be

J: Even the words I said it wasn't ((rubs neck)) intended as a-a crack as you say, it was it was my disappointment in the way things have been going it was and it's not=

Th: O:o ((tips head backwards))

J: =((moves flat left hand in patting motion)) my disappointment of you,=

S: it's the same thing

J: =it's my disappoint-no it's not! ((puts hand back on lap))

Th: For him it is the same thing ((points to Sam))=

J: =Well, to me it's not, it's my disappointment of the way the=

Th: To you its not ((motions to Jill))

J: =business is it's my -- my um ability of not being able to

Th: Yeah ((moves from sitting on floor beside Sam's chair to sitting on floor beside Jill's chair))

J: handle=

Th: =Can you say this to Sam.
J: =er my w:ay of not being able to han:dle - the um -
((therapist glances over shoulder)) the disappointment.
S: Set backs, ((looks away from Jill to wall and back again to
Jill)) you've gotta learn or atatat

Th: So can you tell, can you tell
Sam as yer ((straightens client's drawings on a table beside
her)) ah learning ah can you tell him right now what it feels
like when he says you've gotta handle it. Can you tell him how
you feel when he says that, can you look at him and tell him
J: Well
most of the time I do(hh) ((voice cracking, wipes face)).
Th: Yeah ((moves closer to Jill)).
S: I wasn't even going to tell ((shakes head back and forth))
you about Ryan yesterday and ah
J: Pardon?
S: I wasn't gonna tell you about Ryan yesterday.
J: Well, I'm glad you did ((voice cracking)) but at the same
time - because eventually, ((hand motions toward self, Sam
looking at floor)) I mean I'd know that he'd moved and wondered
what had happened butah ((therapist tucks skirt under herself)) -
((Jill crying))

Th: You feel pretty vulnerable, right now.
J: In my condition once I start I cannot stop ((wiping face)).
S: ((gives Jill kleenex))

Th: Yeah. You feel kind of attacked right now. ((Jill folds
kleenex and brings it to her face, Sam looking at and picking
fingers))

J: Well misunderstood because I don't mean to be ((sniff))
flippant or whatever it's a deep feeling with me ((harder crying,
weeping tears away from face))

Th: And the disappointment is over the sales is not the same as
the disappointment in Sam, it's different from ( )
J: Well it's more
that, I mean I ((sniff, wipes tears, folds kleenex)) I know I
hafta learn to deal with things but there have been a few that
have been pretty hard(.hhhh)((wipes tears, sobbing)). Sue and
Fred's was the worst for me I mean Ryan is the worst for you, so
I know how you feel - but my comeback to you was not -
((crying)) um an attack at you ((therapist shifts to knees, hands on thighs)) (.hhh) ((sniff)) - it was um, I guess a quick way of putting into words how I felt that minute ((sobbing)), was that it's, it's hard ((rising tone))=

Th: = He didn't hear a feeling, ([Jill wipes eyes]) he didn't hear the feeling=

J: = No, he heard the quickness of the way it came out=

Th: = Same old scenario.

J: = Yeah.

Th: He didn't hear the feeling (.hh) and now you're letting him know the feeling and ah as you're letting him know he sees yer tears ([Jill moves kleenex]) and ah it seems like it cut pretty deep for you ((therapist puts hand to chest)) too, pretty pretty deep and your letting him know.

J: = (Sobbing) Well it's just that we were, we try to get everything sorted out ((wipes eyes with kleenex, Sam looking at his hands and moving his fingers)) and there are these setbacks and I jus' and I'm sure Sam feels the same way we jus' wonder why they keep happening ((sobbing, wiping eyes))=

Th: = Yeah, when you see Jill's tears Sam, how do you feel ((looks at Sam))?

S: It doesn't ((shaking head)) really affect me (hhh) ((looks at therapist))

Th: It doesn't affect you?

S: No ((looks at wall)). I dunno (.hhh) um um I'm not too pleased with what's taken place the last couple of days granted um but I, I don't want to be hard and cruel ((sniff)) - um I dunno I think you're more set with money ((therapist touches Jill's leg then returns hand to lap)) than I am in that vein and ah I guess I-I dunno - something that I-I ((sobbing, wiping eyes))=

Th: = Yeah, when you see Jill's tears Sam, how do you feel ((looks at Sam))?

