A COMPARISON OF TWO CASES IN EXPERIENTIAL SYSTEMIC THERAPY: A CASE STUDY APPROACH

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Abstract

The problem of this study was to examine the variables that contributed to a successful case of Experiential Systemic Couples Therapy as compared to a non-successful case using a qualitative, exploratory case study. The main purposes were: (a) to generate concepts that may have led to or hindered therapeutic change, (b) to investigate the process of change in Experiential Systemic Couples Therapy, and (c) to contribute to the clinical understanding of how change occurs in ExST.

The case data sources included documentation (objective measures, situation diaries and reviews of therapy) and video tapes (15 taped sessions from each of the cases). The two cases were chosen using Pinsof's (1988) techniques of Success-Failure Strategy from a larger pool in The Alcohol Recovery Project. A qualitative case study methodology was implemented to discover the major differences between the two cases. Along with these descriptive methods, three sessions from each case were also analyzed using the Vanderbilt Psychotherapeutic Process Scale. The researcher also used Pinsoff's small chunk strategy and analyzed the "best and worst" session of each of the cases. Again a qualitative analysis was done of the sessions, as well as using the Hill (1993) Category Systems.

Key findings from each of the cases were identified and compared. The findings revealed nine major differences which occured between the two cases. The analysis of the cases revealed nine major findings associated with outcome. First, three pre-existing variables were discovered to be associated with the successful and unsuccesful case: client variables, stage of change and length of therapy. Second, three findings were delineated as to why change may have occurred: therapeutic alliance, addressing intimacy issues and practicing opportunities in therapy. Finally, three findings were discovered as to how greater change may have occurred: depth of experiencing, therapist techniques and the completion of a 'story' during a therapy session.

These findings are integrated with current research. As well, implications for future research and clinical practice are discussed. The limitations of this study and it's methodology are also presented.

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CHAPTER 1

INTRODUCTION

Background to the Research Problem

Understanding what constitutes successful marital therapy has been the focus of many research studies. Most of the research has been overshadowed by the demand for outcome studies to discover which of the therapeutic theories would show statistically significant effects relative to control groups or to other therapies (Baucom & Hoffman, 1986; Goldman, 1987; Grigg, 1994; Hahlewegf & Markman, 1988; Halford, Saunders & Behrens, 1993; Johnson & Greenberg, 1985). This inquiry over the years has demonstrated that most psychotherapies can be shown to have efficacy but there are no reliable differences on the therapeutic outcomes between different theoretical models (Jacobson & Addis, 1993). Even the success these investigators have established has come under debate. Jacobson and Addis (1993), in their literature review, point out that in the absence of treatment the improvement rate is so low, that statistical significance is easy to obtain when comparing control groups with treatment groups. In conclusion, Jacobson and Addis (1993) point out that "all treatments are helping some couples, all treatments are leaving substantial numbers of couples unchanged or still distressed by the end of therapy, and all tested treatments appear to have about the same success rates".

Until the past decade, empirical inquires into the subject of how and why therapy succeeds were rare. Recently, the trend in research has been to look at specific factors that are involved in the process of successful treatment. This new research endeavour has been labelled process research, and is still in its infancy, especially in the field of marital and family therapy (Pinsof, 1989). Process research is a critical area of study which seeks to understand the inner workings of therapy and helps link treatment to outcome. As researchers seek to identify, describe, and explain the processes that bring about therapeutic change, change theory can be elaborated and verified as it relates to specific models of therapy (Greenberg, 1986). As the process of therapy is explored, researchers take an in depth look at therapist, techniques and client variables, both during therapy and outside of therapy. Recently, with the methodological improvements of process research,

more studies are also exploring the interaction of the therapist, technique and client variables (Waring, Schaefer, & Fry, 1994).

Process research is an ever growing field that marriage and family therapy researchers are using to understand the therapeutic process and how the therapeutic process is related to client change (Greenberg & Pinsof, 1986). Process research offers theoreticians and practitioners a way to explain how a specific set of interventions creates change in a particular therapeutic context rather than just describing interventions or predicting results (Greenberg & Johnson, 1988). However, there are still only a handful of process studies that have been done in the area of marital and family research (Greenberg, James & Conry, 1988; Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Johnson & Greenberg, 1988, Neumann, 1995; Sweetman, 1996; Wiebe, 1995). In recognition of the complexity of the phenomenon of how change occurs in marital therapy, and the fact that research is still in its infancy in terms of an adequate description and understanding of this process, there is a need for exploratory and discovery oriented approaches to open up the questions of how change occurs. Jacobson and Addis (1993) support this by stating that if couple therapy research is to contribute to the development of effective treatments more discovery-oriented and hypothesis-generating research must be done.

The case study approach has been advocated as an exploratory methodology for studying how multiple variables interact to affect the process and outcome of psychotherapy for an individual (Bergin & Lambert, 1978; Gelso, 1979; Hersen & Barlow, 1976; Hill, 1982) Over ten years ago predictions were made that new research approaches would close the gap between psychotherapy process research and the practice of psychotherapy (Elliot, 1983). Of the six most promising research approaches, Elliot listed systematic, naturalistic case studies as one of them. Hill and Corbett (1993), in their literature review, also recommend case study research as a method for improving process research. Only by studying a case in all its complexity can we begin to discover why techniques are effective (Hill, 1989). As Altman (1988) states "this approach emphasizes holistic units of study of psychological phenomena... and assumes that a holistic system is

best understood by studying the complex set of relationships between its elements, and that the whole is more than the simple aggregation of the qualities of its elements" (p. 264). The goal of this study is to explore the process of change between a successful case and an unsuccessful case of marital therapy to expand theory by use of empirical means.

Research Problem

The research problem in this study is to examine and compare the variables that contribute to a successful case of Experiential Systemic Couples Therapy as compared to a non-successful case using exploratory, systematic case study methodology.

Purpose of Study

The three main purposes of this study are as follows. First, to explore in detail the variables that are different in the successful vs. unsuccessful case of Experiential Systemic Therapy (ExST), thus generating hypotheses of elements that lead to and hinder the change process. Second to empirically investigate the processes of change within ExST, as it has been shown to be an effective treatment for couples in alcohol recovery. Finally, to contribute to the clinical understanding of how change occurs in ExST, thus adding to the applicability and usefulness of certain techniques for clinicians.

Approach to the Research Problem

The approach in this study represents an attempt to discover and build upon theory using case study methodology. With the use of videotaped recordings of therapy-in-practice, this study has examined the process of ExST using contextually embedded empirical research. By employing a systematic case study methodology, matched successful vs. unsuccessful cases (Elliot, 1983) are compared. The case study is a valuable method for looking at the 'how and why' perspective (Yin, 1989) which is the aim of process research. The use of a exploratoy case study design precludes generalisation to other cases, however, through thorough and systematic research methods

this case study can aid in the theory development and the efficacy studies of ExST.

ExST is one of the few therapies that attempt to deal with alcohol in the context of couple therapy. Experiential Systemic Therapy was developed in 1989 by John Friesen, Jennifer Newman, Darryl Grigg and Paul Peel at the University of British Columbia in Vancouver, British Columbia. Grigg (1994) has shown that ExST is an effective individual and marital treatment for alcohol abuse. It was developed as an integrative therapy model which could be used to treat individuals, couples and families suffering from alcohol dependence and related problems.

This study uses an exploratory case study approach that integrates two methods suggested by Pinsof, 1988. The first of these is the Success-Failure Strategy, which creates extreme sub-groups from a group of cases that have been exposed to a certain kind of treatment. The likelihood of finding process-outcome links is maximized in this method. Secondly, the 'Episode' or 'Small Chunk Strategy', which explores smaller chunks of therapy is also utilized in this study. Thus, as well as examining the entire therapy , the researcher examines a "best and worst" session of therapy within each case.

The researcher' s intention is to grasp the essence of change within the therapeutic context. An in depth exploration of the client variables, the therapist variables and the interaction between these contributes to the depth of the study. The researcher first examined 15 taped therapy sessions for each of two couples who completed ExST therapy. Then a further in-depth exploration was done on the "best and worst" sessions from each of the cases. The particular cases were chosen based on a demonstrated improvement or lack of improvement on four outcome measures (DAS, TESCH, SCL-90-R and ADD). The "best and worst" sessions were chosen based on therapist and client post session evaluations.

Definition of Terms

The following terms are defined in order to clarify there usage in this study.

Experiential Systemic Therapy (ExST)

A systemic therapy that integrates family, individual, and couple models in the

treatment of alcoholism. The emphasis of the therapy is on the experiential, symbolic and systemic aspects of therapy. It recognizes the clients experiences in the inter and intra personal domains and involves the cooperative venture between therapist and client.

Process Research

Lambert and Hill (1994) define process research as the examination of therapist and client behaviour and the interactions between the two to explore the variables and mechanisms of change. Process research covers all of the behaviours and experiences of these systems, within and outside of the treatment sessions, which pertain to the process of change (Pinsof, 1988).

Therapeutic Change

Therapeutic change in this study will be defined as a change in client outcome. This study further follows Greenberg's (1986) expanded definition of change (client outcome) to include three types of outcome: a) immediate outcomes, b)intermediate outcomes, and c) ultimate (or final) outcomes. Immediate outcomes are those which are ongoing in therapy and occur within a session itself. These are referred to as "little o's" and contribute to final outcomes (Marmar, 1990). They may even be early indications of positive or negative outcomes (Lambert & Hill, 1994). Final outcomes are referred to as "Big O's" and are measured at post treatment and at follow-up. This investigation will focus on how the "little o's" contribute to the "Big O's" in each of the cases.

Alcoholism

An epigenetic developmental disorder, associated with the abuse of alcohol, the nature of which is determined by genetic mechanisms and intervening ecosystemic factors (Friesen, Conry, Grigg & Weir, 1995).

Successful Case

There were several criteria for defining a successful case in this research. The successful couple revealed above average improvement on the Dyadic Adjustment Scale

(DAS) and the TESCH intimacy questionnaire between pretest and post-test. As well, the male demonstrated average improvement on the Alcohol Dependency (ADD)between pretest and post-test . The male and female revealed improvement on the SCL-90-R as well (see chapter 3 for a complete description). The therapeutic goals set out by the couple at the beginning of therapy, also were met by the end of 15 weeks of therapy. Finally, the client and therapist had to rate the therapy as change producing based on Post Session Reviews and Post Therapy Reviews.

Unsuccessful Case

There were several criteria for defining an unsuccessful case in this research. The unsuccessful couple revealed below average improvement on the Dyadic Adjustment Scale (DAS) and the TESCH intimacy questionnaire between pretest and posttest . As well, there were signs that they didn't make huge improvements intrapersonally (SCL-90-R) or with alcohol (ADD) (see chapter 3 for a complete description). The therapeutic goals set out by the couple at the beginning of therapy, were only partially met by the end of 15 weeks of therapy.

Summary

The background, the research problem, the purpose of the study, the approach to the problem, and the definitions of key terms have been provided in this chapter. Chapter 2 reviews the literature relating to theory and research on ExST, marital and family process research and specifically case study research . Chapter 3 lays out the research design and methodology. Chapter 4 is a summary of the results. Chapter 5 is a discussion of the results, the implications for clinical practice and future research, and the limitations of this study.

CHAPTER TWO

LITERATURE REVIEW

This chapter will review the literature in three areas relevant to the goal of this study. The first area will articulate the theory and research behind ExST. The second area will examine marital process research. Thirdly, case study research will be examined.

Experiential Systemic Therapy

Overview of Experiential Systemic Therapy

Experiential Systemic Therapy (ExST) was developed in 1989 by John Friesen, Darryl Grigg, Paul Peel and Jennifer Newman at the University of British Columbia. The theoretical base for this therapy is an integrated model of therapy designed to bridge the gaps between family, individual and couple models for treatment of alcoholism (Friesen, Grigg, Peel & Newman, 1989; Friesen, Grigg & Newman, 1991). Therapy is a collaborative venture between therapist and client with a focus on the clients experience of inter and intra personal processes. ExST believes the therapeutic system, involving both the therapist and client subsystems, is frequently comprised of complex constituents (Newman, 1995) that factor into the change process. Research validating this method is relatively new but The Alcohol Recovery Project has shown that ExST is an effective individual and couple treatment for alcohol abuse. As the couples in this study underwent Experiential Systemic Therapy (ExST), it is important to provide the theoretical framework and context in which these cases were treated.

Key Dimensions of the Model

ExST theory is based on three key dimensions: systemic, symbolic and experiential.

Systemic Dimension.

The systemic dimension refers to a systemic viewpoint that includes a variety of relationship interactions between parts of self, ideas, problems, people, cultures and nations. Relationships are "the bedrock of human existence" (Friesen, Grigg, and

Newman, 1991, p.2) and any movement in a given system will affect and influence other systems. Therapy becomes a system unto itself and therapists consider themselves participants in the process and thus must remain aware of all the levels of the system they affect and which are affected by them.

Symbolic dimension.

The symbolic dimension is used throughout therapy to provide meaningful ways to describe the totality of the clients experience. Symbols are a metaphoric way to take an ordinary term, name, object or picture from daily life and attribute to it deeper meaning. The use of symbols for exploration help clients go "beyond the grasp of reason", "evoke attitudes and emotions", "include the sensory", "connect to the unconscious" and "bypass reflexive objections" (Friesen et al., 1991, p. 1). A symbolic act can "synthesize behaviour, cognition, perception, and affect" (Friesen et al., 1989b, p.3) into a new experience.

Experiential dimension.

This dimension involves the description and focus on action oriented, here and now experiences for clients.The experiential dimension is a significant factor in facilitating change (Newman, 1995). It is assumed in ExST that experience in therapy can help increase awareness of a clients thoughts, feelings and behaviours. Intensified experience that integrates behaviour, cognition, affect and perception into an integrated whole can lead to heartfelt understandings and changed relationships (Newman, 1995). In ExST these experiences are facilitated through the use of action oriented techniques such as psychodrama, sculpting, enactment, empty chair work and two chair work.

The Four Phases of Therapy.

The four phases of therapy in ExST consist of the following: (a) forming the therapeutic system of trust and establishing a context for change by creating therapeutic goals; (b) perturbing patterns and sequences and expanding alternatives of relating to self and others; (c) integrating experiences of change to one's life ; and (d) disbanding the therapeutic system using evaluation and celebration. These phases do not occur in a linear pattern over time but rather there is a looping back through the phases throughout therapy.

In each session the phases should be evident such that : a) the therapist and client reestablish rapport and choose a focus for the session ; b) interventions will be utilized to upset old patterns, discover and practice new ones ; c) these will then be integrated into their lives and an invitation will be made to practice outside of session ; d) and the session ends with some debriefing, evaluation and celebration.

Transactional Classes of ExST

There are seven transactional classes in which techniques and interventions are drawn from in ExST (Friesen, 1989).

Therapist-Client relationship enabling class.

In this class, the therapeutic alliance is established and maintained throughout therapy. The client must feel understood and safe with the therapist. There needs to be mutual commitment to the therapeutic process on the part of both the therapist and client. This relationship is developed and expressed through empathy, self disclosure and immediacy.

Process facilitation transactional class.

In this class, the therapist focuses on relational patterns and encourages clients to become directly involved with one another during the session. The therapist explores the patterns and the emotions that underlie these interactions and tries to shift the client by using blocking, coaxing, marking boundaries, framing the expression of underlying feelings, etc.

Expressive transactional class.

In this class, techniques and interventions are proposed which make public what was once private through the " exploration, naming and owning of experiences" (p.16). This is facilitated by art, dance, storytelling, baking and metaphor.

Symbolic externalizing transactional class.

In this class, symbols are used to externalize any dilemma, person or thing .

Clients and therapist then discuss it, interact with it, and bring it to life. These transactions include empty chair work, two chair work and symbolic representations.

Meaning shift transactional class.

In this class, therapists help clients expand their alternatives as clients often make sense of their world in ways that leave little room for flexibility. Experiences of the problem are developed that implies a solution or that enhances clients ability to be more compassionate to themselves and others. Reframing, normalizing, circular questioning and regressions are all part of these transactions.

Invitational transactional class.

This class focuses on sharing a concern for client activities in the period between meetings. Transactions help conclude the present therapy session and give the clients opportunity to independently work on goals without the therapist. Some techniques included in this class include: journals, art, penance, practice, homework, letter writing, rehearsal, symbolic quest.

Ceremonial transactional class.

In this class, the focus is on a formal ceremony of recognition and acknowledgement of change. These ceremonies are implemented sparingly but highlight the transformation of the client's in session interaction or the client's interactions in the larger therapeutic system. Techniques used in this class include: celebrations, cremations, wake, rituals, burials, penance, confession, cleansings.

