DISCOVERING THE CHANGE PROCESS:
AN EVENT BASED ANALYSIS

by
Mary C. Manson

B.A. (Honors), The University of Western Ontario, 1983
B.Ed., The University of Western Ontario, 1984
M.C.S., Regent College, 1993

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Department of Counselling Psychology
The University of British Columbia
Vancouver, Canada

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ABSTRACT

This research has sought to qualitatively discover the process of change during a successful couples treatment, in an alcohol recovery context, using Experiential System Therapy (Friesen et al., 1989), and the contrasting process in an unsuccessful case of the same therapy, with the same therapist. This is in response to the need for discovery-based process research, to fill the gaps left by outcome research, in examining the complexity of change in a therapeutic setting. Two videotaped episodes in which the male client negotiated his way through an intrapersonal encounter with a previously avoided part of self (an Intrapersonal Resolution event) were examined; one successful, one unsuccessful. Elliott's (1993) Comprehensive Process Analysis was employed to provide an extensive exploration of the process, effects and context of both events. The results indicated a number of characteristics common to the co-creation of an Intrapersonal Resolution event (IR), as well as thirteen discoveries, in which the successful IR event differed from the unsuccessful IR event: (a) process flow, (b) disequilibrium, (c) readiness, (d) symbolic experience, (e) intelligence, (f) forgiveness experience, (g) core conflict, (h) stress level, (i) self support, (j) spiritual support, (k) supportive partner, (l) support network, and (m) individuated interpersonal experience. Primary among these is the concept of client readiness, which can be integrated into a transtheoretical model, based on the work of Prochaska et al. (1992). This has, I believe, significant implications for theorists, therapists, and training centers.
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CHAPTER 1: INTRODUCTION

Throughout time, story tellers, myth makers and spiritual leaders have told tales of heroes and heroines who, while on a path to destruction, experienced "insight" which positively changed the course of their life. No one does it more poignantly than Charles Dickens in the Scrooge saga. Ebenezer Scrooge was a miserly, miserable old man but his way of seeing and being was permanently altered when he was assisted in an experiential confrontation with his past, present and future. Something shifted in his vision which quite affected his relationship with his family, other people and himself. What activated this experience? How did it happen? What did the change process involve?

Creating change is the primary task of psychotherapy. Discovering how change occurs is the primary task of the change process researcher, and hence the goal of this investigation. The remainder of Chapter One will target (a) the purpose and significance of the study, (b) a literature review detailing the historical process underlying the deficiency and demand for this type of research, (c) a summary of the methodological approaches employed, (d) a review of the process research already completed within The Alcohol Recovery Project (TARP), (e) the research questions derived for this study and (f) definitions of the terms utilized.

Purpose of the Study

The purpose of this research is twofold: (a) to explore and discover the contextual, effectual and processional components of a change event during an Intrapersonal Resolution (IR), in a therapeutic couple treatment context for alcohol dependency, using Experiential Systemic Therapy (Friesen, Grigg, Peel, & Newman, 1989); (b) to explore and discover the dissimilarities of a change event that occurs in a successful versus an unsuccessful therapeutic treatment.
Significance of the Study

Most researchers maintain that the current need in couple therapy research is for discovery-oriented and hypothesis-generating research that will develop our understanding of the change process in effective therapies (Jacobson & Addis, 1993). However, very few studies are truly discovery-oriented because of the potentially immense investment of time without vested results. This study is significant for three reasons: (a) it is decidedly discovery-oriented, (b) it will identify elements in therapy that enhance or inhibit the change process, and (c) given that Experiential Systemic Therapy (ExST) has been shown to be effective for couple treatment in alcohol recovery (Friesen, Conry, Grigg, & Weir, 1995), it is important to explore, expand and refine the processes of change within this therapy.

History of Change Process Research

In 1952, on the basis of his review of the research, Eysenck suggested that people who did not enter psychotherapy improved as much over two years as those who did enter psychotherapy. This claim prompted an eruption of dialogue and a focus on outcome research; before any further study of the therapeutic process, it seemed necessary to establish its efficacy. Following an extensive analysis of studies conducted between 1953 and 1969, Bergin and Lambert (1978) vindicated therapy, contending that it increased the pace of improvement and that, rather than spontaneous remission, those who did not enter therapy often found alternate forms of help. Recent, more compelling meta-analysis has established the conclusion that psychotherapy is, in fact, effective (Smith, Glass, & Miller, 1980).

Once the general effectiveness of therapy was determined, research interest turned towards the comparative effects of different types of therapy. Outcome studies were again employed and again the data spoke: there was no distinctive difference in the effectiveness of one particular therapy over another (Smith et al., 1980).
Following this necessary concentration on outcome research, attention then turned
to process research. *Process* generally refers to what happens in psychotherapy sessions
in terms of therapist behaviours, client behaviours and therapist/client interaction.
*Outcome*, in contrast, refers to the measured client changes that occur as a result of the
process of psychotherapy. Some variables (e.g., client motivation) have been used both
as process variables and as outcome variables - an overlap which has occasionally
blurred the distinction between process and outcome research.

In the Preface to his 1973 landmark book on process research, Kiesler lamented
that psychotherapy process research ranks near the forefront of research disciplines
characterized as chaotic, prolific, unconnected, disjointed, with researchers unaware of
much of the preceding work. The early years of process research were indeed burdened
with frustration with regard to the complexity of the task.

**Progress in Process Research**

Early process research was largely controlled by a scientific community that
highly valued experimentally rigorous research. Thus only clean, easily observable
variables were measured (e.g., head nods). These studies, involving behaviour counts,
word counts, thought units or predetermined time periods, mechanically group content
without regard for the context-specific nuances of the therapeutic interaction (Keisler,
1973). Such trivial, clinically unhelpful research had little relevance for practitioners,
and the gap between science and practice was widened. Elliott (1983) noted that few
practitioners ever read the research literature after completing their degree requirements.
The predicament, as Holsti (1969) summarized well, was that "If you can't count it, it
doesn't count; if you can count it, that ain't it" (p. 112).

The traditional approach to process research was derived from an assumption
referred to as the "drug metaphor" (Stiles & Shapiro, 1989, 1994) - that the "ingredients"
of psychotherapy can be treated like the ingredients of pharmacological therapies in the
evaluation of their strength, integrity and effectiveness. The ingredients are process components and if a component is active then administering a high dose of it should effect healing. If it does not, the process component was presumed to be inert.

Relationships between process and outcome variables, however, are much more complex than was anticipated. The typical aggregate approach, which involves selecting samples of one or more sessions for rating and then summarizing ratings across samples, has been of limited use (Shefler, 1991). This is largely because science assumes homogeneity of process. Its methods are ill-suited to unravel the psychotherapeutic process, which varies over time with different processes meaning different things in different contexts. Therapist interpretation, for example, may be helpful at one point and unhelpful at another, even with the same client in the same session. Within the scientific, mechanistic paradigm, we can measure "if" clients change, but it is fundamentally impossible to measure or count "how" the change process occurs.

In the midst of the ongoing frustration with process research, a paradigm shift inaugurated the introduction of new and multiple methodological perspectives. Hill and Gronsky (1984) identified part of the problem to be the reliance of therapy researchers on the traditional scientific method, and recommended five alternative assumptions as more appropriate for their needs: (a) multiple realities rather than a single, objective truth claim; (b) the elusiveness of clinical phenomena; (c) the difficulty in changing clinical problems; (d) the need to study humans holistically; and (e) systemic rather than linear causality. These new assumptions, the corollary of a more global paradigmatic shift, spawned a change in research methods.

However, the rejection of the term "science" in favour of a new "contra-scientific" methodology may be somewhat misinformed. True science is fundamentally discovery-oriented: its greatest leaps forward occur when researchers are able to discover new phenomena and to grow with their data. In fact, all good researcher/scientists adopt an exploratory style of discovery-oriented, empirical confrontation through thought
experiments, observations, prestudies and unsuccessful initial experiments. It's how the scientist discovers fuller meanings and contexts where the hypothesis holds and does not hold. This contextual information is eliminated when the scientist adopts a logical empiricist stance to write up a study as confirmation. Greenberg (1991) suggests that psychology has been dominated by a logical-empiricist view of hypothesis testing rather than by the spirit of scientific exploration and discovery. He refers to this regime of "methodolatory," which emphasized method over the understanding of phenomena, as "scientism" rather than true science.

To date, the two distinguished traditions for psychological research have been correlational and experimental. One attempts to study individual differences (how people vary in response to similar situations), the other to establish general laws of behaviour (how different people respond similarly across situations). Although many reviewers still maintain that the ideal way to assess process components is by controlled experiment, it would be prohibitively expensive and difficult (if not impossible) to manipulate a single component of therapy process while holding other factors constant across randomly assigned therapist-client dyads in a clinical trial. Instead most studies have measured naturally occurring variation in process and outcome and assessed their intercorrelation (Orlinskky & Howard, 1986). However, in a (yet another) recent effort to positively correlate process to outcome, Stiles and Shapiro (1994) selected several active process components (e.g., interpretation) to measure against therapy outcome. Their results were consistent with the generally disappointing, erratic yield of therapy process-outcome comparisons.

Greenberg (1991) questions the value of this approach to psychotherapeutic research and instead recommends a context specific "process analytic" approach. This is best done by comparing occurrence and nonoccurrence instances of a change performance in similar situations. Process analysts also point out the inappropriateness of random sampling. Behaviour and experience are not random, nor are their causes
randomly distributed. The assumption that randomization takes care of all the uncontrolled variables is just not tenable in clinical trials. The actuality of an unfolding treatment is far better captured by the images in chaos theory than by those in experimental design (Greenberg, 1991). In chaos theory small perturbations of initial conditions are seen as having large, complex effects further down the road. This particular theory enables an approach which attempts to analyze the tangled unfolding of moment by moment human experiences in specific states and contexts.

Progress in process research then, can be divided into two developmental phases (Garfield, 1990; Marmar, 1990). During the first phase researchers conceptualized therapy as a unidirectional process from therapist to client, and investigators searched for simple, discrete variables isolated from their context. Now, during the second phase, researchers consider psychotherapy to be a process of reciprocal influence between client and therapist (Alexander & Luborsky, 1986; Greenberg & Pinsof, 1986; Marmar, 1990). Second generation studies signal a move toward multidimensional, episode anchored, sequentially patterned approaches to the investigation of change processes (Marmar, 1990). Authority based theories of change have been abandoned, along with mechanistic determinism, the assumption that humans are passive organisms, and the search for a "prime mover" among behaviour, affect and cognition. Instead, we have complex models of interaction between client and therapist and a recognition of the necessity of regarding clients in their context. "What is required in order to find the essence of psychotherapy" writes Shefler (1991, p. 37) "is an integration of rational-empirical process research, combined with analytic methodology focusing on the change process in a context sensitive, discovery-oriented fashion,... allowing the relation of complex sequences of change process to outcome."
Current Focus and Limitations

In the last 30 years some significant advances have served to catalyze a growing international effort committed to identifying change processes that impact outcome (Marmar, 1990). More sophisticated video equipment and new ways of thinking have spawned new methodological approaches and a more extensive investigation of therapy process.

Part of the focus has been to create methods that deal with therapeutic change as an incremental process. Some researchers have redefined outcome in terms of unit size (micro versus macro outcome) (Orlinsky & Howard, 1986) and temporality (immediate versus delayed outcome) (Greenberg & Pinsof, 1986a). This is where there is the clearest overlap between process and outcome conceptualizations: a series of micro-outcomes linked to a final macro-outcome, for example, can be conceptualized as a macro-process. While this view of process may be of theoretical use in terms of linking process to outcome, a clear description of the "micro-processes" within these incremental steps is still lacking. This leaves the practicing clinician, for whom this research is ostensibly intended, without any practical guide for facilitating the client's work toward positive change on the incremental level (Clark, 1990). A group of methods has recently emerged in an attempt to fill this gap.

Greenberg (1986a, 1986b), one of the major participants in this effort, has recently made an important move toward a comprehensive mapping of therapeutically relevant processes in a hierarchial set of contexts. Within this formulation, discrete bits of content are embedded in speech acts which are embedded in episodes that, in turn, are embedded in relationships. Kelman (1969) suggested that there are auspicious moments of opportunity for change during therapy and Elliott (1983) has contended that process research should focus on these key significant events in psychotherapy. Studies do suggest that both clients and therapists identify specific events within therapy as important (Elliott, 1989; Greenberg, 1984; Llewelyn et al., 1988; Martin &
Stelmaczonek, 1988). From this perspective, an aggregate of everything that occurs in therapy is not as important as whether significantly helpful or hindering events have occurred (Hill, 1990).

Based on these claims, an "Events Paradigm" has emerged for psychotherapy process research (Stiles, Shapiro, & Elliott, 1986). Events comprised of a number of client/therapist operations, which together precipitate change, are of particular significance. Events are defined as consisting of the client problem marker, the therapist operation, the client performance, and the immediate in-session outcome. Significance is defined as the extent to which a particular therapy event has an immediate impact on the client. One assumption of the Events Paradigm is that these events will be found to contribute significantly to client change in an enduring way. A second assumption is that by concentrating research efforts on these significant events, the complexity of the therapy process can be reduced without forfeiting the most powerful elements of change, since it appears likely that change processes will appear in "purer," stronger form during significant events (Elliott et al., 1985).

Research targeting significant events can facilitate two key goals of psychotherapy change process research. First, it can furnish a better theoretical understanding of effective change processes in therapy ("effective ingredients"; cf. Goldfried, 1982; Greenberg & Safran, 1987; Orlinsky & Howard, 1986; Prochaska, 1984). Second, this type of study can yield useful applied knowledge. Identifying hindering and helpful events is the beginning of creating a set of 'roadmaps' for therapists (Elliott, 1993).

Methodologies for Analyzing Events

To analyze events, Rice and Greenberg (1984) proposed Task Analysis which involves the comparison of a hypothesized idealized client performance with the actual client resolution from a series of cases. This approach has led to a shift from isolated
process variables to the identification of patterns in client and therapist in-session performance as the key strategy in studies aimed at explanation. The segments of interest are not random samples that often fail to capture the salient phenomena in the change process and are not frequency counts, but rather they are change episodes or change events studied in context.

Elliott has recommended his Comprehensive Process Analysis as a "comprehensive" approach to analysing significant therapy events in a way that upholds the richness of clinical work. The conceptual framework of this analysis embraces an integration of the microanalytic (process) and the macroanalytic (outcome and predictor) traditions in psychotherapy research, within a strong contextual base. It is consistent with two important movements: the psychotherapy integrationist movement (Goldfried, 1982) and the move towards qualitative methodology (Patton, 1990). Comprehensive Process Analysis is perhaps the most thorough recent approach to discovery-oriented research.

These two newest research approaches have been helpful in advancing our understanding of the therapeutic process. The focus on patterns within and across therapists' behaviours during a particular therapeutic context allows researchers to link specific therapists' behaviours to treatment outcome. It also offers the possibility of addressing the "process uniformity myth" (Kiesler, 1966) by examining which therapist behaviours are most effective for what client behaviours under which set of circumstances. There is hope that this research might become more relevant to practicing therapists, for whom this research is ostensibly intended, thus bridging the gap between scientists and clinicians (Hoshmand, 1989). Many investigators, in the meantime, continue to contend that more work - both in process research and process research methodology - is essential in this area.

Studies from the first phase were characterized by their discrete approaches with easier to quantify, more reliable, but less sophisticated variables with minimal clinical
interest, and studies from the second phase use more abstract, complex variables which are often difficult to operationalize, yield lower interrater reliabilities and are more challenging to judge. Using multiple variables to study the process of change is an important first step, but there are no generally agreed-upon criteria (Marmar, 1990). However useful, hierarchial conceptions (e.g., Task Analysis) still cannot fully address the question of multiple interactions among contextually welded processes (Shoham-Salomon, 1990). Clinicians have expressed concern that some of the most urgent issues in actual practice are seldom addressed within current research because of these obstacles. Thus, it has been noted, we still understand very little about how people actually change (Prochaska, De Clemente & Norcross, 1992). "A truly crucial issue is left" writes Sechrest with obvious frustration. "If specific procedures are not consequential in therapy, then what is and how will one ever come to know about it?" (1994, p. 954).

This then remains the question. How do people change as a result of the therapeutic process? How do the conversations between therapists and clients (process) reduce psychological suffering and cultivate fruitful, satisfying ways of living (outcome)? Indeed, how do we blueprint the Scrooge project?

Change Process Research: The Alcohol Recovery Project

Some change process research has already occurred using TARP data and employing ExST. Dubberley-Habich (1992) used Conversational Analysis to investigate the change process in a couple participating in a ritualizing intervention. Twelve themes emerged from the data which affected the change process: (1) ritualization, (2) personal and family myths, (3) symbolization, (4) experiential experiences, (5) externalization of a problem, (6) intensification of experience, (7) contextual/systemic approach, (8) constructivist/meaning shift, (9) therapist empathy, (10) therapist genuineness, (11) collaboration, and (12) therapist artistry. A relapse in mid-treatment suggested some
significant contextual issues that were unaddressed in the analysis.

Wiebe (1993) examined how change occurs using an intervention called symbolic externalization in a successful case of ExST, using Comprehensive Discourse Analysis (CDA). Her analysis yielded eight themes that contributed to the change process: (1) therapist/couple collaboration, (2) challenging propositions and competence, (3) cognitive reframing of alcohol as a seducer, (4) moving from an individual to a relational understanding of the role of alcohol in a couple's relationship, (5) accenting and redefining couple commonalities, (6) diffusing defensiveness and tension, (7) regulating the intensity of the experience, and (8) deepening and contrasting experiences.

Newman (1995) also used CDA to investigate two events that demonstrated the change process in successful ExST treatments. She coined the term "syncretic change" to describe the interactional process which influences the creation of relational novelty, and leads from disparate beliefs and behaviour to relational intimacy. The syncretic change process has two parts that represent different but related aspects of the same construct: (a) initial disagreement and conflict, and (b) change which leads to increased mutuality, kindred beliefs and compatible practice. Two change process enhancing themes were manifested: (a) intensification of experience and (b) a collaborative therapeutic atmosphere. Newman (1995) found that six components of intensification outlined in ExST theory (Friesen et al., 1989) were helpful in deepening client experience: (1) defining and detailing the client's dilemma, (2) creating an interaction between clients and the problem, (3) maintaining a present tense focus, (4) employing empathy, (5) utilizing meaningful metaphors and symbols, and (6) personalizing and amplifying physiological states. The means by which intensification enabled the convergence of disparate beliefs and practices was through the facilitation of four tenets of relational novelty which included:

1. Atypical experiencing during which clients are encouraged to speak, feel, think and behave differently than they normally would.
2. Cognitive understanding of new information invoking learning and insights about self, spouse or the problem.

3. Increased awareness such that previously avoided thoughts and unacknowledged experience is brought into consciousness.

4. The evocation of substantive relational themes.

Most recently, Sweetman (1996) completed a study involving two successful cases and one unsuccessful case of ExST. Her research investigated how couples resolved a Relational Impasse event (RI event), using a step by step analysis of the therapist and couple behaviour and interactions, employing Rice and Greenberg's (1984) Task Analytic Methodology.

An ExST-specific model, as well as a transtheoretical model of the change process for the RI event was formulated. The key mechanisms of change within the ExST framework identified in this study were: (1) the Therapist-Client Relationship Enabling Transactional Class, (1) the Process Facilitation Transactional Class, and (3) the Meaning Shift Transactional Class. Five steps in couple performance were identified as transtheoretically significant: (1) formation of a strong therapeutic relationship, (2) disclosure of emotional reactions to the RI, (3) acknowledgment of the problem, (4) individual self-disclosure regarding the impasse, and (5) insight and resolution. The corresponding five steps in therapist performance involved: (1) establishing therapeutic relationship, (2) validation of client emotions, (3) increase client awareness of problem, (4) facilitate client experiencing, and (5) assist client reframing.

In addition, two process measures were found to discriminate between successful and unsuccessful RI events. The successful clients scored higher on the Experiencing Scale and on the Self-Disclosure Scale.
Research Questions for This Study

The target of this study can be articulated as four broad-based research questions, with the goal of generating preliminary descriptive data:

1. What is the context in which an Intrapersonal Resolution (IR) occurs?
2. What happens during such events?
3. What effects do these events have on the clients?
4. What are the factors which distinguish a successful IR from an unsuccessful IR in the two cases selected for this study?

Definition of Terms

Experiential Systemic Therapy (ExST): ExST was co-operatively developed by John Friesen, Darryl Grigg, Paul Peel and Jennifer Newman in 1989 at the University of British Columbia. It is an integrative treatment wherein relationships are viewed as the vital link between human existence and the process of living. The importance of preserving the contextual nature of relationships - the intricate web of systemic connections that sustain our identity - is salient. A review of ExST is given in Chapter Two.

Intrapersonal Resolution (IR): This particular experience, defined specifically for this research, is an event that involves a meaningful, enduring, experiential encounter with a part of self previously unregarded, in a therapeutic environment, during a Relational Novel Episode.

Relational Novel Episode: A key change construct in ExST is Relational Novelty, which refers to the moment in therapy when the client sees in a way s/he has never seen before. It occurs during a session in which the participants have intensified substantive relational themes, patterns, narratives, or behaviours. The client begins to speak, feel, think and respond freely, spontaneously and uncharacteristically as s/he becomes emancipated from the rigid command of her/his lived relational patterns.
Something new is identified about self, a spouse, or the presenting problem and the client faces novel cognitive insight as the curtain is pulled back and unacknowledged experience moves into conscious awareness. Generally, this encounter ends with a de-intensification as the therapist engages the client to talk about the relational novel episode. An IR resides under the umbrella of Relational Novelty: it is Relational Novelty with the restricted focus of self in relationship with self.

*Intensification:* Intensification refers to the therapeutic process in which clients experience their relationship to self or other with increased depth, substance and scope. Intensification perturbs rigid and unsatisfactory patterns.

**Summary**

Chapter One has reviewed the history of change process research as investigators in this area have struggled to examine how change occurs within the complex context of the therapeutic process. Supported by the currently preeminent Events Paradigm, this study uses Comprehensive Process Analysis to examine an Intrapersonal Resolution (IR) event in a successful and unsuccessful ExST treatment, with the goal of discovering the context, the process and the effects of the Event, as well as the differences between the two cases.
CHAPTER 2: METHODOLOGY

In Greek mythology, Hermes, the son of Zeus and Maia, was the messenger of the gods, bringing counsel, omens, and direction to humans. He was represented with a winged hat and sandals, carrying the caduceus - a winged staff which became a symbol for truce and neutrality.

Hermes the interpreter was displaced by Galileo's physics, which plunged humanity into the age of reason, knowledge and objectivity. However, after several centuries of unchallenged Enlightenment, Heidegger's hermeneutic exploration of the human being (1927) claimed that our everyday action always embodies an interpretation of who we are, however veiled and misunderstood. We are inevitably and often unreflectively immersed in an interpretive community - a context from which we cannot escape and perspectives through which we see. Both therapists and clients, as well as researchers, work from within their interpretive contexts. Seventy years have not resolved the hermeneutic challenge, but the hardened paint of established research assumptions has cracked and re-searchers have sought out the enduring symbol of winged interpretation (albeit minus the conviction of neutrality).

The concern in this study, then, is not whether the proverbial baby was thrown out with the bathwater, but that the bathwater is so frequently thrown out. It's the bathwater, however used and dirty, that provides context to a naked baby in a tub. Put simply, in the research process, context is everything.

The remainder of this chapter will highlight: (a) the significance of qualitative research for this investigation, (b) a description of Comprehensive Process Analysis - the analysis chosen for the study, (c) a description of the data collection and event selection recommended for the analysis, and (d) a review of ExST - the therapy under investigation.
Qualitative Research

In an effort to understand cracked paint and bathwater I have chosen the contextually interpretive meaning-making structure of qualitative inquiry to discover some aspects of how change occurs in the therapeutic setting. Qualitative research is a natural language term that defies comprehensive definition. However, the goal of discovery-oriented research is to provide a closer look at psychotherapeutic phenomena, and to discover the relations among the psychotherapeutic conditions, operations, and consequences (Mahrer, 1988). Conditions refer to the client in the session, to what the client is doing, and to how the client is being. Operations refer to what the therapist does in the session - an interpretation, or an empathic reflection for example. Consequences refer to what the client does subsequent to the therapist operation. All of the information generated is descriptive, rather than conclusive.

To enhance the rigor or "trustworthiness," Guba (1981) suggested that a qualitative researcher be attentive to credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity). Different methods of analysis are called upon depending on the specific question to be answered, including: idiographic studies (Allport, 1937), ethnography, ethnomethodology (Garfinkel, 1967), grounded theory (Glaser & Strauss, 1967), protocol analysis (Newell & Simon, 1972), discourse analysis (Labov & Fanshel, 1977), conversational analysis (Frankel, 1984), constructivist approaches (Gergen, 1982), humanistic approaches (Aanstoos, 1985), phenomenology (Giorgi, 1970), hermeneutic investigation (Packer, 1985), narrative analysis (White & Epston, 1989), comprehensive process analysis (Elliot, 1993), task analysis (Greenberg, 1984) and most case studies stretching back to Freud.

Several features frequently distinguish qualitative research: the results are expressed in words rather than numbers; the investigator's own experience, self-knowledge and intersubjective shared social meanings are inescapably present; events are
observed, understood and reported in their context (thus changing the concept of replication); experience is polydimensional; causality is non-linear or 'chaotic' (Gleick, 1987) in order to accommodate people's complex and changing motives.

It is perhaps important to note that qualitative research is not 'better' than quantitative. The intent is not to indict the enlightenment and indemnify mythology but to reach back to Hermes with one hand and hang on to Galileo with the other. Gibbs (1979) has outlined the interdependence between qualitative research that emphasizes holistic data, ecological validity, subjectivity and discovery (in short, the quest for authenticity) and quantitative research that emphasizes theory, manipulation, isolation and control (the quest for certainty). Qualitative inquiry feeds quantitative research which in turn guides inquiry in an ongoing circle of mutual enrichment.

Comprehensive Process Analysis

Approaches to the study of significant therapy events vary in the degree to which they emphasize theory-testing versus discovery. Psychoanalytic events researchers (e.g., Sampson & Weiss, 1986) represent the more traditional confirmatory end of the continuum. Rice and Greenberg's (1984) Task Analytic method is a middle "rational-empirical" approach, and Comprehensive Process Analysis (CPA) represents the interpretive, qualitative, discovery-oriented end of the scale (Elliott, 1989).