S: It doesn't ((shaking head)) really affect me (hhh) ((looks at therapist))

Th: It doesn't affect you?

S: No ((looks at wall)). I dunno (.hhh) um um I'm not too pleased with what's taken place the last couple of days granted um but I, I don't want to be hard and cruel ((sniff)) - um I dunno I think you're more set with money ((therapist touches Jill's leg then returns hand to lap)) than I am in that vein and ah I guess I-I dunno - something that I-I ((sobbing, wiping eyes))=

Th: = Yeah, when you see Jill's tears Sam, how do you feel ((looks at Sam))?

Th: It sounds like your struggling for words right now=

((Jill wipes her nose))

S: = Yeah ((scratches back of neck and between shoulder blades))=

Th: = And you're saying ah when you see Jill's tears um you kind of move into your ((Sam brings hand down to lap)) head 'cause you wanna protect yourself from feeling pain and and Jill is showing [ ]

S: That's probably what it is
Th: your tears (gestures towards Jill with left hand, looks back and forth between clients) and she feels kind of alone here

J: (Jill sobbing, wiping eyes) Well, it just comes across as being hardnosed, you always (flattened left hand makes sharp downward-

Th: Yes

J: = gestures) come across hardnosed at the wrong times=

Th: = So you're feeling abandoned right now - you're feeling alone with your tears (Sam moves fingers) Sam is saying it doesn't=

J: ((sniff, wiping eyes and nose))

Th: = affect him, you feel

S: ((hands folded across lap)) I guess may be when I came in this morning I was almost to the same point you are even though I wasn't in tears and I just got slammed in the face maybe this the way I get back at you, I don't know'=

J: (hhhh)((wiping tears))

Th: = So you're still feeling the pain from this morning and when=

S: Yeah

Th: = Jill (indicates Jill with left hand) is being very open with her tears right now you're kind of slamming back at her.

S: Probably that's what I'm doing yeah.

Th: Oh

J: (sobbing))

S: You see I see the setbacks as stepping stones to the (go) ahead (looks at therapist) and that's the way I try to look=

J: ((sniffling))

S: = at it I mean it's just a matter of you pick yourself=

Th: Yeah

S: = up you get ((shakes head, therapist looks at Jill)) back on track and you take that first step again=

Th: = So you don't want to get close to her right now, you wanna
((sobbing))

[No I don't.

Th: =You don't - yeah so I understand Jill how sometimes you need to protect ((Jill wipes tears, Sam looking at fingers, moving his fingers)) yourself from getting too close to Sam. Sometimes when you get too close to him you feel really alone, you feel really alone=

J: =((sobbing, sniffing))=

S: =I think that the reason, part of the reason why I don't like getting closer is that I'm seeing the vulnerable side of her which I don't like seeing because she is the rudder, the=

Th: (.hhh)((continues looking at Jill while Sam looks at therapist))

S: =((looking at therapist)) catalyst or the you know the strength in the relationship=

Th: =((looking at Jill)) Yeah, so means that Jill has to feel alone with her pain ((turns to look at Sam)) - ((voice very quiet)) yeah - yeah - yeah

J: =((sobbing))

S: =((quiet voice)) Interesting ((looks from therapist to table next to him))

Th: ((quiet voice)) Yes, and it's not only interesting ((looks at Jill)) it's very significant and ah it's wonderful ((Jill moving her kleenex)) that you can, that you can see that it's worth looking at. I'm impressed that you're willing to look at that and to give it some thought because ((looks at Jill, motions toward her)) Jill is is joining you and sharing her pain with you.