Relational Novelty

Relational Novelty is a term which describes the process of change in the therapy session according to ExST theory. Relationally novel episodes are defined and operationalized by Newman (1995). The definition she proposes is as follows:

Relational novelty refers to the enactment of an atypical way of being in therapy which alters the substantive relational themes represented in rigid cognitive, emotive and

behavioural ways of being with self, others and the presenting problem. Relationally novel episodes follow a general pattern that can be identified as beginning with therapist attendance to client's narratives. The therapist collaboratively delves into a salient aspect of the narrative through a therapeutic transaction. The client(s) consent, either implicitly or explicitly, and the therapist guides them through a deep, intense and novel encounter with self, other or the presenting problem. Generally, this encounter ends with a de-intensification during which the therapist may mark client change, congratulate the client(s), summarize the process or ask the client(s) for their views of the experience. The therapist may encourage client(s) to talk about the experience or the client(s) may do so without prompting. (p.9-10)

She has operationalized this definition through a Relational Novelty Identification Form . This is a check list that attempts to get at six tenets of a productive relationally novel episode: (a) therapist and couple collaboration; (b) intensification; (c) atypical processes; (d) identification of novelty; (e) systemic hypothesis; and (f) relational novelty (Friesen et al., 1991; Friesen, et al., 1989; Newman, 1995).

Overview of Research on ExST

This section will list the empirical research done so far on ExST (Grigg, 1994; Dubberly-Habich, 1992; Newman, 1995; Sweetman, 1996; Wiebe, 1993) There have been a number of quantitative and qualitative studies done on different aspects of ExST.

Quantitative Studies

Grigg (1994) conducted a differential treatment outcome study comparing ExST to a behavioural monitoring treatment called Supported Feedback Therapy (SFT). The study uses a multivariate approach to data analysis. The results of this study demonstrate that ExST is an effective therapy for both individual and couple treatment of alcohol. His data came from The Alcohol Recovery Project (TARP) which is a large-scale, two site research project investigating the effectiveness of three systemic family oriented treatment approaches (Friesen et al., 1995) . His data was therefore drawn from a large sample size

(60 families), varied clinical settings, and a large ecological assessment package. This study opens up the possibility of further research into a new therapy that has both been tested and found effective. Four other quantitative studies have been conducted based on the pool of data from TARP. These studies include: a) domestic violence; b) children of alcoholics; c) treatment adherence, and d) therapeutic alliance. The details of these are not necessary for this study but are mentioned to demonstrate the ongoing empirical research conducted on ExST.

Qualitative Studies

One major criticism of outcome studies is their inability to answer the question of how the therapy was effective (Pinsof, 1989; Safron et al. 1988). Four attempts have been made by qualitative researchers to understand the process of ExST (Dubberly-Habich, 1992; Newman, 1995; Sweetman, 1996; Wiebe, 1993).

Dubberly-Habich (1992) used conversation analysis to examine the enactment of a therapeutic ritual burning. The data was based on a video-taped session of successful ExST couples treatment. Dubberly-Habich discovered the importance of attending to the stages of ritual and some of the themes that contributed to the use of this experiential technique.This research is an example of the type of family process research that centers on the description of the process but does not relate the technique to client change.

Wiebe's (1993) process study, however, was focused on how change occurred in a 15 minute video-taped episode of an experiential activity called symbolic externalization. Again a successful case of ExST was chosen. Comprehensive Discourse Analysis was used to reveal themes that contributed to the therapist and client creating relational novelty (an atypical way of being the creates change according to ExST theory). This study is an attempt to link an experiential technique to in-session change.

Newman (1995) set out to expand on each of these studies by going beyond describing a technique alone or linking a particular therapy technique to change. Her research explored the ExST change construct relational novelty irrespective of a particular experiential technique. Newman did her doctoral thesis on a single case of couple therapy that showed considerable improvement in most aspects of therapy, as shown by pre,post

and follow-up tests. The study attempted an in depth look at two relationally novel events using discourse analysis. Results demonstrated that through the syncretic change process, which is characterized by movement away from distance oriented beliefs and behaviours towards intimacy enhancing beliefs and practices, relational novelty was created. The actual process of atypical experiencing, cognitive understanding, enhanced awareness and the evocation of substantive relational themes enhanced couples intimacy. Newman states that intimacy oriented, or syncretic relational novelty, is one particular type of change that can occur in which the promotion of intimacy is encouraged in relationships which are distant and isolated. The notion of relationally novel events and the impact on couple's experience of intimacy are one key to ExST.

Sweetman (1996) took the research around ExST in a different direction by developing a detailed model of successfully resolved relational impasse events (RI event). She analyzed two videotaped episodes of successful resolution and one episode of unsuccessful resolution. To discover patterns that were present in the successful event and not in the unsuccessful event, task analysis was used. Key components and mechanisms of change in both therapist and couple performance and their interactions were identified. A model of the change process for the RI event was created.

Each of these process research projects have helped delineate specific aspects of change occurring in ExST. Most of these process oriented studies were based only on successful cases of ExST couple therapy, except for Sweetman (1996). This present study attempts to expand on previous research by linking and comparing change to the outcome of both a successful and unsuccessful case of ExST. As well, these studies focused on a particular technique or episode. Although each of these studies attempted to embed their research in the context of the whole therapeutic story, minimal analysis was done of the whole story and why change did or didn't occur. Each event analyzed was successful because of the immediate factors and previous therapeutic and client factors. What is missing in the research conducted thus far on ExST is a look at the entire therapeutic story. As well, given the lack of process research on marital therapy in general, this study starts at the exploratory stage to begin to generate empirically based theory around the process of change. Many of these studies used the case-study methodology with a focus on specific

episodes to answer their particular research question. However, in this study the research question is looking at overall variables that could impact change in therapy rather than a particular technique or one specific change agent. It is a broader question and employs the case study methodology, however, it takes a holistic approach to build upon the lack of evidence surrounding the process of change in therapy.

Marital and Family Process Research

Outcome studies continually demonstrate that people change with the help of professional therapy (Baucom & Hoffman, 1986; Goldman, 1987; Grigg, 1994; Hahlewegf & Markman, 1988; Halford, Saunders & Behrens, 1993; Johnson & Greenberg, 1985). Many studies are also reported that show people modifying behaviour without the help of psychotherapy (Biernakci, 1986; Beale 1992). However, all of these studies fail to explain how people change (Rice & Greenberg, 1984). Process research is an attempt to explain the how of client change.

The four ExST research studies discussed in the above sections demonstrate the growing interest in therapy-as-it-occurs, also called process-oriented research . Through the use of audio and video tapes researchers are able to use techniques like coding systems, client recall and hermeneutical analysis of therapeutic discourse. The following review will survey studies that use the above techniques.

Early work in process research focused on counting behaviours in therapy, for example the frequency of laughter in a family with a schizophrenic daughter (Zuk, Boszomenyi-Nay & Heiman, 1963). However, these studies did not relate these behaviours to the larger context of therapy such as the therapists role or change itself.

Three other studies attempted to improve Zuk's work by relating behaviour to change (Winer, 1971; Waring, Schaeffer & Fry, 1994; Postner, Guttman, Sigal, Epstein and Rakoff, 1971). Winer (1971) studied the increased statements of self-differentiation in couples therapy over time in an attempt to relate this to change. She discovered that as couple's became more differentiated in therapy, the number of "we" , "our" and "us" statements would decrease and the number of "I" statements would increase. Again, this

study focused on whether client's changed over time not on how they became self-differentiated. The therapists role was ignored in this research process.

One study (Waring, 1994) analyzed the process of intimacy development in therapy. Waring and his associates (1994) have done the most recent research on self-disclosure and intimacy. Their hypothesis was that self-disclosure would enhance intimacy. Twenty couples were given 10 weeks of Enhancing Marital Intimacy Therapy (EMIT) and completed the Waring Intimacy Questionnaire (WIQ) both at pre and post test. Videotapes were rated using the Self-Disclosure Scale to statistically analyze the amount, depth, rate and affective manner of couple self-disclosure. These results were compared with the results of the WIQ at post-test to make conclusions regarding self-disclosure increasing levels of intimacy. The study demonstrated that changes in depth of disclosures were associated with increases in perceived martial intimacy. As well, couples whose pattern was one of reciprocally disclosing to one another in a positive fashion increased in intimacy. Again this study is limited in its ability to relate the process to the therapist's role and therapist techniques. Little has been done to test empirically what are effective interventions in intimacy development.

Postner et al.'s (1971) study took a different shift in process research by attempting to analyze both family and therapist behaviours. Eleven families participated in a study that coded familial affective expression and the quality and quantity of both family and therapist participation in therapy. These variables were related to outcome by dividing the families into two groups, those who experienced a good outcome and those who experienced a poor outcome. Outcome was determined via a post-therapy interview and a self-report questionnaire. The study showed that over time expression of pleasant emotions increased in therapy and verbal interactions between family members also increased. Neither of these results showed any significant differences between families and therapy outcomes. Researchers accounted for the inability to show significant differences between outcome and behaviour by saying that the sampling method employed did not tap subtle family changes. Again, this study did not intend to discover how change in behaviour was accomplished by therapy.

More recently there has been an attempt to examine the relationship between therapy

process, therapy theory and client change (Greenberg & Johnson, 1988) . Most of the work in the process domain of couples therapy has been done on emotion-focused-couple-therapy (EFT) (Greenberg, James & Conry, 1988; Greenberg & Johnson, 1988). EFT is an experiential treatment based on a blending of systemic and gestalt theoretical perspectives (Greenberg & Johnson, 1988). Johnson and Greenberg (1988) compared characteristics of successfully treated couples that differentiated from treatment failures. Subjects were selected based on change scores. From a sample of 29 couples, three were selected who showed the least amount of change and three were selected who showed the largest amount of change as measured by the DAS after eight sessions of EFT. They chose the "best" therapy sessions for each couple as identified by post-session questionnaires completed by therapist and client. These were transcribed and analyzed using the Experiencing Scale (Klein, Mathieu, Keisler and Gendlin, 1969) and the Structural Analysis of Social Behaviour (SASB) (Benjamin, 1974). Two characteristics were identified and shown at a higher percentage for the most successful couples vs.least successful: (a) higher levels of experiencing- that is, greater emotional involvement and self-description in the sessions; and (b) autonomous and affiliative actions- that is, more acceptance and less hostility and coercion. Researchers discuss the limitations of the small sample size and the correlational nature of this study. However, this investigation is an important contribution to marital and family process research in that it attempts to explain how certain interventions create change in a given therapeutic context. The questions still left unanswered are the details of the therapists role in facilitating deep experiences and the means by which change events were created during the interactions of the therapist and couple. As well, the selection of "best" sessions for coding removes the therapy from the context of the "best" therapy and limits the holistic picture a researcher gathers.

Thus far this review of the literature on marital and family process demonstrates the evolving desire of researchers to understand how client change occurs in therapy. Limitations to this type of research are numerous. The review shows that coding and rating systems lack the ability to pick up the subtle complexities of therapy and the therapeutic process. Isolating best episodes can limit the scope of the research to the point of not getting a holistic look at therapy. In fact, Wynne (1988) questions the reliance on

quantitative methods to pursue process oriented questions.

Wynne's (1988) overview of family therapy research states that the clinical and theoretical contributions are limited when employing quantitative methodology to understand the change process. His recommendations are that change process research involve exploratory, discovery-oriented, single and multiple case study approaches. Yin (1989) also suggests that qualitative case study design methods be used to address research questions that focus on how an event, phenomenon, situation, state or process came to exist. This call has lead to further studies of family therapy that employ qualitative techniques (Greenberg et. al, 1988; Dubberly-Habich,1992; Wiebe, 1994, Newman, 1995, Sweetman, 1996). Only Greenberg (1988) will be discussed as the others were reviewed in the above section

Greenberg et al. (1988) used 21 client retrospective accounts of critical change incidents to distinguish five significant change processes. The couple's reports were given after eight sessions of emotionally focused couples therapy (EFT). Reports revealed that major change processes were: (a) partners feeling expression leading to a change in perceptions by the listener; (b) learning to express needs; (c) acquiring understanding; (d) taking responsibility for one's own experiences; (e) and receiving validation from the partner.This study demonstrated that clients views can relate to and inform theoretical views of change. The most significant finding they felt was the change process where expression of feelings lead to change in interpersonal perception. Researchers felt this was not discussed in the literature and demonstrated that the expressing of underlying feelings and the resulting interpersonal process are possibly more important than the intrapersonal aspect.

In summary the research available on ExST and process research has lead to the researchers choice of an exploratory, case-study to look at the processes of change in therapy. As Hill (1990) states it is "useful for individual researchers to observe the therapy process and generate testable hypotheses in the service of developing empirically based theories" (p.289). The research on change in therapy reveals the depth and complexity of this phenomena. As well, research recently has taken the view that change is a dynamic

process which is influenced by many varied dimensions and rich events. ExST therapy is relatively new but demonstrates some of the more recent attempts at family and marital process research within the context of it's firm theoretical foundations and efficacy studies. Process research has evolved to a place of exploring the question of how change occurs through the use of qualitative methodology. Recent research also recognizes the need to include more than just focusing on isolated "events" or techniques.

Case Study Research

Case studies have been reported extensively in the field of psychotherapeutic research (Wedding & Corsini, 1979). These published accounts of work with special cases have often relied on the therapist's subjective accounts of what occurred. For case study methodology to become less impressionistic and limiting, standardized measures must be used in conjunction with subjective accounts (Hill, Carter & O'Farrell, 1983).

Early attempts to use standardized measures with case study research provided some important contributions to the understanding of the counselling process. (Frank & Sweetland, 1954; Lennard &Bernstein, 1960; Murray, 1954; Seeman, 1949; Synder 1945, 1947, 1963). One weakness in some of these studies (Frank & Sweetland, 1954; Lennard &Bernstein, 1960; Murray, 1954) was that the researchers did not include outcome measures which precluded comparison with other cases for overall changes. Synder (1945) was the first researcher to compare successful cases with a non-successful case. Criteria for selection of the unsuccessful case was based on the clients and therapists perception that no change had occurred. Successful cases were chosen by three judges who were trained clinical psychologists. The audio tapes were transcribed and analyzed. Then each idea was classified into one of seventeen categories of counsellor statements, or of twelve categories of client's statements. Reliability and validity was improved by having two classifiers make sample checks. The frequency of each category in the unsuccessful case were compared by means of chi squares with those in the successful cases. The results showed little tangible differences between the counselor's role in any of the cases. The client's

statements showed slightly clearer indication of differences between the successful and unsuccessful cases. However, the frequency of certain categories is really only indicative of the unfavourable outcome rather than the nature or cause of the failure. The researchers turned to a more qualitative reading of the protocol to get an answer to the question of, "why one case was unsuccessful ?". They concluded that the client's negative factors were the biggest hindrance to improving in counselling. This early study reveals: 1) the need for better selection of cases based on pre-selection criteria and outcome measures; 2) the need for both objective analysis and subjective description; and 3) the need to understand the interaction between the client and the counsellor.

Strupp (1980) conducted a series of systematic case studies comparing success and failure in time-limited psychotherapy. The aim of the research was to gain insight into the variables that promote or alternatively impede psychotherapeutic change. In three different comparisons, Strupp compared two patients who were treated by the same psychotherapist for similar issues and under comparable conditions. Strupp attempted to control for variables such as age, sex, education, marital status, therapist and problem. All the male patients were university students who suffered from anxiety , depression, and difficulties in relating comfortably to peers. Assessments to determine successful vs. unsuccessful cases were made by means of a comprehensive battery that provided evaluations from the perspective of a) the patient, b) the therapist, and c) the independent clinician.

Strupp's (1980) study then conducted a detailed study of two contrasting dyads using a variety of outcome measures and process variables. The outcome measures included: a) MMPIs taken by the patient at intake, termination and follow-up; b) video-taped assessment interviews conducted at similar points ; c) global change ratings completed by patients, clinicians, and therapists at termination and follow-up; and d) ratings of target complaints by patients , clinicians, and therapists at beginning and termination. The process measures included: a) interviews with the patient and the therapist about the therapeutic experience and a clinical analysis of these; b)patients response to an adaptation of the Barrett-Lennard Relationship Inventory at third and final sessions; c)ratings of the third session of therapy by two independent clinical raters using the Vanderbilt Psychotherapy Process Scale (VPPS); and d) a clinical study of selected

sections of audiotapes from the session.

The outcome measures showed a distinct difference in change results between the successful and the unsuccessful case. Each of the results from these measures are displayed and discussed. One particular weakness of these outcome measures are that the successful client stayed in therapy for more hours than did the unsuccessful client did.

The process variables are written up in a case study report form first describing the course of therapy in each case, and then analyzing and discussing the comparative data between cases. The cases were compared on patient characteristics, ratings on the Vanderbilt Psychotherapy Process Scale, patient perceptions, and therapist variables. To assess the differences in patient characteristics and behaviour, a list , shown by other authors to coincide with the criteria of suitable personal factors for short-term psychotherapy, was created. The most objective measure, the VPPS, is an 85 item instrument that characterizes the patient's and the therapist's behaviour during the hour. Two independent judges rated the client and the therapist on a scale ranging from 1 (not at all) to 5 (a great deal). When comparing the two cases any items that showed more than a 1.5 difference were listed. Qualitative data was used too supplement the results and make connections between the interactions of the client and therapist variables. Patient perceptions were explored based on the Barrett-Lennard Relationship Inventory. The therapists were observed by clinical observers and a qualitative evaluation was done for each case.