Selecting Comprehensive Process Analysis

Elliott's CPA framework has been selected for three reasons. First of all, a Task Analysis study has recently been completed using TARP data (Sweetman, 1996). Secondly, CPA is a discovery-oriented approach and therefore less constrained by theory in its attempt to describe the process of therapeutic change. Task analysis, for example, usually assumes a predetermined context and task. Rice and Greenberg typically employ volunteers in an analogue setting who are instructed to come to the interview with a
specific problem that is appropriate to the technique under investigation. For this research, it was desirable to have more freedom to discover what happens spontaneously in an ongoing therapy.

The third reason to use CPA is the growing recognition of the importance of context in understanding therapy events. While Rice and Greenberg (1984) recognize contextual importance, Task Analysis models are generated strictly on the basis of client's in-session performance. This approach disregards a broad range of contextual information that may provide meaningful clues about the influence of background factors in the change process.

Background of Comprehensive Process Analysis

Comprehensive Process Analysis, developed by Robert Elliot over the last decade, reflects the influence of both the sociological Grounded Theory tradition and the philosophical Interpretive-Hermeneutical traditions of qualitative phenomenological research. Elliott describes CPA as emerging from his frustration with the repeated failure of his research to generate clinically or theoretically meaningful results, in spite of increasingly sophisticated statistical methods. It became clear to him that whenever he immersed himself clinically in particular significant therapy events, he gained a much richer understanding of what brought about change. The assumptions which governed his quantitative investigations had disregarded the natural complexity of therapy.

It is believed that greater clinical usefulness is likely to result when therapy research corresponds closely to the qualitative clinical approach of skilled practitioners. What is needed in therapy research right now is more description of the change process, of what factors contribute to this process, and of how these factors and processes unfold (Elliott, 1989; Rice & Greenberg, 1984). Description is an exploratory research task, which calls for open-ended, qualitative research inquiry. The key is to make clinical-qualitative measurement rigorous, without robbing it of the flexibility and sensitivity that
makes it powerful and relevant. "Hints followed by guesses" wrote the poet, "and the rest is prayer, observance, discipline, thought and action" (T.S. Eliot, 1941). Elliott's research methodology is like Eliot's verse. The CPA approach requires that we listen for the hints that illuminate what is happening in the perceptual worlds of the therapist and client and then to solicit the "rest" for the integration of complex sets of information. It involves guesswork. But it is decidedly disciplined guesswork and is perhaps the best attempt so far to strike a balance between clinical understanding and methodological rigor.

Orientation to Comprehensive Process Analysis

A useful way of summarizing the CPA method is to describe the six operating principles on which it is based (Elliott, 1993).

1. Focus on Specific Classes of Change Event. In contrast to the simplification strategies typically used in therapy process research, researchers in the "Events Paradigm" (Elliott, 1983a; Rice & Greenberg, 1984; Stiles, Shapiro & Elliott, 1986) argue that a more productive tactic is to simplify by focusing investigations on specific, well-defined classes of change events (e.g., resolution of intrapersonal conflict using the Two-Chair technique). Of course then the question for the researcher is "how should significant events be classified?" On what basis, for example, should events be collected - therapeutic task, therapist technique or effect generated? How broad or narrow should collections be?

2. Use a Comprehensive Framework of Sensitizing Concepts. The CPA framework is divided into three major domains. The first domain concerns the relevant characteristics of the "peak" speaking turns within the significant event, organized by a two-dimensional micro-analytic structure: person (client or therapist) and aspect of process (action, content, style, and quality). The second domain is the "effects" of the event, organized into five parts: (a) Immediate Effects, (b) later
Within-Session Effects, (c) Postsession Effects, (d) Treatment Outcome (client posttreatment changes traceable to the event), (e) Effectiveness (quantitative posttreatment outcome data). The third, most complex, domain is the context of the event, organized into four levels: (a) Background (what client and therapist bring to therapy), (b) Presession Context (relevant events between beginning treatment and present session), (c) Session Context, and (d) Episode Context. (See Table 1 on the following page.)

3. Use Multiple Qualitative Observers. Ideally CPA recommends a team of three or four analysts.

4. Verify the Clinical Significance of Events. It is desirable to verify the clinical significance of the event using available quantitative data, including client and therapist ratings of the helpfulness of the event, postsession questionnaires and standard posttreatment outcome measures.

5. Record and Test Analyst Expectations for Collections of Events. Phenomenological Approaches (like CPA) strive to let the data "speak for themselves," rather than to test specific hypotheses. Nevertheless, it is difficult for analysts to bracket their expectations and to keep their implicit theories out of the results. Therefore, it is useful to record and assess expectations as part of potential observer bias.

6. Construction of Process Models or "Pathways" and Need for Replication. Observers tie themes together into explanatory "pathways" at each stage of the process.

These six operating principles provide a framework for the analysis. Elliott (1993) indicates that this structure is flexible, and can be adapted according to the researcher's needs and resources.
Table 1

Framework for Comprehensive Process Analysis

I. Micronalysis of Event Factors
   A. Explication of implicit and explicit propositions in event
   B. Sequence of event
   C. Client factors: includes content, action, style/state, quality
   D. Therapist factors: includes content, action, style/state, quality

II. Effects
   A. Immediate effects
   B. Within-session effects
   C. Postsession effects
   D. Treatment outcome
   E. Overall effectiveness

III. Contextual Factors
   A. Client and therapist background
   B. Presession context
   C. Session context
   D. Episode context

Note. Adapted from Elliott (1993, p. 18).
Steps in Comprehensive Process Analysis

1. Events are collected along with needed information.

2. Single events are analysed according to the following steps:
   a. A detailed transcript of the event and surrounding episode is made.
   b. Analysts take process notes on the entire treatment in which event occurs.
   c. Using all available information, analysts develop an expansion of explicit and implied meanings in the peak speaking turns.
   d. Analysts develop a consensual expansion of the event.
   e. Analysts develop a draft pathway of the relevant features of the peak speaking turns, contextual factors, and sequence of client effects.
   f. Analysts develop a consensual version of the pathway.

3. Analysts identify the common elements or themes in the collection of events:
   a. Identify themes in each part of the pathways.
   b. Develop a consensus on the themes.
   c. Events are evaluated for clinical significance.
   d. Common themes are integrated into conceptual models.

Comprehensive Process Analysis is not rigidly confined to these steps and, like the operating principles, can be adapted to the researcher's needs. In this study, because of the tremendous time commitment and based on the recommendations of a recent CPA analyst (Clark, 1990), there will be a single primary researcher and two secondary analysis consultants, rather than a team of analysts.

A Five-Dimensional Model

The recent calls for more intensive research on therapeutic change events underscore the importance of conceptual models of therapy process. Models, thus far, seem to fall into two categories, referred to by Elliott (1993) as "systems" and "dimensional."
The systems (or generic) approach focuses on complex temporally-organized models in an attempt to approximate the richness of psychotherapy, and are typically presented as flow charts. Dimensional models complement systems models by clarifying assumptions and concentrating on simpler structures which may otherwise be lost in the complexity. The dimensional models, including those of Greenberg (1986) and Russell (1988), were reviewed by Elliott (1991), and his conclusion "that no adequate dimensional model has so far been proposed" (p. 24) inspired him to create his own to parallel the systems framework of CPA.

Elliott's five-dimensional model derives particularly from distinctions outlined by Kiesler (1973), Russell and Stiles (1979), Fiske (1977), and Labov and Fanshel (1977). The dimensions of this model provide a conceptual grid for analysing therapy process, based on logically or empirically established important features, using "microanalytic" and "macroanalytic" submodels (see Table 2). Person/Focus and Aspect of Process combine to create a process "microscope" to scrutinize important therapeutic moments. Unit Level and Sequential Phase fit together macroanalytically to comprise an encompassing hierarchical model of the process as a matrix of different levels of units crossed with sequential phase.

1. Perspective of Observation. The most fundamental dimension is the perspective or "point of view" from which therapy is described. This stance encompasses the observer's goals, beliefs, expectations, biases, sensitivities, previous experiences, current commitments, and access to the phenomenon under observation. In the study of change process there are three primary perspectives (client, therapist and researcher), plus the "text." The text refers to the actual (transcribed) interaction.

2. Person/Focus. In couples therapy there are three people involved and so it is necessary to specify who is being described at a given moment. In addition, it is important to attend to dyadic and triadic properties such as relationship or sequential transactions within the system and subsystems.
Table 2

*Five Dimensions of Therapy Process*

I. *Perspective of Observation: Who is providing data?*
   A. Client
   B. Therapist
   C. Researcher

**MICROANALYTIC MODEL: (Dimensions II & III)**

II. *Person/Focus: Who is being studied?*
   A. Client
   B. Therapist
   C. Dyad/System

III. *Aspect of Process: What variable is being studied?*
   A. Content: what is said
   B. Action: what is done by what is said
   C. Style/State: how it is done or said
   D. Quality: how well is it done or said

**MACROANALYTIC MODEL: (Dimensions IV & V)**

IV. *Unit Level: At what unit is the therapy process studied?*
   A. Speaking Turn: interaction unit
   B. Episode: topic, task unit
   C. Session: occasion unit
   D. Treatment: relationship unit

V. *Sequential Phase: Temporal orientation and purpose*
   A. Process
   B. Effects
   C. Context

*Note.* Adapted from Elliott (1993, p. 37).
3. **Aspect of Process.** The therapeutic communication process consists of various components or subprocesses, referred to here as aspects. As long as their fundamental unity is kept in mind, the distinctions are a useful way to sensitize observers. Each aspect is easiest to understand as an answer to a question about the process.

a. **Content:** What was said or talked about?
   i) Propositions (extraction of explicit and implicit ideas)
   ii) Type of Content

b. **Action:** What was done by what was said?
   i) Response Modes (general interventions)
   ii) Task/Intention (treatment model specific interventions)
   iii) Conversational Mode (actions structuring interaction)

c. **Style/State:** How was it said/done? What does that reveal about the speaker?
   i) Verbal (e.g., syntactical complexity, vividness)
   ii) Paralinguistics (e.g., pausing, nonfluencies)
   iii) Nonverbal behaviour (e.g., gestures, facial expressions)
   iv) Attitude toward other (e.g., therapist directive)
   v) Mood (e.g. client depressed)

d. **Quality:** How well was it said/done?
   i) Therapist: Skillfulness
   ii) Client: Working

4. **Unit Level.** The conversational and multilevel nature of therapy process is what makes the "unit problem" an enduring one for process researchers (Bordin, 1974; Greenberg, 1986). Arbitrary units (e.g., 2-minute segments) have often been constructed for research purposes, although, in fact, a hierarchical organization of units exists in the communication process (Elliott, 1988; Pearce & Cronen, 1980). While this organization can be broken into nine or more psychologically and linguistically meaningful levels, four of these seem most relevant to the study of the change process in psychotherapy.
a. Speaking Turn: a single uninterrupted utterance by one speaker.

b. Episode: a large block of interaction unified by a particular topic (what is being talked about) or task (what is being worked toward). In addition to its phenomenological validity, the episode is a useful contextual unit and when clients are asked to identify significant events, these approximate episodes. The major methodological limitation is that a clear reliable method for unitizing episodes has not yet been established (Bond, Hansell & Shevrin, 1987), and as such process researchers frequently rely on arbitrary 10-20 minute segments from the middle of sessions.

c. Sessions: a time limited occasion of therapist/client communication.

d. Treatment: the highest level unit consisting of the entire course of therapy.

5. **Sequential Phase.** In the final dimension of this model, one must specify the temporal point of view, or measurement purpose. In CPA, the research in this dimension focuses on three major domains: process, effect, and context (outlined in #2 of the six operating principles described above). Sequential Phase must be considered with a particular level of unit; thus each unit of process has its accompanying units of context and effect. Context and effect are not unitary but form layers corresponding to the hierarchy of unit levels.

**Nature and Implications of the Five Dimensional Model**

Since this model maps so precisely onto CPA, one might question its generality. In fact, it is more comprehensive than other dimensional models (see Elliott, 1991) and the five dimensions are actually quite essential for "perceiving" the therapy process. In order to observe process, one must specify (1) who observes (Perspective), (2) who is observed (Person), (3) what is observed (Aspect), (4) at what resolution (Unit Level), and (5) for what purpose (Sequential Phase). The five dimensions thus define the essence of therapy observation: without an observer, target, attribute, unit, and purpose, no
observation is possible.

Beyond defining, Elliott (1993) suggests that these dimensions draw on a set of assumptions about the nature of therapy; assumptions which in fact constitute a "metatheory" of therapy. Thus, each dimension can be stated as a principle of this metatheory (i.e., a theory of what a theory of therapy should address).

1. Therapy is an interpretive (hermeneutical) process. Client and therapist each actively construct meanings. (Perspective Dimension).

2. Therapy is an interpersonal process. Client and therapist actively collaborate to bring about the therapy process and outcome. (Person/Focus).

3. Therapy is a multichannel communication process. Client and therapist operate within multiple, parallel communication processes. (Aspect).

4. Therapy is a hierarchically organized process. Client and therapist operate simultaneously on multiple, logical levels. (Unit Level).

5. Therapy is a temporally-organized process, understood in terms of context and effects. (Sequential Phase).

These principles present therapy as organized complexity (cf. Prigogine & Stengers, 1984). If this view is accurate and useful, then there is little room for simple theories of therapy, but there is a great deal of room for "micro-theories" which do justice to a particular piece of the overall complexity (Elliott, 1993; Rice & Greenberg, 1984).

*Comprehensive Process Analysis*, like most "post-modern" philosophic positions, takes a pluralist stance on standards for evaluating truth and on what counts as an explanation. Correspondence theory, coherence theory, pragmatist criterion and consensus criterion all have value as worthwhile but fallible guidelines in the search for "truth"; CPA is not intended to represent a single objective "Truth". Eight different relationships of meaning (or modes of explanation) explain therapeutic phenomena: intentional, narrative, categorical, analytical, hermeneutic, personal cause, material cause, and mechanical cause (Elliott, 1993).
Experiential Systemic Therapy

This next section provides an overview of the ontological roots, the basic conceptual framework, and the theoretic underpinnings of ExST. Following this is a discussion focusing on innermost system of ExST's systemic framework; the dynamic, dialogical relationship between intrapersonal parts and the corresponding impact on intimate partners.

Ontological Roots of ExST

ExST is linked to the post-modern therapies which have developed out of a Kantian-Hegalian epistemology, where there is a commitment to the claim that the knower actively constructs the known. This epistemology formed the basis for the organismic model, whose root metaphor is the plant. In a plant, the organization of the cells is a feature of the whole organic unity: the whole is not the sum of the parts. The plant is inherently active in that it is generally self-regulating. And there is the potential for intrinsic, qualitative growth in an irreversible direction. This is in contrast to a Lockean-Humean epistemology, the basis for the alternative, mechanistic model, whose root metaphor is the machine. Within this model, the whole is simply the sum of the parts. All movement is quantitative, acted upon by external factors.

The post-modern influence on ExST recommends that knowledge is uncertain, provisional and transitory rather than a progressive unfolding of Truth. The dualities of modernism (therapist/client; subject/object; rational/irrational) are blurred and all real and original positions disappear. However, within the uncertain, transitory definition of post-modernism, itself refashioned spontaneously and provisionally, it is important to distinguish particular aspects of ExST.

Within the new paradigm, the therapist cannot "know" better than the client. Along this line, ExST indicates a shift away from the objective accumulation of knowledge about families and the value-free application of this knowledge by
disinterested, professional expertise. Instead there is a move towards therapeutic symbols and metaphors based on narrative and context. The concept of equifinality becomes important since it suggests that there can be different processes under different conditions, to the same end. Since language has the power to not only represent reality, but to mediate or even constitute it, ExST therapists seek to engage clients in the art of conversation, venturing to understand their reality in a discourse-sensitive manner.

Therapy then, is a dynamic, collaborative process during which both client and therapist take up positions in one another's narratives. The therapist becomes part of what must change; s/he does not stand outside and "fix" the problem. In place of causality as the ultimate description of human action, the therapist focuses attention on the historic event unfolding in its context and the client is viewed as being tacitly knowledgeable on the topic of her/his own problems. Freed from the weight of an all encompassing meta-theory, the therapist adopts a posture of humility and fallibility and the client maintains dignity and respect.

ExST differs from Narrative therapy (a truly "pomo" therapy) since it works largely out of the client's experience and is not dependent on a cognitive recasting of "reality." Within ExST, truth may be perceived as obscured or coloured by individual perspective, but it is not eliminated or diminished.

**Basic Concepts of Experiential Systemic Therapy**

ExST consists of three interlocking dimensions: the experiential, the symbolic and the systemic. The systemic dimension is an eco-systemic perspective which emphasises the malleable, relational, interdependent patterns occurring in interactions between intrapsychic parts of self, physiological organs, ideas, people, the environment, cultures, nations and the cosmos. ExST recognizes the complexity of the multi-dimensional web that connects us to an epistemology which constitutes a "sacred unity of the biosphere" (Bateson, 1979, p. 19).
The symbolic dimension adds both solemnity and playfulness to the therapeutic experience. Symbols are metaphors with meaning at multiple levels and in this way are important attempts to analogically access perceptual experience. ExST views the act of therapy as a symbolic change ritual and thus employs symbols to represent obstacles such as symptoms, relationships with people or objects, intrapersonal experiences, etc.

In the experiential dimension, ExST asserts with May that "a client does not need an explanation, he needs an experience" (1967, p. 10). Experiencing in therapy integrates behaviour, cognition, affect and perception to create fresh awareness and expanded alternatives in a client.

A key construct in ExST is Relational Novelty, which emerged out of the significance placed on experiencing. Relational novelty refers to the moment in therapy when the client sees in a way s/he has never seen before. It occurs during a session in which the participants have intensified substantive relational themes, patterns, narratives, or behaviours. This intensification perturbs atypical client involvement and a previously renounced painful experience is brought into client awareness. The client begins to speak, feel, think and respond freely, spontaneously and uncharacteristically as s/he becomes emancipated from the rigid command of his/her lived relational patterns. Something new is identified about self, a spouse, or the presenting problem and the client faces novel cognitive insight as unacknowledged experience moves into conscious awareness. The curtain is pulled back and a previously unseen horizon comes into view as the client's web of relationships absorbs the novelty of new potential. Generally, this encounter ends with a de-intensification as the therapist engages the client to talk about the relational novel episode. An IR resides under the umbrella of Relational Novelty: it is Relational Novelty with the restricted focus of self.
Theoretic Ascendants to Experiential Systemic Therapy

ExST encompasses and draws from a number of theoretical approaches which target human relationships, including Sullivan's Interpersonal theory, Object Relations and Attachment theory.

Object Relations Theory maintains that the establishment of meaningful relationships begins in infancy, with a focus on the mother as a major developmental force in the psychic makeup of the child. A child's attachment (attachment theory) to specific nurturing figures becomes crucial to her/his well-being; no amount of care from others can completely overcome the anxiety of separation from them. A recent study (Dutton & Starzomsky, in press) shows a strong correlation between attachment measures, substance abuse, and marital violence. Substance abusing and maltreating adults seem to share a common history characterised by insecure, unstable and/or pathological relations with their parents. Both Object Relations Theory and Attachment Theory assert that these early relationships provide the prototype for later social relations (i.e., that relational "patterns" are formed in a child's early years, and that models of self are formed interactionally). Interpersonal Theory suggests that human personality is the relatively enduring pattern of recurrent interpersonal situations. Several common themes emerge.

1. The focus is on human transactions and not on the behaviour of individuals.
2. The self is social and interpersonal, beginning in infancy and continuing in its development and functioning throughout life.
3. Certain patterns of interaction emerge from the attempt to elicit particular response behaviours from significant others.
4. Emphasis on the subjective environment represents a clear phenomenological existential stance.
5. The focus is on a two-person mutual influence, or bidirectional causality.
6. Communication--both verbal and non-verbal--is the vehicle for human
transactions.

7. The primacy and distinctiveness of "affect" promotes strong process orientation.

ExST draws on the Experiential Theory demonstrated in Psychodrama and Gestalt Therapies which maintains that the deepest and most profound 'knowing' results from experience rather than dialogue or didactic instruction. The past, present and future patterns of interaction are experienced in the here and the now. The emphasis is on active spontaneity and creativity, focussing on the I-Thou encounter.

These themes have a distinct relationship to therapeutic practices:

1. The therapist becomes an active participant in therapy, experiencing "live" the client's rigid, duplicitous, largely non-verbal manner of communication.
2. The central assessment task of the therapist is to pay attention to the client's patterns of interaction.
3. The goal is to discover creative alternatives to the existing constricting patterns.
4. The therapist's interventions are based on tentative formulations which facilitates participatory exploration. Clients and therapist co-create scenes characterizing interpersonal patterns.
5. The client experiences deeply the problem and its context.

Awareness of potential developmental antecedents to client behaviours is important within ExST. Separated from their context, client behaviours may appear unprincipled or malevolent. However, behaviours of all kinds are communicative acts and from this perspective presenting problems are symptoms which are viewed compassionately as conveyers of messages.
Intrapersonal Relationships Within ExST

The struggle to live as a unified self in the face of multiple and varied fragmentations is an issue often neglected by systemic therapists. And yet, it would seem that there are systems within systems which operate in complex interactive harmony or discord.

ExST theory suggests that the innermost systems - intrapersonal patterns - are formed as the result of a confusing cacophony of voices inside an individual's head, each clamoring for the authority to guide behaviour. These voices are distinct, complete with idiosyncratic goals, passions, epistemologies and communication styles. One voice may deliver harsh criticism, paralyzing a person's confidence. Another will bolster self-esteem by offering nourishing encouragement. Another will become desperate for relief and demand escape through alcohol, drugs or food. Each of these voices apparently views itself as essential for the survival of self, sabotaging or hiding from any potential interference.

The monolithic self is, in fact, a myth. Individuals cannot be characterized by descriptors that highlight only one part of themselves. Each person has many parts, and thus can think, feel and want many different things. The assumption that each member of a family has the capacity to access a range of possible selves expands the therapist's vision enormously.

What is crucial to inner well being is the relationship among the parts. The more extreme one part becomes, the more extreme those opposed to that part will become, and the more polarized the inner family will become. If any one sub-part takes over and dominates, it is likely that the person will become closed to innovative impulses, and will have a stiff, narrow, single-minded (literally) way of viewing and responding to the world. The Self then, rather than a central mind, is a highly dynamic field of criss-cross dialogical relationships. Instead of "synthesis" as a final goal, it is more reasonable to conceive of an ongoing synthesizing activity.
The impact of intrapersonal patterns on interpersonal patterns is substantial. When people mistake parts of a person for the whole person, they become locked into rigid ways of relating. Interpersonal patterns likewise impact intrapersonal patterns. This is particularly relevant for work with couples.

The process of engaging the different parts of self first involves identification of the parts. This process of experiencing deeply one's inner relational patterns may be formidable, provocative, gratifying or unpleasant but it is always concerned with the integration of fragmented or rejected parts of self. ExST theory suggests that split off parts are recognized, accepted and accommodated back into the whole self. Following an assessment of the inner self's relationship to interpersonal conflict, the individual seeks personal differentiation, intimacy, and community - congruent with the relational themes of love, trust, cooperation and forgiveness.

Summary

This is a study then, which qualitatively explores a Significant Event using Elliott's (1993) Comprehensive Process Analysis (CPA). The five dimensions of CPA define the essence of therapy observation: (1) Perspective (who observes), (2) Person (who is observed), (3) Aspect (what is observed), (4) Unit Level (at what resolution), and (5) Sequential Phase (for what purpose).

The treatment under investigation is Experiential Systemic Therapy (ExST), consisting of three dimensions: the experiential, the symbolic and the systemic. The strong relational themes in ExST stem from the theoretic influence of Interpersonal Theory, Object Relations and Attachment theory. Since this study examines an Intrapersonal Resolution event in couple's therapy, the particular systemic focus is on the dynamic, dialogical relationship between intrapersonal parts, and the corresponding impact on intimate partners.
CHAPTER 3: DESIGN AND PROCEDURE

This chapter will focus on the specific methodological strategies used in this study. A description of: (a) case study design, (b) data collection procedures, (c) demographics of the subjects, (d) subject selection and (e) event selection form the bulk of the chapter.

Design

Psychotherapy research has, in recent years, witnessed a renewed interest in the intensive exploration of the individual case (e.g., Rice & Greenberg, 1984). Hilliard (1993) suggests that single-case designs be viewed as a subclass of intrasubject research in which aggregation across cases is avoided and the generality of one's findings is addressed through replication on a case-by-case basis. The term intrasubject refers to a focus on the temporal unfolding of variables within each participant, and is relevant to the psychotherapy process. The term process implies the temporal unfolding of variables between client and therapist.

Since this research is primarily qualitative, there is no manipulation of the independent variables and so according to the distinction suggested by Cook and Campbell (1979), it would be a passive-observational study. No hypotheses have been generated; thus the context is one of discovery. Based on these differentiations, the design I propose is categorized as a case study (Hilliard, 1993).

Procedure

All data used comes from The Alcohol Recovery Project (TARP), in which 150 families participated in fifteen sessions of Experiential Systemic Therapy (ExST) or Supported Feedback Therapy (SFT) for the treatment of alcohol dependency. The structure of the study followed a repeated measures experimental group design. All
counselling sessions were videotaped.

**Project Description**

The first phase of TARP began in 1987 with the development of manuals and therapist training. The second phase was consumed with data collection. The third phase began in 1994 and involves quantitative and qualitative data analysis. This present study is part of the ongoing qualitative research.

**Subject Inclusion Criteria for TARP**

Each of the 150 families that participated in TARP were screened for the following inclusion criteria:

1. The father was struggling against a dependency to alcohol, and had consumed alcohol within the previous 3 months.
2. The mother had experienced no alcohol problems within the previous 5 years.
3. The couple was experiencing marital distress, but still living together and desiring to preserve the relationship.
4. The couple had been living together for at least 1 year (married or common-law).
5. The couple was ready and willing to participate in couples therapy, should they be assigned to that treatment condition.
6. Each family included one or more children who lived at home, or were in regular contact with the family. All children, 9 years of age and older, were asked to participate in the project.
7. Families could be remarried or blended, and the children included could be of either parent.

Families that met the above criteria were excluded at point of screening if one or more of the following exclusion criteria were evident:

1. The father's problem with alcohol was not severe enough for him to exceed the
critical cut-off score of 5 on the Michigan Alcoholism Screening Test (MAST; Selzer, 1971).