J: =((sobbing))

Th: It seems like you're both disappointed and ah she's sharing her vulnerable side which means she's ((motions towards Jill)) taking a big risk to be spontaneous and to be very open and honest with you and right now ((motions towards Sam)) it's it's too scary for you to

S: It's the same thing, I used to get the tears over alcohol ((shaking head)) and I used to do the same thing I would withdraw=

Th: =Yeah, so maybe you're still in that pattern ((rotating arm)) of withdrawing from the tears because in the past ah the tears
were to do with alcohol, now the tears are to do with ((hands moving, left hand touches chest)) very real core of who Jill is and her willingness to share herself ((Jill moving kleenex)) with you and it right now ((looks at Sam)) you don't want to come close to her but are willing to look at that as something very interesting (.hhh) and the challenge when you leave here will be - to - ((raises hand, continues looking back and forth between clients)) deal with that because Jill ((touches Jill's knee)) does not feel safe right now she shared a very deep part of herself and it ((looking back and forth between clients)) hasn't been (.hh) something that's felt safe to do so she may choose to withdraw, she may choose to withdraw ((looking at Jill)) - or ((rolling gesture to Jill)) she may choose to keep doing this with you in - in sharing her vulnerability ((Sam continuing to look intently at therapist)) with you she's really honouring ((Jill wipes nose)) who you are, she's honouring you deeply and you've also shared your vulnerability ((gesturing towards Sam)) with us. Telling her of when you came to the bedroom (.hhh) you talked about the financial sii-tuation you let her know this morning, that in here, that it's not just disappointment it's also the pressure and rejection and pain and fear and ah ((Sam scratches nose)) it - it triggers you to point where you feel vulnerable in your self esteem especially when you're not 100 percent ((Jill moving kleenex, therapist rolling hand)). So you've shared your vulnerability with her and she's shared hers' with you and ah ((indicating Sam with her hand and looking at him)) in the past there was a pattern where there were tears it was usually to do with alcohol so you would withdraw (.hh) so now there's a chance to do something different ((rolling left hand)). And I wonder what you'd like to do that's different right now? ((pause, Sam claps hand lightly, looks at Jill))

((Sam leans over and hugs Jill))

S: I love you honey. (I really do)

J: ((sniff))

((couple continues embracing, therapist stands up, moves to other side of room and looks away))
APPENDIX P

TRANSCRIPTION OF SAM'S VIEWS ON MARITAL DECISION MAKING
Excerpt from Session #8
(Reference to Sam's biblical argument for unequal division of decision making power between men and women in marriage).

S: See I look at it and I don't know if this is explaining it at all that there's this saying where there's a poem or whatever ah were ah when God made woman He didn't make her from a bone from the head or a bone from the foot to be above him or a bone from the foot to be trod on by him but from Adam's rib to be beside him and nurtured within him and my attitude is that in the decision-making process she is 49% and I am 51%. There's gotta be somebody who has [Th: Exhaling loudly] the decision, the control and the decision and the final say. We work together at it and we do listen to each I feel quite well on anything major or even basically minor we hear each other out but when the decision comes down it's the head of the household which I am I am the patriarch of the family.

Th: Is that right Jill?

J: I don't think we really had too many decisions to be made.

S: Oh buying and selling of the house and major decisions and even minor decisions as to how our kids are going to be brought up and how we are going to discipline them and I mean all sorts of things we make on a regular basis.

Th: So the patriarch has 51% of the decision-making process and the matriarch has 49%.

J: Yeah but you see I probably wouldn't agree with that.

Th: You wouldn't agree with that

J: Yeah I think that you you feel that way and it's good that you do if you need that then it's good that you feel that but I feel that we come to an agreement on any major issue umm together. I don't think it's ever I mean if it's such a major decision and I didn't agree with it then I'd remember it.
APPENDIX Q

TRANSCRIPTION OF DISCUSSIONS CONCERNING THREATS OF ABANDONMENT AND PHYSICAL INTIMIDATION
Excerpt from Session #4
(The first reference to throwing things at Jill)

J: Even when he blows up he, it’s more like he’ll thru- he’ll throw something. I’ve never thrown anything but you have. [S: Uhuh]. [Laughing] He threw his dinner at me once.

S: I didn’t throw it at you [J: [Mumbling] Well you]. I threw it in your direction.