The results are discussed within the understanding that these are only inferences and it is impossible to achieve certainty on how the changes came about. In comparison one, Strupp (1980a) suggested the following findings: a) the successful client made a meaningful connection to therapy and the therapist , the unsuccessful client didn't; b) there are clear differences in individuals ability to profit from therapy but these have less to do with mental health and more to do with their ability to participate in particular therapeutic tasks.; and c) the therapist was consistent throughout therapy with his behaviour and his techniques for both cases, the successful client responded well to this the other client didn't. In comparison two, Strupp (1980b) found similar findings in that the treatment outcomes were a function of the quality of the therapeutic interactions, which in turn was

importantly determined by the patient's respective character structures and manner in which they related to therapy. For example the highly resistant patient was not as ready for the demands of psychoanalytic therapy but also therapists may react adversely to a patient's negativism and hostility which, in turn, may contribute to a negative outcome. In comparison three, overall results again demonstrated that the therapeutic outcome was related to a patient's ability to connect to the therapeutic relationship and to work on therapeutic tasks. This particular study also revealed even more clearly that one of the major deterrents to the formation of a good therapeutic relationship was the therapist's personal reactions. Every time a client responded with hostility via transference, the therapists tended to respond with counter hostility in the form of coldness or distancing. The entire study, across all therapists, failed to reveal a single instance in which a difficult patient's hostility and negativism were successfully confronted or resolved.

These studies provide an excellent model of one type of systematic case study. However, there are a few criticisms with their research. First, only one of the sessions was analyzed intensely (third), thus data on patient and therapist variables during all other sessions were not available apart from the qualitative conceptulizations from certain sections. Secondly, most of their data focused on variables involving the process as it related to client and therapist variables. The authors make mention of the interaction between these variables only briefly as they describe the course of therapy and the possible outcomes but they do not assess these in any formal way. One of the major suggestions from these studies refers to the necessity of understanding the interaction of the therapist and the client variables and how this interaction affects success. The results of their comparisons make it clear that the interaction of these variables are a significant area of study if one is to understand how and why change comes about.

A recent case study (Wiseman, Shefler, Caneti, & Ronen, 1993) compared a successful and unsuccessful case of Mann's time-limited psychotherapy. This study improved on some of the problems with Strupp's (1980) design. The researchers combined an events approach and Strupp's design to conduct their comparison. The clients were two patients treated by the same therapist during a project conducted at the University of Jerusalem. One client (B) showed greater improvement than client (A) as assessed by the

Target Complaints Scale, the Brief Symptom Inventory and the Goal Attainment Scale. Each of the 12 therapy hours from each case were transcribed. These were rated by three judges independently to identify and demarcate the central issue (CI) events. The CI events were copied verbatim on separate cards and these were then rated using the Vanderbilt Psychotherapy Process Scale (VPPS). Inter-judge reliability on the VPPS subscales ranged from .38 to .85. After the raters completed their independent VPPS ratings of the data, they discussed disagreements until a consensus was reached. The definition Wisemen et al. (1993) used for a CI was an event that begins when the patient, or therapist mentions the central issue that was presented at the beginning of therapy and ends when the patient or therapist changes to another topic. According to this definition of a CI event, 23 events were identified in total. Two statistical procedures were conducted on the data, the Wilcoxon test and a Multiple Regression Analysis. As well, an intensive analysis occurred of 10 events to delineate the four components of an event, that is, marker, therapist operations, patient performances, and event outcome.

As a result of this study a preliminary model was developed to identify an event in Mann's therapy. Also the comparison of cases using VPPS ratings across the three phases of treatment (initial, middle, and termination) showed a rise in patient participation in the successful case, and a decline in patient exploration in the unsuccessful case.

This study combines the use of two methodologies in a helpful context specific approach. It improved on Strupp's study by intensely analyzing important parts of the actual therapy through the transcripts of the central issues. In the present work, the case study methodology revealed the central themes and these were transcribed and analyzed.

There are a few criticisms with their research. First, they make some assumptions about the CI's as being essential change agents. Secondly, the researchers then perform statistial analysis on a limited number of events. Thirdly, most of their data, like Strupp (1980), focused on variables involving the process as it related to client and therapist variables. In the preliminary event identification they begin to make mention of the interaction of the therapist and the client variables and how this interaction affects success, but admit more research is necessary to make the model clear. The present study attempted to take a more holistic look at the therapy to see how client, therapist factors and the

interaction of these affects change. Finally, the CI's were rated from transcripts rather than the video's, which significantly decreases the accuracy (Suh et al, 1986). This present study uses the VPPS with actual video tapes.

Hill, Carter and O'Farrell (1983) also used a systematic case study involving a variety of outcome and process variables to understand the effective ingredients in the counselling process of one client. The client was a university student who complained of anxiety, and interpersonal problems with a fiance and her mother. She was treated for 12 sessions using time-limited counselling. The outcome measures in this study included the Hopkins Symptom Checklist, the Tennessee Self Concept Scale and the Target Complaints Scale. Each of these scales was administered at pretreatment and at three points after treatment. As well, satisfaction with counselling and amount of improvement were rated by the client at three points after treatment. Three of the four measures demonstrated some level of improvement at post treatment and at follow-up, although many of the gains by seven months seemed to have disappeared. There was no improvement on the Tennessee Self Concept Scale.

The following process measures were used to analyze all twelve of the transcribed sessions: a) Counsellor Verbal Response Category System (CVRCS); b) Client Verbal Response Category System (CVRCS); c) Mahl's Non-ah Speech Disturbance Ratio (a measure of anxiety); d) activity level as measured by ratio of number of words spoken by the client to the total number of words spoken by both client and counsellor; and e) Counsellor intentions. As well, a Therapy Session Report was filled out at the end of every session by the therapist and the client.

To get a more detailed description of how change occurred, a further intensive analysis was done of the " two best and two worse" therapy sessions. These sessions were identified based on the Therapy Session Reports, where results revealed that there was relative consensus between client and counsellor. First, the sessions were transcribed and four different instruments were applied to each transcript. The four different instruments included the VRCS for client and counsellor, the counsellor intentions and the activity level. Secondly, a qualitative, descriptive analysis of the four sessions was done. Thirdly, comments on the post session questionnaires about significant events and issues within

each session were compared. Finally, a sequential statistical analysis was completed which determined the immediate effects of counsellor verbal behaviour on client responses.

The results from the intensive analysis provided interesting data for greater understanding of the client and technique variables. Four observations were made about client variables but only one of the observations connects it to a counsellor variable. First, counselling was considered too brief for this client's personality and complaints. Second, the client had a very high baseline of story-telling behaviour and seemed unable to engage in experiencing or insight.Third, the client moved from description at the beginning of sessions to more experiencing by the end of the session but she always went back to description at the start of each session. The fourth observation was that insight only began to occur in the second half of counselling and only sparingly. The client seemed to remain in the self-exploration and understanding phases of therapy. This was also the pattern of the counsellor as they seemed to aim the first part of therapy at helping the client self-explore and only in the second half did they use more interpretation, confrontation, intentions of insight and reframing. Direct and indirect change attempts only began to occur towards the end of treatment.

It was suggested through the integration of the different process measures, that interpretations were the most effective change agents. The authors believe there were four mechanisms that contributed to the helpfulness of the interpretations: a) unconditional acceptance of the client by the counsellor; b) inappropriate behaviour was pointed out and appropriate behaviour was reinforced; c) the client was encouraged to engage in a process that examined how and why she behaved; and d) the process itself gave her permission to behave differently.

The researchers are to be applauded for their commitment to the empirical, comprehensive analysis of psychological techniques. However, Lambert (1983) sights three criticisms about this case study: (a) inadequate assessment of change using objective measures; (b) failure to employ a theoretical framework for the case analysis; and (c) inappropriate choice of client to study. This present research attempts to address these criticism by assessing change using numerous measures, comparing opposite cases and employing a theoretical framework (ExST) within which the case is analyzed. The choice

of client was limited by the nature of the TARP project and the limitations of this will be discussed in the research.

Hill (1989) went on to conduct eight more case studies of brief psychotherapy. Her underlying belief was that therapist techniques are responsible for client change. Thus the case studies were set up with the purpose of discovering the impact of therapist techniques.All the clients were females who suffered from depression or anxiety. Each of the case studies were again systematic, using objective and subjective measures to collect data. Process measures included the Hill Counsellor Verbal Response Category System, the activity level, the Helpfulness Scale, the Client Reactions System, the Client Experiencing Scale, the Client Post-Session Questionnaire, the Therapist Post-Session Interview, the List of Helpful and Hindering Components in Psychotherapy. Some of these used objective raters, others gave direct feedback from client or therapist. The relationship between the client and therapist was measured using the Working Alliance Inventory. Outcome measures included the Session Evaluation Questionnaire, the MMPI, the Hopkins Symptom Checklist-90-R, the Tennessee Self Concept Scale the Target Complaints, the Hamilton Depression and Anxiety Scales, Post-therapy interviews of client and therapist, a six-month client follow-up interview, and a one-year client follow-up questionnaire. The analysis of the cases were broken down into the descriptive measures, the outcome and the therapist techniques. The descriptive measure scores were compared to the mean for all eight cases. The study was extensive and rigorous using transcripts, video playback and numerous measures. The use of multiple cases greatly increased the external validity. Comparison of these cases also provided a stronger basis for making causal statements about the effects of the therapeutic treatment. Further the examination of multiple perspectives on the cases helped reduce bias.

Hill's (1989) results showed evidence that therapist techniques were the most helpful change agents in therapy for cases 1,5, and 6. For case 7 and 8 therapist techniques were more helpful than other variables in therapy. Cases 2, 3, and 4 showed evidence that therapist techniques were helpful change agents. Specifically, the research showed that therapist disclosures were among the most helpful technique and also lead to

the highest levels of client experiencing. Therapist interpretation was also shown to be helpful in every case, which supported past empirical and clinical literature. Other techniques that were helpful in some cases were open questions, direct guidance, confrontation, paraphrase and approval. Other cases showed that paraphrase, direct guidance and confrontation were not that helpful. Closed questions were not found to be helpful in any of the cases.

Summary

The literature demonstrates a growing interest in process research. Continued research in the area of marital and family therapy is necessary, specifically as it relates to factors that delineate how change occurs. Recommendations encourage the use of exploratory case studies that systematically use subjective and objective analysis to further our understanding and theoretical perspectives on how change occurs.

In response to this recommendation, this present research focuses on the entire therapeutic story as well as a small episode of therapy, thus embedding it in context. Using an exploratory case study methodology that employs numerous analysis, factors that discriminate between a successful case of ExST and an unsuccessful case of ExST will be delineated.

CHAPTER 3

METHODOLOGY

The literature review demonstrated the utility in using a qualitative research design for investigating complex processes in therapy. As well, the literature reveals the lack of research done on the process of couple's therapy, thus the case study methodology is a helpful choice of design to answer the exploratory nature of the research question. This chapter will describe the design of the study, the subject selection, the data collection procedure and the method of data analysis.

Research Design

The following section will describe the design chosen for this study. Hill (1982) suggests four methods for measuring change, three of which are used in this study. The first method is to use a non-quantitative model that would rely more on clinical judgment. Hill states that this is especially valuable at an early stage of theory building. She suggests that an alternative to getting rid of bias is to combine the more traditional quantitative data (frequency and ratings) with the qualitative data. This research has done just that in choosing the case study methodology which integrates qualitative and quantitative data.

The second method she suggests is the analysis of a matched successful vs. unsuccessful case.This method is followed in this study according to (Pinsof, 1989). In this method quality is assumed based on outcome rather than judgment of observers. As well, by dividing cases one could determine if some variables occur more frequently in the successful vs. unsuccessful cases. This present research analyzed a successful and unsuccessful case from a larger sample.

The third method of examining the change process, the critical incident analysis, was used in modification, as this research used small chunks (the best and worst session of each case). Hill (1982) admits that the problem with critical incidents are that they lack contextual framework and that change does not occur from any one event. Rather there is a build up to that intervention and also a follow-through. She suggests a combination of critical moments analysis with analysis of preceding and subsequent behaviour could

resolve this issue. Thus looking at the small chunks of "best and worst" session within the entire therapy can enrich the discovery of how change occurs.

Following are specific descriptions of each of these methods as they relate to the present research.

Case Study

> The definition of a case study design as set out by Yin (1994) is as follows:
> A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. As well, the case study inquiry copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis (p.13).

Case studies have been criticized for their inability to establish causal relationships because of the interconnection of all the variables and the lack of controls with unstructured treatment (Hill, 1989). However, Kazdin (1981) states three criteria for drawing valid inferences of case studies: (a) a careful review of process data, (b) competing hypotheses accounting for change are examined, and (c) multiple cases are used. This case study analyzed a variety of process and outcome measures, using purely qualitative data as well as category systems and scales. The data was explored from a number of different angles, including client and therapist variables, the techniques and interventions used, and the interaction of these. As well, two cases were analyzed. Specifically, an embedded multiple-case design was used to examine a successful and unsuccessful case of marital ExST therapy.

The rationale for using case study methodology is based on the following three ideas: (a) comparing two unique cases with different outcomes will aid in the understanding of the process of change in couples therapy ; (b) a comprehensive case study can provide the detail necessary to further the understanding of marital therapy; and

(c) research is in its infancy on the process of marital therapy, thus these case studies can contribute to theory-building and future research.

The Success-Failure Strategy

To further increase the validity of the case study the Success-Failure Strategy was utilized in choosing the cases (Pinsof, 1988). The Success-Failure Strategy rank orders a group of subjects on preselected outcome variables at different significant points of therapy. The cases that fall within the low end of the distribution (therapeutic deteriorators) are compared with the cases at the high end of the distribution (therapeutic improvers) (Sweetman, 1996). Homogeneity of the cases is an essential element to maximize when using this strategy. Thus it is important that all cases are exposed to the same treatment, are similar demographically and diagnostically, are similar in presenting problem and interpersonal context and are treated with the same therapist. All of these were true of the cases used in this case study.

Using the success/failure strategy maximizes the chances of discovery by using extreme-group analysis (Pinsof, 1988). The advantages of using this type of design are numerous: (a) it loads the dice in favor of uncovering process-outcome strategy; (b) it creates extreme groups exposed to similar treatment; (c) it maximizes the extent that nonlinear process-outcome relationships are likely to be found; and (d) it would also elucidate linear process-outcomes (Pinsof, 1988).

The cases selected for this study met these criteria. Successful vs. unsuccessful outcomes were based on four instrument measures (Dyadic Adjustment Scale, The Tesch Intimacy Scale, The Alcohol Dependency Data Questionnaire and the Symptom Checklist-90-Revised). The successful couple revealed marked improvement on the first two measures from pre to post test as compared to the rest of the sample. Improvement also was shown on the other two scales. The unsuccessful couple revealed marked deterioration or lack of improvement on the first two measures as compared to the rest of the sample. The female from the unsuccessful couple also revealed a lack of improvement on the SCL-90-R.

The Episode or Small Chunk Strategy

The Episode Strategy is an attempt to analyze small chunks of therapy, specifically looking at "little o" outcomes. Attempting to link "Big O" outcomes to some dimension of therapy has been the point of most outcome research and has been widely critized (Gottman & Markman, 1978; Hill, 1982; Stiles, 1988). By breaking therapy down into "little o's", researchers can meaningfully discuss the outcome of an episode.

The three main reasons in this study for choosing the "best" and "worst" session are: (a) process-outcome links can be discovered in a smaller unit ; (b) small-chunk results are meaningful and valuable, (c) looking at embedded units serves to focus the case study and allow for the use of more objective measures, and (d) analyzing smaller units can illuminate and reinforce the differences discovered in the overall therapy sessions.

Procedure

All data used will come from The Alcohol Recovery Project (TARP), in which 150 families participated in 15 sessions of Experiential Systemic Therapy or Supported Feedback Therapy (SFT) for the treatment of alcohol dependency. The study was structured according to a repeated measures experimental group design. All counselling sessions were videotaped.

Project Description

Phase I of this project began in 1987 with the development of treatment manuals and the training of alcoholism therapists in ExST and SFT. Phases II began in 1989 and ended in 1994 and involved the data collection. Phase III began in 1994 and is continuing. This phase includes quantitative and qualitative data analyses. The present study is part of the ongoing qualitative research.

Subjects

The following section provides the criteria for selection of the subjects in this particular study. First however, a description of the larger pool of subjects that participated in The Alcohol Recovery Project (TARP) is discussed. Secondly, a description is given of

the selection of one successful case and one unsuccessful case out of TARP.

The TARP selection of subjects.

The following inclusion criteria were used for selecting subjects: (a) male alcoholics who had consumed alcohol with the last 6 months and their partners who were not alcohol abusers; (b) between the ages of 21-65; (c) experiencing marital stress but desiring to preserve the relationship ; (d) parenting at least one child 9 years or older; (e) trying to recover from alcohol; (f) willingness to complete 15 sessions of treatment over 15 to 20 weeks; and (g) willingness to complete 5 periods of assessment including screening, pretest, mid-test, post-test and follow-up in 15 weeks. Families were excluded if one or more of the following exclusion criteria were evident: (a) the father's alcohol problem with alcohol not being severe enough for him to exceed the critical cut-off scored of five on the Michigan Alcoholism Screening Test (MAST); (b) the mother's use of alcohol was severe enough to exceed the cut-off score of four on the MAST; (c) both father and mother scored above 99 on the Dyadic Adjustment Scale indicating negligible marital distress; (d) evidence of dementia, suicide risk, psychotic disorders or chronic medical conditions as measured by high scores on the Symptom Checklist-90 (Friesen et al., 1994).