2. The mother's use of alcohol was severe enough for her to exceed the cut-off score of 4 on the MAST.


4. Mother or father scored exceptionally high on either the psychiatric or depression sub-scales of the Symptom Checklist-90 Revised (Derogatis, 1983), indicating a severe psychiatric disturbance.

The families that met the criteria were randomly assigned to one of the therapists providing treatment and to one of the three treatment groups: (a) SFT-Individual, (b) ExST-Individual or (c) ExSt-Couple. A large battery of questionaires were administered in order to assess outcome. These fifteen instruments measured three levels of client functioning: (a) level of alcohol dependency, (b) intrapersonal distress, and (c) marital adjustment. The Shipley Institute of Living Scale (Zachary, 1986) was administered to each participant to ensure that they had the verbal and reasoning skills to complete the pretest, midtest, posttest and follow-up questionnaires.

**Therapist Variables**

Therapists interested in participating in the project were required to: (a) have the equivalent of at least a Master's degree in Counselling Psychology, (b) have had at least 3 years prior experience with substance abuse clients and (c) submit 10 video tapes of their counselling work to a screening committee. A 3 week intensive training workshop in Experiential Systemic Therapy was conducted for those therapists selected for the project.

Friesen et al. (1995) report a high degree of treatment adherence for all therapists involved in this study, suggesting that all ExST treatments were carried out according to
the manual. However, a recent case study analysis demonstrated that at least one therapist for one treatment diverted drastically from the theoretical and clinical mandates of ExST (Sweetman, 1996).

Selection of Cases

Two couples who participated in the project, one successful case and one unsuccessful case, were chosen for this study. The selection process was as follows.

Given the large number of videotaped sessions, the selection was initially narrowed by choosing to look at couples therapy (N=24) rather than individual work. Then, those treatments deemed as "successful" and "unsuccessful," using the Success-Failure Strategy (Pinsof, 1988) were isolated. The Success-Failure Strategy involves rank-ordering subjects on pre-selected variables at treatment termination. The cases at the low end of the distribution are compared with those at the high end. Successful, in this study, is defined as a male client from the ExST-Couple treatment group who improved during the treatment period, by two standard deviations from the mean, on at least one of the measures administered, and showed some improvement on the remaining measures. Unsuccessful uses the same criteria (in the opposite direction) to distinguish a client who, within the standardized calculations for this particular sample, "deteriorated" during the treatment. That is to say, the "deterioration" may only be "real" according to the forced distribution of standardized statistics, and does not necessarily represent true client decline. The definitions of successful and unsuccessful were formulated on the basis of the widest possible gap between client outcomes. The male partner was chosen as the focal client, since TARP targeted alcoholic men.

Four instruments (out of the 15 administered) were chosen to assess four levels of client functioning: (1) alcohol dependency, (2) psychiatric symptomatology, (3) marriage, and (4) family. These levels are representative of the areas of interest in this study: the instruments chosen best represent these levels.
1. The Alcohol Dependency Data Questionnaire (ADD) gauges the level of alcohol dependency in the husband. It is a 39-item form rated on a 4-point scale ranging from never (0) to nearly always (3). A final score of 0 indicates no dependency. Scores from 1-30 indicate mild dependence, between 31-60 indicate moderate dependence and between 61-117 indicate severe dependence. A split-half reliability of .87 has been reported (Raistrick, Dunbar & Davidson, 1983). A larger score at posttreatment from pretreatment would indicate client deterioration.

2. The Symptom Checklist Revised (SCL-90-R; Derogatis, 1983) surveys intrapersonal distress. It measures the level of psychiatric symptomatology, using a 5-point scale of distress (not at all = 0..., extremely = 4), on a range of subscales including depression, hostility, paranoid ideation, obsessive compulsive, somatization, interpersonal sensitivity, phobic anxiety and psychoticism. The authors report reliability coefficients from .77 to .90. A larger score at posttreatment from pretreatment would indicate client deterioration.

3. The Dyadic Adjustment Scale (DAS) assesses marital adjustment. This 32-item scale taps four dimensions of the marital relationship: (a) Dyadic Consensus which measures the degree to which couples agree on important relationship matters, (b) Dyadic Satisfaction which measures the degree of satisfaction and commitment to the relationship, (c) Affectional Expression measures the degree to which the respondent is satisfied with the expression of affection and sex in the marriage, and (d) Dyadic Cohesion which measures the degree of couple togetherness. Scores range from 0 to 150 with a score below 100 indicating marital dissatisfaction. Reliability has been reported as .96. A lower score at posttreatment from pretreatment would indicate client deterioration.

4. The Family Satisfaction Inventory (FSI) measures family satisfaction. It is a 14-item instrument that asks respondents to rate how satisfied they are with the (a) family emotional bonds, coalitions, time, space, decision-making, interests and recreational
activities (cohesion dimension items) and (b) family assertiveness, control, discipline, negation, roles and rules (adaptability dimension items). Items are scored on a 5-point Likert scale ranging from 1=dissatisfied to 5=extremely satisfied. The mid-point of 3 indicates generally satisfied and divides the scale into satisfied and dissatisfied response fields. Reliability has been reported as .75; internal consistency is .92. A lower score at posttreatment from pretreatment would indicate client deterioration.

Decision Criteria

A successful case and an unsuccessful case were selected based on scores from these four measures. A suitable unsuccessful treatment was one in which both partners from the ExST-Couple group (N=24) indicated z-scores at least two standard deviations below the mean on at least one of the measures previously identified, and had scores below the mean on the remaining three.

A suitable successful case was likewise identified if both spouses indicated z-scores two standard deviations above the mean on one of the measures, and demonstrated z-scores above the mean on the remaining three. A second decision criterion was to select a successful and unsuccessful case in which the same therapist delivered both treatments.

Only two treatments fit both criteria and so Case 2030 (successful) and Case 2046 (unsuccessful) were chosen. For Case 2046, the first decision criteria was amended to permit the incompletion of the posttest DAS, due to relationship breakup, to count as a two standard deviation deterioration, since the pretest score was sufficiently elevated.

Graphs depicting the scores from pretreatment to posttreatment, for the husband and wife of each couple are found in Figures 1 to 4.
Figure 1

*Pre- and post-treatment psychosocial functioning of 2030 female*

![Graph showing pre and post treatment scores for female participants on SCL90, DAS, and FST scales.]

Figure 2

*Pre- and post-treatment psychosocial functioning of 2030 male*

![Graph showing pre and post treatment scores for male participants on ADD, SCL90, DAS, and FST scales.]

Figure 3

*Pre- and post-treatment psychosocial functioning of 2046 female*

![Figure 3](image)

Figure 4

*Pre- and post-treatment psychosocial functioning of 2046 male*

![Figure 4](image)
Selection of Events

Identifying and Collecting Significant Events. The first step in implementing CPA is the identification and collection of significant events. Elliott (1993) has defined significant therapy events as a within-session sequence of client and therapist responses which facilitate particular therapeutic effects in the client. A significant event typically involves a client request for help in understanding something about self, followed by a therapist interpretation involving the client's core conflicts, delivered in a warm, collaborative manner. This in turn is followed by client-generated helpful insight into self and further exploration (Elliott, 1984). Significant events range in length from a single sentence to an entire session, but are generally 2-6 minutes long, with one or more "peak" or particularly significant responses.

Elliott (1993) suggests that there are three major classes of criteria for evaluating clinical significance: Experiential Criteria (based on the client's experience); Shift Criteria (based on observable shifts in client process); and Critical Process (the presence of specific client or therapist "markers"). Given the perimeters of this project, it is impossible to ask the client directly for his experience, and thus the focus is on Shift Criteria (from both observer and therapist perspective) and Critical Process Criteria.

Event identification based on third party process observation or therapist input has the advantage of providing events with specific, theoretically-relevant features. However, it is potentially hampered by the fact that researchers and therapists, from their theoretically biased posture, may miss what was most helpful or important to the client.

The first step in selecting a significant event is to develop operational definitions of (a) an event and (b) the marker that introduces the event. The manner in which these definitions were developed was based on the work of Friedlander et al. (1994) in their use of the Modified Analytic Induction Method (MAIM; Bogdan & Biklen, 1992, pp. 69-72). The steps in MAIM are: (a) to sketch out a rough definition of the phenomenon under study, (b) to purposefully observe and select events that facilitate the expansion of the
definition, and (c) to modify the definition to develop a descriptive definition of all cases. The definitions developed are as follows:

1. **An IR Event** - The event under investigation in this study is an event that involves a meaningful, enduring, experiential encounter with a part of self previously unregarded, in a therapeutic environment, during a Relational Novel Episode, identified by a marker and resulting in therapist intervention. An event adhering to this description is called an Intrapersonal Resolution (IR) event. Six inclusion criteria were identified:
   a. Expression of a good working relationship with the therapist.
   b. Emergence of previously avoided or warded-off material (cf. Horowitz et al., 1975).
   c. Client movement into higher levels of experiencing or deeper forms of processing.
   d. Description/exploration of the nature and meaning of feelings.
   e. Important self-disclosure.
   f. Articulated, spontaneous new vision or insight regarding self.

2. **The Marker** - The marker is threefold: (1) a client generated disclosure that there is a part of their "self" that they do not know or understand, (2) a client request for help, (3) a therapist-generated client experience.

Therapeutic events that fulfilled all six inclusion criteria and were marked appropriately were considered *Intrapersonal Resolution (IR) events*. The events themselves were not measured in terms of successful or unsuccessful since it is difficult to evaluate a client's "experience" and since it was not necessary given the discovery based objectives of this study. However, one IR event was selected from a successful treatment and the other from an unsuccessful treatment. After intensive observation involving more than 100 hours of video viewing, the two best IR events were chosen.
Inter-Judge Reliability

To ensure that the episodes selected for analysis appropriately fulfilled the criteria and matched the definitions, three judges evaluated the events. Two judges were graduate students in Counselling Psychology; the other was a professor in Counselling Psychology. All were quite familiar with the project and the process. The events were reviewed independently and 100% agreement indicated that there was no discrepancy between the judges and the researcher. All individual assessors concurred that the marker and the six inclusion criteria were present in the episodes selected.

Summary

This study investigates an Intrapersonal Resolution (IR) event for a client undergoing ExST, who significantly improves, according to z-scores considerably above the mean, based on four pretest/posttest outcome measures. A second IR event is investigated for a client whose scores (based on the same measures) are significantly below the mean, while undergoing the same type of treatment with the same therapist. The target person is the male partner in couple's therapy within TARP. The identified IR event was based on the existence of a defined marker and six inclusion criteria.
CHAPTER 4: A SUCCESSFUL CASE

The second step in CPA involves analysis of the significant event. This chapter will implement CPA with a successful treatment of ExST and Chapter 5 will examine an unsuccessful treatment. The successful case is identified as 2030-11-1. The 2030 refers to who the clients are and where the therapy took place, using TARP coding. Event 11 means that the event occurred in the eleventh session and 1 means that this is the first of two events in this study.

It may be helpful to set the stage for CPA by creating a feeling for the clients, therapist and therapy under investigation.

The Setting

Tim and Pam (not their real names) arrive at the first session before their therapist. Tim paces around somewhat restlessly, hands in pockets, stopping to peer at the sunset photographs on the wall (an important symbol for him) and finally slouching into a chair. When the therapist arrives Tim crosses his long legs loosely, and leans back with head lowered and supported by his left hand. Pam, sitting to his left, is blocked by this gesture, but seems not to notice. She sits forward in her chair, eagerly, like a good student. Pam, when asked, expresses her needs quickly. Tim breathes heavily and admits he's angry right at the moment - "ballled up inside." The therapist sits across from them, forming the peak of a triangle, and skillfully punctures the subtle tension by letting Tim talk and gently validating his feelings. Tim speaks carefully, precisely, firmly, and over time relaxes slightly. Pam is quiet and non-intrusive when Tim speaks, as if she is aware of the immense pressure that has built up in him and the importance of releasing it slowly, lest it explode. When she talks she is careful, tentative, and yet eager, hungry for ears that understand.

Patterns are manifested quickly. Tim is angry and tense. Something deep inside
him seems to torment him and his carefully controlled behaviour seems more like the
exacting tick of a time bomb than real self-control. Prior to this therapeutic commitment,
he sought immunity in alcohol. He is fighting against both himself and his abusive
solution and it is inevitable that he also fights with his partner. He says she won't talk
with him, share her feelings with him and this reflects the secrets and emotion that he
keeps from himself. She says she can't say anything because she's frightened of his
anger, and this maintains the fear she's carried all her life. Both suffer from a damaged
sense of self-worth. He fights this by trying to be blameless and she embraces it by
taking the blame. He is a fighter. She is a pleaser. She has, on occasion, acquiesced to
the demands of life itself with suicidal gestures.

They are caught, as I see it, in a tragic sculpt where she is on her knees reaching
out, longing to be healed by touching genuine love and he is untouchable, wrapped and
buried in a tomb, longing for the stone to be rolled away. This imaginary sculpt reveals
an ironic twist, typical of the complementarity within a fragmented self and within a
fragmented marriage. Pam's behaviour is passive and submissive, but her inner stance is
active in reaching out. Tim's behaviour is active and aggressive, but somewhere inside
he is paralyzed, inert. Tim sustains his paralysis by having a relationship with alcohol
and Pam sustains her reaching-but-never-touching position by having a relationship with
an alcoholic.

It is a second marriage for both of them. Both Pam and Tim are probably "thirty-
something" years old.

Ten sessions have occurred prior to the session which contains the significant
event. In previous sessions Tim has shown the therapist some drawings of rather horrific
infant self-images from his dreams. They are obviously important, but in earlier sessions
other more "urgent" relational issues have predominated. Pam was unable to attend the
eleventh session, and it is an appropriate time to explore the drawings. Tim is amenable
to work. Pam's absence for the IR event was not a deliberate breach of "couple's"
therapy: the best example of an IR simply occurred during this session.

The Intrapersonal Resolution event (which follows) occurs at the beginning of session eleven and includes lines 47 to 96 in Appendix 2. The bracketed numbers represent pauses in seconds. (All the elements of transcription are found in Appendix 1.)

T: So that was about the first time that the-. You know what I almost see? I almost see like a plane going over and these people are stranded-waiting to be seen.

C: ((blows out air)) When I um (3) did that it was like- you're outside looking in ((blows out air)) I don't believe this (starts to choke up) (2) ((deep breath)) and you didn't even know this was there and then they (see) you from inside and they're reaching-from inside (2) (T: uhhuh) (3) uh (2) it was really unsettling to know that was there. To find out. Boy, I could see it, you know, it was (2)

T: ---- you could see it (3)

C: I don't know why-I just feel so upset now. Because I drew it out and thought about it, and thought about it and I talked to him. But I found out that he was inside and he-((sob)) once he saw me look-looking ((sobs?)) (2) he reached (5) And it was urgent-I couldn't not do anything about it (3) ((exhale)) And I felt really, really sad. And I didn't know what to do ((voice cracks)) but I knew I had to do something so I just kept talking to him ((db)) and saying that I would do somthing ((sobs)) When I went in there he went back to a little baby.(5) ((deep breath)) And that's when I had that dream about it was a mummy.((sob)) (T:yeah) Somebody gave it to me ((voice cracks)) (2) and he kept looking at me (4) And I- ((sobs hard))

T: Take a deep breath (2)-a deep breath.

C: And I gave him back and he closed his eyes. When I gave him back and he opened his eyes again and he looked at me. And it was like a horrible look 'cause he was in agony.((swallows) And I didn't know what to do (4) ((heavy breathing)). Then I gave him back and I couldn't take him anymore. And um I
kept seeing him so many times so I had to -and I drew him out and I said, "I'm going to do something- about you." And I was really afraid of him. So I drew him out. I tried to get the face like it was. It was horrifying almost. (1) And it scared me really bad. And then when I told him I was comin' and I was going to do something. (2) ((exhale)) He rested a little. So- (3) And so things started going away a little bit and I promised that I wanted-to know what to do-I wanted to figure out what to do. (3) And I was so shocked still to find that thing living inside of me=Then we had the Christmas break. And- And- I felt (3) like I'd run out of gas. I didn't know what to do. And uh I was going to lots of meetings and talking to my sponsor, and it was- helping a bit but still I wasn't going any further I was sort of losing contact.

T: right, (2) so he's over here?

C: yeah (4)

T: This is him?

C: yeah (5) ((sniff)) so ((sniff)) like I was holding him- I could reach something really, really important- really important and I didn't know very much about it yet. It was too scary to take it out-it was too scary  But I knew that- out here somewhere there was help (1) and it was- a promise of peace and rest and some serenity and tranquility (1) on the horizon which wasn't very far away. It was close enough, If I figured out how to walk down there, get there, reach there, whatever. But I can't do that by myself. (3) And so I guess it was like: it was stormy inside of me. And so I was thinking that there was ((deep breath)) a vicious wind blew down my valley-the canyon at times and broke-the connection. And uh (1) so now=and Christmas I really love. Christmas was sooo-it's like it was next door for me and I enjoyed it but it wasn't like I was totally there.

T: ---- the connection with it was broken I guess.
The drama of CPA follows in three acts: (a) Process Analysis, (b) Effects Analysis and (c) Context Analysis. This analysis will follow the general process of the event, rather than the temporal or historical order; that is, we will begin "inside" the significant event and work outward. It may be helpful to read the entire transcript information first (see Appendix 2).

Analyzing Process: Explication and Microanalysis

The therapeutic communication process consists of several different components or subprocesses, described here as aspects. These aspects are distinct, but may parallel, contrast or support one another. As long as their fundamental unity within the process is kept in mind, the distinction provides a useful way to sensitize observers (Elliott, 1993). The four aspects used in CPA are: (a) Content, (b) Action, (c) Style, and (d) Quality. These are derived primarily from the writings of Searle (1969), Russell and Stiles (1979, 1992) and Schaffer (1982).

Content

The Content aspect of process refers to the semantic element of communication, that is, what is said or meant. There are two major approaches to content: propositional and content analytic. In CPA both approaches are used. The propositional approach involves the extraction of ideas conveyed in particular client and therapist utterances (explicit and implicit), and is carried out primarily during the explication step (see Appendix 5). The Content Analytic part addresses the "kind" of content involved (themes or kinds of ideas) and is largely evidenced in the Sentence Flow Chart (see Appendix 4) during the microanalysis of the peaks. The content of the session is structurally outlined in Appendix 3.

Client Content. In Event 2030-11 client content is further explored by asking the question "What themes or kinds of ideas seem important for understanding this event?"
The therapist touches a core relational theme by suggesting that the faces drawn by the client (Tim) looked "stranded" and "waiting to be seen." The visual metaphor of "seeing" seems prominent (see Sentence Flow Chart, Appendix 4). Sometimes Tim was "looking" inside and sometimes he was "seeing" outside but he seemed unable to connect the two perspectives. The part of self symbolized by the horrified baby made eye contact with the adult on the outside, and it is this contact that Tim describes. It activates an unfamiliar emotional upheaval for him; it "unsettles" and "upsets" the client and it seems to be relentless. Since he has determined to abstain from his habitual alcohol escape, he wants to restore stability by intellectually "figuring it out." This is new territory and he is temporarily paralyzed by the internal conflict of "not knowing what to do/need to do something." Thus Tim experiences a split on a number of fronts: inside/outside, baby/adult, he/l, emotional/rational, unfamiliar/familiar, helpless/active.

There are also some painful feelings. Tim describes himself as feeling "really, really sad" and "really afraid." The sadness is demonstrated by his tears and slumped posture: his emotional behaviour and physical carriage are congruent with his affect words. This, in turn, is congruent with his story, which is indeed sad; a pitiable infant, agonizingly grasping for eye contact with powerless urgency. The fear is evidenced in Tim's rapid speech and breathlessness. The image is scary in its horrific suffering and the process of rescuing the baby is overwhelmingly frightening.

Four features of the content appear to be important for understanding the event:

a. Unsettled feeling
b. Insight regarding dissociated part of self (intrapersonal split)
c. Sadness (painful feeling)
d. Fear (core relationship theme)

Therapist Content. The most important feature is the therapist-generated image of being stranded and waiting to be seen.
Action

The Action aspect of process refers to what the client or therapist does by what they say - what the philosopher Searle (1969) calls the "illocutionary act," since, he argues, speech acts are constituted by the exchange of intentions. The purposive nature of therapeutic communication is reflected in the words that are used to describe this action: goal, intent (Stiles, 1986b), task (Rice & Greenberg, 1984), and plan (Weiss, Sampson et al., 1986).

The most common therapeutic action variables are the therapist and client "response modes" (Goodman & Dooley, 1976; Hill, 1986; Stiles, 1986a) which describe generic speech acts, and "response task" which describes the specific nature of the task at a particular moment within a particular type of treatment. Response modes have been researched extensively and there are eight generally agreed upon fundamental therapist response modes and seven client response modes. This study employs Elliott's (1993) summary of Hill's (1986) descriptive definitions of response modes. The eight therapist response modes, listed here in skeletal form, are as follows:

1. **Question:** (a) closed "yes/no," (b) closed specific information, (c) open question word, (d) open "tell me," (e) open "I," (f) open fill-in
2. **Advisement:** (a) command, (b) obligation, (c) suggestion, (d) informational
3. **Reflection:** (a) quote, (b) paraphrase, (c) implication, (d) nonverbal, (e) exploratory, (f) summary, (g) first person, (h) collaborative
4. **Interpretation:** (a) explanatory, (b) classifying, (c) parallel
5. **Reassurance:** (a) agreement, (b) support, (c) praise, (d) minimizers, (e) permission, (f) sympathy
6. **Disagreement:** (a) simple, (b) discrepancy, (c) warning, (d) criticism, (e) questioning, (f) correction, (g) hidden
7. **Self-Disclosure:** (a) general, (b) process
8. **Information:** (a) procedural, (b) third party, (c) general
9. **Other.**

The seven client response modes are as follows:

1. **Request:** (a) direct, (b) informational, (c) indirect
2. **Agreement:** (a) strong, (b) mild, (c) positive alliance signs
3. **Disagreement:** (a) strong, (b) mild, (c) negative alliance signs
4. **Description:** (a) third party, (b) abstract, (c) behavioural, (d) narrative
5. **Self-Disclosure:** (a) feelings, (b) reaction, (c) self-characterization
6. **Insight:** (a) causal, (b) thematic, (c) awareness
7. **Planning:** (a) goal clarification, (b) alternative exploration, (c) consequence exploration, (d) commitment.

**Client Action.** The client's self-appointed task in Event 2030-11-1 is to try and figure something out about himself, using the drawings that emerged from his dream as a window into his history/inner landscape. He agrees with the therapist's exploratory reflection and provides further narration for the agonized images in his drawing, in an effort to reach and to respond to his restless feeling of inner unsettledness. This is done primarily through the response mode of self-disclosure (see Explication, Appendix 5).

**Therapist Action.** The therapist's task is to reach out and connect with the client (by sharing what he sees in the client's drawing), to communicate that he understands, values and has received a message from the client's symbol (drawing). Throughout the peak, the therapist facilitates Tim's exploration of painful memories, insights and feelings by supporting Tim and regulating the intensity of the experience. The empathy is accomplished primarily in the reflection response mode (lines 47, 54, 96) and the event is moderated with advisement (lines 65) and question response modes (lines 81, 83). (See Explication, Appendix 5).

**Style/State**

The question geared to access Style/State is "How was it said or done?" "What
was the speaker's psychological state in saying it?" It includes a wide range of phenomena such as linguistic variables (e.g., syntactic complexity), paralinguistic variables (e.g., nonfluencies, pauses), nonverbal behaviour (e.g., gestures, facial expression), mood (e.g., depressed, angry) and attitude toward other (e.g., friendly, patronizing).

**Client Style/State.** The client during the peak of this event is upset and sad. There are lengthy pauses and frequent "sniffs". His voice breaks but he persists, sometimes speaking very rapidly, intensely, almost eagerly, and then becoming very quiet and nearly inaudible. He and the therapist are sitting beside one another, fraternally, looking at the drawings on the coffee table and Tim is active in pointing and gesturing. At times, when he weeps, his head momentarily collapses into his hands.

**Therapist Style/State.** The therapist exhibits a positive, affiliative style by being calm, supportive and reassuring, with a soft, quiet voice. He also maintains a subtle task-oriented manner, being empathically involved, but with some neutrality and distance. He seems very comfortable with silence and permits, at times, a lot of "space" around words. The Style/State of the therapist complements the Style/State of the client.

**Quality**

The final aspect of event process is quality. It is not enough to describe content, action and style without asking the question, "How well was it said or done?" Quality is evaluated in relation to the model of treatment and the current task, since the same statements may be judged very differently in different therapies or tasks. Response quality refers to "skillfulness" in considering the therapist, and to "working" with regard to the client.

**Client Quality.** During this peak Tim worked very hard to stay with immediate experiencing without becoming blocked by embarrassment or fear, in spite of the fact that his father disapproved of emotion and he is shocked and afraid of what's inside
himself. He is expressive, able to access feelings and to clearly articulate his own insights.

Therapist Quality. The therapist was skillful in introducing the experience (getting the client going), in empathy and brevity (staying out of the client's way) and regulating intensity (keeping the client breathing).

Analyzing Effects: Tracing Consequences and Evaluating Effectiveness

The second section of analysis targets the effects of the significant event. The effect of a significant event refers to what are variously referred to as "effects," "impacts," "effectiveness," and "outcome" at each of the four main unit levels of turn, episode, session and treatment. In CPA the effect begins as soon as the peak speaking turn begins and continues through the end of treatment and beyond to follow-up assessments: (a) Immediate Effect, (b) Within-Session Effect, (c) Post-Session Effect and (d) Post-Treatment Effects. These widening effects can be used to assess the clinical significance of a therapy event, by distinguishing between effects which are maintained over time and those which are diminished.

Immediate Effect

The immediate effect begins with the first peak speaking turn in the event and continues through the rest of the episode. The analysis involves an informal sequential, schematic narrative in which the researcher selects and links what appear to be important steps by which the effect unfolds.

Process Effect. An obvious place to start is with process effect: it is 'right there' on the tape and provides a structure within which to describe Experienced Effects.