Excerpt from Session #4
(Reference to Sam’s Threats to Leave the Marriage)

J: We had an argument, we had been arguing on a regular basis, for some time. But we had had one particular argument and arguing with Sam is not easy. There’s no two ways about that, Sam is [claps hands] and you don’t get your say as such. You can’t, you can’t finish what you have to say ’cause Sam is very easy, he doesn’t have to look after the children because that’s you know like Sam can leave and Sam quite often does.

S: Did.

J: Yeah, admitted, well things are different now, they really are, but, yeah, did you would leave. And leave me you know with all these things to say and ah I never did get them said.

Th: So you would feel kind of abandoned? Ah you’d, things you’d need to say.

J: And alot of things I wouldn’t say because I would feel like if I did react that way then you’d leave, so.

Th: So it was scary to, to say what you needed to say because he might leave.

Excerpt from Session #6
(Reference to Jill's fear of Sam when horsing around together)

J: I'll say something though about the playfulness. Quite often I will be playful but you but it’s always you know to be playful you your your physical. Andum you always get the better of me. You never let me be [S: I'm not supposed to] playful. N:no, that's it. Sam, if I'm playful, like say I threw a bucket of water at him, in the summer, I'd get a gallon dumped on me.

T: So he wouldn't be a quiet railroad spike lying on the ground.

S: [Laughing fiendishly]

J: No, no
T: He would, so what-
J: If I went like this with water [flicking motion] he'd throw me in the shower!
S: Oh that does not always happen.
J: It happens it happened in the past.
T: You're afraid to be playful because you're gonna get something back that's maybe more than you wanted.
J: Oh it's always more
S: Yeah but you gotta get paid back-
J: If I pinched his knee he'd pinch mine harder.
T: I see, so you're-
S: [Inhaling loudly]
J: [Rising inflection] You are like that, you are:
T: You are wary, you're a little afraid of being playful with Sam.
J: Well I mean I know he wouldn't hurt me as such but it's always it's always worse than what I would do to him
APPENDIX R

TRANSCRIPTION OF DISCUSSIONS CONCERNING ALCOHOLIC DRINKING
AND SAM'S THREATS TO LEAVE THE MARRIAGE
Excerpt from Session #1
(Reference to the Avoidance of the Topic of Alcoholic Drinking)

J: And a lot of it is unsaid, like this is more than I've ever said probably, to you, about your drinking. As far as, ah, being able, I dunno know how, how. Like Sam knows how I feel more from my reaction than from me saying exactly how I feel. Because there's no point in saying it when he's drinking because it's like water off a, off a duck's back. And when he's not drinking why say it anyway? Because, the problem isn't there, so why disturb what is smooth.

S: Let sleeping dog lie. Yeah.

J: Yeah

Th: Uhuh. So you both agree that it's good to let sleeping dogs lie, I think this is what you were saying when you were filling in your papers here, it was stirring up some stuff.

J: Uhuh

S: Yeah

Excerpt from Session #1
(Reference to Sam's Threats to Leave the Marriage)

S: What keeps us together I think is 'cause we love each other and we show ah

J: Sam is a good man, I mean he's a very sensitive ah pushover a lot of the time, pushover meaning, well he's he's he can be very romantic, he treats me very specially at times.

S: Most of the time.

J: Most of the time.

Th: Most of the time.

J: Yeah, it is most of the time. Umm, he has a very strong family umm value. Like our children are very important to both of us. Sam has always said umm I mean we've we've come close to, you've come close twice to walking out but again I think that's been when Cathy first came over.

S: Oh

J: It was after April was born.
APPENDIX S
TRANSCRIPTION OF SAM'S REMARKS CONCERNING "LONE MALE"
ROLE EXPECTATIONS
Excerpt from Session #3

S: One thing I have, I have difficulty here is you come in here and bear it and then you have to go get in the car with each other and you drive from here home and I find its like, I find that really tough. I like, the last week I spent, I think three days recovering from that, you know because I'm not used to just opening the book and letting it be read.

Th: Yeah, so what you're learning Jill now is that it feels really tough to spend time together after you've opened yourself up to her. You feel awkward.

S: I feel awkward, yeah.

Th: Right now you don't know how to handle that.