Couples were randomly assigned to one of three treatment modalities: Experiential Systemic Therapy (ExST) couples, Experiential Systemic Therapy individuals, or Supportive Feedback Therapy (SFT). All three treatments are systemic in nature. Each therapy session was video-taped. At pre- treatment, mid-treatment, post-treatment and follow-up, couples filled out over 30 different measures to give an ecosystemic assessment of each family. As well, couples completed weekly situation diaries. The TESCH Intimacy questionnaire (Tesch, 1985) and the Dyadic Adjustment Scale (DAS) (Spanier, 1976), the Alcohol Dependency Data Questionnaire (ADD) and the Symptom Checklist Revised (SCL-90-R) were all filled out at pre, post and follow-up times.

Selection of subjects for this study.

Selection of the couples for this study came out of the TARP pool. The criteria

was set up to select the couples in which one or both spouses deteriorated or improved the greatest amount on marital issues and other factors. The marital measures were given highest priority in the selection of the cases because the researcher was particularity interested in the process of marital therapy. Thus the cases were selected based on the following selection rules:

1. Cases chosen from the TARP sample had the same therapist and used Experiential Systemic Couple's Therapy. These limitations narrowed our selection of cases but were essential variables to control.

2. One couple showed above average improvement on the TESCH and DAS scores from pre to post test based on Z-scores. Improvement on the ADD and SCL-90-R from pre to post test based on Z-scores had to be shown as well.

3. One couple showed below average improvement on the TESCH and DAS scores from pre to post test based on Z-scores. The scores on the ADD and the SCL-90-R from pre to post test based on Z-scores were looked at but changes on these were not taken as first criteria. Couples who did not improve much on these scores were considered first in relationship to all the other criteria.

4. The highest possible gain scores of the sample and the lowest possible gain scores of the sample were chosen, from the TESCH and DAS. While checking to be sure they met the criteria listed above in #2 and #3.

5. Male TESCH and DAS scores were selected first. The female scores demonstrated a similar direction of at least a .5 standard deviations above or below the mean (z-scores).

Using the following the above procedures, the following couples were chosen. Couple A (Bill and Ann) are the couple chosen who showed improvement. Pre-treatment DAS raw scores for Bill and Ann were 60 and 59. Post-treatment DAS scores rose 38 points for the male and 61 for the female (raw: male- 98, female- 120, z-score male: 1.4; female-2.3). Pre-treatment TESCH raw scores for Bill and Ann were 179 and 135 respectively. The post-treatment TESCH scores for Couple A rose 35 points for the male and 78 points for the female (raw: male-214, female: 213 ; z-score male: 0.9; female: 2.1).

Bill's raw scores, from pre to post treatment, for the ADD decreased from 72 to 46. Bill's raw scores, from pre to post treatment, for the SCL-90-R decreased from 103.1 to 47.9. Sue's raw scores, from pre to post treatment, for the SCL-90-R decreased from 73.7 to 50.4.

Couple B (Sam and Donna) are the couple chosen who showed less improvement. Some of the scores for couple B actually deteriorated in therapy. Sam and Donna's pre-treatment DAS raw score was 110 and 86.2. Post-treatment scores for the DAS show Sam's score decreasing by 14 points to 96 and Donna's by 22.5 points to 63.7 (z-score male: -1.5; female: -1.6).Sam's raw score on the TESCH decreased by 65 points from 219 at pre-treatment to 154 at post-treatment. Donna's TESCH raw score decreased by 7 points from 183 at pre-treatment to 176 at post-treatment (z-score male: -2.7; female: -.5). Sam's raw score on the ADD and SCL-90-R showed some improvement by the end of therapy, however, in therapy by the final session he was still drinking regularly. Donna's score on the SCL-90-R deteriorated significantly in therapy, (raw-pretest: 77.3; post-test: 102.4; z-Score: 2).

A number of other factors in the selection of the cases help decrease the extent to sampling variables, and increase the extent to which process variables are likely to account for outcome variance (Pinsof, 1988). In looking at the entire TARP sample the whole group was fairly similar demographically and diagnostically. The smaller sample, the cases were chosen from, was even more homogeneous: 1) presenting problem of alcohol and marital distress; and 2) interpersonal context was a couple. The two cases selected for this study demonstrate homogeneity in even more areas. For example, the therapist in each case is the same and is one of five ExST therapists who participated in TARP. She is a white, Anglo Saxon background who was in her early 50's at the time of the project. Both cases were conducted out of a government alcohol and drug agency in an urban area of British Columbia. The developmental stage of the family is similar as both have children in there early 20's that were the wife's from a previous relationship. Thus each couple has issues with the blended family and divorce. Finally, the couples are similar in economic status as demonstrated by the similar job the man in couple A shares with the women in couple B and the concern over finances expressed by each couple.

Therapist Selection

The therapist involved in the project were at the Master's level or higher in counselling psychology or related field. All of the clients had at least three years of experience working with clients exhibiting alcohol and drug dependencies. Each of the therapists in the study went through an intensive 3-week training, followed by 2 weeks of additional training and then videotaped supervision. Weekly supervision was given to the therapist by experts in their treatment modality. Each treatment was carefully recorded in manuals and the findings of the adherence study revealed that treatment was delivered as planned in the respective manuals.

Therapist variables did not influence the selection of the subjects as key therapist variables were found to be held constant across treatment cases. Friesen et al. (1995) report a high degree of treatment adherence for all therapists involved in this study. A high degree of treatment adherence refers to the fact that ExST treatment was delivered as outlined in the treatment manual by all therapists. In addition, no treatment effects were found to be associated with therapist or gender of therapist.

Selection of the "Best and Worst" sessions

Hill et al. (1983) use a therapy session report to reveal a consensus between client and therapist as to the best and worse session. Therefore, the results from the Post Session Review were analyzed and revealed that the therapist and the client generally concurred on which of the sessions were the best and which were the worst. A low score on the PSR demonstrates a high degree of change occurring, the lowest score obtainable being 5. The scores for the PSR's were tallied separately for the therapist , the mother and the father. These were then compared to come up with a consensus of the "best and worst" session. Session number one was not included in the tally because this session is generally an information and rapport building session, and often doesn't begin "working" on issues. For Case A the review revealed that the therapist and clients rated session 12 as one of the top two best (Therapist: session 12=7, session 6= 7; Male: session 12=6, session 7=7; Female: session 12=10, session 10= 9). The researcher also rated the

sessions during viewing and session 12 was noted as one of the best three sessions. Thus session 12 was chosen to analyze as the "best" session. Session 8 was chosen by each participant as one of the top two worse sessions (Therapist: session 8=12, session 5=11; Male and Female: session 8=15, session 4=16). Thus session eight was chosen to analyze as the worse session. It is clear which sessions fell in each category, however, it does not mean that the worse sessions were hindering, simply that they were not as helpful or as effective as the others. For case B, the review revealed that the therapist and the clients included session 14 as one of the top two best (Therapist : session 14=5.5, session 8= 5; Male: session 14= 7, session 10=5; Female: session 14= 5, session 4=5). The researcher also rated session 14 as one of the top three. Thus session 14 was chosen to analyze as the "best" session. Session 2 was chosen to analyze as the "worse" session as it was rated by each participant as one of the top worse sessions (Therapist: session 2=13, session 3= 14; Male: session 2=13, session 6=32; Female: session 2=25, session 3=30).

The Origin of the Data Record

The data for this case study included video-tapes and documentation. Video recordings of two complete therapeutic cases, each completing 15 sessions, one hour a week. In total there was 30 hours of taped therapy sessions. Couple A's recordings were relatively clear, however, approximately 5 minutes total in the 15 sessions were inaudible. Couple's B recordings were also relatively clear however, tape number 9 and 10 were poorly recorded and in certain parts only the clients' voice is audible. For the purpose of the present study the entire 15 sessions of each case was reviewed at least seven times. During the data collection , the researcher transcribed certain sections of each session. As well, the "best" and "worst" session from each case was transcribed in its entirety and edited for accuracy.

Numerous documentation was part of the data record. Throughout therapy each spouse was required to complete a number of questionnaires. These questionnaires were given a pre-treatment, mid-treatment , post-treatment and a 15 week follow-up to assess the client's progress at each of these points. As well, the spouses and the therapist were asked to complete Post Session Review Forms (PRS) immediately following the session to

measure its effectiveness. At completion of the therapy, the couples and the therapist had to complete the Post Therapy Review Form. Couples were also asked to complete a "weekly situation diary" each week to assess the activities and thoughts of the client outside of therapy.

Measures

The TARP project used a variety of measures to assess client behaviour and change in relationship to the therapy process, marital and intrapersonal functioning, and alcohol dependency.The results of three of these measures were used to determine success or non-success in this case study. As well, the study used three therapy measures that will be included in the data collection.

For the purpose of this study it was important to rank the group of couples on only a few outcome measures to get a clear distribution of cases at the low end and the high end. Experiential Systemic Couples' Therapy has as a very clear goal to improve the marital relationship. Thus the researcher felt it was important to select the outcome measures that would reveal changes in the marriage relationship as criterion for determining success. It was also important to look at the measures of alcohol dependency for two reasons: 1) this is a presenting problem in this project ; and 2) research has shown that the abuse of alcohol significantly impacts intimacy in a marriage (Nurse, 1982). Finally, the score on the SCL-90-R is also significant because it assesses intrapersonal distress.

Dyadic Adjustment Scale.

The Dyadic Adjustment Scale (DAS, Spanier, 1976) measures marital satisfaction. It is a widely used self-report questionnaire consisting of 32 items which can be scored as a index of global marital adjustment (total score) or can be broken down into four subscales. Scores on the instrument range from 0 to 151. The four sub-scales include: (1) Dyadic Consensus, which measures couple agreement on relationship matters; (2) Dyadic Satisfaction, which pinpoints the degree of satisfaction and commitment to the relationship; (3) Dyadic Cohesion which measures couple togetherness; and (4) Affectional Expression, which reflects the degree of respondents satisfaction with the expression of sex and

affection. Most items involve a 5 or 6-point Likert-type scale defining the amount of agreement or frequency of an event. A raw score of 97 or lower places couples in the distress category and a raw score of 114 is considered normal for happy couples. A larger score at post-treatment from pretreatment would indicate improvement.

It is, at present, the instrument of choice for the assessment of marital adjustment. The DAS has an internal consistency of .96 with reliability of .73 for the Affectionate Expression sub-scale, . 86 for the Cohesion sub-scale, .90 for the Consensus sub-scale and .94 for the Satisfaction sub-scale.

TESCH Intimacy Scale

The TESCH is a measure of marital intimacy. It is a 57 item questionnaire that has clients rate statements about their relationship on a six-point Likert scale (Appendix 1). There are three subscales of the questionnaire. Romantic love is the first scale and is defined as love and emotional expression, physical intimacy and interdependence. Supportiveness is the second scale and is defined as respect, helpfulness and acceptance. The last scale, communication ease, is defined as being oneself, clear communication and lack of ambivalence towards relationship. An improvement from pre to post test is shown with a higher score.

Symptom Checklist Revised

The Symptom Checklist Revised (SCL-90-R; Derogatis, 1983) measures the level of psychiatric symptomatology on a range of symptoms. The authors report reliability coefficients from .77 to .90. A smaller score at post-treatment as compared to pretreatment would indicate improvement.

Alcohol Dependency Data Questionnaire

The ADD (Raistrick, Dunbar & Davidson, 1983) was used to asses the change in the severity of alcohol dependency at pretest, post test and fillip. The questionnaire is a 39-item instrument that rates the range of dependency on a four point likert scale including no, mild, moderate, and severe dependency. A shortened for of the ADD was created consisting of 15 items and was compared to the original form. The correlation between the

two tests was highly significant (r =.92). The shortened version of the ADD has a split half reliability of r =.87. A lower score at post-treatment from pretreatment would indicate improvement.

Post Session Review (PSR)

The PSR is a questionnaire that was created for this project to identify the level of change occurring in therapy. It is completed by both therapist and client at the end of each therapy session. A seven point likert scale is used for respondents to rate their agreement or disagreement on the following items: changes made both within the session and in personal relationships and the degree of openness and awareness with respect to feelings and thoughts and how they connect to the problem. Short answers are required to describe the most significant part of the session.

The Post Therapy Evaluation Form (PTEF)

The PTEF is a 9-item measure completed at the end of therapy by the client and the therapist to assess the effectiveness of the therapy. This was also designed for this research project.

Weekly Situation Diary (WSD)

This is another measure designed for the project and filled out by each spouse during the week. The WSD consists of five parts. Part one looks as changes made, level of satisfaction, and level of closeness in relation to self and others. Part two pertains to specific activities such as alcohol consumption and attendance of support groups. Part three and four are filled out by the alcoholic only and are a record of the amount and type of alcohol and drug consumption . Part five of the form is optional and any additional information can be listed.

Data Collection and Data Analysis

It would be misleading to separate data collection and data analysis into separate sections since data analysis is an ongoing process in qualitative research. Data collection and analysis went hand-in-hand through out the course of this research. Throughout this process of analyzing the documentation, the videos, and the coding of transcripts, the researcher kept track of emerging themes and began to develop concepts and hypotheses to make sense of the data. As hunches emerged, the researcher went back to the data to explore a particular hunch in detail and thus get a clearer picture of what was happening. Following Yin's (1994) design the study has two aims. The first aim is to look at the two cases holistically (Holistic) to describe the differences in the process and outcome of the treatment. The second aim is to examine the differences in the factors of change within the counselling process. This was accomplished by analyzing the "best and worst" session (Embedded units) in each case.

The purpose of the data collection phase was to conduct an intensive analysis of the two cases using both process and outcome measures and both objective and subjective data. To allow for a more complete description of the complex phenomenon, many variables were included (Hill, Carter, & O'Farrell, 1983). The purpose was to be thorough in discovering the significant differences between the two cases.

During the data collection phase the researcher attempted to adhere to the three principles of data collection: (1) using multiple, not just single, sources of evidence; (2) creating a case study data base; and (3) maintaining a chain of evidence (Yin, 1989). The following section explains the two sources of evidence which make up the focus of data collection for this study: Documentation and Direct Observation. Under each type of evidence, there were numerous data collection strategies used in an attempt to improve the construct validity of this study. Reliability is improved in this study as a permanent database was retained on computer and in field notes, and array of data is accessible to a third party. Finally, a chain of evidence is followed as the initial study question led to the case study protocol, which gives procedures for the data collection.

The data analyzing stage, although overlapping with data collection, also came out

of the principles of analysis set up by Yin (1994). Yin states that it is important to have a general analytic strategy. This study chose the descriptive analytic strategy because of the nature of this study being exploratory. Then specifically, the data analysis chosen was dependent on the type of data collection done.

The following section describes the two phases of this case study, holistic and embedded, giving the details of the data collection and analysis in each phase. The first phase is the holistic look at the entire therapy in each of the cases. The second phase is looking at the embedded unit of the "best and worst" session in each of the cases.

Phase one- Holistic Collection and Analysis of Data

Client variables

A qualitative assessment was done of the pre-therapy client variables by looking at the results on the pre-tests, the client screening information and the client self-report about their own background.

Outcome measures

Questionnaires.

The DAS, TESCH and SCL-90-R and ADD were studied intensely and compared. Each of the tests answers were viewed with an attempt to get at the exact areas of change that occurred.

Goals of Therapy.

It was important to look also at the goals set out at the beginning of therapy to assess whether those had been impacted during the course of therapy. Clients created the goals at the beginning of therapy and gave self-reports during therapy and at the end of therapy as to the success of reaching them. Thus the researcher assessed the level of reaching these goals based on observable behaviours in therapy and on the clients own verbal assessment.

Process Measures

Questionnaires.

Each of the three process measures developed by the TARP project were studied and notes were taken. These included the the Weekly Situation Diary (WSD), the Post Session Review (PRS), and the Post Therapy Evaluation (PTE).

Qualitative Observation.

A majority of data collection and analysis on the process of therapy came from the intensive task of watching the video tapes while taking copious notes, exploring hunches in more detail, transcribing many sections, and noting recurrent similarities or differences which emerged. The basic steps, described by numerous case study researchers, were used (Bogdan & Bilken, 1982; Ritchie & Spencer, 1992) :

Data Collection

1. The researcher initially observed these tapes twice using a discovery-oriented approach to the data (Mahrer, 1988). Notes describing sessions were taken as the researcher viewed the videotapes. This phase of data collection involved copious notes which included comments about the process of therapy, the issues worked with, the therapist techniques and the client's response. Notes also included questions of the data, moments of confusion, insights, and speculation of what was occurring.

2. A number of areas emerged that may have shown differences between cases. These hunches were noted (Appendix A) and then followed up on by going back to the data for verification.