Process Effect Pathway:

1. T explores/reflects meaning of Tim's drawing
2. Tim agrees, expresses his new awareness,
3. Tim discloses disturbed feelings
4. T reflects, affirms
5. Tim explores feelings of sadness, urgency
6. Tim refers to dream about mummified baby
7. T calms, regulates
8. Tim describes suffering/horror of baby/himself
9. Tim discloses feelings of fear, shock, desperation
10. Tim loses contact in his story and in the session
11. T asks clarifying question about drawing
12. Tim answers "yes"
13. T repeats clarification, shows interest, re-establishes contact
14. Tim acknowledges importance of potential insight, ignorance of process, fear of proceeding, and hope of help
15. Tim describes inner storm, connection broken
16. T repeats part about broken connection

Experienced Effects (Client Reactions). Immediate effects consist of the inner experiences through which the client passes, as well as the observable process. These "experience steps" (cf. Gendlin, 1981) are important because they are not always self-evident, because they often help explain seeming "gaps" in process effects (cf. Spence, 1982), and because they allow the researcher to begin to model the internal actions or cognitive-emotional processes engaged in by the client as he/she constructs meaning (Elliott, 1993). In addition, they allow the researcher to connect the event to categories of experienced effect which have been established in the literature.

In this case, Experienced Effects are generated primarily from observable Process Effects, and to a lesser extent from client and therapist reports. This sorting out of effects is frequently an interpretive, hermeneutic process.

Client Experience Pathway:
a. feels understood by therapist (=positive interpersonal)
b. contacts emotional pain (=self/affect awareness)
c. experiences unexpected, intense, painful distress with regard to abandonment of infant (=negative self-awareness)
d. need to respond (=problem clarification, cognitive realization)
e. experiences fear symptoms (=emotional reaction)
f. experiences relief (=emotional reaction)
g. distances from experiencing (=problem clarification)
h. feels hope (=positive self-awareness)
i. knows he can get help (=emotional reassurance, cognitive realization)

**Within Session Effect**

a. After an non-eventful discussion of Tim's childhood (mid-session), the therapist brings Tim back to the experience of the IR (from early session) (line 213)
b. The therapist assists Tim in reconnecting by being able to feel the baby's sadness and to be the adult comforter. Tim as adult comforter assures baby of his presence (line 238, 240).
c. Tim feels authentic rest, safety (not just relief) (line 253)

**Postsession Effect**

Assessing postsession effect requires that the researcher engage in detective work, looking for "footprints" left by the event.

*Immediate Postsession Effect.* At the very end of the session, Tim thanks the therapist and says "I don't feel so sad. It's a treat." It was the only time during the treatment when he expressed such gratitude.

*Subsequent Session Effect.* In the following session Tim comments that "things are moving again." However, his "slump" has taken its toll on his marital relationship
and a good deal of the session is focussed on his wife who has felt abandoned. He feels accused by her comments and his feelings of "badness" are aroused: "I don't know what I've done but it must be really bad, because I'm being treated really bad and one way or another I gotta know what's going on so I blow up because I gotta know." The therapist chooses to pursue the possibility of any potential violence rather than exploring the "bad person" theme. Eventually the therapist refers to the significant event from the previous session: "For me it relates to last week - what you didn't get as a child was a constant state of safety - that sense of caring, self nurturing 'I'll always be there for you, I won't let you go'." He suggests that Tim needs to include his family in that nurturing. It is a difficult session for both husband and wife and in closing Tim comments "I feel more topsy turvy than I feel sorted out."

In the ensuing session Pam confesses that: "I've never really acknowledged even to myself how I feel... I can't lie to me anymore... he thinks we're improving but I'm deceiving the both of us." She has now responded to Tim's confrontation with "himself" by courageously confronting her own inner "stuff". Later she remarks that she remembers Tim saying that he wasn't who he thought he was and now she understands that. Tim encourages her to have an extra session with the therapist alone since it (the significant event session) was so helpful to him.

Near the end of the session, the therapist says to Tim that "even though you're dealing with this stuff, there's a certain calmness in you today that hasn't been there before" and comments on the progress thus far, the hope for the future, and congratulates his client on the work he's done. Tim is pleased but realistic. "I feel change" he says. "On the other hand, it seems like it barely skims the surface."

In the next session, the therapist again comments on the change which seems to have stayed with Tim: "You seem different, you look different - your eyes, voice, posture - it's nice to hear you laugh." Later in the session, Tim describes his experience:

I felt at first like there would be a solution - a big answer - and what it
feels like now is that rather than provide answers, it's begun to clear away some of the bad stuff - and open the doors and curtains and let the fresh air in and the sunshine in on parts that I didn't even know were there - so we're at the very beginning, like learning to learn. I couldn't have done it without finding out this guy (points to drawing) was inside of me. Finding him and then bringing him home was really difficult emotionally ... but it's okay now.

The therapist points out that there is a look of beauty in the new composure that Tim now has, and Tim continues:

I've always really enjoyed getting a glimpse of the really beautiful things.... There are things that happen sometimes that are so immensely beautiful that they shift you - they take your whole body and spirit and you know you've been privileged and I'd forgotten what it was like.

The next session, Pam, encouraged by Tim, comes by herself. She begins by laughing about a dream she had the previous night regarding all the things they were not going to talk about. The therapist pursues this and discovers that there is, in fact, a secret. Because she does not have Tim's permission, she does not share the secret, but the therapist now knows there is missing information for him and the burden of a secret for his clients. They do not divulge their secret in subsequent sessions, since the sessions are videotaped, but they do tell the therapist eventually, off camera.

Extratherapy Postsession Effects. Participants in TARP also filled out a Weekly Situation Diary in which, among other things, they recorded thoughts, feelings, events from the past week. The significant event took place in session 11 on February 5, 1992. On February 16 Tim wrote:

things are improving over all, but my days don't flow together with any amount of cohesiveness, they're very up and down and disparate and I can't get to feeling myself on any kind of continual basis yet.

On February 23 he refers directly to the session with the significant event:

I am feeling more like a person this week .... I have made an effort to let my wife be herself .... I'm feeling more whole and more able to look at myself and make an effort. I think a lot of this comes from having had an extra session with the counsellor and bringing home the inner child. I don't feel nearly so sad or disjointed and I feel more able to work on this stuff again.

Finally, on April 12, the last entry records:
Life seems to have smoothed out into a more regular, even, predictable pattern in most ways that are important and I feel more relaxed and even in myself.

**Posttreatment Effect (Outcome)**

The final level at which the effect of a significant event is considered is that of the entire treatment (since information about the overall effects of therapy may bear on the effect of the significant event). TARP employed a variety of quantitative outcome measures; several have been selected for measuring treatment effects.

On the *Alcohol Dependency Data* questionnaire (ADD), the client scored 74 at pretest and 4 at posttest with a z-score of -1.5 based on the difference. The improvement was significant and he ranked 8th out of 82 men in his category for the study. Tim maintained his commitment to sobriety for the entire treatment (over a 7 month period), and beyond.

On the *Symptom Checklist Revised* (SCL-90-R), Tim's pretest score was 118.9 and his posttest score was 52.2. (Normal is between 40 and 60.) His z-score, based on the difference, was -2.6 which earned him the "most improved" ranking (1/83) for husbands. Pam's pretest score was 142.5 (extremely distressed) and her posttest score was 47.2, demonstrating an extraordinary improvement (z-score difference = -4.6) and the greatest achievement in TARP.

On the *Dyadic Adjustment Scale* (DAS), Tim's pretest score was 94 and his posttest score was 123 (z-score difference .9), with a 5th best ranking. Pam scored 62 (pretest) and 110 (posttest) with a 1.7 z-score difference and a 4th best ranking for improvement.

On the *Family Satisfaction Inventory* (FS), pretest scores for the client and his wife were 25 and 29 (respectively) and posttest scores were 57 and 49. Tim's score was most improved for the husbands (z-score difference 3.3) and Pam ranked fourth for the wives (z-score difference 1.7). All the scores are graphically represented in Figures 1
These quantitative indicators of clinical significance can be translated into descriptive qualitative terms, and evaluated in terms of their relevance in explaining the effect of the event, by "narratizing" the data into a coherent story (Elliott, 1993). In this case, Tim and Pam: (a) experienced treatment as meaningful and helpful on a variety of intrapersonal and interpersonal dimensions and (b) the event thus represents the process of a successful treatment. Tim and Pam recognized and celebrated their achievement by getting married several months after the treatment (although they refer to one another as husband and wife during therapy). The therapist was invited to, and attended, the wedding.

The relief Tim experienced after his extrication from the "cement casement" and the unbinding of mummified burial cloth, and the self-reunion during the significant event, enabled him to set Pam up to release herself (and him) from their horrible secret. Pam quit her mundane job and has found meaningful employment. Both she and Tim have established a strong support network.

At this point, Tim and Pam have achieved a visible self-integrity. Tim, who was angry/aggressive outside and paralyzed/inert inside is now more alive inside and relaxed outside. Pam, who was active/reaching inside and passive/submissive outside is now more operative outside and at peace inside.

Analyzing Context:
Exploring the Sources of Significant Events

The last section examines context. Psychologists are infamous for their neglect of context, and there have been repeated calls for greater attention to participant situation (e.g., Elliott, 1993; Heatherington, 1989; Rice & Greenberg, 1984). The central task of understanding why the significant event occurred cannot be seriously addressed until we begin to examine its context (Elliott, 1993). This analysis, following the format of the whole analysis, will conform to the general process of the event rather than the temporal
or historical order: that is, we will begin "inside" the significant event and work outward.

**Episode Context**

The first step in analyzing context is to understand how it arose within that particular episode of the therapy session. Five important characteristics of Episode context are examined: Client Episode Task, Therapist Episode Task, Relevant Events, Local Cue and Explanatory Links.

*Client Episode Tasks.* The episode begins with Tim expressing frustration with his present state. He believes that he was just about to access something important, and then the "connection" broke and he was stranded mid-process. It has left him "feeling very jugged and mixed up." Therefore the client seems to have three main episode tasks:

a. Sort out internal confusion
b. Reconnect with feelings
c. Get things moving again

*Therapist Episode Tasks.* Following the ExST approach, the therapist's tasks in Event 2030-11-1 are:

a. Stay with and show understanding of Tim
b. Facilitate expression and experience of feelings
c. Help Tim explore sources of current feelings

*Episode Relevant Events.* The sequence of relevant episode events, just prior to the local cue/peak, runs as follows:

a. T states new task, to explore Tim's drawings
b. Tim responds with exasperated sigh
c. Tim expresses confusion in loss of connection with the image
d. T suggests abandonment feelings for Tim
e. Tim explains the necessity of covering up his exposed raw feelings when the
connection was lost

f. T attends

g. Tim begins to disclose using symbols and metaphors

h. T clarifies

Local Cue. Distinguishing the immediate stimulus for the significant event focuses attention on it as the "precipitating cause" of the significant event. The Local Cue and the beginning of the event will stand as a conversational pair or basic sequence unit.

a. local cue: the therapist hits key image for Tim (i.e., being stranded) as he participates actively and intimately in the exploration of Tim's drawings

b. beginning of event: Tim expresses emotion (sadness), reconnection begins.

Explanatory Links. The client, who has shown no pain/sadness thus far, gets quite choked when the therapist says "You know what I almost see? I almost see a plane going over and these people are stranded, waiting to be seen." The key word "stranded" seems significant since it is also Tim's current condition in the midst of his "loss of connection." It also suggests the client's sense of agency since the therapist's use of the word "abandoned" a few speaking turns earlier, aroused no response. "Stranded" is a situation one has put oneself into, the direct object (e.g., I am stranded), whereas "abandonment" is something that happens to one (e.g., I've been abandoned).

The therapist is very warm and very involved, actively reaching out to make contact. He forms a bridge between what he sees and what the client has expressed visually, and perhaps it is that effort of reaching (a salient image for Tim) that establishes the local cue.
Session Context

The next level of context is the session in which the significant event occurs. This involves an examination of the client and therapist session tasks, the general state of the therapeutic alliance and session relevant events.

Client Session Task. The episode containing the significant event occurs fairly early in the session so that client session task is quite similar to client episode task. Tim begins the session by saying that it is a difficult time for him and for his wife right now, both together and separately.

Therapist Session Task. The therapist initiates the task of collaboratively exploring Tim's drawings.

Therapeutic Alliance. Bordin (1979) distinguishes two aspects of the alliance; the bond aspect (degree of felt, observable emotional connection between client and therapist), and the task aspect (degree to which client and therapist share a common understanding and commitment to the goals and tasks of therapy). A good alliance seems to engender positive expectations for the client, as well as a willingness to work and to overlook therapist blunders. However, a good alliance does not seem to be essential in order for significant events to occur (Elliott, 1993).

The alliance at the beginning of this session takes a minor blow when the therapist appears to defend Pam's position. However, this has happened before and does not seem to dampen Tim's unconditional belief in the therapist's ability and personal concern.

The Therapeutic Alliance Scale-Couple (TAS-C) is a 7-point Likert scale measurement of the client's feelings and thoughts with regard to the therapist and to the actual therapy sessions. For the 29 items, Tim chose the extreme response of 1 (completely agree) for all the positive statements and 7 (completely disagree) for every negative item. Positive items include statements like: the therapist cares about me as a person, I trust the therapist, my partner and I are in agreement about the therapist.
Negative items include statements like: the therapist is not helping me, the therapist does not understand our goals, I do not care about the therapist as a person.

In addition to the written affirmation, Tim frequently comments during therapy that he trusts both the therapist and the therapeutic process, in spite of the fact that he does not always "like" the sessions or see immediate pay-offs.

Session Relevant Events. Near the beginning of the session, the therapist almost gets hooked into defending Pam by saying, "... I see a loving wife reaching out to her husband." Tim responds defensively by saying, "I've seen a lot more," asserting an ongoing complexity/hideness theme. The therapist extracts himself from the situation by recognizing that they should wait until Pam is present for that conversation, and moves on to explore the drawings. The therapist's choice of words are significant since "reaching out" is a salient construct for Tim. Also the experience of "seeing" seems thematic. As well, Tim maintains that he does not show emotion or "lose control" unless his listener has been tried and shown trustworthy.

The sequence of pre-episode events are as follows:

a. Tim sits in room waiting for the therapist, gets up and examines sunset photos on the wall, sighs a lot.

b. T arrives, asks Tim how he is

c. Tim is doing slightly better than previous two weeks, but it is a difficult, slow progress (continues sighing)

d. T seeks clarification

e. Tim expresses needs (for support, acceptance)

f. Tim expresses relentless low self-esteem feelings, lonesomeness

g. T further clarifies

h. Tim describes very deep need for control (fear of loss of control), difficult to show emotion

i. T brings Pam in - she seems worthy of his trust
j. Tim defends himself, then withdraws and acquiesces
k. T reroutes from couple issues
l. T presents some session task options

Presession Context

Presession context is the level of context most directly relevant to the significant event session and includes pertinent events (inside and outside of therapy) which have occurred since treatment started. The content of the significant event, for example, usually does not just emerge "out of the blue" but instead passes through a series of intervening steps or pathways.

Previous Sessions. In the first session Tim states that he'd like to experience "whole change," and says very clearly "I want to do this."

The following week he begins by saying, "I feel like I have no skills - like a baby. I know nothing about this spot I get stuck in. I just have to white knuckle it." He goes on to say that there are a lot of parts of him that he doesn't understand. He reacts very strongly (angrily, fearfully) to Pam when she made a decision without him and adds that "it's like watching TV - I'm not a part of it." Again, his external situation mirrors his internal state: he feels disconnected from (not a part of) his wife and disconnected from (not a part of) himself. Feeling like a baby, stuck, not understanding, afraid - it all neatly foreshadows the significant event.

In the fifth session Tim describes a part of him, his core, that feels like it has been "coated in layers of cement." The three of them talk about fear, injustice and power and Tim reveals his dream about the mummified baby. He talks very intensely, quickly, passionately. The therapist comments that something about Tim looks haunted when he talks, and wonders if something happened to him when he was very young. Tim reveals that just then he felt like part of him went to a different place, as if he were two people.

In the sixth session Tim describes another baby dream. This time he had half a
baby in his arms and he wouldn't put it down, even though he was climbing up and down a ladder. Everyone kept saying "put it down, it's dead" but he didn't, and eventually the baby smiled. "The smile," said Tim, "was a really big thing."

During the next session, Tim and the therapist work through a misunderstanding/miscommunication from the previous session (by doing a sculpt) and the working through seems very meaningful for Tim, as he says several times "I trust you."

The eighth session is a hard one for Tim. He feels accused and blamed by his wife and the therapist, as if he's the "bad guy." The therapist talks about the harshness and abuse that keeps "sneaking in." At the end of the session, Tim says he feels left out, empty and lonely. When the therapist asks "Where?" he says, "in my stomach," and when asked "what is it saying to you?" Tim responds softly, "cover me up," and he begins to weep.

Tim begins the ninth session by saying he feels like "mosaic man - some holes and some pieces." He is pleased that there are some pieces.

In the tenth session, the one prior to the significant event, Tim is tired. He feels lost, "out there," and can't keep up his momentum towards change. The therapist tries to connect with client by asking if he can come to where Tim is, but Tim responds "I don't know - I don't feel like I'm in my body." He feels, he says, like a TV out of focus. The therapist explains that this sometimes happens when people stay sober and they access feelings and memories that they've kept numbed. It's why some people can stay sober for a month or two, but then as soon as the feelings start to surface, they begin drinking. Tim resonates strongly with this. He says he feels "really, really shaky," as if there is a lot inside him that could get broken easily. He diminishes it ("nothing's happened to me that's that bad") but admits that he feels like he's coming apart and that he feels "really, really sad." He is very quiet. When the therapist brings Pam in, Tim distances quickly.

The therapist inquires "what's happening?" and Tim, after a long pause, says inertly, "I
I'm wrapping it up, putting it away." He shuts down and the connection between the client and therapist, the client and his wife, the client and himself is severed for the remainder of the session.

*Extratherapy Events.* It has been noted that therapy comprises only about 1% of the client's waking time. When the client is not in therapy, he is working, interacting with others, experiencing symptoms, coping, encountering obstacles, experiencing support or progress, reviewing the previous session, anticipating the next session, and so on. Relevant Extratherapy may also involve the therapist as he receives supervision, or mulls over various aspects of treatment.

Extratherapy support for Tim comes from AA. Shortly after treatment started he asked an AA person to be his sponsor, and was accepted. "It makes me feel safer" he wrote in his weekly situation diary. He also embraced the AA belief in a "higher power" or God, and, while not overtly religious, derives strength from knowing that there is Someone bigger than he is out there.

Tim seems to have been in a state of disequilibrium, on the verge of some change, for a couple months prior to the significant event. On December 1 he wrote in his weekly situation diary:

> At this point in therapy I find myself feeling very shaken up as far as my "normal" status quo within myself and within our relationship as a couple. A great part of myself that is in the deep core of me is being woken up or shaken up or made to surface and get ready for close examination and change. It feels as if heavy tremors are shifting me at my innermost deepest core. It is not pleasant....but I want the changes.

The therapist mentions during one of the sessions (early in treatment) that he had discussed a therapist/client relationship incident, from the previous session, with his supervisor, who suggested doing the sculpt. The sculpt was very important in experientially securing the therapeutic relationship.
Background Context

Analyzing Background Context is typically the most difficult and complex part of CPA. Relevant characteristics of client and therapist which preceded and were brought to therapy include Personal, Social/Organizational and Cultural/Subcultural. Client background is organized into three broad headings, Schemes, Style/Symptoms and Situation/History; therapist background is divided into two areas, Personal Characteristics and Treatment Principles. Client Schemes and Therapist Treatment Principles parallel one another in that they consist of relatively stable, repeating sets of beliefs and are assessed in the same way (Elliott, 1993).

Schemes: Conflict Themes and Person Schemes. Schemes (or schemas) are internalized plans for construing, feeling and acting towards self and others; they are composed of relatively stable sets of implicit beliefs or assumptions (Pascual-Leone, 1991). In CPA work we are primarily interested in two types of scheme, Conflict and Person. Conflict schemes are motivational, comprised of repeatedly occurring wants or wishes coupled with feared negative consequences (Luborsky & Crits-Christoph, 1990). Person schemes are internal working models of how self and others are, or should be (Horowitz, 1987). CPA studies to date have found Conflict schemes to be most relevant (Elliott, 1993).

Conflicts are identified using Luborsky and Crits-Christoph's (1990) Core Conflictual Relationship Theme (CCRT) method, which postulates that client conflicts emerge because of wishes or wants and corresponding expected consequences. It involves studying the tape, transcript and process notes from the whole session, looking for stated and inferred client and therapist schemes.

Client schemes are as follows:

a. Caring Person Scheme: a caring person is inclusive of others, is fair, reliable and honest (leads to conflicts).

b. Conflict Theme (derived from others): wants to be protected, safe, held, loved;
fears desertion and being left alone (leads to client style, event content).

c. Conflict Theme (derived from self): wants to be in relationship; fears inadequacy, (leads to client style, symptoms).

Client Style/Problems. Client style consists of relevant characteristics of the client which appear to be more or less stable, including typical coping or defensive styles, both internal and interpersonal. Also contained within Style are strengths and liabilities which the client brings to treatment. In evaluating Style, the researcher asks, "What seems to be generally true about how this client deals with problems, helps to explain this event?"

Problems or symptoms, the second type of client internal factor, refers to the client's presenting problem or clinical symptoms. In identifying problems, the researcher asks, "What does the client complain about, or present as a difficulty?" The difference between Style and Problem is sometimes fuzzy since it may be the client's style that presents the problem. It is important to note that the researcher is not attempting to complete a definitive client profile, but rather to identify certain common aspects of the client which cast light on the significant event.

Style: copes by avoiding feelings and painful issues (alcoholic)

Style: bright, insightful, creative, articulate

Style: motivated and hopeful in resolving problems

Style/Problem: ruthlessly "fair", hard on self

Problem: feels overwhelmed, worn down mentally and physically

Problem: feels angry, hurt in marital relationship

Problem: feels sad, fearful deep inside, without apparent cause

Client Situation/History. Descriptions of Client Situation/History fall into two groupings: situation refers to relevant characteristics on a social organizational level (especially stressors and supports) and history refers to a personal level of analysis. While reviewing all this information, the researcher asks, "What would someone need to know about this client's life in order to better understand this significant event?"
a. Tim grew up with a harsh, non-supportive, non-emotional father and a physically abusive alcoholic mother who wouldn't stop hitting him, even when he asked, and who would never admit she was wrong. He considers his upbringing normal and average (during the significant event session), but writes later in a letter to the therapist that his childhood was "frightening and confusing" with a mixture of love and ridicule. His mom "suffered mightily from her own demons." (leads to C Style/Symptoms)

b. Pam also comes from an alcoholic family where there was physical abuse. (leads to C Conflicts)

c. Tim is absolutely committed to the change process and testing scores indicate inflated hope/belief. (leads to Session Tasks)

d. Tim entered therapy highly distressed. Most of his symptoms are manifested in his extreme somatization scores on the SCL-90 (sore muscles, heart racing, nausea, numbness, tingling, heavy feelings in limbs, trouble falling asleep, etc.) which perhaps conveys an absence of self-awareness or denial on other dimensions. (leads to Event Content)

**Therapist Personal Characteristics.** Since the therapist also brings aspects of himself to therapy, it is important to address therapist history, orientation and experience. The researcher can ask the question "What do I see about the therapist as a person that helps me to understand this event?" as well as noting anything relevant that appears over the course of the treatment. Any additional data is also included, as in this case, information gleaned from viewing four complete treatments with this therapist (70 hours), and several phone conversations with him.

a. Experiential orientation

b. Quiet, soft spoken, gentle confrontational, comfortable with silence, supportive (leads to alliance)

c. Recently, reluctantly divorced
**Therapist Treatment Principles.** The therapist's beliefs about; (1) how to intervene and (2) how clients can best improve themselves (assumptions of change) are usually schematic in nature and implicitly guide the therapist. In this case the therapist believes it is important to:

1a. be aware of rigidity or novelty in client patterns
1b. focus on relationships, including therapeutic relationship
1c. respect client tolerance for intensity of experience
1d. allow clients to work without therapist imposed goals
1e. focus on novel experience of strengths already present
1f. heighten awareness of destructive patterns
1g. grieve the loss of destructive patterns (e.g., alcohol)

The therapist also assumes that:

2a. given support, people change positively
2b. change can only occur when client comes to a place of honouring himself

**Summary**

This chapter has analyzed an IR event in a successful ExST treatment using CPA to examine: (1) Process (Content, Action, Style and Quality), (2) Effects (Immediate, Within Session, Postsession and Posttreatment), and (3) Context (Episode, Session, Presession and Background). The information that has accumulated during this analysis will be discussed in Chapter 6.
CHAPTER 5: AN UNSUCCESSFUL CASE

This chapter will implement CPA with an unsuccessful case in TARP. As with the previous case, 2046 represents TARP coding for client identification, -12 means that the significant event occurred in the 12th session, and -2 means that this is the second event under investigation.

The Setting

Carl and Liz (not their real names) are sitting across from one another when the therapist (the same therapist as in the previous case) arrives for their first session. Liz is dressed professionally in a black skirt, white blouse and checkered blazer. She sits tightly, legs crossed, hands folded, back straight. Carl, wearing jeans and a T-shirt, slumps loosely. Almost before the therapist is seated, Liz leans forward and seeks clarification regarding a mix-up in session times. Her voice is tense, anxious, accusing. She speaks too quickly and the words tumble over one another as they fall unhappily from her lips. Carl answers her and he speaks defensively, exasperated. His words wear shields and stagger in disarray.

There is not even an inkling of warmth or respect between them. They are almost childlike in their callow verbal warfare. She complains, criticizes, berates, accuses; her voice so taut that it begins to quiver. The therapist tries to focus on her feelings but she cannot. She inevitably responds to his repeated affect queries with "I feel that he should..." and then she's off on another allegation of discontent. She seeks alliance with the therapist against Carl. Senseless with her own unaccessed pain, she cannot hear, she cannot see, she cannot feel. Carl feels misunderstood. He has worked hard to become who she wanted him to be and is angry with the injustice of then being rejected. He knows how he feels; he feels angry and hurt. He is unemployed and it leaves him with too much time, not enough self-esteem, and more inducement to drink.

Patterns are manifested early. He pursues her relentlessly and she is distant and
disinterested. And yet she keeps the relationship alive by shouting insults and accusations, and invoking his defensive diatribes. Neither is able to extract themselves from the frenzied grip of their destructive relationship, each claiming that to be the responsibility of the other. Carl has developed a relationship with alcohol to hide from his self-loathing. Liz hides by being in relationship with someone onto whom she can project and act out her own self-aversion. Carl and Liz are not married but have lived together for 4 years. Both are probably "thirty-something"; both were married previously.