S: Yeah, ( ).

Th: And so it's really important thatah she knows about this. So what you're doing is handling it by letting her know that it's awkward for you. And it may be

J: But let me say something to you as well. Is that no matter how much you open that book, I've seen most of it anyway.

S: But it's hard for me to come to grips with that too.

Th: So you wanna reassure him that, none of this is something that you can't handle. You can handle it and he's saying that "intimacy, emotional intimacy is scary for me". And I understand it's, hey it's

S: It's the male stamped, you know umm we're strong, we're tall, we're you know we're the breadwinners, we're the ones that you know stand alone.
APPENDIX T

TRANSCRIPTION OF DISCUSSIONS CONCERNING JILL'S CHILDHOOD
Excerpt from Session #5
(Reference to Jill being silenced as a child)

J: The way I am, I mean as a child I was constantly basically told my opinion wasn’t worth anything until I was out on my own and this and that and the other. So when you’re silenced alot ya ya end up being silent, you don’t say. I never used to tell my parents what I did. They’d say didjahave a nice time, "Yes", and that was it.

Excerpt from Session #5
(Reference to Jill being removed from school)

J: I wanted, I took my "O" levels wanted to go on and take my "A" levels, I was very interested in school, enjoyed school and reasonably bright with it. But I had to leave school, I wasn’t allowed to continue because "what do girls need to go to school for, get out into the working world earn some money."
APPENDIX U

THE ALCOHOL RECOVERY PROJECT PROMOTIONAL LITERATURE
The Project
A new, creative approach to helping couples and individuals with alcohol-related problems is now being offered. This innovative treatment, called "Experiential Systemic Therapy", has been developed especially for people struggling with alcohol dependency.

If your family is selected, you will participate in up to 15 therapy sessions. This program is now available in two B.C. Alcohol and Drug Clinics funded by the Government of British Columbia.

The Aim
The aim of the project is to offer couples and individuals an opportunity to obtain relief from alcohol problems, and to carefully monitor the benefits of the therapy.

The Therapists
The therapists selected for this project have been carefully chosen and trained. High quality service by the therapists is ensured through ongoing clinical supervision.

Who may participate?
Families in which the man is:
- Trying to recover from alcohol problems,
- Parenting a child or children four years and older,
- Experiencing marital distress,
- Aged 21 – 65 years.

What is involved?
Successful alcohol recovery programs need careful monitoring.

As well as receiving professional therapy, family members will be requested to complete questionnaires to determine the benefits of the treatment. The questions asked are similar to the self-tests found in popular magazines, and should prove to be fun and thought-provoking.

You will be invited to complete the questionnaires in your own home, and at your own pace.

Recognition
In recognition of the time and effort taken to complete the questionnaires, families will receive up to $200.00.
APPENDIX V

PARTICIPANT FAMILY'S CONSENT FORM
PARTICIPANT FAMILY'S CONSENT FORM

1. We agree to participate in "The Alcohol Recovery Project", conducted by Dr. John D. Friesen, Department of Counselling Psychology, The University of British Columbia.

2. We understand that participation in this project is voluntary and involves a minimum of sixteen weeks and a maximum of thirty-six weeks participation.

3. We understand that we are free to withdraw from the project at any time or to refuse to answer any questions, without jeopardizing the treatment we are receiving.

4. We willingly consent to have therapy sessions videotaped if we are chosen for this part of the project.

5. We understand that we will be completing a series of questionnaires and that we will receive monetary compensation for their completion.

6. We understand that we will be required to answer questionnaires at various intervals over a minimum period of fifteen weeks and a maximum of twenty-seven weeks.

7. We commit to this project with the understanding that the information is to be kept strictly confidential, is to be used for research purposes only and is to be destroyed upon the project's completion.

8. We acknowledge receipt of a copy of this consent form.

9. We further understand that if we have any questions or require any further information, we may contact the project office at 228-3499.

Signed the ................................ day of ............................................., 19........
in ................................................................., B. C.

Father ...................................................... Mother ......................................................

Child ...................................................... Child ......................................................

Child ......................................................

Witness ......................................................