3. To further crystalize the data on some of these issues, a number of data collection strategies were implemented. To look in-depth at the quantity of certain techniques the tapes were watched and the therapists techniques were counted. Notes were also made in regard to sustained use and effectiveness of a technique in a session to assess its quality. As well, notes were made regarding the clients response to the techniques. Each of the other hunches was followed up by watching the video tapes numerous times in their entirety. As other issues or hunches emerged these were also assessed in the data. During the viewings specific notes were taken on each of the hunches. The researcher also transcribed many sections of the videos that addressed any of hunches for more than two

speaking turns. As the researcher reached a saturation point, in terms of data collection, this process was stopped. Each videotape had been viewed at least 7 times. Thus a thorough collection of the data occurred.

Data Analysis

1. Read and reread the data

At this point all the notes, transcripts and scale results were read numerous times, as the researcher immersed herself in the data.

2. Keeping track of themes, hunches, interpretations and ideas

During the reading, the researcher made notes on the data and about the data to begin recording any themes that began to emerge.

3. Looking for emerging themes.

The researcher began to list emerging themes in the data, specifically as they related to the differences between the cases. All differences and similarities were included in a tentative list of themes.

4. Constructing Categories

Categories were then chosen according to the themes that were emerging. The categories were broadly based but contained sub categories which were given a numerical number for indexing purposes (Appendix B). The data was read again and the researcher indexed all the data (notes and transcripts) numerically according to which category or categories it belonged. An example of how this was done can be seen in Appendix C.

5. Sorting the data

The data was then pulled apart and data was rearranged into groups according to the particular numerical category it belonged.

6. Developing and mapping concepts

Each category was analyzed as, the researcher attempted to map and interpret the data set as a whole. During this process some of the categories were broken up into two concepts, others were combined if they overlapped.

7. Literature read and integrated.

As key differences were developed, literature and other theoretical

frameworks were added to the categories.

The Vanderbilt Psychotherapy Process Scale (VPPS)

In addition to looking at the data with a purely ethnographic exploratory methodology, the researcher chose the Vanderbilt Psychotherapy Process scale as a supplementary measure which functioned as a check to bias and another lens into the data. Thus the VPPS was chosen as an instrument that was sufficiently sensitive to capture the quality of the interaction, yet did not require transcriptions or ratings of small chunks of therapy.

The VPPS is an atheoretical general purpose instrument for assessing significant aspects of the interactions in psychotherapy. VPPS is a means for systematically characterizing attitudes and behaviors exhibited by the patient and the therapist, and by implication to capture salient features of their interaction (Suh, Strupp & O'Malley, 1986). This qualitative measure focuses on entire therapy sessions and is seen as a compromise between broad, global clinical impressions and narrow, atomistic assessments of single communications.

The VPPS was developed first in 1974 but has undergone numerous revisions and the most recent revision (1987) was used in this study. The two major parts of the VPPS are: a) items dealing with the patient; and b) items dealing with the therapist. Each part breaks down further into two items, one dealing with the participants "behaviour" and the other describing the participant's "demeanor". Raters observe the tapes and then rate the 80 items on a five point likert scale ranging from 1(not at all) to 5 (great deal). These 80 items have been divided into eight subscales based on a principal components factor analysis with Varimax rotation (O'Malley, Suh, Strupp, 1983): patient participation, patient hostility, patient exploration, patient dependency, patient psychic distress, therapist exploration, therapist warmth and friendliness, negative therapist attitude. Internal consistency as measured by coefficient alpha ranged from .81 for patient dependency to .96 for patient exploration. For all eight subscales interrater reliability has been reported ranging from .79 to .94. A manual, including a section for training raters, develops the procedure completely (Strupp, 1985) and was followed in this study.

To get an representative assessment of the therapy from beginning to end, sessions 1,7 and 13 from each case were rated using the VPPS. The sessions in there entirety were rated by two judges. One judge was the primary researcher. The other was a Social Work student in her final year of university in Victoria. She was trained by the primary researcher, using the manual provided. She rated the sessions independently of the researcher. It is important to note that the second rater was blind to the final outcome of the cases. Interjudge reliabilities for each of the subscales were calculated using a Pearson correlation coefficient between the two raters. The coefficients for each of the subscales were as follows: Patient Participation .96; Patient Exploration .73; Patient Hostility .86; Patient Psychic Distress .54; Patient Dependency .96; Therapist Exploration ..83; Therapist Warmth and Friendliness .80; Negative Therapist Attitude .95. After the raters completed their independent VPPS ratings, discrepancies of more than one point were discussed until consensus was reached (Suh et al., 1989). These ratings were then used in the study.

Phase Two-Data Collection- Embedded

The embedded sub units of this study are the "best and worst sessions" from each case. The best session for case A was # 12 and for case B was #14. The worst session for case A was #8 and for case B was #2.

Process Measures

Counselor Verbal Response Category System (CVRCS; Hill, 1993).

The CVRCS is a system that provides a standardized method for analyzing counselor verbal behaviour. Total description of all levels of the counselor's behaviour is not possible but rather the focus is on behaviours or skills that can be observed and operationally defined. Each of the categories is mutually exclusive and anchored in observable behaviours so that minimal inference is necessary. To correct for different amounts of talking, proportions of response modes were used rather than frequency counts. There are 6 clusters in this system that are broken down into 12 categories: (a) Minimal reponses- minimal encouragers and silence; (b) Supportive Interventions-approval; (c) Directive Interventions-information, direct guidance; (d) Questions-closed questions and open questions; (e) Paraphrase; (f) Interpretive Interventions- interpretation, confrontation

and self disclosure.

Client Behaviour System (CBS; Hill et al., 1992).

The CBS is also a standardized method for analyzing client's behaviour. Total description of all levels of the client's behaviour is not possible but rather the focus is on behaviours or skills that can be observed and operationally defined. Each of the categories is mutually exclusive and anchored in observable behaviours so that minimal inference is necessary. There are 8 categories in this system: resistance, agreement, appropriate request, recounting, cognitive-behavioural exploration, affective exploration, insight and therapeutic change. Each client response unit (grammatical sentence) and speaking turn (called a predominant judgment) is assigned to one category. The standard procedure for judging which category to put the predominant judgment in , is based on judges putting more weight on the initial portion of the speaking turn. This is based on conceptualizing client responses as occurring in response to counselor interventions.

The procedures followed in this study are laid out in the Manual for Hill Counsellor Verbal Response Category System (Hill, 1993). The initial step was to transcribe the four sessions word for word including timing the silences. The second step was the unitization of transcripts, which is coding the speech into grammatical sentences. Once this was complete, coding of the transcripts into the categories began. Hill's recomendation is that three judges be used to improve reliability, however, time and money did not allow for this. One other fellow researcher was trained as a judge . They randomly spot checked each of the transcripts and they also checked any areas marked by the researchers as unclear. Discrepancies on unitizing or coding were discussed until consensus was reached.

Qualitative analysis of the process of therapy.

The third measure used for the best and worst sessions was the qualitative analysis of the session. The researcher studied the transcripts intensely to look for the process of therapy. Notes were taken regarding the therapist variables, the client variables and the interaction of these. A summary of each session looking at the differences between them was done.

Summary

In summary the data collection and analysis stage was extensive and varied. The researcher attempted to collect data based on the specific purpose of viewing the complexities of marital therapy from a wide source of information.

The complexity of the phenomenon under study warrants the use of the case study methodology. In an attempt to reveal the complexities, several qualitative methods were utilized. Data was collected from a variety of sources and then analyzed using a systematic and well-defined procedure. Each of the steps are documented and available for retrieval and exploration.

CHAPTER FOUR
RESULTS

In this chapter the results of all the data collection and analysis will be presented in the following four parts. The two cases will be compared throughout. Part one includes the client pretreatment variables: background, pretreatment test results, presenting issues and goals of therapy. Part two includes the results from the objective measures: outcome measure results and the VPPS results. Part three includes a qualitative analysis of the differences between cases. Part four includes the results from the study of the "best" and "worst" sessions: the data from the Counsellor Verbal Response Category System, the Counsellor Behaviour System, and a qualitative clinical comparison of the sessions.

Part 1

The following section will give a description of the couples involved in this study to lay out clearly the pretreatment variables. Included in this section will be the clients background, the pretreatment test results and the presenting issues. This was based on client report and questionnaire information. The names and identifying client details have been changed so as not to jeopardise anonymity.

Client Background

Couple A

Bill and Ann (middle-aged) came to therapy after a attending another treatment program. This was a treatment program for Bill but involved Ann in a week of couples work. Bill had been dry for over eight weeks and said he didn't crave alcohol. He had started drinking when he was an adolescent, was hooked by early adulthood and had been fighting it since. This was the first treatment program he had been in. He was feeling more positive about their relationship then ever. Bill came from an alcoholic family where his dad drank a lot, was abusive and was almost always absent. Bill had three other siblings. Bill married Ann and they had no children of their own.

Ann came from an intact family. Her mother was often sick and this left Ann in the role of caring for her father and younger sister. Her parents were not alive having died some years ago. She had a son out of marriage whom Bill adopted him when they were married. There was no history of alcohol in the family.

Couple B

Sam and Donna (middle-aged) came to therapy after Sam attended a treatment program. This was an individual treatment program. Sam had been sober ever since the completion of the program, approximately 3 months ago. Sam had started drinking at an early age and continued to drink throughout most of his adult life.

Sam and Donna had been together for about 20 years. Sam and Donna had one child and Donna had one child from a previous relationship. Donna came from an intact family and had three siblings. Her father drank, was an not an alcoholic but was an "awful man even when he wasn't drinking". Her father was physically abusive to the whole family. Donna used the words controlling and manipulative to describe her family. She had been married previously. He was an alcoholic, emotionally abusive to Donna, and sexually abusive to their daughter.

Sam also came from an intact family and had one other sibling. His father was sick for much of Sam's life. His father was a farmer and always kept his distance from Sam. His dad died when Sam was in early adulthood. His mother was still alive. Sam was married previously, but it lasted less than a year. They never had children because he was afraid of having children for fear of being an abusive father.

Pretest Results

Couple A

At pretreatment, Bill was tested on the ADD questionnaire and obtained a score of 72 indicating a severe dependence on alcohol. At the onset of treatment he had been sober for eight weeks and stated that he didn't crave alcohol at this point. Both Ann and Bill scored within the distressed range when measured on marital satisfaction using the DAS. Ann scored 59 and Bill scored 60, indicating that they viewed the marriage to be

considerably distressed. As well, both of them scored within the distressed range on the TESCH (Bill, 179; Ann 135). Bill reported a high psychiatric symptomatology during pretreatment (103.1) as reported on the global SCL-90-R. Ann reported some moderate psychiatric symptomatology during pretreatment (73.3) on the same measure.

Couple B

At pretreatment Sam was tested on the ADD questionnaire and obtained a score of 78 indicating a severe dependence on alcohol. At the onset of treatment he had been sober for five months. Sam scored just at the border of distress and Donna scored within the distressed range when measured on marital satisfaction using the DAS. Sam scored 110 and Donna scored 86.2, indicating that Donna viewed the marriage to be considerably more distressed. As well, Sam and Donna reported some distress on the TESCH, however, Donna's score was lower which indicated that she saw their relationship as considerably less intimate (Sam, 219; Donna, 183). Sam reported a moderate psychiatric symptomatology during pretreatment (62.2) on the global scale of SCL-90R. Donna reported slightly higher psychiatric symptomatology during pretreatment (77.3) on the same measure.

Generally, couple A demonstrated more marital distress than couple B. This makes it even more interesting to assess the deterioration of couple B's relationship over therapy. Couple B even made statements about their relationship being healthy initially, however, they actually deteriorated over the course of therapy on marital measures and psychiatric symptomatology.

The Presenting Problems

Couple A

Within the first sessions the following information was revealed. Bill had a number of enduring patterns that he was becoming aware of. He realized he would engage in distancing behaviours to avoid confrontation. He would shut down or actually leave the

situation. Ann's distancing behaviours involved backing down from a conflictual situation, denying her own needs and returning happy later so that everything would be O.K.

This pattern was beginning to change and yet the new changes were causing difficulty. Ann was attempting to express anger, deal with conflict more openly. Bill wanted her to assert herself but still found himself saying 'why bother' and giving up if he couldn't please Ann.

Ann played the role of the giver. Always looking out for everyone else and not for herself. From a very early age, she had been the care giver in the house. It was always difficult for her to say no. Last year she attended individual counselling for 3 months and was feeling like she was making some progress with the avoidance pattern. Bill's drinking was almost always outside the house and he would often leave for days at a time. Ann always accepted him back, playing the typical co-dependent role. With the cessation of his drinking, she had struggled with self-worth, which she received from looking after Bill.

Bill used alcohol to cover up his emotions. If things began to get heated, painful or stressful etc. he would drink. Anger was an emotion he would suppress. Since the cessation of drinking he was experiencing more frustration and anger than he used to. The anger was being expressed rather than being buried but he didn't want to accept it. He feared he would get sucked back into the old partern of suppression of anger and then drinking to excess.

The goals of therapy.

The following therapeutic goals were expressed, discussed and written down within the first session:

1) They both wanted to strengthen their relationship
2) Bill wanted to find ways of expressing anger and frustration that felt more comfortable and lead further away from alcohol. This was especially within their relationship.
3) Ann wanted to have patience for the process
4) Ann also wanted to trust herself to say what needs to be said

5) Bill wanted to stay sober

Couple B

Within the first session, some positive steps emerged as well as issues regarding Sam's family. On a positive note, Sam felt like he was completing things and getting more time with the family. Donna was enjoying her new career and feeling very positive about herself. Sam continued to find it difficult to be around his brother's family because they drank a lot and weren't that encouraging about Sam's abstinence. There was also a lot of tension with his brother around financial situations.

During the second session, some of the presenting problems became clearer. Sam had a hard time with finances. For years Donna covered more than half the finances especially to help support Sam's drinking habits. He had a belief that what was his was his and what was hers was hers. Since starting education, she hadn't had a steady income and thus relied on Scott for financial help. She felt guilty every time she had to ask for even a little bit of money. She longed for this to be equal and fair. He originally rescued her from a destitute place as a single mom with no money. She had always operated in a co-dependent role of supporting his drinking habit and needing to care for him for her own self-esteem.

More specifically in terms of their relationship, they said they had a good friendship. They laughed and talked together, however, they never spent any time together socially or doing recreational activities. As well, the whole area of sexuality had been a tension for over two years. They had not made love for years and had only attempted about four times. Sam had been dealing with impotency for years. He always needed to drink prior to sexual contact. Eventually, the more he drank, the less O.K. his sexual experiences were. Anxiety continued to increase. Sam thought too much about it and just got anxious.

The goals of therapy.

The therapeutic goals were expressed, discussed and written down as follows within the second session and added to in the third and fourth sessions.

1) Donna wanted to clear up problems around financial issues, sexual issues and fairness issues in their relationship

2) Donna wanted to have more fun with Sam

3) Donna wanted to let go of responsibility for her family and the feeling of being used

4) Donna wanted to let go of her need to change people

5) Sam wanted to become more giving and generous without guilt

6) Sam wanted to regain a sense of intimacy, especially sexually

7) Sam wanted to like himself more

8) Sam wanted to let go of the past with his father's legacy of neglect

9) Sam wanted to stay sober

10) Scott wanted to be more honest

11) They both wanted to get rid of guilt

Part two

Outcome Measures

Marital Measures

The Dyadic Adjustment Scale (DAS; Spanier, 1976)

The DAS was used at screening, pretreatment, post-treatment and follow-up. The raw scores for the couples are graphically displayed in Figure 1. As stated earlier, each of the couple's marriage showed high levels of distress at pretreatment. Couple A scores increased at post-treatment and particularly Ann's score (120) was above the mean (114.8) for married couples. Compared with the rest of the TARP sample, Ann's increase in the DAS was significant as it demonstrates a z-score of 2.3 (Figure 6). Couple B scores decreased at post-treatment. Sam's score, which had not been in the distressed range at pretreatment, fell into the distressed range (98). Donna's score (63.7) fell even further into the distressed range. Both Sam's and Donna's scores compared with the rest of the TARP sample demonstrate a z-score of -1.5 (Figure 5) and -1.6 (Figure 6) respectfully.

The TESCH Intimacy Questionnaire.

The TESCH was used at pretreatment, post-treatment and follow-up. The raw scores on the global scale for the couples are graphically displayed in Figure 2. As stated earlier each of the couple's marriage showed low to moderate levels of intimacy at pretreatment. Couple A scores increased at post-treatment and particularly Ann's score (213) revealed a large increase from pretest (135). Compared with the rest of the TARP sample this was significant as it demonstrates a z-score of 2.1 (Figure 5). Couple B scores decreased at post-treatment. Sam's score, which had been in the higher range at pretreatment (219), fell into the low range (154). This was significant especially in comparison to the entire TARP sample as this score demonstrates a z-score of -2.7 (Figure 6). Donna's score (176) also showed a decrease.

The increase in total scores at post-test for couple A suggests that there was much less marital distress and more marital intimacy experienced by both Bill and Ann after treatment leading to the conclusion that ExST marital treatment was successful. The decrease in total scores at post-test for couple B suggests that there was much more marital distress and less marital intimacy experienced by both Sam and Donna leading to the conclusion that ExST marital treatment was unsuccessful with this couple in the area of marital satisfaction.