Prior to the significant event session, Carl has reluctantly and painfully agreed to separate, according to Liz's request. He has physically moved out but remains very attached on a number of other fronts. The Intrapersonal Resolution event (lines 384 to 435 in Appendix 6) begins approximately 85 minutes after the session began; the session is protracted into a 2 hour occasion. Liz is away at a conference and, as with Tim, the IR event occurs when he is in session alone with the therapist. As before, the bracketed numbers represent pauses in seconds.

T: Carl, breathe deeply and hold it. Let it out slowly. (6) There you are. (2) What are you doin' with your hands? What are your hands saying? (hands are clenched together above his head)

C: (2) Oh I guess I haven't- I'm mad at him- I'm mad at him. (1) I'm frustrated with him. I'm angry with my mother.

T: Can you say that, "I'm angry with you, Dad.'? 

C: (3) "I'm angry with you, Dad.'

T: Say it again.

C: "I'm angry with you Dad.'

T: and louder.

C: "I'm angry with you Dad that you didn't stand up for me.'

T: Can you say it louder?

C: (3) No
T: What's he doing? Is he leaving?
C: No. No he's just sitting, ignoring and just-
T: Why can't you say it louder?
C: He heard me.
T: He heard you. How do you know he heard you?
C: Oh. Just by his face.
T: What are you doing now? What's happening for you?
C: (3) I uh- I'm staring at him.
T: What are you feeling?
C: Say something. I'm a kid. Say something.(5) Oh I don't know.
T: What do you need him to say?
C: (2) What do I need him to say?
T: Yeah
C: Same thing I tell Greg (Liz's son). Don't treat me like that. I don't- Don't treat me like that.
T: That's what you need him to say? "Don't treat me like that, Carl." Is that what you need?
C: Exactly. (2) Exactly (4)
T: So yell at him again.
C: Oh that's - I treat Greg how I wanted to be treated.
T: Stay with dad. Stay with your dad.
C: I am. He's part of that. Like I can see my Mom and Liz. Liz being the same and I look at Greg being me.
T: "Don't treat me that way, Carl." (3) "Don't treat me that way, Carl." (4) "Don't treat me that way, Carl." (3) "Don't treat me that way."
C: He heard. He heard he knows. aahh aha (9) fuck. (13) (brings hands together tensely, gingerly)
T: What would happen if you slapped your hands together? Is that what you want to do?
C: No I- I'm just thinking or maybe I'm praying - I don't know.
T: What are you praying for?
C: That he would've been stronger. I wished he were stronger. I don't like being like this. I don't like being like this. (5) I don't like this part of me. Oh god. I got it from you, right from you. (4) It's unfair, very unfair. aahh
T: What's that part of you talking about? The part of you that's afraid? Of not being accepted?
C: Oh god, I want to change that. I gotta change that. I can't do that no more. I don't want to do that no more. (5) I don't want to do that no more. (6) no more. please, (whispers) (14)

Comprehensive Process Analysis, in the same form as the previous chapter, will focus first on analyzing processs, then effects, and finally context. As with the previous significant event, it may be helpful to read all the transcript information first (see Appendices 5 through 8).

Analyzing Process: Explication and Microanalysis

The four aspects used in CPA, following the same subprocesses as in Chapter 4, are:
(a) Content, (b) Action, (c) Style, and (d) Quality.

Content

What kind of themes or ideas seems important for understanding this event? (See Appendix 7 for the structural outline of session content, and Appendix 8 for the sentence flow chart.)

Client Content. Carl's relationship with his parents seems central in understanding this event. He expresses quite plainly that he feels anger and frustration towards his father and anger towards his mother. He tells his deceased father that he is angry with him during an empty chair exercise. He is angry with his father because his father didn't stand up for
him, and didn't stand up for himself. Carl sees his father very clearly during this experience and what he sees is a man just sitting there, obtusely overlooking his son's wrath with silent impotence. Carl is frustrated and provoked and yet there is a tendency for him to respond to his dad's inertia with his own. He cannot really yell at his father when the therapist encourages him to do so. It is difficult for him to yell at (i.e., be mean to) someone who just sits there, particularly when that posture is by nature his own. He hurts on his dad's behalf as he has been hurt.

This perhaps is his greatest consternation. He scorns his father for being weak but feels cursed with the same weakness. Like his father before him, he permits his partner to control how, where, what, when and with whom he does things. Like his father he has been hurt by the harsh control of his spouse. Like his father he has turned to alcohol for comfort and friendship, and now it too controls him. He sees in himself the same powerless, emasculated creature that lived in his father and he detests this part of himself.

Contrasting and paralleling the aversion and anger directed at his father and himself is his defensive assertion that he and his dad are nice guys, unlike his mother and his partner who are mean. He likes being nice but doesn't like being weak.

Carl's powerlessness is perhaps the loudest theme. Somehow he has set himself up to perpetuate the anemic existence that he despises. He seems trapped by external forces that control his existence and tormented by internal voices that rage against his impotence. He wants to get rid of that weak part of himself. He wishes, with a certain desperation, for change, but is paralyzed by the fear of not being accepted.

Five features of the content seem to be important for understanding the event:

a. relationship with deceased, alcoholic father
b. fear, pain
c. link between mother and current relationship
d. intrapersonal wish
e. core interpersonal scheme ("caring person")
Therapist Content. The therapist seems to have a clear agenda for Carl in this event. He wants Carl to get angry and to direct it towards his father, thus addressing a conflict between Carl's problematic reaction and a primary relationship.

Action

What was done (tasks, intentions, response modes) during this event? (See Appendix 9 for the IR event explication.)

Client Action. Carl's task is to confront and change the part of himself that he dislikes. He wants to be different by getting rid of the part of 'self' bequeathed him by his father, but is reluctant to take any real action. There was no specific client agenda for change. This event emerged out of Carl's complaints about his situation.

Client action is accomplished using Self-Disclosure of Feelings, Mild Disagreement, Third Party Description, Strong Agreement, Awareness Insight and Indirect Request Response Modes.

Therapist Action. The therapist's task is to enable Carl to connect with the emotion inside him by getting angry, giving him an alternative, new experience. He encourages Carl to express raw emotion and to stay with those feelings long enough to really experience a new posture. He suggests that Carl accept and offer help to his aversive self, rather than to "get rid of it". He challenges and questions Carl's reluctance in an effort to create agency in his client and he forces him to stay on task. Promoting agency and staying on task is helpful, given Carl's wavering and tangential tendencies, but the irony is that sometimes his "enabling" is very like control (a key issue for Carl). The therapist also attempts to regulate the intensity and duration of Carl's experience, and eventually initiates closure, although not until after a very intense, very long session.

Therapist action is accomplished using both Open (e.g., line 385) and Closed (e.g., line 389) Question Response Modes and Suggestion/Advisement Response Modes (e.g., line 391).
**Style/State: How was it said or done?**

*Client Style/State.* Carl is agitated, sobbing, intensely emotional and in a highly vulnerable state. He is breathing very quickly and heavily and at times requires therapist intervention to prevent hyperventilation. Occasionally his head collapses into his hands, but most often his hands are clasped behind his head leaving him helpless and exposed, or held up in a prayer like clench. He speaks breathlessly at times, other times with angry precision or shakiness, other times with painful exasperation. Then his voice gets quiet, resigned, and he whispers a plea for help.

*Therapist Style/State.* As the session becomes more emotional, the therapist becomes both more caring and harsher. He moves across the room to sit closer to Carl in a gesture of affiliative empathy, but his arms remain crossed in a posture of firm assertion. Sometimes he speaks loudly, partly because Carl has a hearing difficulty and partly to be firm, but because his voice is naturally quiet it seems to have a harsher-than-appropriate edge when he is loud. Other times his voice is gentle and soft (although he usually has to repeat himself then and the softness is lost). Some speech acts are confrontive, strong and clear and others are supportive and caring.

**Quality: How well was it said or done?**

*Client Quality.* Carl works moderately well to very well. He allows the experience to surface and is open and expressive. He seems amenable to follow the therapist's process advisement and is willing to stay with the immediate experiencing and its evolving meaning. However, sometimes he is reluctant, sometimes he is lost in the intensity of his experiencing, sometimes he finds it difficult and he can't always articulate what's going on.

*Therapist Quality.* The therapist is confronted with a number of tensions. He wants to firmly guide his somewhat recalcitrant client through the important experience of being strong and agental during a vital encounter with his deceased father. On the other hand he wants to be empathic and gentle. Mixed with this are his own issues of himself being in
Carl's position a few months earlier. The therapist is helpful in offering breaks and instructing Carl to "keep breathing," but sometimes the experiencing seems too intense for the client. Most often the therapist chooses firmness over empathy in a slightly to moderately skillful manner.

**Analyzing Effects:**

**Consequences and Effectiveness**

The four levels of effects analysis in CPA include: (a) Immediate effect, (b) Within-Session Effect, (c) Post-Session Effect and (d) Post-Treatment Effects.

**Immediate Effect**

*Process effects* (Process effect pathway)

1. Carl expresses anger towards father and mother
2. T asks him to say it directly at father (empty chair)
3. Carl addresses father with his anger
4. T questions Carl about what he sees
5. Carl describes father's unresponsive posture
6. T questions Carl with regard to his feelings
7. Carl asks his father to say something
8. T asks what he needs his father to say
9. Carl needs his father to take a stand
10. T voices words Carl wants his father to say
11. Carl agrees
12. Carl deviates from experience (talk about stepson)
13. T continues to repeat words of Carl's prototypical father
14. Carl stops him (physically distressed)
15. T questions Carl's gestures
16. Carl prays/wishes that father would have been different and that he would be
different

17. Carl expresses unfairness
18. T questions part of Carl's self
19. Carl pleads for change

**Experienced Effects** (Client Experience Pathway).

1. Carl is in touch with his feelings (= self-awareness)
2. Expresses anger, childhood pain (= experientially involved)
3. Experiences distress, disappointment, anger (= hindering emotional reaction)
4. Realization of interpersonal scheme (= self-insight)
5. Feels understood by therapist (= positive interpersonal)
6. Experiences relief, grief (= emotional reaction)
7. Feels misunderstood, distracted by therapist (= negative interpersonal)
8. Experiences distress (= hindering emotional reaction)
9. Feels burden of father's shortcoming (= hindering problem clarification)
10. Feels exhausted, desperate wishing (= hindering emotional reaction)

**Within Session Effect**

a. As the therapist leaves to get Carl a glass of water, Carl says "Can you do me a favour - can I hug you?" The therapist responds "absolutely" and they embrace for about 45 seconds while Carl sobs quietly and the therapist holds him. Carl comments that he doesn't ever remember a man holding him. The therapist's large physical stature and Carl's small size serves to simulate a father/son embrace.

b. After the therapist has left, Carl collapses in his chair sighing heavily and whispers painfully "Ahh dad."

c. When the therapist returns, Carl is silent for a few minutes, comments that he must look like hell since he sure feels that way and then says "Ohh I wish I'd done this so
many years ago." After a bit more silence he says very sincerely "Thanks. I really appreciate it."

Extratherapy Effect. Extratherapy effects are sometimes revealed in the client's weekly situation diary. However there were no weekly situation diaries for Carl past the ninth week.

**Postsession Effect**

*Immediate Postsession Effect.*

Although this intense 2 hour session is over, Carl seems reluctant to leave and keeps bringing things up.

a. He wants to seek the therapist's advice regarding some employment opportunities.

b. The therapist encourages Carl to relax and to think about the profound and important experience that he's just been through, and not to worry about employment at this moment. The therapist recognizes the intensity of Carl's experience and requests another session with him the following morning (which Carl is unable to make).

c. The therapist also encourages Carl to love and look after the fearful part of his self that Carl wants to get rid of. Carl has difficulty understanding this.

d. Carl expresses some concerns that the counselling sessions will soon be over and he's not ready. "When I look at what I just went through - I've put myself in a very vulnerable position tonight - I'm in a position where I don't want to be at." The therapist assures him that his needs will be attended.

e. Carl begins to talk about his living situation and the therapist insists "Carl, what you've done here tonight is going to take you places in terms of how you relate to other people. Carl, you've done enough tonight."

*Subsequent Session Effect.* The session immediately following this one is with Liz alone. She begins the session with "I know that he was here last week and he cried and all that - he didn't say why - but he did babysit, I know you said not to..." and she's off into her
concerns; the significant event was not mentioned again.

The next session is with Carl alone. He is very angry with Liz and desperately lashes out at her. The therapist observes that Carl has lost weight and that his eyes are red. He asks if he's been drinking. Carl says he has not, but that he hasn't been sleeping or eating much due to the stress. He says that he's not himself with Liz and never wants to be involved with her again. He, as the therapist observes, justifies all his behaviour in terms of her treatment of him. The therapist encourages him to find and care for his "self" rather than to throw it away. Carl is defensive and angry and "doesn't care," "can't be bothered" with anything regarding this relationship. The therapist tries to help Carl connect with the feelings toward his dad and himself and the experience of the significant event, but it is difficult.

Earlier in the week Carl has been validated by another woman who affirmed his position and he now "likes himself" (i.e., he does not need to change, Liz does). The therapist continues to work on Carl's relationship with his self. He sounds annoyed at one point when confronting Carl on his abusive response to Liz's verbal abuse and says harshly "You're just going to give up your self that easily - let someone else control your behaviour - to hell with what you think." Carl says yes, with Liz. The therapist says "that's weird" and Carl agrees.

The next session is with both Carl and Liz. Carl has moved back in with his sister and her husband, with whom he lived (and drank) prior to meeting Liz. Nothing regarding the significant event emerges: the session is spent on arbitrating conflict and working out separation details.

There were no more sessions available on video, although since there was no closure, one could assume that further sessions ensued.

Post-treatment Effect. The quantitative outcome data indicates that Carl and Liz did not positively change as a result of the therapeutic process. Carl's z-score for the difference between pre- and post-testing on the ADD was -1.3; only five out of 82 scores deteriorated more than his. On the SCL-90 his score deteriorated four points: seven of 83 people
deteriorated more than he did. (This is slightly deceptive however, since significant improvement on this measure is dependent upon having a highly distressed score at the outset.) Carl did not complete the posttest questionaires for DAS and FS, since his relationship was severed at that point, but his pretest score for DAS was unrealistically high at 103 (95% of the project participants scored between 83.2 and 91.0). Carl deteriorated on all four measures.

Liz also deteriorated. Her SCL-90 score went from 61.9 at pretest to 66.9 at posttest and to 73 at followup, positioning her fourth worst among the spouses. (Liz was the only member in the two couples to complete followup questionaires.) The difference in pretest and posttest for the DAS was -1.9: only three couples deteriorated more than this. Her family measures (FS) indicated no change during pre, post and followup.

Analyzing Context:
Sources of Significant Events

As in the previous analysis, context is divided into episode, session, presession and background.

Episode Context

Five important characteristics of Episode context are examined: Client Episode Task, Therapist Episode Task, Relevant Events, Local Cue and Explanatory Links.

Client Episode Tasks. The client seems to have two main tasks:

a. to express feelings towards deceased father
b. to get rid of the part of him that is like his father

These tasks were evident in Carl's extensive emotional reactions to exploration involving his relationship with his father.

Therapist Episode Tasks. The therapist, following the ExST approach, has several tasks:

a. to facilitate the expression of feelings
b. to facilitate a symbolic representation of the problem
c. to show empathy, stay with the client
d. to facilitate and regulate an experiential exploration
e. to facilitate intrapersonal and interpersonal integration.

Sometimes the therapist seems to slip from his empathic, facilitative, regulating tasks. For example, when Carl talks about his anxiety about babysitting Liz's children during the upcoming weekend, the therapist responds in an irritated and confrontational tone, "we talked about that last week, you said it was no problem." At one point when Carl says "I'm not angry," the therapist blatantly challenges him by saying "I don't believe you."

*Episode Relevant Events.* In this event, the sequence of relevant episode events runs as follows:

a. Carl makes excuses for not expressing feelings to deceased father
b. T challenges him
c. Carl asks rhetorically "Why is it so tough to say that?"
d. Carl remembers being angry with his father
e. T tries to get him to say it to his father
f. Carl gets angrier in his memories
g. T calms him, asks him what his hands are saying (IR begins here)

*Local Cue.* The immediate stimulus, just prior to the event, is the therapist's calming presence and instruction to breathe deeply, followed by a question regarding Carl's gesture of clenching his hands. This brings Carl out of his angry memories and enables a "here and now" experience.

*Explanatory Links.* The client, who has been reluctant to focus on how he really feels about his dad, is induced to face his "father" issue by the therapist, who won't let him deviate (line 417). A memory of the "one time" he yelled at his father befalls him and the old, sequestered feelings of anger surface. Finally he admits, at the beginning of the IR event, "Oh I guess I haven't - I'm mad at him, I'm mad at him."
Session Context

Since the client's experiencing begins just as the hour is almost completed, and the session lasts for a total of 2 hours, there is significant session context prior to the event.

*Client Session Task.* Carl arrives aggitated and angry at Liz for her ability to be so cold to him while he still loves her. His task is to sort out the confusion he feels in his situation, although what he wants to do is just complain bitterly about all she does.

*Therapist Session Task.* The therapist wants Carl to become an agent in protecting himself so that he doesn't go "willingly to be slaughtered." His task is to intensify Carl's anger so that he is able to express it.

*Therapeutic Alliance.* Part way through the first hour, the therapist asks "How are you with me? In your letters you're critical of my approach." Carl responds positively about the relationship. The therapist persists by saying "If you experience me as breaking up the most important thing in your life, and not being constructive about putting it back together, then why the hell aren't you upset with me?" Carl laughs nervously at this blatant immediacy and mumbles "I guess I did write that, didn't I?" explaining that he was frustrated when he wrote it (in a letter to the therapist). The therapist insists "Why aren't you angry with me?" and Carl insists "I'm not angry, I'm just questioning." Carl's question asks if there's any hope of working out his relationship with Liz. The therapist replies "Not unless both members of the couple want it and can say so. You can't do it against someone's will." The therapist then asks his client "So how's your relationship with me when I tell you that?" Carl says it doesn't bother him. The therapist perseveres "Does it make you want to rush up and give me a hug?" and Carl laughs "No, I wouldn't wanna go that far." The therapist continues to push and challenge, trying to make Carl admit that he's angry and to express it. He sits across the room from Carl, leaning back and with his arms crossed.

In addition to his harshness, the therapist is also empathic and it is an empathic response that eventually triggers the beginning of the experiencing episode. Soon after that the therapist moves across the room to sit next to his client. It is interesting to note that the
therapist's question "Does it make you want to hug me?" foreshadows the event's anticlimax when Carl does, in fact, want to hug the therapist.

On the therapeutic alliance measure, Carl reports either complete (1) or strong (2) agreement on all positive statements like "I trust the therapist," "the therapist cares about me" and "the therapist and I are in agreement about the way therapy is being conducted." He reports complete (7) or strong (6) disagreement on all but one of the negative statements like "the therapist is not helping me" and "the therapist does not understand me." The exceptional statement was "the therapist does not understand my partner" to which Carl responded "agree" (3).

Session Relevant Events. Early in the session, Carl's voice shakes while talking of Liz. The therapist accurately empathizes; "so there's a great deal of sadness..." and Carl agrees. The therapist points out that there's not only the loss of Liz, but that loss also forces Carl to face some of his own issues; self-esteem, the way he sacrifices himself, etc. Carl begins defensively in disagreement, but after a few words admits that it's true, but that it is hard. The therapist asks, "Are you aware of your sadness in your body? What's it like?" and they explore sadness for a few minutes. After sadness the therapist pursues the anger he suspects resides in Carl.

This is the first time Carl has been able to acknowledge and explore the issues and feelings that emerge when Liz and alcohol are no longer controlling his life. He confesses that he's angry (a significant admission) at the weak part of himself that lets other people use/control him. Without changing his leaning-back-arms-crossed posture, the therapist carelessly shoves a chair over to one side saying "how 'bout we bring that part of you into the room?" (If the client had treated the chair, representing a part of him, that ungraciously, the therapist would have drawn his attention to it, since symbols are potent and meaningful.) Carl goes on to say that it is also the part that is afraid - afraid of not being accepted. He hates that part of himself. Carl then quickly moves into another dimension of experiencing and the therapist is left behind to ask what his client is seeing, feeling, hearing. The therapist
leans forward at this point, validating and supporting, and then asks if he can sit beside Carl. The anger Carl feels toward his father is broached, but given the cacophony of voices and visions in Carl's head, it is difficult to stay with a particular emotion directed at a particular person. The therapist attempts to bring him back to his anger and it is this issue that comprises the IR.

**Presession Context**

*Previous Sessions.* The themes of strength and weakness emerge during the first session. Liz complains that Carl is weak, a burden for her, and that she is mad at herself for being weak enough to be with him. Carl is defensive. The therapist tries unsuccessfully to have them look at their own feelings, but offers them hope: counselling will help them.

The next session is similar. Liz criticizes Carl: "he doesn't change, he doesn't grow, he's not strong enough." She berates herself at the same time: "he makes me feel weak, why am I with such a loser?" The therapist asks Carl how he feels when he hears that and Carl retorts with his own accusations. The therapist urges them to slow down, explore feelings. "Part of the fighting" he says "is to rescue one another from your sadness... maybe that doesn't make sense right now." Liz is verbally abusive; Carl can be physically abusive (throwing things). The therapist encourages them to work on identifying their own feelings, rather than how they feel about the other person, but it is difficult.

In the third session Liz says very clearly that she wants Carl to leave. The relationship hasn't been good for a long time and she no longer wants to work at it. Carl is astonished, deeply hurt, and an argument ensues. The therapist points out that a fundamental rule has been broken for Carl: that if you work at something hard enough, it will pay off. The therapist also self-discloses that a few months earlier he was in a situation remarkably similar to Carl. Eventually Carl's pain is intolerable and he gets up and walks out. The therapist calls after him to make arrangements to see him alone the following morning.

The next morning Carl is still in shock. It hasn't really hit home. He tries to figure
out a medical reason for Liz's meanness. He "hurts like hell." He disagrees with everything the therapist says until the therapist comments, "It's like your dad never came to your hockey games, you've never had the experience of someone being there for you. You're not there for yourself."

In the fifth session Carl and Liz continue to argue like children. The therapist tries to intervene as they each strive to get the last dig in. Liz is resolutely committed to Carl's departure and he is tenaciously committed to staying. The therapist attempts to create an opportunity for Carl to initiate leaving, to give him some power, to walk away with dignity. Carl, when asked, experiences the therapist as realistic and honest but not supportive. Liz feels relief. "It's a relief just to say it," she admits, prognosticating the IR when Carl finally "says" what he needs to say.

Carl does decide to leave and during the sixth session the therapist congratulates him for taking initiative. Carl doesn't see it as initiative; he sees it as giving in. Liz is benevolent during this session. She wants to help but has "got to be careful not to tell him how to lead his life" since she can "be overbearing at times." She tries to explain that Carl is a good person, but they just weren't good together. Carl is unmoved and another argument ensues.

In session seven, Carl is alone. They talk about change. Carl says he's worked hard not to be like his father (whose behaviour he excuses because he was traumatized in the war). The therapist encourages him to think about his father; it may be important. The dialogue is superficial (not intense) and friendly and at the end of the session the therapist says, "I have a sense that something very satisfying, very powerful is going to happen for you."

During the eighth session, the therapist tries to point out patterns. Each of them seems unable to connect with their anger, believing that they don't have the right to be angry, and then chastising themselves for being weak. They argue. The therapist wants to talk about boundaries.

Carl comes alone for the next session. They talk about how Carl can take some of his own power back. Carl remains defensive. Carl talks about getting rid of his weaknesses. To
his drinking self (one of his weaknesses) he says "I'm going to kick your ass hard" because he doesn't want to end up like his father. He's heard it all his life from his mom; "You're just like your father, just like your grandfather." The therapist comments that it's no wonder that part of himself turns to alcohol for friendship since Carl is so hard on him. Carl says "if you get kicked in the ass hard enough, you smarten up." At the session end, the therapist suggests that they return to this "self abuse" later.

In session ten, Carl is defensive and light: "I'm fine, doesn't bother me." Liz is distressed. She wants the therapist to make Carl stop calling so much; she is unable to say "I need space" and to make it happen. Both are terribly enmeshed, but neither can see or acknowledge it. The therapist encourages them to work on just sitting in silence and connecting with their bodies, rather than blaming, figuring out, giving advice.

In the session prior to the IR event session, the arguing continues. The therapist confesses he has difficulty staying clear because of the closeness and similarity between his own situation and Carl's. The therapist tries to create a sculpt, but Liz is reluctant and disagrees with Carl's experience of her. Liz says she wants to separate forever. Carl believes it is stupid to go to counselling if the purpose is not to get back together. His leaving has been an effort to cooperate with Liz, within his larger goal of reunion. They argue some more. The therapist comments that they flee to words and arguing to avoid feeling. He wonders what's underneath all the words. They argue some more.

**Extratherapy Events.** Carl does not have any outside support. Liz doesn't like his family (because they drink too much), and ties there have been attenuated. Carl doesn't like AA because of the reference to a higher power or "God." He has no colleagues, since he is unemployed. Neither he nor Liz have friends since their time and energy have been consumed by one another.

Carl's unemployment is a significant issue for him. He believes that if he could find work, Liz would respect him, and the relationship would be restored. After he moves out, he transfers the time and passion that were devoted to the relationship (arguing) to job hunting,
no doubt to avoid being with himself.

Liz wants Carl out of her life and tells this to the therapist in a private phone conversation, shortly after therapy began. The therapist admits now that he probably would not have done couple's therapy with them if he'd known Liz so clearly wanted out. Unless things changed between enlisting in TARP and the commencement of therapy, Liz violated inclusion criteria number three, which states that although the couple was experiencing marital distress, they both desired to preserve the relationship.

**Background Context**

Both client and therapist bring some relevant characteristics to the sessions that preceded therapy.

*Client Schemes: Conflict Themes and Person Schemes.*

a. Caring Person Scheme: for Carl a caring person is loving, considerate, doesn't hurt the person they care for (leads to event, conflicts).

b. Strong Person Scheme: a strong person is smart, stands up for what they think is important and protects those whom they care for (leads to event, conflicts).

c. Conflict Theme: (derived from others) wants to be strong, assertive but fears not being accepted (leads to C style, event content).

d. Conflict Theme: (derived from self) wants to get angry (at father, mother and Liz) but fears being mean, hurtful (leads to C symptom, event content).