Interpersonal Measures

Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1983).

The SCL-90-R was used at pretreatment, post-treatment and follow-up. The raw scores for the couples are graphically displayed in Figure 3. The results show that Couple A decreased in their level of psychological distress and symptomatology. Bill's scores showed a dramatic decrease in the raw score from the pretest (103.7) to the post-test (47.9). This finding suggests that Bill experienced a high level of symptomatic distress which then decreased, revealing less evidence of psychological distress at the end of treatment. Compared with the rest of the TARP sample this was significant as it demonstrates a z-score of -2 (Figure 5) Ann's score also decreased from a high level of distress and symptomatology to a normal level. The results show that couple B both

decreased and increased in raw scores from pre to post test on the global scale of the SCL-90-R. Sam didn't show extreme levels of distress at pretest (62.2) and decreased at post-test (47.5). Donna, however, showed higher levels of distress at pretest (77.3) and increased her score at post-test. Compared with the rest of the TARP sample this was significant as it demonstrates a z-score of 2 (Figure 6). This finding suggests that prior to treatment she experienced moderate to high levels of symptomatic distress and at the end of therapy was experiencing very high levels of distress (102.4).

Alcohol Measures

Alcohol Dependency Data Questionnaire (ADD; Raistrick, Dunbar & Davidson, 1983).

The ADD was used at pretreatment, post-treatment and follow-up. The raw scores for the couples are graphically displayed in Figure 4. The results show that both husbands decreased in their level of alcohol dependency. Bill's scores showed a decrease from the severe range (72) to the low-moderate range (46). At the end of therapy, Bill had stopped drinking and was attending support groups. There were no follow-up results available for Bill. Sam's scores revealed a decrease from the severe range (78) to the low range (26). At the end of therapy, Sam admitted he was still drinking and had no definite plans to stop. He was not in any support groups. At follow-up his score was in the severe range again (72).

Therapy Measures

Post Session Review (PSR).

Both the client and therapist completed the PSR at the end of each of the 15 sessions. This was used by the project to aid in assessing dimensions related to the process of change in therapy. Below is a summary of the clients assessment of each session for each case.

Couple A

Both Bill and Ann's findings were fairly consistent with a few minor variations.

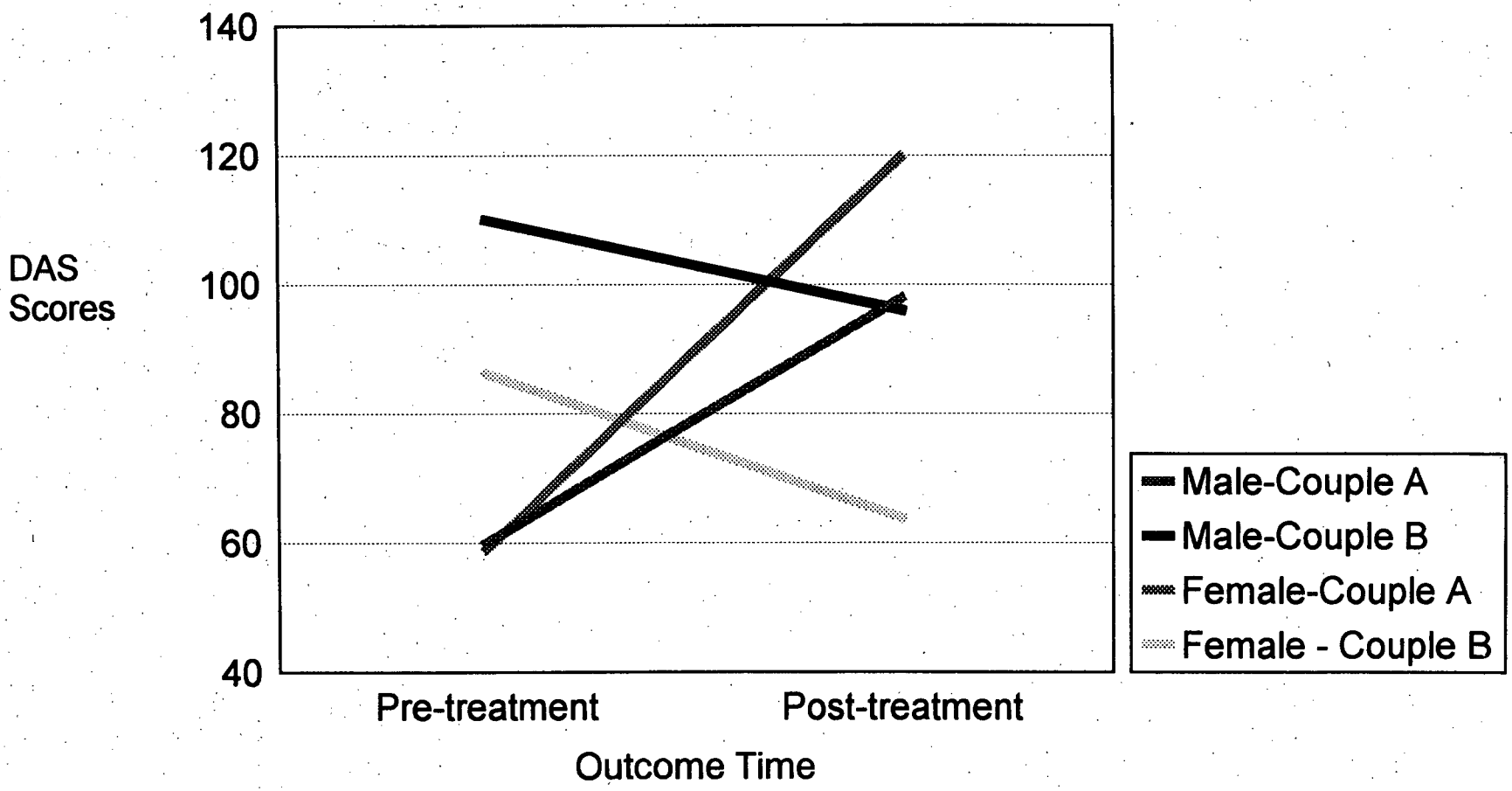

Figure 1. Dyadic Adjustment Scale scores for male and female from each of the cases

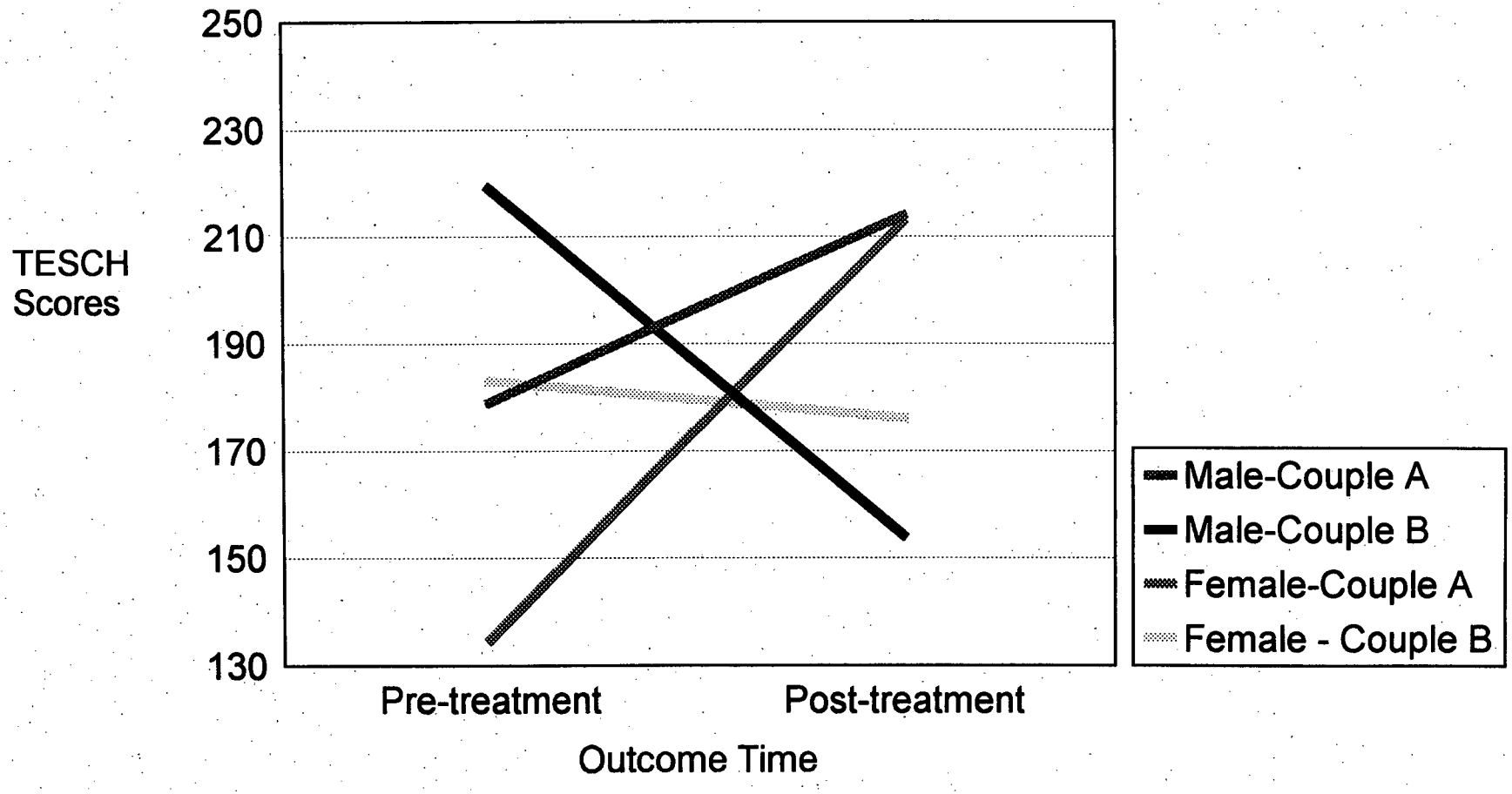

Figure 2. Tesch Intimacy Scale scores for male and female from each of the cases

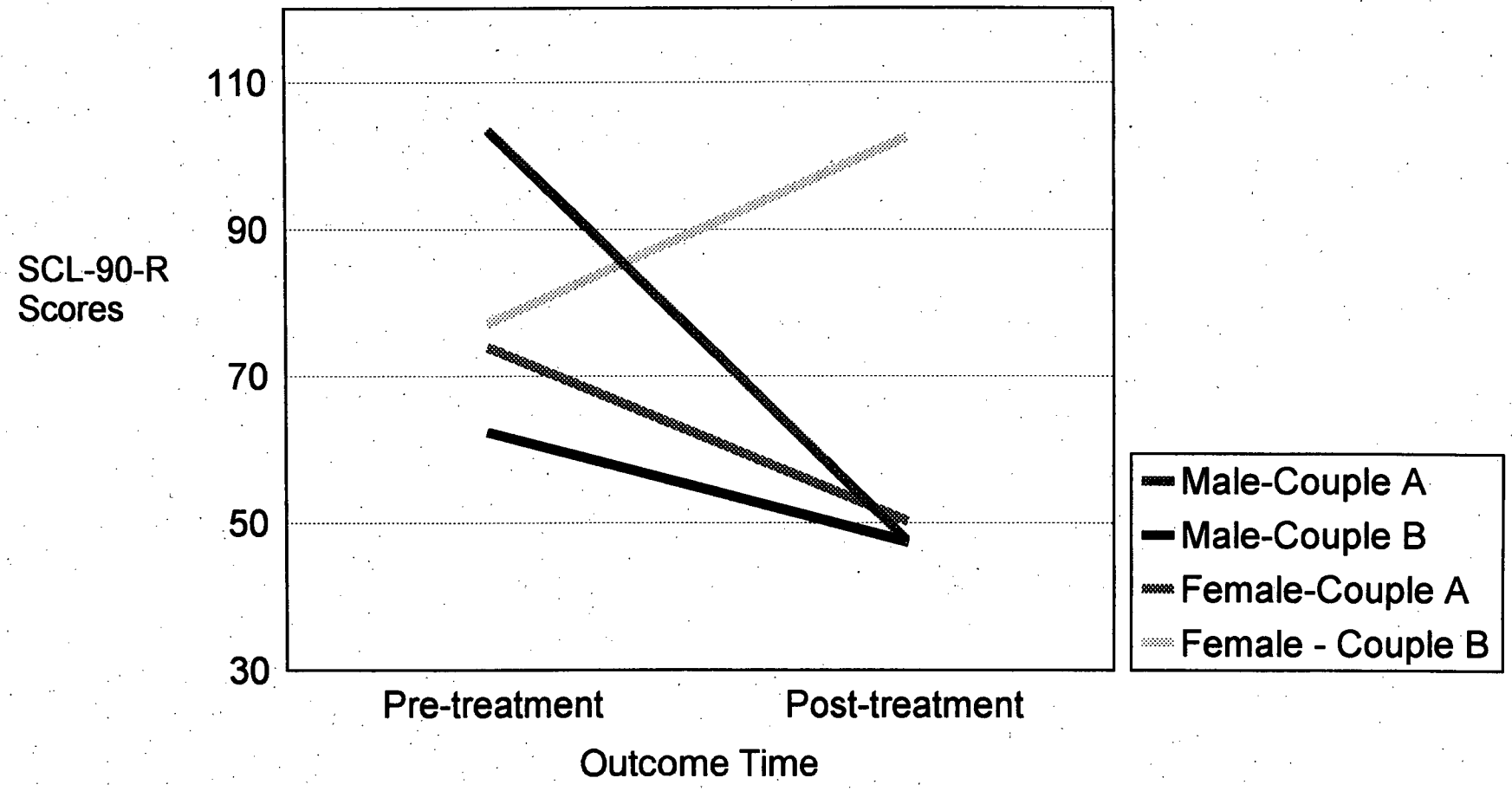

Figure 3. SCL-90-R scores for male and female from each of the cases

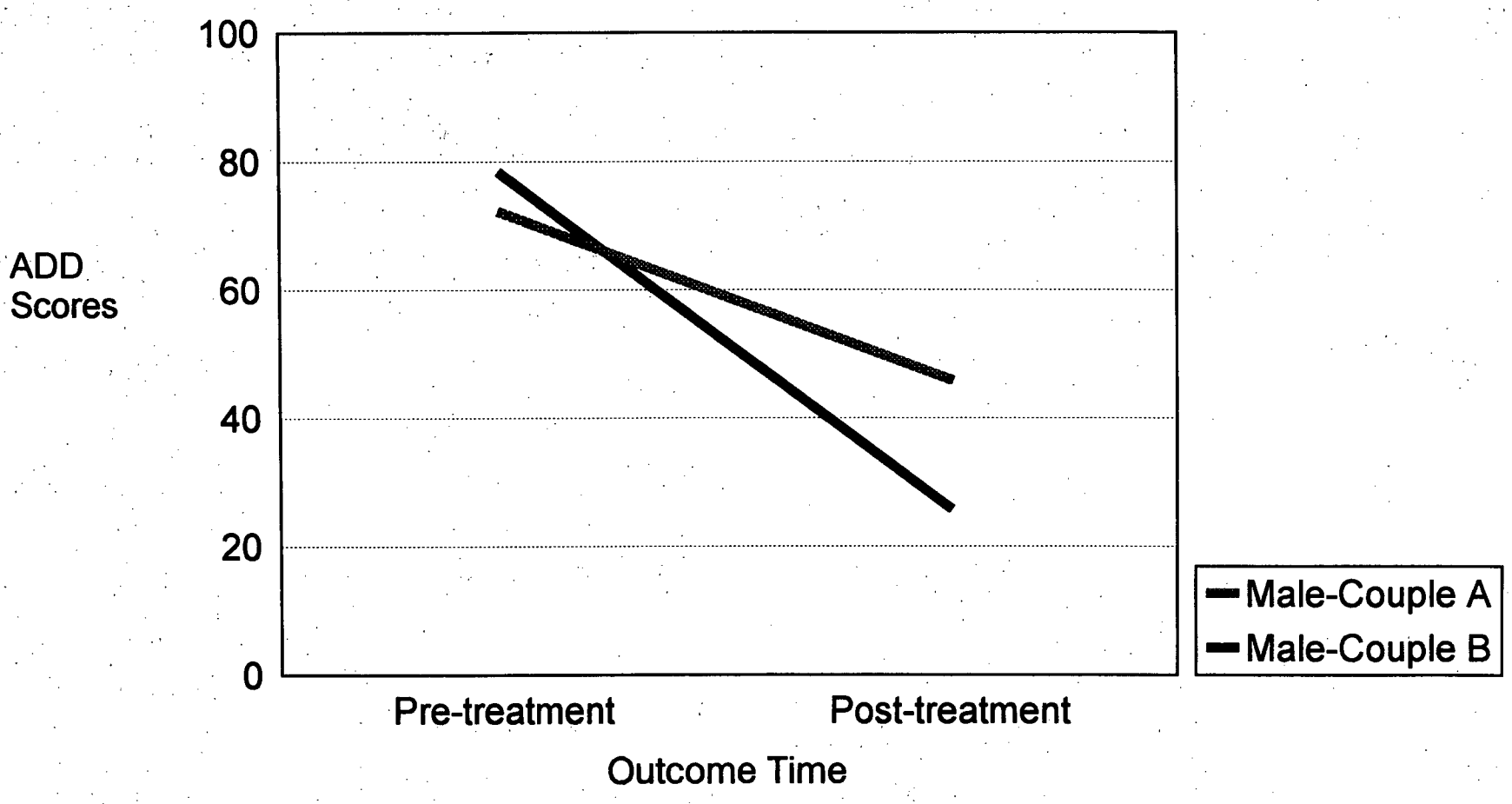

Figure 4. Alcohol Dependency Data scores for male and female from each of the cases