*Client Style/Problems.*

a. style: vulnerable, open, kind, verbal,

b. style/problem: eager to please, insecure, angry, fearful, "kick me" syndrome, self-abusive, defensive rather than assertive

c. style/problem: avoids feeling/expressing anger by drinking, scolding, fantasizing, violent acts

d. problem: unresolved, sequestered anger towards father (and mother) leads to
unresolved anger towards self and partner (general problems with intimacy)

Client Situation/History.

a. History: Carl grew up with a domineering, "mean," "cold," unloving mother who controlled both him and his compliant, "kind," powerless, frequently unemployed father. His father became an alcoholic. Carl has one childhood memory of his father being strong (he rescued/punished him for running into traffic) and no memories of his mother being loving. He is compassionate towards them, but decidedly does not want to be like them. Ironically, there are an uncanny number of similarities between Carl and his father (leads to client conflict, style/problems).

b. Recent death of father. Doctor says he "killed himself" through neglect and drinking (leads to event content).

c. History of unemployment and unsatisfactory employment with relatives. This has caused a lot of stress in his relationship with Liz (leads to conflict).

d. His wife from a previous marriage left him shortly before he met Liz. The details of that divorce were worked out while he was living with Liz, leaving no space for grieving his loss or contemplating his "self-in-relationship" (leads to conflict, style/problems).

e. Current issues in marriage revolve around Carl's "weakness," his unemployment, his drinking, his interaction with Liz's children, his occasional violent responses, his interaction with his family (leads to session tasks).

Therapist Personal Characteristics. Since the therapist is constant, the therapist characteristics and treatment principles are largely the same as the previous case. However, in some ways, the therapist was different with Carl and Liz than he was with Tim and Pam. He remains soft-spoken, quiet, compassionate, but there are significant moments of harshness, loud severity, blatant disagreement, and stringent challenge, which were absent in his relationship with Tim and Pam. This perhaps stems from the obstinate, senseless arguing between Carl and Liz, that seemed impenetrable at times. Also Carl's hearing difficulty
required a louder voice and the therapist's voice gained an unmistakably harder edge when he spoke louder.

Mixed in with this was the therapist's own recent, reluctant separation from his wife, whom he loved. He self-discloses a great deal with these clients (maybe too much) and is quite open about his emotional coalition with Carl. Perhaps, at times, his own issues become confused, and he is unable to differentiate between their differing processes and paces.

For these, and perhaps other reasons, the therapist somewhat neglects two of the treatment principles he identified as important for him:

1c. respect client tolerance for intensity of experience,
1d. allow clients to work without therapist imposed goals.

Summary

This chapter analyzed a IR event using CPA, in the same manner as the previous one, although this IR event occurred in the context of one of the least successful cases of ExST. Comprehensive Process Analysis involves an examination of: (1) Process (Content, Action, Style and Quality), (2) Effects (Immediate, Within Session, Postsession and Posttreatment, and (3) Context (Episode, Session, Presession and Background). The accumulated data from both chapters will be discussed in Chapter 6.
CHAPTER 6: DISCUSSION

The major research questions, outlined in Chapter One, pursued the (1) context, (2) process, and (3) effects of therapy during an Intrapersonal Resolution event. The fourth question targeted the characteristics which distinguish a successful event from an unsuccessful event. Comprehensive Process Analysis has been implemented in Chapter Four and Five to organize the raw material from which "answers" can be discovered.

Because CPA is a discovery-oriented method, the final chapter of this study will focus on an explication of the discoveries uncovered in the course of the analysis. As such, chapter six will: (1) explore various discoveries within the structure of the identified research questions; (2) discuss and integrate the implications of these findings; and (3) observe methodological discoveries, limitations and offer recommendations for future theory development and research.

Context, Process and Effects: "Shared Feature" Discoveries

The first three research questions have formed the crux of the CPA analysis. The questions, asked again here, will highlight the shared features of the two cases under investigation.

1. What is the context in which a IR occurs?

Episode Context

a. Clients have a task/wish to confront internal 'self' (express dissatisfaction, desire for change)

b. Therapist facilitates experience, stays with, shows understanding

c. Therapist initiates event by tapping a key feeling which was being immediately experienced by the client (i.e., enlarging a prevailing image, pursuing a pertinent gesture)

d. Clients were alone (without spouse), although engaged in couples counselling.
Session Context
a. Clients express difficulty, frustration in life, in relationships
b. Strong therapeutic alliance
c. Clients easily, realistically express feelings of lonesomeness, sadness, fear, anger
d. Clients express needs

Pre-session Context
a. Prior to the event there have been 10 or 11 sessions incorporating positive experiences, some progress, strengthening of alliance (i.e., developmental therapy history)

Background Context
a. Identification of wish/fear conflicts
b. Anger and hurt in their primary relationships
c. Client history with unsupportive, unavailable, critical parents, with whom they maintain an unresolved connection

2. What happens during such events?

Response Modes
a. Client self disclosure
b. Therapist empathic reflection, question, advisement

State
a. Client weeping, reflective
b. Therapist calm, supportive, caring

3. What effects do these events have on the clients?

Immediate
a. Heightened self-awareness
b. Strong emotional reaction
c. Problem clarification  
d. Cognitive realization  

*Post Session*  
a. Some realization of depth/importance of experience  
b. Specific gratitude to therapist for creating the experience  

**Successful and Unsuccessful: "Distinguishing" Discoveries**  

4. What are the factors which distinguish a successful IR from an unsuccessful IR event in the two cases selected for this study?  

The fourth research question is more complex. Thirteen discoveries, in which the successful IR differed from the unsuccessful IR event, that have emerged from studying the analyses have been identified and labelled: (a) *process flow*, (b) *disequilibrium*, (c) *readiness*, (d) *symbolic experience*, (e) *intelligence*, (f) *forgiveness experience*, (g) *core conflict*, (h) *stress level*, (i) *self support*, (j) *spiritual support*, (k) *supportive partner*, (l) *support network*, and (m) *individuated interpersonal experience*. Each discovery will be categorized according to interaction, client, context, or therapist factors and discussed briefly. Some salient points are then demonstrated using this study of Carl and Tim, and integrated into a transtheoretical model.  

**Interaction Factors**  

(a) *Process Flow*: Tim's Process Effects flow in a forward direction. Carl's Process Effects are scattered, jumbled, with no flow or direction. There is no sense of conversational pairing between client and therapist; their sentences do not connect and flow (e.g., Appendix 6, lines 314-350). This is also evidenced in the Experienced Effects, where Carl's experiences bounce up and down through anger, distress, feeling understood, relief, feeling misunderstood, exhaustion (see Chapter Five, Analyzing Effects, p. 81). For Tim, on the other hand, experiencing moves progressively through pain/distress, fear, relief, distance,
Client Factors

(b) Disequilibrium: Tim was decidedly dissatisfied with parts of his life, and having breached the rut he was in, finds himself "unsettled," "topsy-turvy," "shaken," and with "tremors in his innermost core;" all signs of the disequilibrium that frequently precedes a change.

Carl clings to the status quo and when change is thrust upon him (Liz terminating their relationship), he is completely unprepared and stunned. He says things like "Things are fine the way they were - we just need to improve our communication a bit."

(c) Readiness: Tim was sober for two months prior to the commencement of therapy, searching for an integrated self and family, and realistic about the change process. In the first session, when asked what he'd like to accomplish in therapy, Tim says:

I want out of this rut... I want change, whole change... I don't want to drink... I want to be with me and my family... I want to start, change doesn't happen all at once.

Tim's desire for change is constant throughout therapy, and he frequently confirms "I want to do this. I want to change."

Carl was overwhelmed since he had no plans for personal growth. His goal was to secure his relationship with Liz through "better communication." When Liz makes her voice clear, he feels scandalized.

Carl had no articulate awareness of the "people" inside him, and the realization is confusing and frightening.

Carl: ... Oh this is a scary experience... (Appendix 6, line 46)
T: You probably have a lot of pain stored up... This part of yourself shocks you. (line 52, 53)
Carl: Oh I'm sure I have lots of pain. (sobs) lots. (line 54)
T: What are you feeling right now? (line 55)
Carl: ...Uh, I don't think anything (line 58)

T: ... I think it is good that you see this part of you. But I also think its shocking.

You don't quite know what's happening.(line 78)

Carl: uhuh. (pause) Oh, Jesus Christ.

He had no idea this sort of experience (the IR) could happen, nor is he particularly certain he wants it. Partway into the experience he asks himself, "Oh boy, (long pause) do I want to open this? (pause) oh boy" (line 329). In the end, he is thankful for the experience (line 445), but it was more shocking than penetrating; more cathartic than transformative. He was not ready for change.

This concept of readiness is connected with the ExST notion of causality based on Maturana's (1985) structural determinism which suggests that although structures are plastic and capable of change, in order to have the experience of change one's structure must fit onto the structure with which they are interacting. In other words, there was no complementary structural coupling between Carl's stage of readiness and the IR event, nor between Carl's situation and the therapist's.

(d) Symbolic Experience: Tim easily responded to the therapist's request in the first session for a symbol representing his goal, and came prepared in session two with a photograph of a sunset, taken from a mountain top he had climbed alone. He wanted to be there again, in the beauty, but this time with Pam beside him. He knows it is hard work "climbing through all the rocks and dirt and old growth" but "the view is worth it."

It was so beautiful and clean up there... I want to go... with Pam...I want change...it's available...I know we can do it together.

Tim's IR experience was dramatically enhanced by his use of symbols and metaphors. There was a 'baby' inside him, terrified, wrapped in burial cloth, encased in cement. He went on a journey to rescue him, hold him, and assure him. Although we can assume he experienced some significant fear/abandonment incident as an infant, we have no idea of the details; nor does he; nor does it seem to matter. He sees, confronts, grieves, resolves, hopes,
and rests all on a symbolic experiential level, without interpretation.

Carl on the other hand, was unable, or not ready, to enter the world of symbols and metaphors. When, in the second session, the therapist asks him about the symbol representing his goal, Carl's response is "Oh, I forgot." Although, in fact, he did not forget, but was just embarrassed (he says later) talking about it in front of Liz, it is significant that a symbolic goal made him embarrassed.

During the IR event, Carl saw himself, his father, his mother and his partner in stark, detailed reality, unaided by symbolic meaning, and it is a colossal stress on the denial mechanisms he has set in place. He remembered things he had forgotten and saw things he had screened. The unfiltered starkness was overwhelming.

Tim's successful symbolic encounter bears witness to the ExST emphasis on analogical processes and the use of symbols. Tim generated and lived with his symbol, and the therapist perturbed the transformational potential. Thus it became the language through which Tim's meaning systems could be accessed.

(e) Intelligence: Perhaps related to Tim's ability to work on a symbolic dimension was his verbal dexterity and intelligence. Tim was bright, articulate and able to grasp and express complexity. Carl was less gifted in this area, which was exacerbated by the belief that he was not "smart," since he made comments such as "I know I'm not as smart as her" and "you can only be told you're stupid so many times..." (session 2).

This is confirmed by the Shipley Institute of Living Scale, given to each participant in TARP to ensure that they had the verbal and reasoning skills to complete the pretest, midtest, posttest and followup questionaires. Tim's score of 3936 is significantly higher than Carl's score of 2828.

(f) Forgiveness Experience: The idea of forgiveness, although not explicit, emerges. Tim's problematic self, represented by the baby, smiles at him as Tim holds the infant in the second dream (session six). This assures him, and Tim commits himself to the "baby".

Tim: ...I had half a baby in my arms and I wouldn't put it down and I carried it up and
down the ladder... everyone was saying, "Put it down, it's dead." ...and later I remembered...that it smiled at me.

T:  It makes you sad. You look tearful.

Tim: ya, it's sad, but this one [this dream] was better cause it smiled and that smile was a really big thing.

The smile, no doubt, meant that Tim was forgiven and the relationship was restored.

Carl's problematic self, represented by his father, gives no response. He says nothing, does nothing; he just sits there (Appendix 6, line 398). Carl is bound by this dormancy which offers no forgiveness, no freedom, no restoration of the relationship. "Forgiveness" says Daniel Klassen (1996) "sets the injurer free and allows the injured to start life anew .... a powerful bond is broken" (p. 14).

(g) Core Conflict: Both Carl and Tim lacked an integrated sense of self but they were on opposite ends of the separateness-relatedness dialectic. Carl's core conflict was an inability to be separate since he lacked autonomy, initiative and power and he desperately clung to his relationship as the source of his identity. Although Liz says very clearly in session two, "Carl, I want you to leave, I don't want to be with you and I haven't for a long time," he does not actually move out until after session nine. During the interm he argued about staying. At times he simply refused to budge, claiming irrationally "I have as much right to live there as she does." When he eventually moved out, he called Liz relentlessly, confessing later that leaving was a cooperative gesture under the assumption that they would reunite. He cannot accept an autonomous identity and as such brought about his worst fear: he has replicated the weak, voiceless, fettered creature that was his father (session twelve).

Tim's core conflict was an inability to be relational since he lacked the ability to be intimate and to trust. He clung to the distance and isolation he had created, symbolically represented by the cement casing and the burial cloth wrapped around him. There was an ongoing theme of secrecy and hiddeness and Tim frequently made comments like "you don't know the whole story" (e.g., session nine). He often inadvertently rejected Pam's attempt to
reach him in his sadness. In session six he brushed off her warm, earnest, "I want to be there for you" with an impatient, "Well you are there for me." At times when she physically reached out to touch him, he offered neither response nor reception. He cannot be in an intimate relationship and thus has brought about his worst fear: aloneness, being stranded, and being left out (sessions two, five, eight and eleven).

This core conflict difference may be significant in that ExST, with its strong relational emphasis, may be more beneficial for autonomous clients seeking relatedness, than for enmeshed clients seeking agency.

(h) Stress Level: Carl was under a tremendous amount of stress. His partner, whom he had tried hard to please, broke their relationship shortly after therapy began. He was compelled to move out. He was unemployed and looking diligently for work. He was attempting to break his alcohol addiction. A breakup, moving, unemployment, and becoming dry are all significant stressors, and are predictably overwhelming when they occur simultaneously. Additionally stressful, it was a fourfold attack on Carl's fundamental rule: "if you work hard and keep positive, you will succeed" (session three). In session four when the therapist asked "how are you going to be when you can't change something into a positive?" Carl responded by unemotionally criticizing his father. During the silence that ensued, his denied reality leaked through a momentary crack and he says in a thin, rasping voice: "fuck it hurts damn it I don't know." By session fourteen Carl arrived with red eyes, an unkept, weary appearance, noticable weight loss, and maintaining defensively that "I'm fine, things are fine." He was probably drinking by that point, since stress is a primary trigger for relapse and he demonstrated the classic indicators of denial, irritation, loss of structure, weight loss, irregular sleep patterns, defensiveness, etc. (Gorski, 1990). In his state of stress and loss of control, Carl was clearly unprepared for the change process. During the IR event he begins to hyperventilate on two occasions and the therapist intervenes to direct his breathing back to normal. The IR event functioned as catharsis, rather than as metamorphisis, and its appropriateness is questionable.
Tim was experiencing significantly less stress. He was aware that he needed a lot of stability and support in order to do the work required to change. He anticipated that Christmas would be stressful and he delayed his investment in self-exploration until January. He and his family had moved the previous year and they were settled and content in their new home. His job, which he enjoyed, was secure. Pam was committed to their relationship. Although there was formidable turbulence inside of him, there was no new contributing external stress. He was finally ready to look inside.

(i) Self Support: Carl's objectives for himself were practical and unreflective. Practically, he needed a job and, having lost Liz, devoted his energy towards that. He saw a job as solving most other problems, since he believed he would recover Liz and her respect, and also distance himself from his father who was usually unemployed. Carl's relational goal was for him and Liz to stay as they are. His intrapersonal goal was to "get rid of" a part of himself (exclusive) by giving that part a "hard kick in the ass" (abusive). When the therapist asked him to "hit that chair as hard as you hit yourself" Carl responded, "I don't want to break the chair" (session nine). Breaking a part of his "self" merited no consideration. His efforts were totally focussed on not being like his father.

Tim on the other hand, desired movement both intrapersonally and interpersonally. He wanted change that would unite him with himself and with his wife. He wanted to "bring that little person home" (inclusive) and clung to the image of himself holding the baby securely in his arms (nurturing). His efforts were directed towards getting to know himself. The two images of "kicking yourself in the ass" and "holding yourself in your arms like a baby" are sharply contrasted. The first involves physical aggression, punishment; it represents negative masculinity. The second involves nurturing, vulnerability; it represents positive femininity.

(j) Spiritual Support: Tim acknowledged a spiritual dimension, and Carl did not. In a recent study on the processes of change in Alcoholics Anonymous, Snow points out that spirituality was not represented as a viable change process. "Spirituality illuminates an
aspect of change that is difficult to conceptualize.... and may be best represented as a level, or some combination of process and level of change." In other words, it is not clear whether spirituality is a means to change, a focus of change, or some combination of the two (Snow et al., 1994). Both AA and ExST are grounded in a spiritual approach, which warrants further clarification and investigation.

**Context Factors**

(k) **Supportive Partner:** Tim had a willing partner, who although struggling herself, was able to confront her own issues, who was committed to the relationship, and who could hear his pain. Carl had an unsupportive partner, who could not hear about his experience, who could not help and who could not commit to the relationship.

(l) **Support Network:** As well, Tim maintained a support network outside of his partner and his therapist. He went to AA, met with a solicited advisor, and believed in God. Carl did not seek help. He scorned AA, had no friends, does not believe in God, and usually blamed someone else (Liz) for his secluded situation. After Liz declared her desire for separation, the therapist asked Carl if he had friends who could support him, and Carl's sarcastic response was "No, Liz doesn't believe in friends" (session three).

**Therapist Factors**

(m) **Individuated Interpersonal Experience:** The therapist was much more directive and enmeshed with Carl. He wanted Carl to experience his own agency, he wanted him to move, he wanted him to accept the reality that he himself had been forced to face. He wanted him to succeed at the failure of his relationship.

Tim had his own agenda. The therapist just had to be there for him, to support him on his journey, rather than lure him or "take" him. He was freely connected with Tim, bonded on some metaphysical level, but not enmeshed. Tim's experience was entirely his own, and yet there was a very real intimacy between the two men (as observed and as stated
by the therapist).

The interpersonal theory which forms an essential component of the ExST model suggests that change occurs when the therapist provides a relationship that enacts a resolution of the client's conflict, rather than a repetition of it. At times Carl is able to elicit the same response from his therapist as he does from his family. The therapist says on a number of occasions "I don't believe you," in much the same way as Liz tried to "catch" him in deceit during the first session. Once the therapist said "that's just weird," perpetuating Carl's experience of "stupidity" and foolishness. The therapist seemed to lose sight of his role in disconfirming Carl's pathogenic developmental experience, and reacted instead out of his own conflicted feelings.

Perhaps it was impossible for the therapist to be that way with Carl, given his own similar, recent separation, but it is unfortunate that the therapist succumbed to Carl's conflict at times, rather than providing a corrective interpersonal experience.

Client Readiness

...some (seed) fell by the wayside; and it was trodden down, and the fowls of the air devoured it. And some fell upon a rock; and as soon as it was sprung up, it withered away, because it lacked moisture. And some fell among thorns, and the thorns sprang up with it and choked it. And other fell on good ground, and sprang up and bore fruit a hundredfold. (Luke 8: 5-8)

It is worthy of note that ten of the thirteen discoveries are client factors. Of those ten, the concept of "readiness" seems outstanding. Although largely unexplored in the scientific, therapeutic community (Prochaska et al., 1992), it is not a particularly new idea in parables and folklore. Certainly Scrooge was not prepared to change after a single experiential encounter. However, he did allow the thought to cross his mind for the first time after that encounter, and following the third, most demanding experience, he was ready to take action. In the two client experiences under investigation in this study, Tim was prepared for action prior to the IR event; Carl was not.

It seems probable that people enter therapy in various stages of readiness, and that the
seeds of change must fall on prepared ground in order to bring forth observable fruit. Clients who are trodden down, with thorns and rocks in their life need to become cultivated for change. The question, then, is not only "how" people change, but "when" people change.

A Stage/Process Construct for Carl and Tim

Carl entered therapy in the early stages of the change process. He had just begun to read some popular self-help books and responded to the TARP advertisement in the hope that with some outside "expert" help, Liz would re-commit to the relationship, and they would continue as a couple. However, he was essentially unaware of the problems in his life and unprepared for self-change.

In the first session he was defensive. He stated that "drinking is not the problem," and that they have a few communication issues that are "rough, but not that bad." In the second session Liz expressed her position clearly, and Carl still could not see the problem.

T: (after Liz's extensive criticism of Carl) Try saying to him "I feel a lot of pain."
Liz: (starts to cry) I feel a lot of pain. ...
T: How does her statement affect you?
Carl: She doesn't care how hard I try....

(later in session)
Liz: ...It's a waste of my time. He doesn't change. He doesn't grow. He's not strong enough.
T: How is that for you?
Liz: He makes me feel weak. Why am I with such a loser?...
T: How do you feel when she says that?
Carl: ...I don't believe it.

In the third session the therapist encouraged Liz to say directly to Carl what she wants. She says calmly and plainly "Carl, I want you to leave." Carl was stunned by this and states during the next session that "I was shocked, beyond shocked." In spite of Liz's continual
insulting denunciation, her pain, and her inducement to leave, Carl was shocked that she wants out of the relationship. He was fundamentally unaware of the problem and as such is not ready for change. G.K. Chesterton's statement that, "It isn't that they can't see the solution; it is that they can't see the problem," is descriptive of Carl's stage.

In the sessions prior to the IR event, Carl is able to absorb the increased information made available to him. Liz doesn't want him. He has to move out. He now needs a job more than ever since his role as 'house-dad' is over. His identity has been dealt a threatening blow. Circumstances are forcing him through the initial stages of readiness but it is a highly stressful way to proceed.

During the IR there is a shift for Carl. Such an experience is new for him (Appendix 6, line 5) and at the beginning he is not acquainted with his feelings (line 56-58). During that event he becomes painfully aware of the problem as he learns about himself (lines 55-88, 131-167). He acknowledges his anger (line 177, 260) and fear (line 20-24, 255). He says things to his father that he has never been able to say (line 390) and stays with the experience enabling a dramatic catharsis (lines 384-406). He wishes for change (line 433-435), although he does not fully appreciate his own agency in effecting that change (line 428-430). Even though he does not experience forgiveness from his father, he requests a hug from the therapist and their long, warm embrace symbolizes the love and acceptance he has not received from his dad. Carl acknowledges gratefully the experience of being held (line 445-446).

Carl does not emerge from the IR event 'healed' or even ready to take action. Rather its cathartic process enabled a shift into a more advanced stage of readiness wherein he was able to see more clearly who he was, where he had come from and what his options were. The move towards taking deliberate and active charge of his 'self' may require further cultivation and preparation.

Tim, on the other hand, entered therapy further down the road where the ground was well worked. He recognized the destructive grip of alcohol and had tried and failed to quit
drinking in the past. He is once again determined to do so, having secured a stronger support system this time than ever before. He is committed to Pam and after some tumultuous years they are prepared to work through issues together. He is willing to face himself - the terrified baby stuck inside - after a lifetime of hiding, and simply wants guidance and company during the process. He is packed, geared up, and in shape to climb the mountain in order to get to the beauty.

A Spiral Pattern

Tim's background suggests that the concept of stages does not mean that change occurs as a linear progression. Even in the session prior to the IR event (session ten), Tim is in a state of disequilibrium, on the brink of moving forward or retreating backward, and in this session the latter happens.

Tim: ...if I could just give you my feelings without words ... I don't feel like I'm in my body ... I feel like a T.V. out of focus ...

T: Sometimes this stuff happens when people sober... gives people access to feelings they've kept numb. Often people can stay sober for one month, two months, three months and then they go back drinking ...

Tim: That's me ... I feel really really shaky ... I feel like I'm coming apart. ...

T: (later in session) I'm wondering what happened to that part of you that feels shattered now. Did you get what you needed ... you seem changed.

Tim: (long silence) I guess I'm wrapping it up, putting it away.

It is not known how many times Tim had this experience of "wrapping it up, putting it away." Just as the dynamics of relapse exist in people resolved to quit an addictive habit (Donovan & Marlatt, 1988), those on a path to intrapersonal change seem to experience retreat. Prochaska et al. (1992) propose a spiral pattern of change for addicts in which people recycle back to the precontemplation or contemplation stage, after having reached the action stage. They do not, however, regress all the way back to where they began because they
have learnt from their mistakes. As well, having experienced a different way of being in the world, they cannot "unexperience" it. A similar spiral pattern seems appropriate for intrapersonal change.

The next session, just prior to the IR event, Tim has connected with hope again (Appendix 2, lines 33-35) and he realizes that there are many parts to him (lines 41-45). During the IR event, Tim sees further inward (line 53), has more hope (line 86-87) and finally experiences active progress in liberating himself (line 88, 89).

Insofar as taking action is a particularly stressful stage, it is predictable that Tim would increasingly rely on the support and understanding from helping relationships. If the support had not been in place, he may have retreated back into an earlier, preparatory stage. The session following the IR event (session 12) was difficult and demonstrates his reliance on the therapist:

Tim: ...seems like you go through half a mile of dry land and then 16 miles of swamp. I feel more topsy-turvy than I feel sorted out...

T: It's a great challenge to be a couple ... how was our relationship affected by this session...

Tim: I trust you like you wouldn't believe. I have to trust that you know what you're doing.... Pam and I are working really hard...

In the next session it is clear that he is also able to trust Pam. The therapist observes a stronger connection and understanding between them. By session fourteen Tim comments, "I don't have to take my anger at the whole world out on Pam anymore."

A Transtheoretical Model

Using the transtheoretical constructs of both stages ("when" people change) and processes ("how" people change), Prochaska et al. (1992) offer an integrative perspective on the structure of intentional change of addictive behaviors.

Stages of Change. A linear schema of stages was discovered in research with
smokers attempting to quit (DiClemente & Prochaska, 1982), and has been demonstrated with alcoholics (Snow et al., 1994) as well as with twelve other populations (Prochaska et al., 1994). Clusters of individuals have been found in each of the stages of change and these stages have been ascertained by two different self-report methods: a discrete categorical measure (DiClemente et al., 1991) and a continuous measure (McConnaughy et al., 1989). Brief descriptions of the five stages are as follows:

1. **Precontemplation** is the stage at which there is no intention to change behavior in the foreseeable future. Individuals are unaware or underaware of their problems.

2. **Contemplation** is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it in the next six months. At this point individuals are weighing the pros and cons.