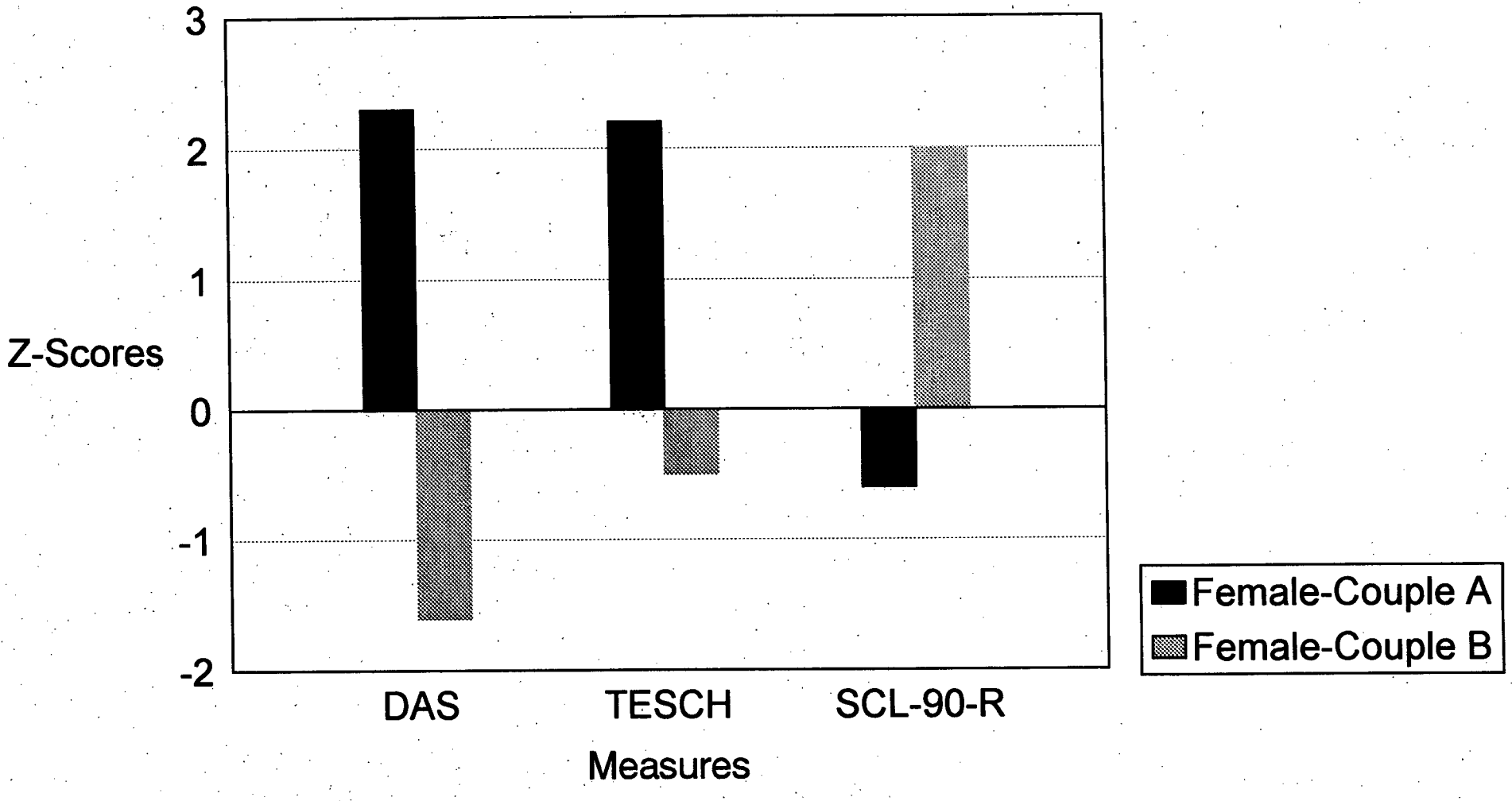

Figure 5. Post-Treament Z-Scores for females from each of the cases on the following three measures: DAS, TESCH and SCL-90-R

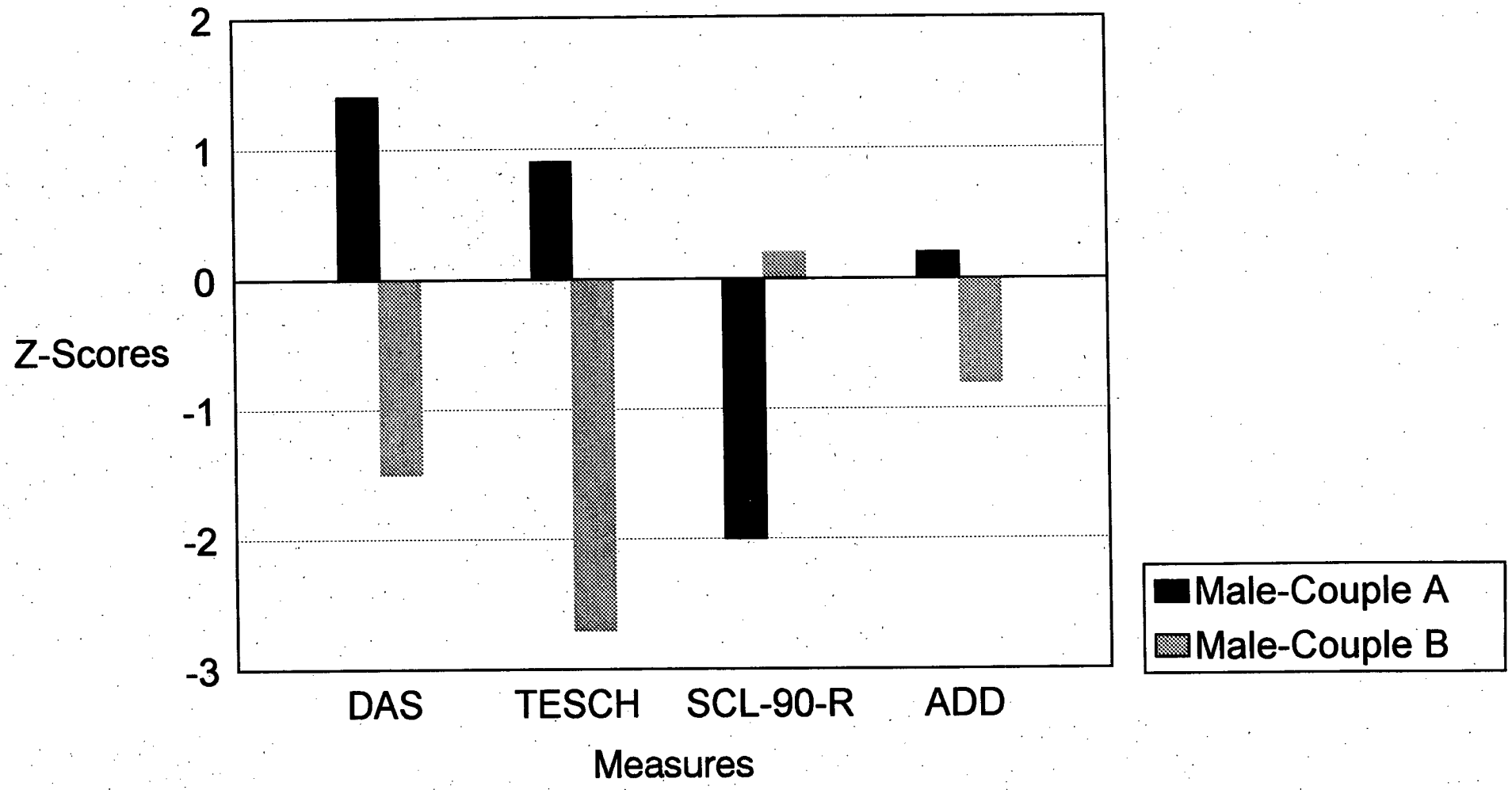

Figure 6. Post-Treament Z-Scores for males from each of the cases on the following three measures: DAS, TESCH and SCL-90-R

Generally Ann tended to strongly agreed or completely agreed that she had been open with her thoughts/feeling in therapy. Bill rated this strongly disagree after the first session but then rated this the same as Ann in future sessions. In 10 of the 15 session, Ann stated that she strongly agreed that she had made some valuable changes and in 2 sessions that she agreed she had changed. Bill's ratings were slightly lower as 13 of the 15 session he stated he had made valuable changes but more of the sessions were rated as agreed (7). Ann also strongly agreed, with a few agreed ratings, in all but two sessions that she was more aware of how her usual ways of feeling, thinking or behaving were connected to the problem. Bill's ratings were similar and only varied in that three sessions were neither agree or disagree. Both Bill and Ann agreed or strongly agreed that the sessions helped them to make significant changes in their personal relationships , and to deal with the problem in their everyday life.

The therapists ratings were very similar to the clients and at times even slightly higher. In 12 of the 14 sessions (Bill was absent for one), the therapist strongly agreed or completely agreed that her client had made some valuable changes. The therapist rated Ann the same on 11 of the 15 sessions. The therapist strongly agreed or completely agreed that both Bill and Ann were open with their feelings and thoughts, became more aware of how their feelings, thoughts or behaviours were connected to the problem, made significant changes in their personal relationships and learnt to deal more effectively with the problem in everyday life.

These highly consistent findings suggest that the ExST marital treatment was perceived as successful by both Couple A and the therapist .

Couple B

Both Sam and Donna's findings were fairly consistent with a few minor variations. In 9 of the 14 session (she missed one), Donna stated that she strongly agreed or completely agreed that she had made some valuable changes . Sam's ratings were slightly higher as 13 of the 15 sessions he strongly agreed or completely agreed he had made valuable changes. Generally Donna tended to strongly agree or completely agree that she had been open with her thoughts/feeling in therapy (11 of 14). Sam rated this strongly agree or completely agree in 11 of 15 sessions. Donna also strongly agreed, with a few

completely agree ratings, in all but three sessions that she was more aware of how her usual ways of feeling, thinking or behaving were connected to the problem. Sam's ratings were similar . Donna agreed or strongly agreed that the sessions helped them to make significant changes in their personal relationships after session number four. Sam didn't strongly agree that the sessions helped make significant changes in his personal relationships until after the seventh session. Donna strongly agreed or agreed that 10 of the session would help her deal with her problem more effectively in her everyday life. Three of the session she strongly disagreed that they would be helpful. Sam agreed or strongly agreed in all but one (strongly disagreed) that this session would help him deal more effectively with everyday life.

The therapists ratings were similar to the clients, however were slightly lower. In 8 of the 15 sessions, the therapist strongly agreed or completely agreed that Sam had made some valuable changes. The therapist rated Donna the same on 8 of the 14 sessions. The therapist agreed that both Donna and Bill were open with their feelings and thoughts in most of the session, occasionally one of them would get a higher ratio. In all but two sessions the therapist strongly agreed or completely agreed that the clients became more aware of how their feelings, thoughts or behaviours were connected to the problem. The therapist agreed or strongly agreed, in 14 out of 15 sessions, that the couple made significant changes in their personal relationships and learnt to deal more effectively with the problem in everyday life.

The results from the PSR demonstrate the need for understanding the definition of "unsuccessful" for this study. Unsuccessful does not mean that the clients didn't enjoy therapy, benefit from it and perhaps even find it helpful. This will be expanded on in the comparative analysis done in part three. However, in light of the entire TARP project, couple B was chosen from the low end of cases based on a number of criteria (see Chapter three).

The following assessment of the PSR show that the therapist and client believed therapy was somewhat helpful. Couple B tended to rate therapy consistent with couple A. The therapist's ratings were slightly lower for couple B than for couple A.

Post Therapy Evaluation Forms (PTEF).

To evaluate the overall effectiveness of therapy the clients and therapist both completed the PTEF.

The therapist rated the overall therapy exactly the same for each couple with only one minor variation. For both cases the therapist felt "very satisfied" with the therapy, and believed the clients were "much better" and the changes were "definitely related" to therapy. The therapist "strongly agreed" that the therapy was helpful to the clients as individuals, in their marriages, and in their immediate families. The only difference on the PTEF was how the therapist rated the client's condition at present. Bill and Ann were described as "excellent", however, Darlene was described as "very good" and Sam as "good".

Weekly Situation Diary (WSD).

The clients were requested to rate whether they experienced change with respect to self, marriage, family, friendships and work as being worse or better using the WSD weekly.

Couple A

The 15 sessions of therapy occurred over 20 weeks and therefore there were 20 WSDs for the couple. In the first week Ann rated herself as changing "much better" and her marriage as "better". However, from there the changes seem to go back and forth between "somewhat worse" to "somewhat better" up until week 12. At this point they were more consistently "somewhat better" or "better" except for week 16 (which involves one of Bill's slips with alcohol) where she rates the changes as "somewhat worse". The other scales seemed to be generally rated as "somewhat better", except for work being rated lower on six occasions.

In the first two weeks, Bill rated himself and his marriage as changing for the "better" . Generally, Bill rated these two scales higher than Ann. Fairly, consistently self was "somewhat better" or "better" except for week 16 (which involved one of Bill's slips with alcohol) where he rated the changes as "much worse". Marriage was occasionally "somewhat worse" (2) and once "much worse", but generally fell between the "no change" and "somewhat better ratings". The other scales seemed to be generally rated as "no change" or "somewhat better", except for friendship which was rated lower on five occasions.

In regards to Ann's satisfaction level of herself and her marriage, she generally rated these categories between somewhat satisfied and somewhat dissatisfied. She seemed to start out more satisfied at the beginning of therapy, then went through some times of dissatisfaction in the middle part of therapy but concluded therapy more satisfied again. Again she remained fairly satisfied with her family and her friendships but often experienced dissatisfaction with her work. Bill's satisfaction level of himself and his marriage were generally rated "somewhat satisfied" except for five occasions when marriage dropped into the dissatisfied range. Again he remained fairly satisfied with his family and his work but often experienced dissatisfaction with his friendships. The last three weeks of therapy he felt much more satisfied with his friendships.

On a scale of 1 to 10, clients had to rate how close their marriage, self, family, friendships and work came to their ideal. Ann rated her self ranging from 2 to 8 with the majority of scores averaging 6. On the marriage scale her scores were ranging from 2 to 8 with the majority of scores averaging 5. Her family score remained more consistent at about an average of 5 and her friendships scored an average of 6. Work had a wider range from 1 to 6 with a majority falling in the lower range. Bill rated his self, marriage, family, and work mostly with a 7 or 8, dropping down below 4 on two or three occasions. Friendships were fairly consistently rated ranging from 3 to 5 , until the last two session when they received a 6 and 7.

Couple B

The 15 sessions of therapy occurred over 20 weeks and therefore there were 20 WSDs for the couple. For the first 16 weeks Donna rated herself as changing " better", however, the last four weeks she was "somewhat worse" or "worse". In the first two weeks her marriage was rated as "better". However, from there the changes seem to go back and forth between "somewhat worse" to "somewhat better" up until week 15. At this point they were more consistently "somewhat worse" or "no change". The other scales seemed to be generally rated as "somewhat better", except for family being rated lower on six occasions and work being rated lower in the last two weeks. In the first three weeks, Sam rated himself and his marriage as changing "much better". These were then rated at "better" except for three occasions when they were "somewhat" worse. Generally, Sam

rated these two scales higher than Donna. The other scales seemed to be generally rated as "no change" or "somewhat better", except for family which was rated lower on three occasions.

In regards to Donna's satisfaction level of herself, she generally rated this category between somewhat satisfied and extremely satisfied, except in the last three session where it dropped to somewhat dissatisfied. The marriage scale was rated as satisfied for the first three sessions but was consistently rated as dissatisfied during therapy (except for two occasions) and extremely dissatisfied by the end of therapy. The Family scale moved between dissatisfied and somewhat satisfied, which followed a similar pattern to the marriage scale. Again Donna remained fairly satisfied with her friendships and her work but in the last three sessions experienced dissatisfaction with her work. Sam's satisfaction level of himself and his marriage were generally rated "somewhat satisfied" except for four occasions when marriage and self dropped into the dissatisfied range. Again he remained fairly satisfied with his friendships and his work but often experienced dissatisfaction with his family. The last three weeks of therapy he felt much more satisfied with his friendships.