3. **Preparation** is a stage that combines intention and behavior criteria. Individuals in this stage are intending to take action within the next month and have unsuccessfully taken action in the past year. On the continuous measure they score high on both the contemplation and the action scales.

4. **Action** is the stage in which individuals modify their behavior, experiences, environment in order to overcome the problem. It requires a considerable commitment of time and energy. The action stage is often erroneously equated with change, overlooking the prerequisite and maintenance part of the process.

5. **Maintenance** is the stage in which people work to prevent relapse and consolidate gains. It is a stabilizing but not a static stage.

**Processes of Change.** Although there are 250-400 different psychological therapies (Karasu, 1986) based on divergent theoretical assumptions, Prochaska et al. (1992) have identified only 12 different processes of change based on principal components analysis. Processes used early in treatment were the single best predictors of outcome; better than 17 predictor variables including demographics, problem history and severity (Prochaska et al. 1985). The nine change processes with the most theoretical and empirical support are as
follows:

1. **Consciousness Raising** involves increasing awareness about one's self and the problem using observation, confrontation, interpretation, bibliotherapy.

2. **Dramatic Relief** involves experiencing and expressing feelings about one's self and the problem through role playing, psychodrama, experiential therapy.

3. **Environmental Reevaluation** involves assessing how one's problem affects the physical environment.

4. **Self-reevaluation** involves assessing how one feels and thinks about one's self in relationship with the problem using imagery, corrective emotional experiences.

5. **Self-liberation** involves increasing alternatives for nonproblem behaviors available in society.

6. **Reinforcement Management** involves rewarding one's self or being rewarded by others for making changes.

7. **Helping Relationships** involves being open and trusting about problems with someone who cares through a therapeutic alliance, social support.

8. **Counterconditioning** involves substituting alternatives for problem behavior such as relaxation, positive self-statements.

9. **Stimulus control** involves avoiding our countering stimuli that elicit problem behaviors and restructuring one's environment.

A cross-sectional research project involving thousands of participants revealed an integration between stages and processes. Processes 1-3 were in operation between stage 1 and 2. Process 3 was functional between stage 2 and 3. Process 4 was functional between stage 3 and 4. Processes 5-9 were employed between stages 4 and 5. Thus it seems likely that the stage at which a client enters therapy is significant in determining the therapeutic processes and in determining outcome.

Figure 2, on the following page, presents an expanded Overview of the Therapeutic System Life Span, adapted from the ExST manual (Friesen et al., 1989), to incorporate a
stage model of therapeutic change. Within this model, clients typically move through four phases of therapy regardless of when (at what stage) they enter therapy, but "when" is key in determining measurable outcome. For a client who enters during the preparation stage, the integration phase will show distinct change. For a client who enters during precontemplation, the integration phase may show little measurable improvement, or may even appear as deterioration on outcome measures, as the client becomes aware of problems previously buried. This is significant since most research studies base treatment effectiveness entirely on outcome studies.

This model explains why the therapist in this study was unimpressed by the outcome data which indicated Carl's deterioration. The therapist recognized that Carl did not take meaningful action (like Tim), but he was nevertheless convinced that Carl "moved" in a forward direction in terms of self-awareness and contemplation of change.

Following phase four, clients either leave therapy, or continue therapy, entering the next stage and moving again through the four phases. There is also the possibility that a client may regress a stage, and begin work again in phase one of the preceding stage (e.g., the spiral nature of Tim's change).

Based on the process predictors of this model, Carl entered therapy in the **precontemplation stage** and the treatment ended while he was in the **contemplation stage**. He experienced the processes of **consciousness raising** (lines 4-5, 64-65), **environmental reevaluation**, (line 133-165), **dramatic relief** (lines 177-228) and **self-reevaluation** (lines 433-435). Carl's IR was representative of the **dramatic relief** process associated with Stage One at the first level of the Therapeutic System.

Tim entered therapy during the **preparation stage** and the treatment ended while he was in the **maintenance stage**. He experienced the processes of **self-liberation** (lines 246-263) and **helping relationships**. Tim's IR was representive of the **self liberation** process associated with Stage Four at the fourth level of the Therapeutic System.
Figure 5

Model of therapy stage process

- **Stage 1: Precontemplation**

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<th>Phase 1 →</th>
<th>Phase 2 →</th>
<th>Phase 3 →</th>
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<tr>
<td>forming</td>
<td>perturbing</td>
<td>integrating</td>
<td>disbanding</td>
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| a) consciousness raising  
  b) dramatic relief  
  c) environment re-evaluation |

- **Stage 2: Contemplation**

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<td>a) self re-evaluation</td>
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- **Stage 3: Preparation**

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<tr>
<td>a) self-liberation</td>
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- **Stage 4: Action**

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<tr>
<td>forming</td>
<td>perturbing</td>
<td>integrating</td>
<td>disbanding</td>
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</tbody>
</table>
| a) reinforcement management  
  b) helping relationships  
  c) counter-conditioning  
  d) stimulus control |

**Note.** Adapted from Friesen et al. (1989, p. 10) & Prochaska et al. (1992).
Since Prochaska's model specifically emerged from studying the change process for addictive behaviors, the processes of *reinforcement management*, *counter-conditioning* and *stimulus control* are applicable for client addictions like drinking or spousal abuse, but may not be salient for intrapersonal or interpersonal work in couple's therapy. More research is required to identify the relational processes for this stage.

"Readiness" as a Central Construct

It is possible for most of the other "discoveries" to be accommodated within this "readiness" model.

(a) *Disequilibrium* is based on a stage model of development, and represents the transition between stages. As such it can alert the therapist to immanent change potential.

(b) The client's ability to enter into a *symbolic experience* without resistance may signal readiness for change, particularly within ExST, where symbols are key components of the change process.

(c) Client *intelligence* level may be significant in how and when clients change and the development of "readiness." It may also be pertinent in deciding the *kind* of therapy best suited for a client, since ExST may work optimally with an intelligent, educated client population.

(d) The *support* relationships of *partner, friends, spirituality, and self* play a significant role in client preparation for action and preparation for maintenance of change. Counter-conditioning and stimulus control processes are most effective when based "on the conviction that ... change supports a sense of self that was highly valued by oneself and at least one significant other" (Prochaska et al., 1992, p. 1109).

(e) The absence of a *forgiveness experience* may bind the client and stagnate the readiness-for-change process. Likewise, a forgiveness experience, symbolic or real, may signal a client's readiness for change.

(f) The absence of *process flow* may indicate the client is not ready for the process
precipitated by the therapist.

(g) The presence of significant stress in the client's life suggests that they are incapable of taking on the additional stress of actively changing at that time.

(g) Change is an individuated experience and the therapist cannot produce or control it, but rather guides and facilitates readiness.

**Implications**

The discoveries presented in this study have implications for clinicians and training programs as well as specific implications for ExST theory development.

**Implications for Clinical Practice and Training**

Research with an addict population (Prochaska & DiClemente, 1992) demonstrates that people who progress just one stage in a month double their chances of taking action. In other words, if an individual in the precontemplation stage moves to the contemplation stage during a period of several weeks, the likelihood of active agency in the individual increases significantly. Although the large emphasis on client factors may seem to diminish therapist involvement, there are important implications for clinical practice.

The most obvious is the need for therapists to assess a client's readiness for change in order to do the right thing (process) at the right time (stage). Although this assessment may be intuitively taken by experienced clinicians, there is little literature and no explicit model to accommodate efficient, prescriptive, therapeutic interventions. As such, many therapists focus primarily on the processes identified with the action stage - stimulus control, counter-conditioning, reinforcement management - without the requisite awareness, decision making and readiness provided in the earlier stages. This practice may lead to temporary behavior modification but seems unlikely to create true change, which, this thesis suggests, calls for some sort of Intrapersonal Resolution experience, or self-liberation process where the client faces a part of self previously avoided.
If this stage theory of client readiness is valid, it should be incorporated into training programs since new therapists are perhaps more likely to push action processes on clients in their enthusiasm to produce change. Given the studies that indicate that time is a critical factor (stage progression in less than a month increases probability of change), it is important for therapists to have credible readiness assessment skills. Greater emphasis on the developmental nature of change needs to be acknowledged and studied, and stage appropriate processes practiced.

The concept of stage regression should also be considered. Some clients who have tried and failed to change feel like failures; embarrassed, ashamed, guilty. Regression sometimes creates demoralization and resistance to thinking about future change. As a result they return to the precontemplation stage and can remain there for various periods of time (Prochaska et al., 1992). The intrapersonal journey is more hidden and therefore it is more difficult to identify relapse than it would be for substance addictions. However there is research that suggests relapse, like change, follows particular identifiable processes (Gorski, 1990) and it is important that therapists be familiar with the process indicators reflecting regression, rather than bewildered, annoyed or oblivious. As well, therapists should remember that intense, experiential therapy during elevated client stress is more likely to produce regression than change (Gorski, 1990). More research is needed in this area.

It also seems that facing previously avoided parts of self is best accomplished on a symbolic dimension. If we have learnt anything from myths, parables and folklore, it is that people "hear" better when the voice speaks out of internalized stories and symbols, rather than stark confrontation. Symbols are personal and spacious enough to permit slow or rapid growth into readiness, which is precisely what a non-omniscient therapist cannot always accomplish.

The complex therapist task of dealing with client readiness is exacerbated in couple's counselling, where two people, at different stages, engaging different processes, for potentially different goals come together needing different interventions. However,
assessing readiness in each partner may provide crucial information for the therapist in helping to restore a seemingly unreconcilable relationship.

The fact that the IR occurred during a session where the client's partner was unable to attend may be significant for therapists doing couple's work. The personal nature of facing a previously avoided part of self may require the undivided support of the therapist in a private setting. Once the innermost system has been encountered, the other layers of systemic relationships can be confronted. Systemic therapists often focus primarily on interpersonal interaction, overlooking the vital intrapersonal system. For both Tim and Carl the individual sessions were accidental - part of the process - and not designed or requested by the therapist. If it is not appropriate to request individual sessions, the therapist should at least be mindful of not thwarting the "process" when individual sessions naturally emerge.

Both Tim's and Carl's IR occurred about the same time in the therapy treatment (11th and 12th sessions). Both men had drank a lot of alcohol over the years to shroud and sequester a part of themselves and were unlikely to face this part impulsively. This may suggest that an IR requires an established, trusted relationship with the therapist, and "brief" therapies foil the opportunity for an Intrapersonal Resolution experience.

It is also important that therapists encourage clients to establish a strong support network (self, partner, friends, community, support group, spiritual) before they take action, given that the research identifies action as a particularly stressful stage (Prochaska et al., 1992). Confronting a previously avoided part of self is a courageous and stressful act requiring some external stability and support. Therapists are often torn between recognizing a client's great need for change and recognizing a coexisting lack of support and stability. Although Carl was immediately grateful for the IR, this study suggests ultimately that the intensity should have been monitored more closely, or the experience delayed until later, given his absolutely nonexistent support and high level of stress.
Implications for ExST Theorists and Therapists

The discoveries emerging from this study suggest that the therapeutic process is more complex and multi-dimensional than many theorists originally conceived. The construct of "readiness," for example, is not noticeable in the draft version ExSt manual (Friesen et al., 1989). As with most therapies, there seems to be an implicit assumption from both theorists and therapists that clients enter therapy in the preparation stage, ready to clarify problems and to attempt solutions. The validity of this assumption is, no doubt, based on the conjecture that therapy most often is voluntary: people choose therapy when they are "ready." However, with addiction treatment programs, therapy may be mandatory and thus client preparation incomplete. In couples work, one person may be ready for change; the other may accompany their partner for a variety of other reasons. Sometimes an individual may seek therapy to solve a particular problem, and be unprepared for self-change.

Along with forming the therapeutic alliance then, an important initial therapist task during phase one of the therapeutic system is the identification of client readiness. Further research is required to facilitate clear stage identification; therapist awareness is important until then.

It is also important for therapists to distinguish true therapy ineffectiveness from early stage movement. Because progressing from precontemplation to contemplation may appear as deterioration on outcome measures, it is significant that it be identifiable as progress.

Recognition of process indicators seems to be crucial in the identification of stages (for both change and relapse). The therapist in this study appeared frustrated and was occasionally impatient with Carl's inability to see his situation clearly. Rather than pushing the processes of self-reevaluation and self liberation, more effort needed to spent on the process of consciousness raising. The appropriateness of this initial stage process was evidenced in Carl's reference to what "the book said" or to what "so and so said" suggesting that he was engaged in an information gathering process. Carl's unwillingness or inability to completely stop drinking and to acknowledge his problem also indicated early stage
behavior.

Corresponding processes for particular stages also need further development and refinement within the ExST model. Prochaska et al. (1992) identified nine salient therapeutic processes in his transtheoretical research, but the experiential, systemic emphasis of ExST may work best with particular processes, not necessarily included in their selection. As well, it may be useful to investigate whether the processes associated with precontemplation work the same with first time precontemplators as with those who have retreated back to that stage after experiencing failure.

The use of symbols and metaphors in ExST is important. Used at the right time, they can be a deeply meaningful passage into self-understanding, and an eloquent language with which to communicate unintelligible experiences. Perhaps some stages are more conducive to the use of symbols than others, or perhaps different kinds of analogical exchange work best at particular stages of readiness. Would Carl have been able to respond, for example, if the therapist in this study had asked him for a symbol which represented who he was right then, rather than a symbol which represented his goal; the idea of goals being inappropriate for the precontemplation stage.

The relational orientation of ExST may also have obstructed Carl's success. It would be helpful if therapists using the ExST model had a conceptual framework that emphasized the separateness-relatedness dialectic of core conflicts. This would enable them to be aware of their relational focus and/or the tendency to become enmeshed with clients who need to experience autonomous agency. The challenge of successful relationships is one of balancing intimacy and autonomy. The problems that many clients present reflect an inability to achieve an integrated sense of self as both an independent, agential, competent person and an emotionally available, trusting, committed person. According to the Interpersonal Theory substantiating ExST, if clients are to break away from the established dysfunctional patterns of their childhood attachment, they need to experience a new, consistent, balanced relational interaction with their therapist. Thus the therapist needs to be
able to identify where the separatedness-relatedness imbalance occurs and to encourage clients in the opposite direction, regardless of the treatment's theoretical emphasis.

Within ExST theory there is also the belief that "the deepest and most profound knowing results from experience rather than dialogue or didactic instruction" (Friesen et al., 1989, p. 33). The experiential therapies assert with May that "... a client does not need an explanation, he needs an experience" (1967, p. 10). The "discoveries" in this investigation suggest that, while this may be true for those in the action stage, it may not hold constant for those in earlier stages. The analysis in this study indicates that ExST was an ideal therapy for Tim, who was bright, articulate, able to use symbols, and very prepared for change. He formed a strong alliance with the therapist, and it is probable that any ExST therapist would have sufficed.

The treatment was less helpful for Carl. The therapeutic emphasis on goals, symbols, relational novelty, and intensification experiences, seemed frustrating for the client, who was under a lot of stress and who believed the therapist wasn't doing a good job of getting Liz to be nicer to him. For Carl, increased self/environment information and awareness processes in therapy were well-suited. The cathartic IR appeared beneficial and Carl was grateful, but it is difficult to establish its constructive role given his subsequent relapse into denial and drinking, the deteriorated outcome measures, and without access to the last session tape or to Carl's perspective.

**Methodological Discoveries**

As the present study demonstrates, CPA has the potential to handle the complexity of the therapeutic process, at least on the level of a single, significant event. The comprehensiveness of analysis left very few stones unturned. It does, however, require "a great deal of time and ability to manage a sometimes overwhelming amount of complex data" (Clark, 1990). In fact, even given the opportunity, the time and effort required to complete CPA using a team of analysts and the process of consensus (as Elliott recommends) would have been unrealistic and highly inefficient for this study. The present study was
completed by a single analyst (with periodic verification from outside judges), which made it more feasible in terms of time, but less convincing from a reliability standpoint. For complex sets of data, the tension between feasibility and reliability is ongoing.

**Limitations**

This investigation was limited on several fronts. Notably absent from the analysis was client input which precluded observer, therapist, and client triangulation, which Stake (1994) claims is a major conceptual responsibility of the qualitative case study researcher. The nature of the initial contract between TARP directors and the clients included a time-limited access to clients. This research, several years after the treatment occurred, is outside of the time limitations, and, even if it was not, client memory of events would be notably reconstructed.

Secondly, the data are from a small heterogeneous sample of couples in alcohol recovery in Vancouver. The results may not be entirely generalizable to other populations. Thirdly, CPA was completed by a single analyst. While it was inefficient to do otherwise, the absence of consensual observation hampers any effort towards objectivity.

**Research Recommendations: Where to Go From Here**

The discovery nature of this research precludes conclusive outcome. More study is necessary to confirm the conjectures postulated in this investigation. However, there is sufficient unearthing to warrant further research, particularly in the area of "readiness" for change and the use of symbols in the change process. Future research could examine: (a) the concept of readiness (*when* people change) in a larger client population; (b) the concept of readiness from the client's perspective; (c) the long term of effects of change occurring at various stages of readiness; (d) the interaction of disparate client readiness in couple's counselling; (e) the integrity of the Expanded Overview of the Therapeutic Life Span described in this study; (f) the role of symbols in the change process; (g) the role of extra-
therapy factors such as forgiveness; spirituality, support and intelligence in the change process; (h) the characteristics of the disequilibrium signaling an immanent potential stage shift; (i) the client characteristics that signal the appropriateness or inappropriateness of particular therapies; and (j) clear indicators of the process variables associated with stages of change and relapse. How and when people change continues to be of focal interest in the research community, even as it has, for centuries, captivated those who read and write stories. The mystery of moving from 'not seeing' to 'seeing' and from 'not hearing' to 'hearing' is so gratifying for all systems and individuals involved, that in humanity's search for "the good life," various aspects of the change process will always be discovered, rediscovered and celebrated.
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APPENDIX 1: ELEMENTS OF THE TRANSCRIPTION

1. Speaker Identification: T = the therapist, C = the client
2. Interruptions: //
3. Pauses: bracketed numbers in seconds, e.g., (3)
4. Unclear hearings: ----- 
5. Nonverbals or nonword sounds: use double parentheses, e.g., ((blows out air))
6. Timing deviations: use colon (:), e.g., really or repeat letter, e.g., sooo; number of
   colons or number of letters indicates length of stretch
7. Emphasis: underline words
8. Sentences run together: use = to indicate no break between sentences

Abbreviations

1. ((db)): deep breath
2. ((ex)): exhale
APPENDIX 2: TRANSCRIPT: 2030-11-1

T: Tell me about this. (3) Let's move our chairs so we-(chairs moved) Do you know? (2)

C: MHM Well-((exasperated sigh))(6) The connection broke.(3) It was complete.(4) But it broke down.(3) But there's a big, big space because it's a long reach for me to go from there to there (3) but we got there.

T: The contact before Christmas//mhm and then we had Christmas break-Oh I see-till Christmas.

C: And it's not like anything bad(1) happened but where I was at that point(3) left me feeling very, very jumbled and mixed up and confused.

T: And maybe abandoned

C: And you think well-ya all the feelings that were coming up- were-brought up to the top.

T: Yes

C: and then they got left there and I couldn't handle it very well. So I had to do something with them so I started covering them, because it was too much. Right up top is like raw wounds.

T: Yes.(3)

C: And I felt very disoriented, and I thought (2) I'm doing something wrong, but I had to think a lot about this. It wasn't anything wrong, nothing bad, it just was the way it went, and so that was ok and so (6) I'm getting moving again-like that one session we had I just felt completely disoriented again still afterwards it didn't seem to do anything at all (1) as far as straightening things out.(2) I almost felt worse after (1) than before. Because things were going back to sleep I guess. I just stirred them all up (T: uhh) but then afterward the next meeting which was the last week things-started to take direction again.

T: yeah- well what about it do you think got things to take direction?
C: ((deep breath, releases air loudly))(6) I don't remember. It's just the whole thing felt a lot better.
T: yeah (3) (points to part of drawing) so this arm is starting to stretch out? (1)
C: Well (4) it's being repaired. (2) The grief is going back. The stuff that blew away.
T: Oh-oh-oh ------- .
C: Yeah it still is. (5) And he's weaving it back together (1) that's the feeling (5) and the sun's coming up again. It doesn't feel like (3) I'm wandering around in the dark. (8)
T: Tell-Tell me about how this relates to these-what are they doing? (6)
C: Well this was the first drawing and this was just what came out, I- I just started to put that down. I didn't even know what it would look like. I didn't know what the faces should be like or anything.
T: ((clears throat)) (5)
C: And- that was the first one and that seemed to be the most accurate so I thought=and these others just seem parts-(3) different parts of the same p- personality or person and it just went back a long way and I don't remember how far back. But it went back a long way. And that was (3) just realizing he was there. (3)
** ** SIE begins here ** **
T: So that was about the first time that the-. You know what I almost see? I almost see like a plane going over and these people are stranded-waiting to be seen.
C: ((blows out air)) When I um (3) did that it was like- you're outside looking in ((blows out air)) I don't believe this (starts to choke up) (2) ((deep breath)) and you didn't even know this was there and then they (see) you from inside and they're reaching-from inside (2) (T: uhuh) (3) uh (2) it was really unsettling to know that was there. To find out. Boy, I could see it, you know, it was (2)
T: ---- you could see it (3)
C: I don't know why-I just feel so upset now. Because I drew it out and thought
about it, and thought about it and I talked to him. But I found out that he was
inside and he-((sob)) once he saw me look-looking ((sobs?)) (2) he reached (5)
And it was urgent-I couldn't not do anything about it (3) ((ex))And I felt really,
really sad. And I didn't know what to do ((voice cracks)) but I knew I had to do
something so I just kept talking to him ((db)) and saying that I would do
something ((sobs)) When I went in there he went back to a little baby.(5) ((db))
And that's when I had that dream about it was a mummy.((sob)) (t:yeah)
Somebody gave it to me ((voice cracks)) (2) and he kept looking at me (4) And I-
((sobs hard))

T: Take a deep breath (2)-a deep breath.

C: And I gave him back and he closed his eyes. When I gave him back and he
opened his eyes again and he looked at me. And it was like a horrible look 'cause
he was in agony. ((swallows) And I didn't know what to do (4) ((heavy
breathing)). Then I gave him back and I couldn't take him anymore. And um I
kept seeing him so many times so I had to -and I drew him out and I said, "I'm
going to do something- about you." And I was really afraid of him. So I drew
him out. I tried to get the face like it was. It was horrifying almost. (1) And it
scared me really bad. And then when I told him I was comin' and I was going to
do something.((ex)) He rested a little. So- (3) And so things started going
away a little bit and I promised that I wanted-to know what to do-I wanted to
figure out what to do.(3) And I was sooo shocked still to find that thing living
inside of me=Then we had the Christmas break. And- And- I felt (3) like I'd run
out of gas. I didn't know what to do. And uh I was going to lots of meetings and
talking to my sponsor, and it was- helping a bit but still I wasn't going any further
I was sort of losing contact.

T: right, (2) so he's over here?
C: yeah (4)
T: This is him?
C: yeah (5) ((sniff)) so ((sniff)) like I was holding him- I could reach something really, really important- really important and I didn't know very much about it yet.
It was too scary to take it out-it was too scary. But I knew that- out here somewhere there was help (1) and it was- a promise of peace and rest and some serenity and tranquility (1) on the horizon which wasn't very far away. It was close enough - if I figured out how to walk down there, get there, reach there, whatever. But I can't do that by myself. (3) And so I guess it was like it was stormy inside of me. And so I was thinking that there was ((deep breath)) a vicious wind blew down my valley-the canyon at times and broke- the connection. And uh (1) so now=and Christmas I really love. Christmas was sooo-it's like it was next door for me and I enjoyed it but it wasn't like I was totally there.
T: ---- the connection with it was broken I guess

*** SIE ends here ***

C: To me it means something that its in the valley because it should be- (1) up here I find that almost all-and there were definitely highlands it was good for a lot of reasons it wasn't like it was bad or anything (2) it was just I felt not all I could be and (3) finally it's getting (2)-it's getting repaired

T: I think you must have been terribly hurt when you were a little boy.
C: ((ex)) You know I've talked to Pam about this. I've talked to myself about this and (2) I really don't (2) feel- I can't figure what was the big deal because I had like what I thought would be your average upbringing. My parents loved us. They weren't uh in any way perfect=but who is? They did better what they had when they grew up. They worked really hard to give us what- some-some-something they didn't have and. They did- (2) They came from England. They came to
Canada with nothing. And they put us in a good home and cared about us and my mother (4) was really physical, especially with me, which I- (1) I know was wrong and I really didn’t like—but I know what happened. I didn’t totally bury it or anything that I can see it would cause me this much trouble later. (2) She had the daylights beat out of her when she was kid. She got shuffled from home to home. (2) Nobody wanted her. So she gave me (1) not perfection (1) but she gave me what she was able.

T: I’m sure both your parents did.

C: It was more than what she got.

T: What does being physical mean? (3)

C: I got (4) beatings with a- (2) whatever she had, a spoon, a stick, all that stuff

T: You can still ---- she’s here, ---- do you?

C: Yeah, I can and I do. I don’t like her all qualities of her but I love her (5) primarily for being my mother, I guess I was sort of mixed up for awhile, for a long time but I did my best to work through this when I was somewhere around thirty-thirty-two or so because it- (1) started bothering me a lot.

T: What have you tried?

C: I just thought lots about it and talked to my brother about it and talked to—I was going to AA

T: Are you talking about about the battering and beatings and stuff that happened?

C: yeah.(6)

T: Did he get beat? Is that what this is about?

C: (3) My brother, yeah.(4) Oh I think so.(6)

T: It looks like he was very horrified, very scared.

C: MHM. (3) ((sniff)) It shouldn’t have happened (6) it was wrong. (7) ((sigh)).(6) ((sniff)) It was wrong.

T: yes.(17)
136  C: ((db))
137  T: What's happening right now? (5)
138  C: ((ex)) (2) I've thought about this before. I know what happened. I know it was
139       wrong. I've hurt once but I don't want to live there.
140  T: Looks like part of you has been stuck back there.
141  C: I guess part of me, yes, (3) I guess I couldn't do it all by myself (2) I don't know
142       what to do about it.
143  T: Is this a man or a woman? That's you?
144  C: That's me.
145  T: What was your-You never talk about your father
146  C: My dad died when I was twenty-one. (1) so he's) been dead twenty-twenty
147       years.(4) and I don't think about him so much. I loved him lots and lots and lots.
148  T: What was he like as a dad when you were a kid?
149  C: ((ex)) (3) He was uh-(7) he was uh- (2) kinda on the stern side. He wa::s kinda
150       strict. (3) But he was the same with himself as he was with other people. He was
151       fair - very, very fair.
152  T: Are you like him?
153  C: Uhm- I think I'm quite a bit like him. I try to be a little softer-I try not to be so
154       stern, so strict, uh I try to be as fair= he was conscientious. He was the kind of a
155       guy that uh (2) his word was good always. Till the end-you could do a handshake
156       deal with my dad. (4) If he said he would do something, be somewhere, (1) he
157       was. He was as reliable as they come. And he was dead honest about himself and
158       with other people. He was slow to (6) to- to- compliment. And he wasn't effusive
159       with (1) demonstrations of of- love
160  T: Tell me a story of you two together.
161  C: When we were together? (2) My dad did uh neat things like uh he'd take me
162       around to the uh docks, the dock yards to see the ships. He'd take the ships to the
yard docks. He liked the ships. He'd take me around and show them to me. He'd
take me to uh- (2)
T: Tell me about one time. Can you tell me about one time you were with him?
C: (2)The docks? I don't remember. It's kind of blurred. I was pretty (young).(1)
He took (1) me fishing. I remember once
T: Tell me about it.(2)
C: We'd uh (1) go out here over to Vancouver to the ---- go fishing quite often. We'd
just- we'd get up early in the morning and uh pack a big lunch and get us a good
breakfast and take it out.(2) Walk along the dikes and uh (T: Who was there?)
My dad and I and sometimes uh a friend of his, his fishing buddy from- that he
also worked with- real easy going, funny guy, always cracking jokes. And he had
a dog. (3) And the dog would uh come if you whistled the old theme song to uh
s-s-------. And we'd sit on the uh- (2) on the dikes in the summer and (2) they'd
teach me to fish and just watch the float go down the river and cast it out again
and- I'd watch it. He used to take maybe a bottle of beer or else there'd be coffee
when it was cold, and uh sandwiches and he'd uh tell me a story about when he
was young and where they went fishin' in England, (2) and answer my questions
and just be there with me, listen to me, talk to me, (1) and uh we were friends, for
that time. (2) And uh (1) at the end of the day you know if we caught some fish it
would be great and he'd keep givin' me pointers and if I caught a fish he'd let me
do it. He be tellin' me keep your rod tip out or let him go, let him run but he
wouldn't do it for me so I lost one or two but he let me do it. (4) But our day
ended and we'd walk back to the car and drive home and I'd be really, really tired
and I'd fall asleep in the car and I'd just be like really content.
T: If your father were here and he saw this character what would he do?
C: This guy?
T: This guy.
C: This guy here? Well jeez I don't know. He'd be surprised to see it. He'd be surprised to see me so emotional.

T: What would he do?

C: (ex) What would he do? Well if he were sitting here, he'd look at it and he'd have to take it in, digest it and be quiet.

T: And what if he saw that right there? Saw this baby? This horrified child? (ex) I think he'd be surprised.

T: What would he do?

C: (5) Be standoffish. He'd probably be standoffish and a bit disapproving. (ex) I think because he would not like to have seen that happen and he wouldn't like it to be connected with him.

T: See what happen? (2)

C: That anything went wrong with his children. That I felt down and that I was part of his family—it would be a reflection on him.

T: So would you protect him by not showing him that? By not showing him your pain?

C: Actually (ex) No I don't think I kept it all away. But the message I got was don't, don't be emotional. Grow up. Stifle it. Shut up.

T: Do what you're told? By whom?

C: (5) Just do what you're told. By everyone. Do what you're told. I guess I was really brought up to respect authority. Do what you're told. Respect authority. Obedience.

T: What happening with that part of you now? Can you be that part of yourself?

C: It makes me feel really, really sad. This so much sadness in that part of me.

T: Can you be sad for awhile?
C: Yeah, what I feel like is that uh, I'm going to uh, like I'm not going away. I'm going to hang onto him, protect him-I don't care. ((voice breaks))

T: This is you right here. You're this now (points to adult in drawing)

C: (2) Yeah.

T: Can you switch back for a second to be that little baby. You probably don't have words for that place. You probably just have sadness.

C: ((ex)) (4)

T: I wonder if there's some way you can have both- I want- Is there a way you can have both the sadness and the comforting at the same time?

C: That's how I kinda feel. That's more like how I feel- like both, I feel like it was uh really separate from me for a long time. Now that I've gotten a hold of it, it's uh, very, very, very important to hold on and not to ever let him feel ((voice breaks))

left alone anymore.

T: Can you talk as if you're talking to him here? Now that I've got you?

C: (12) I don't know - I do it- mentally.

T: Can you say it out loud?

C: (10) I just say things-like just say that I'm- here I am and I'm not-I'm not going to let you go. ((db))

T: Say that again. I'm not going to let you go (3)

C: I just tell him I've got him and I'm not going anywhere anymore

T: Say "I won't let you go." (2)

C: I won't let you go ((firmly)). ((db/ex))

T: Just say that again "I won't let you go." (4)

C: I won't let you go ((very quietly)). (5)

T: keep breathing

C: (2) -----fine (6) ((ex))

T: keep breathing
C:  ((breathes deeply))  (6)
T:  Keep breathing. You're okay now. You're reconnected(2)
C:  I'll never ever leave him by himself anymore-stuck away by himself all those
years-I forgot-they're stuffed away and I can't stop them. (12)
T:  What's he doing here now? (3)
C:  ((sniffs)) He's coming inside of me (3)
T:  Can you make a sound that maybe a child would make after hearing those
comforting words? (3) You're just a baby. How would your body feel if you just
heard those comforting words?
C:  Just (3) resting. Just relaxed ((db)) like the- (2) just I can go to sleep, resting,(2)
just relaxed, I feel safe now. (10) Like when a baby goes to sleep in your arms.(2)
Feels safe.((sniffs))(3)
T:  You're safe now. Maybe you could just relax and go to sleep. (2) just rest now (2)
because your not going to leave yourself.(14)
C:  ((ex 2x))(3) ((sniffs 3x))  (12)
T:  What's the expression on his face now?
C:  (3)((sniffs)) hmpfh (16) ((really quietly)) It doesn't look so terrifying- looks so-
happier he's starting to smile. His face-
T:  Is that how you feel at this moment? How that part of you feels?
C:  (2) It feels- a lot softer and a lot safer.(5) ((db)) It feels like it's comfortable ((very
quietly)) ((sniffs)) (36)
T:  Do you-----?
C:  ((ex)) ((softly)) Oh it's a long story -----  
T:  Pardon.
C:  It's really a long story ------(5)
T:  I think it's a long story (3) I think probably an important story.
C:  (12)((db/ex))(50)
T: We're hard to figure out aren't we? There's more to us than we could possibly imagine.

C: Thank you.

T: Thank you. I feel that you're doing something important.

C: I don't feel so sad. It's a treat. ((sniff))

T: (15) I look forward to your next pictures.

C: (20)

T: Every child deserves to be held. (4)

C: (32)
APPENDIX 3: SESSION EPISODE STRUCTURE FOR EVENT 2030-11

1.0 Relationship as a couple
   1.1 Progress, but slow, difficult
   1.2 Beliefs about relationship with wife

2.0 Exploration of drawings
   2.1 Explanation
   2.2 Clarification
   2.3 Intense feeling

3.0 Exploration of childhood
   3.1 Beatings from mother
   3.2 Mother's own impoverished past

4.0 Relationship with Father
   4.1 Story about fishing with dad
   4.2 Father's reaction to drawings?

5.0 Relationship between self and baby in the drawing
   5.1 Intensification of sadness
   5.2 Intrapersonal dialogue
   5.3 Resolution, rest

6.0 Long Pause
   6.1. Mention recent case of incephalitis
   6.2 Not enough time to discuss
   6.3 End
APPENDIX 4: SENTENCE FLOW CHART 2030-11-1

T: So that was about the first time that the-.
   You know what I almost see?
   I almost see like a plane going
   over and these people are stranded-
   waiting to be seen.

C: When I did that it was like-
   you're outside looking in
   and you didn't even know this was there
   and then they see you from inside and they're reaching-
   from inside

T: uhuh

C: it was really unsettling to know that was there.
   To find out.

   Boy, I could see it, you know,

T: ---- you could see it

C: I don't know why-
   I just feel so upset now.

   Because I drew it out and thought about it,
   and thought about it
   and I talked to him.

   But I found out that he was inside and he-
   once he saw me looking
   he reached

   And it was urgent-

   I couldn't not do anything about it

   And I felt really, really sad.
And I didn't know what to do
but I knew I had to do something
so I just kept talking to him
and saying that I would do something

When I went in there he went back to a little baby.
And that's when I had that dream about it was a mummy.
Somebody gave it to me
and he kept looking at me

And I-

T: Take a deep breath (2)-a deep breath.

C: And I gave him back
and he closed his eyes.

When I gave him back
and he opened his eyes again
and he looked at me.
And it was like a horrible look 'cause he was in agony.

And I didn't know what to do
Then I gave him back
and I couldn't take him anymore.

And um I kept seeing him so many times
so I had to -
and I drew him out
and I said, "I'm going to do something- about you."

And I was really afraid of him.
So I drew him out.
I tried to get the face like it was.

It was horrifying almost.
And it scared me really bad.

And then when I told him I was comin'
and I was going to do something

He rested a little.

And so things started going away a little bit
and I promised that I wanted to know what to do-
I wanted to figure out what to do.

And I was soo shocked still to find that thing living inside of me
Then we had the Christmas break.
And-I felt like I'd run out of gas.

I didn't know what to do.
And uh I was going to lots of meetings
and talking to my sponsor,

and it was helping a bit but still I wasn't going any further

I was sort of losing contact.

T: right, (2) so he's over here?
C: yeah (4)
T: This is him?
C: yeah-

like I was holding him-

I could reach something really, really important-
really important

and I didn't know very much about it yet.

It was too scary to take it out-
it was too scary

But I knew that out here somewhere there was help

and it was a promise of peace and rest and some serenity and tranquility
which wasn't very far away.
It was close enough,

If I figured out how to walk down there,
get there,
reach there,
whatever.

But I can't do that by myself
And so I guess it was like it was stormy inside of me.

And so I was thinking that
there was a vicious wind blew down my valley-
the canyon at times

and broke the connection.
And so now Christmas I really love.
Christmas was sooo-
it's like it was next door for me
and I enjoyed it
but it wasn't like I was totally there.

T: ---- the connection with it was broken I guess
APPENDIX 5: EXPLICATION: 2030-11-1

T: When I look at your drawing do you know what I see? I see a group of people who look as if they have been stranded and it's as if there's a plane going by overhead and they have been waiting and waiting and so desperately want to be seen. (= exploratory reflection; introducer)

C: When you say that, something inside me feels really sad and I choke trying to talk without crying. (= agreement)

I had no idea that there were parts of me, deep inside me, that were pressing against me with such heartbreaking needs. (= awareness insight; key proposition)

I find it very, very unsettling. (= self disclosure, feelings)

It is unnerving to suddenly see that there are unquestionably raw, gaping wounds inside of me that are crying for attention. (= self disclosure, description)

T: You can see it really clearly now and its really close to the surface. (= paraphrase reflection)

C: Yes. (= agreement)

I don't understand my feelings of torment, confusion and sadness. (= self disclosure, feelings)

I just can't get the image out of my mind. I tried to work through it; I drew a picture of my impression because I had to get it out, and I've thought about it over and over again. I've also tried to talk to the baby whose representation you can see in the drawing. (= self disclosure, description).

But as soon as I made contact with this part of me, I became aware of the magnitude and the urgency of the need, and it was too big for me. (= awareness insight)

I don't know how to deal with that much sadness, but I've got to do something because he needs me. He was reaching out for me and it's crucial that I be there for him. I promised I would and I must. (= self disclosure, description)

It felt like I went back to being a little baby. (= self disclosure, feelings)
That's when I had that dream about the mummy - where someone gave me a mummified baby and while it was in my arms it opened its eyes and stared at me with such unbearable sadness that I was afraid so I gave it back and the other people that were there put it back in its case (sobs deeply). (= self disclosure, feelings)

T: This is overwhelming for you. (= reflection)

I can hear the necessity of your sadness but just let go of it a little bit and take a deep breath. (= advisement)

C: The look on the baby's face was really horrible as if he were in terrible agony. It was terrible not knowing what to do. (= description)

I gave him back, but the image of his face stayed with me with excruciating clarity and so I tried to capture the image on paper. (= description)

It was a horrifying image. It scared me and I was afraid of him, but at the same time I felt immense compassion and it was absolutely essential that I help him somehow. (= self disclosure, reaction)

Once I promised to help, he seemed to relax and the feelings receded a bit. (= description)

I need to figure out what to do because: (a) I don't like things that I can't figure out and (b) he so needed my help. (= self disclosure, self characterization)

It was a huge shock for me to realize that there was this big part of me, that I knew nothing about, right inside of me. (= self disclosure, feelings)

And now its very uncomfortable knowing that its there and I can't communicate with it. (= self disclosure, feelings)

Over Christmas we had a hiatus of sorts - I ran out of energy, Christmas distracted me, and I stopped moving. (= description, context)

I feel like I've lost contact with that part of myself. (description, feelings)

T: Is this him over here (points to one of the pictures)? (= question)

C: Yes. (= agreement)
When I was holding him, I knew that there was something really, really important there, but I didn't know what it was. (= self disclosure, reaction)

As much as I need to look at things and figure them out, I am uncomfortable with strong emotions just like my dad was, and I was too afraid to look at this. (= self disclosure, feelings, self characterization)

But, in contrast to my fear, I also had hope that there was help available - that peace and rest were not too far away. (= self disclosure)

It's close, but I can't get there by myself. It's too much for me on my own. (= self disclosure, planning)

It's as if there was a storm brewing inside of me that was building in strength as it swept viciously through the valley (which was more like a canyon in places) and over Christmas the connection was severed by the strong winds. (= description)

I felt disconnected, disoriented and 'not really there'. (= self disclosure, feelings)

T: I hear that there is a broken connection but I'm not sure what that means to you. (= reflection, open question)

C: The storm in the valley was a good thing because if there's bad stuff down there then I want to deal with it. (= description, self characterization)

The high parts of the terrain were pretty good: I didn't feel like life was so bad. But, at the same time, I felt as if there was something not quite right. I was not all I could be. (= self disclosure)
APPENDIX 6: TRANSCRIPT: 2046-12-2

C: ... (2) I'm not I- I don't know if I'm angry or not uh I'm angry in the sense (3) that I let people use my easy and I- I don't like that part of me at all.

T: How bout we bring that part of you in to the room?

C: ((ex)) I don't know how to do that.

T: (pushes a chair over) this is the part of you that lets other people use you, lets other people use you (C:yeah) so you don't like that part of you? (2)

C: No of course not no. (3) But-t-I /

T: what does he look like, that part of you that does that?

C: What does it look like? (T:yeah)(8) uhm (5) what's it look like. Well I think someone who's- (3) I guess it's it's the- ((db)) (9) ((taps finger loudly on shoes several times))

T: Keep breathing Carl.

C: I know.

T: Keep breathing.(10)

T: You've come to something. If you can stay with this it'll be important.(4)

C: I don't uhm (6) I guess it's a part of uhm (3) part of me is most afraid (7) its always gotten me in lots of shit

T: Most afraid of what?

C: It's the part of this that's afraid of being uhm-(5) of not being accepted. (2) uhm. ((ex)) hell.(3) It bothers me because (1) I know most people I meet accept me very well. And- And I don't have a problem (meeting) people. not at all. I'm not afraid to talk to them and. I know not everyone likes me. That's for sure, but it is a part of me that is - I don't know. I don't know it's it's just it's uhm a fear. I guess of not being accepted. Where it comes from, I don't know. I hate it. I absolutely hate it. (3) And its I guess uh (4)

T: So how//
C: Oh I've done some dumb things because of that.

T: You've done some dumb things because of this? that part? (C: oh) and you hate that part (C: major, major, major dumb) you hate that part and you feel that part is the part that's afraid. And it's afraid of not being accepted. And you want (C: yes) you just want to get rid of that part

C: Oh would I like to? yeah.

T: What's what's he doing? Is- Is he? If that part of you was alive right now would he be looking up, looking at you? Would he be trying to get out of the room? What would he be doing?

C: (4) [(don't know what he'd)] be doing. Oh I think he'd be looking up. (2) But why I don't know.

T: Would he be crying? (C: pardon?) Would that part be crying?

C: No I don't think crying. More ((db)) (5) more just saying help ((sigh)) (25)

T: Carl your tears are important. This is obviously important. You can let what's happening to you just happen. That would be good.

C: But I don't know help from who. I don't know (4)

T: So that part of you is saying "help," "help" and you're saying I want you out of my life. I want you away.

C: ((coughing, sob)) (13) (Boy/oh) this is a scary experience. ((sobs)) ((ex)) (32)

Oh, Jesus I didn't even cry when my father died. This is insane. ((cough)) (5)

T: You have a lot of stuff stored up.

C: Pardon?

T: You have a lot of stuff stored up.

C: Can't hear you.

T: You probably have a lot of pain stored up (7) An' it shocks you. (4) This part of yourself shocks you.

C: (5) Oh I'm sure I have lots of pain. ((sobs)) ((ex)) (12) lots. (30)
T: What are you feeling right now?
C: What am I feeling?
T: Yeah.
C: (2) Uh I don't think anything.
T: What's happening in your body? What d' ya feel in your body?
C: Just very weak, very worn out. (7) I just feel that I'm struggling, struggling ahh.
T: And you need help.
C: Pardon?
T: You need help.
C: Yeah. Definitely.(7) Yes. (3) I know I've never ever been able to do this on my own. ((ex)) (35) oh, boy oh if I (10). That's good to- ((coughs)).
T: What's good?
C: (7) It's uhm- (2) It's good to uhm: (7) It's uh I-I-I don't know how to express that. It's good to see that part of me but it's (6) it's it's uhm a part of me that uh has (4) uh how can I put it? - has existed almost like forever (2) has its good sides, has- has more bad sides than its good but it has both. (21) ((ex)) it uhm
T: Carl, I'm wondering if I could just sit beside you for a moment.
C: Sit beside me?
T: Yeah.
C: Yeah. ((Therapist moves)) ((heavy sobs)) (25)
T: You're hurting a lot.
C: Yeah. Yeah. ((heavy sobs)) (11) I'm just (2)
T: I think it is good that you see this part of you. But I also think it's shocking. You don't quite know what's happening.
C: uuhuh. (10) Oh, Jesus Christ.
T: I think you've been storing this sadness for years and years. You haven't cried for
years and there's a lot of losses.

C: No I haven't ((coughs)) I feel guilty. Oh Christ, (3) And I didn't even cry. shit.

((heavy sobbing)). Fuck (16)

T: You didn't even cry at your father's funeral.

C: No ((voice breaks)). No (7)

T: So part of this is saying good bye to him.

C: I don't know. (5)I don't know

T: This seems almost like he's in the room right now too.

C: Oh God no.

T: No?

C: ((heavy sobbing)) (10)

T: His presence is here you've mentioned him several times.

C: (5) In my mind it has.

T: If he was here what would you like to say to him? What do you need to say to him?

C: (2) That I love him - he knows that (voice breaks).

T: Sometimes you need to say things even though people know them.

C: I sure miss him. (5)

T: Is he in that chair now? Could you imagine him there?

C: (3) uh- (4) What would I say to him? Oh God I wish I didn't (2) no. (5) What would I say?

T: Yeah. What would he look like if he was sitting there? You can picture him very easily he was uh

C: Oh yeah. He'd be apologetic. What would I say. uh.

T: Why don't you just say hello?

C: (4) Say hello - oh no - umm (7) No I don't want to bring him back like that. (9)

What would I say if I said anything? (T: yeah). Sorry I didn't see you on Monday.
T: Sorry I didn't see you on Monday?
C: Yeah.
T: He died on Tuesday?
C: Wednesday. He asked me, an' I said, "No, I can't. I'm starting this company. I'm so busy. I don't have five-friggin' minutes. He fuckin' dies on me in two days. Shit that- and I say to him- ahh fuck. I can't say, "no" to people I don't even like, but I say no to him. agghh. That's almost a relief.
T: Did you say it to him? Or do you need to still say it to him?
C: No, I said it.
T: Are you sure? I think maybe you need to say it directly to him.
C: No, but I can't put him there. I can see him in my head.
T: OK let's talk to him in your head then.
C: Oh god. I tried so hard to (T: What do you mean?) Oh god, why didn't I see you? It wouldn't have made any difference. I should've went.
T: You wish you went.
C: I wish I had went. Yeah. I'm sorry I never.
T: Can you say, "Dad I'm sorry I never went to see you on Monday."
C: (heavy sobbing) Oh. Oh. (Voice cracks) "Oh, Dad, I'm so sorry I didn't see you" (Voice cracks). ahh. So sorry
T: So sad. and so sad I think. and so sad. "Dad, I'm so sad, so sad I didn't see you on Monday."
C: No. I don't know if I'm sad if I'm - am I sad? I don't know. I feel guilty. I feel very guilty I didn't go. very guilty.
T: What do you need from him?
C: Pardon?
T: What do you need from him?
C: Ahhh - what do I need from him? I don't know if I n-need anything.
support right now (would be nice) uhm.

T: Maybe ask him for that. "Dad I need your support right now."

C: (6) He can't hear when he's not there.

T: Oh sure he can. The memory - the good feelings. That doesn't go away when someone dies. They are certainly a resource to you. They live on.

C: (7) Could he help me? uhh - naw probably not.

T: Maybe you need him to do something he hasn't done before -

C: Need him.

T: Yeah.

C: Strong. (4) He was not strong.

T: He was what?

C: He was not strong. (8)

T: You don't know that. You don't know what he had to cope with. (3)

C: Well, I see him (7). I see him when I see me. That's-s-s That's almost scary. (4)

T: Could you ask him that? "Dad I need you to be strong."

C: (8) Oh, shit. He would say, "why?"

T: See what this- See what happens for you, when you say that--"Dad I need you to be strong. I need you to be strong."

C: (6) Why I need him to be strong?

T: Yeah. (C: yaahhh) Can you say that to him, to your image of him? "Dad I need you to be strong."

C: (8) ahhh It's uh It's difficult. (T:yeah) Cause I see it an almost critical way which shouldn't be. (3)

T: You seem almost critical of him.

C: Yeah. Instead - instead of I need you to be strong. I'm almost sayin' I want you to be strong- stronger and uh
T: What about saying, "Dad I'm angry at you for not being strong."

C: (3) Oh god. I am that I think. (ex) shit. (6)

T: And for leaving me.

C: I'm more angry for being uhm- not being strong.

T: Can you say that to him? "Dad I'm angry for you not being strong."

C: No. That would hurt his feelings so bad. ahh (9) If I was seven. When I was seven years old - could say it. I was- (5) ((db))

T: Can you be eight?

C: Seven- seven years old.

T: Try this out now. "Dad I'm angry at you!"

C: ((coughs)) No. I'm very angry. (6) You've taken my whole life away. ((heavy sobbing))

T: Can you say that? "Dad, I'm angry that you're not strong."

C: I'm I'm angry at. I'm angry (3). Help. Help. Help (whispers)

T: Say that again.

C: I said, "help."

T: Say that again. (2) Can you say that louder?

C: No. Not my father. I don't know who. I don't know who is there.

T: Can you try saying "help" again?


T: Who's there? Who's there? I don't know. ((db)) (10)

C: ahh. ((db))

T: This is important what's happening. Very important what's happening. (9) Say "help" again and see if you- see what happens.

C: (5) Oh. Oh shit. ((db))

T: Get angry again, angry that he's not strong.
C: (3) I'm (2) Oh my god. (6) Scary.
T: Tell him that "Dad I'm scared."
C: (4) Oh no. No that's that's that's scary.
T: Huh? I can't hear you.
C: The that's not- that's not scary.
T: What's not scary?
C: Uhh. That I- That I just=Oh what a vision.
T: What was your vision?
C: Oh god. I don't fuckin believe it. What a scary thought.
T: What is the thought?
C: (4) I- I- uh I seen Liz and my mother. Oh god. The-the-there was this.
T: What do you see? Carl, What do you see?
C: Well-well they're the same. They're like- They're like the same. Oh shit. The
same identical (2) The same person. Oh god, no.
T: Say that again. Say, "No."
C: Say what?
T: Just say, "My god, no."
C: But, it's true. That's what I see. H-oh I don't want that, no, god. (5) Oh my dad, if
my dad hada been stronger, I wouldn't be here. I wouldn't be in this...(3)
T: Can you say it again?
C: ...situation
T: "Dad I need you to be strong."
C: (2) Oh, I need you to be strong. I've nev- never before.
T: Say that again, "Dad I need you to be strong."
C: (6) I need you to be strong, strong. I've never said this - to you
T: What's she doing? What's she doing? Carl, what is she doing?
C: Oh, she's tellin' him. She's oh- (4) She's just tellin' him what to do, when to do it,
how to do it. Oh, ah no. Why?

T: What do you need to do?

C: Why was she like that? Why? Oh why thiss - Oh my whole body.


C: (5) I almost think- I almost hate. (4) My mother ((cries loudly))

T: Mother what?

C: I'm tryin' to think. (4) I was thirty-eight. Thirty-eight was the first time (6) first

time my mother did say it. I don't remember her ever sayin' she loved me. Never-

never- never- never- never. (2) What an awful thought. (2) Oh I tried so hard to

be so- so opposite of her. (()) so opposite (3) Oh god I wouldn't wanna be like

her.(7) I- I just know- (5) oh oh oh boy

T: Do you want to take a break right now, Carl?

C: (mumbles) I don't know. I'm numb.

T: Do you want to do some more work or do you want to take a break? If you want

we could relax for awhile. Why don't we do that?

C: (mumbles) ((db))

T: Look around the room. Just look around the room. Look at the lamp in the

corner. Over here. Ok?

C: Oh I can't even focus.

T: Ok. Ok. Don't don't bother focusing in. You've been doing alot of heavy

breathing. So you've hyperventilated a bit. That's what's happenend. OK? good. I

want to (stamp) your feet a bit to put- to bring yourself back more into the room.

Are you listening to me?


T: So (stamp your feet a bit) good.(6) Look around the room just to see some

objects, the ceiling. You can look down at the carpet, at the trunk in the corner.

(8) Now look at me.