On the ideal scale, Donna rated her self ranging from 2 to 9 with the majority of scores averaging 6 and dropping lowest in the last part of therapy. On the marriage scale her scores ranged from 1 to 7 with the majority of scores averaging 5 and dropping in the last part of therapy. The family score, although slightly higher, showed this pattern. Her friendship score remained more consistent at about an average of 8. Work had a wider range from 2 to 9 with a majority falling in the upper range until the last part of therapy. Bill rated his self, marriage, friendships, family, and work mostly with the a 7 or 8, dropping down below 5 on five occasions.

Couple B's results from the WSD's seem to correlate more closely to the marital (DAS, TESCH) and interpersonal measures (SCL-90-R). Especially Donna's results show much more dissatisfaction with marriage and self by the end of therapy.

Goals of Therapy

Couple A

In the fourteenth session, the therapist asked them position themselves in relationship to how close they were to their goals. The husband and wife both moved very

close and stated that the goals were 90% accomplished. Evidence during therapy of movement and of new ways of behaving towards each other and their own feelings demonstrated goals being met. In session 14 and 15, both of them read through the goals and verbally acknowledged the changes they had made in each of the specific areas.

Couple B

Couple B never stated specifically how many of the goals had been accomplished. The therapist asked them to place the goals in relationship to other symbols and themselves but they never stated how many of the goals had been reached. Donna's first goal was to clear up problems around financial issues, sexual issues and fairness. Financial tension was still evident, but by the end it was getting slightly better the client's stated. The sexual issue was still very tense and nothing had changed in this area. Donna' s second goal was to have more fun with Sam, however, at the end of therapy they weren't spending much time together and they stated how busy Donna was. The third and fourth goal for Donna was to let go of responsibility for her family , of the feeling of being used and of the need to change people. These issues were worked with more in the last few sessions, but mostly awareness was being raised. However, even in the last few sessions she was still demonstrating a lot of co-dependant behaviour. Sam's first goal was to become more giving and generous without guilt, and in session 15 he felt he was making progress. Secondly, Sam wanted to regain a sense of intimacy, especially sexually, but this did not happen. Sam did express that he was liking himself more and becoming more comfortable with himself. His father's legacy of neglect had been talked about in two sessions and was begining to be processed. Another of Sam's goals was to stay sober, however, he was still drinking and admitted that in session 15. Guilt was a issue for both of them. Only Sam's guilt was discussed with any depth or length. Session 15 was a ritual throwing away of his guilt. It was impossible to know what became of guilt after that.

Post-treatment Measures of the Therapeutic Process

The Vanderbilt Psychotherapeutic Process Scale

The following section will list the results from the Vanderbilt Psychotherapeutic

Process Scale. Session one, seven and thirteen were rated from each of the cases. The results from the VPPS are listed below according to each of the sub scales: Patient Participation, Patient Hostility, Patient Exploration, Patient Psychic Distress, Negative Therapist Attitude, Therapist Warmth and Friendliness, Therapist Exploration. Inter judge reliability for each scale was relatively high as Pearson correlation coefficients ranged from .54 to .96 (see chapter 3). As well, after the correlation was calculated the judges met to discuss and come to consensus on discrepancies. The higher the score the more evident it was within the session. In addition to scores on the VPPS sub scales for the three sessions, scores within a sub scale are stated.

Patient Participation (PP)

The couple scores for PP differed slightly over the three sessions. Couple A shows more active participation than couple B. The interesting thing was that couple B scores increased on Patient Participation as therapy went on, whereas couple A maintained a high score right from the beginning. Scores are listed in table 1.

Table 1

Patient Participation Scores on the VPPS

	Session					
	1		7		13	
	Couple					
Scale Scores	A	B	A	B	A	B
Scale Total (possible 15)	13.5	9	17	11	17	14.5
Sub scales (possible 5)						
Logical and understandable	4*	2	5*	3	4*	2
Spontaneous	3.5*	1	3	3	3	3
Took the initiative	3	3	5*	3	4	3.5
Actively participated	4	4	4	3	4	4
Trusts therapist	4	3	5	4	5	5
Withdrawn (-)	2	2	2	1	1	1
Inhibited (-)	2	1	1	2	1	2
Passive (-)	1	1	2	1	1	1

Patient Hostility (PH)

The couples PH scores also showed differences between the cases. Overall couple A showed lower hostilty scores. Although neither couple showed high scores on hostility, couple B demonstrates more hostility especially through intellectualizing and defensiveness. All scores are listed in Table 2.

Table 2

Patient Hostility Scores on the VPPS

	Session					
	1		7		13	
	Couple					
Scale Scores	A	B	A	B	A	B
Scale Total (possible 30)	8	12	7	11.5	8	11
Sub scale (possible 5)						
Intellectualising	2*	4	2*	4	2	3
Defensive	2*	4	1*	3	1*	3
Negative reaction to Th.	1	1	1	1	1	1
Hostile	1	1	1	1	1	1
Frustrated	1	1	1	1.5	1	2
Impatient	1	1	1	1	2	1

*Differences of more than 1.5

Patient Exploration (PE)

The scores between couple A and B were substantially different for the PE scale. Couple A received high scores in each of the sessions, whereas couple B received low to moderate scores.Couple B did demonstrate an increase in exploration over the course of

therapy. Scores are shown in Table 3.

Table 3

Patient Exploration Scores on the VPPS

	Session					
	1		7		13	
	Couple					
Scale Scores	A	B	A	B	A	B
Scale Total (possible 40)	30	16	34.5	22	33	23.5
Sub Scales (possible 5)						
Productivity of the hour	4*	2	5*	3	4	3.5
Focused on the problem	3*	1	5*	3	4	3
Tried to understand reasons	3.5*	2	4*	2.5	4	3
Struggling to control feelings	4*	2	4	3	4*	2.5
Talked about feelings	4*	2	4*	2.5	5*	3
Explored feelings	3.5*	1	5*	2.5	4*	2.5
Motivated	4	3	4	3	4	3
Concern with relationship	4	3	3.5	2.5	4	3

*Differences of more than 1.5

Patient Psychic Distress (PPD)

Couple A scored highter on the PPD scale than couple B. This was especially true in the emotional category as couple A expressed a lot more emotion both anger and tears. Scores are listed in Table 4.

Table 4

Patient Psychic Distress Scores on the VPPS

	Session					
	1		7		13	
	Couple					
Scale Scores	A	B	A	B	A	B
Scale Total (possible 25)	9.5	7	18	16.5	16	10.5
Sub Scale (possible 5)						
Guilty	2*	4	4	4	3	3.5
Emotional	3.5*	2	5*	2.5	4.5*	2.5
Overwhelmed	2	1	4	4	3	2
Self-Critical	2	3	2	3	2	2
Depressed	3	2	3	2	3	2
Defeated	2	1	3	4	4.5	2.5
Ashamed	1	1	2	2	1	3
Functioning (-)	3	3	3	3	3	4
Optimistic (-)	3	4	2	2	2	3

*Differences of more than 1.5

Patient Dependency and Negative Therapist Attitude.

These were listed together because virtually no difference was found between the two cases on these Scales. All but three of the items in each of these scales were rated with a 1 (not at all). The three subsscales not rated with a one were given a two. Thus both couple A and B showed little dependency on the therapist . As well, the therapist did not demonstrate any negative attitudes in either of the cases.

Therapist Warmth and Friendliness (TWF)

The scores for couple A were significantly larger in session one than for couple B on the TWF scale. Other sessions show a difference but it was not as pronounced. All scores are listed in table 5.

Table 5

Therapist Warmth and Friendliness on the VPPS

	Session					
	1		7		13	
	Couple					
Scale Scores	A	B	A	B	A	B
Scale Total (possible 45)	36	24.5	40	31.5	38	31.5
Sub Scales (possible 5)						
Communicated approval	4*	2	4*	2	4	3
Helped P feel accepted	4*	2.5	5	4	5	4
Empathetic	4*	2	5	4	4	3
Involved	5*	2	5	4	5	4
Showed warmth	4	3	5	4	5	4
Supported P's confidence	4	3	4	3.5	4	4
Relaxed	4	4	4	3	4	3
Optimistic	3	3	3	3	3	2.5
Repectful	4	3	5	4	4	4

*Differences of more than 1.5

Therapist Exploration (TE)

The scores for case A were consistently higher for The TE scale than for couple B. Case B showed an increase in scores as therapy progressed. The largest gap between couple A and B was related to the therapist encouraging more depth to occur in couple A's sessions. All scores are listed in table 6.

Table 6

Therapist Exploration Scores on the VPPS

	Session					
	1		7		13	
	Couple					
Scale Scores	A	B	A	B	A	B
Scale Total (possible 65)	43	26	52	36.5	53	40.5
Sub Scales (possible 5)						
Helped P evaluate feelings	4*	2	5*	2.5	4	4
Offered new perspective	3	2	5*	2	5	3
Tried to understand P	4*	2	5*	3.5	4	3
Helped P recognize feelings	3	2	5*	3	5	3
Helped P understand reasons	3	2	4	3	5*	3
Encouraged Depth	4*	1	5*	1	5*	3.5
Identified Themes	3*	1	3	2.5	4	3
Maintained focus	4*	2	5	4	5	3
Modelled behaviour	4*	2	4	3	4	4
Helped P control feelings	2	1	4*	2	4	4
Encouraged P responsibility	3	2	3	3	4	3
Conveyed Expertise	4	3	4	4	4	4
Self-Disclosed	2	2	1	1	1	2

*Differences of more than 1.5

Part three

In this section, the results of the qualitative, clinical analysis of the cases will be presented. After careful analysis, six major differences between cases were identified: (a) the first session and its impact; (b) the phases of therapy; (c) the use of symbols; (d) the use of experiential techniques; (e) the creation of intimacy in therapy; and (f) the major issues in therapy. Each of the differences are presented using evidence from the cases themselves to discuss the client and therapist variables as well as the interaction of these.

The first session

As the first sessions from each case were analyzed throughly, differences became obvious. The first session in each case began to demonstrate differences that were somewhat descriptive of the whole process of therapy. Following is a summary of the first sessions of case A and B, and an analysis of the differences between the cases.

Summary of first session

Case A.

Within the first few minutes of session one, Ann expressed a feeling of frustrationn and the therapist used immediacy to address what she said. Ann expanded on this feeling and the therapist focused on this. This lead them into fifteen minutes of conflict resolution where they were all actively involved in an exploration of feelings and behaviour. Through this the therapist pointed out patterns that were present. The therapist then stated the goals for this particular therapy session so they were all aware of what needed to happen in this hour. Immediately, the therapist then asked questions pertaining to the use of alcohol. She was very involved as a listener and reflected a lot of feelings. Both clients were given opportunity to talk about their experience and as they did, they co-created, with the therapist, the goals for the entire therapy. Once the goals had been expressed and written on paper, the therapist asked the clients to physically stand in relationship to their goals. They explored this experience in the here and now and this tapped into some strong emotions, especially for Ann. She used the metaphor of a rock to describe much of what she was feeling. The therapist asked her to bring in this symbol for next week . The

therapist asked Bill to describe his feelings and they discussed how the symbol of a trophy represented how he was feeling. She also directed Bill to bring this in. At the end of the session the therapist congratulated them on how aware they were and how much they had already done in the first session.

Case B.

The therapist started the session by asking the question, "What is your perspective about what had been going on ?" Both Sam and Donna gave a lot of story around alcohol and its impact on their lives. The therapist used mostly minimal encouragers (umm) for the first 12 minutes as she listened to the story. Twice she started to reflect and the client interrupted. The therapist then said, " Let me interrupt for a moment , how does Sam feel about this?" Donna stated how he felt but moved it back to the story. After another five minutes of listening, the therapist used immediacy to question a joke that was made. This moved the focus of therapy to talking about family and the therapist started to write out a family genogram as they were talking. After about twenty minutes into the session, the therapist asked Donna to hold the thought about Sam's brother and talk instead about her perspective on alcohol. The therapist reflected some feelings but a lot of her questions were information gathering. The therapist used immediacy once more to have Sam think about something Donna said fleetingly. This didn't go anywhere. She also asked the couple open ended questions to get them to explore the feelings behind what they were saying. The couple had a hard time staying with her questions and often moved back to story. At the end of the session, the therapist asked them to think about their goals of therapy for next session.

Analysis of the Differences in the First Sessions

There were significant differences in the clients themselves and in the way the therapist conducted the first session. Obviously, these differences interact with one another to impact the session. They are listed below.

There were obvious differences in the two couples right from the beginning. Couple A had some awareness of their own communication patterns and issues, some ability to address their feelings and to stay focused. Couple B was much more inclined to

story-tell and had a hard time talking about feelings or staying focused.

The therapist set up the goals of the first session explicitly with couple A but never did that with couple B. Even her first question with couple B was vague and unfocused. The therapist seemed more involved with couple A than couple B in three ways: (a) the amount of direction she provided for the session, (b) the amount of active reflection of feeling, and (c) the amount of probing in the here and now. With couple B the therapist seemed more passive, using more minimal encouragers and more restatement of couple responses. She also did not give the session direction through experiential techniques but just let it move "naturally". The therapist not only set up the goals of therapy with couple A but had them involved experientially by the end of the session and this elicited symbols from the clients. The therapist didn't use any of these techniques with couple B.

Pattern of therapy

During the data collection phase it became obvious that there were some differences in the overall therapeutic story of each case. Stories in literature follow a pattern that readers begin to recognize. Good literary works sustain the reader's attention by moving the story along through this structure. The narrative pattern begins with an introduction, wherein the setting, main characters and problem were introduced. The main body of the story follows culminating in a climax. After the climax had been reached the resolution and story conclusion bring the drama to a close. This was a pattern that seemed to be true of most of the sessions in case A but only a few of the sessions in case B.

Generally, the above pattern seemed obvious to pick out in Case A but was not as obvious in case B. The researchers initial hunch, that more often Case A sessions involved sticking with an issue, processing it and moving to a new place, proved true after more intensive analysis. Sessions in Case B, however, seemed to move from one issue to the next using exploration but didn't follow as clear a pattern. The researcher went back to the data to gain a fuller understanding of the patterns present. Each session was observed again, explored, compared, analysed and integrated into a pattern or not. The researcher defined the pattern as following these four phases : (a) Choose an Issue; (b) Explore and Develop Alternatives (thoughts, feelings and behaviour); (c) Experience and Reinforce

Change; (d) Conclusion. Data demonstrated that there were some significant differences in the story patterns of the two cases. Table 7 and 8 list the sessions from each case that seemed to follow this pattern.

Analysis of the Differences in Story Pattern

Case A.

Almost all of the sessions in Case A followed the pattern of therapy as shown in Table 7. Most sessions involved the therapist checking in with the couple and out of that finding an issue to explore intensely. This checking in would take 10-20 minutes of therapy and then the therapist would suggest they focus on an issue. Most sessions used some kind of experiential technique to process the issue. Often there would be a lot of exploration around an issue and then the therapist would direct them to change or experience the issue in a different way. This often brought on new feelings or deepened changes. It was not possible to say that the experiences of change were permanent, however, in the context of the therapy session issues were experienced differently from the original issue. Thus these sessions demonstrated a immediate postitive outcomes (little o outcomes). One underlying theme of most of the sessions (1,2, 3, 4, 6,7,8,9,12,13) was the couple distanced around an issue. By the end of the session a new understanding and often closeness in relationship was developed. The second major theme (10,14, 15) was the couple came in fairly connected and by the end of the session this was deepened and reinforced. Session 11 involved the women alone, but this session also followed a story pattern.

Session one was mostly about goal setting, however, in the first 15 minutes the couple worked through a conflict with the help of the therapist. The couple revealed feelings and old patterns in a way that by the end of the fifteen minutes they experienced something different. Session fifteen was not included because it didn't follow the pattern clearly. The focus was more on celebrating the changes that had occurred and bringing closure to the therapy. The couple felt very connected and this was celebrated with ritual. This was an essential session when looking at the entire therapeutic story because it represents the overall story conclusion.

Table 7

Sessions with Clear Examples of the Pattern of Therapy from Case A

Session	Chose an issue	Explore and develop alternatives	Experience and reinforce new way of being	Conclusion
1	Conflict over a decision	-explored old ways of dealing with conflict - therapist helped them work through conflict instead of avoiding	-discussed new way of working through issue -discussed new understanding of the others feelings	-summarized, debriefed -congratulated the new experience -related it to the bigger issues of therapy
2	Fear as symbolized by a Ann's rock	-discover patterns of the rock, the fear of being taken over and the fear of not knowing who she is - talked to pain, tried different voices, pain moved away	-discussed learning about caring for self and about how to set up boundaries	-summarized and reinforced Ann's experience of Bill not fixing it. -congratulated for new pattern
3	Boundaries and barriers symbolized as walls	-explored the wall and the feelings around it, how they interact in the wall -took the wall away and experienced new ways of relating and new feelings around this	-both expressed a change of connection over session -discussed what to do in the future with the walls : how they come up and how to deal with them	-reinforced feelings of not having a wall -encouraged them to work through this -gave homework to work keeping walls out
4	Ann's fear as externalized in a chair	-explored feelings around fear and behaviour it brought out -moved the fear and explored	-both expressed feeling lighter and more intimate -discussed what to do with fear in the future	-debriefed and reinforced new feelings

5	Explored alcohol using symbolic externalization	-explored issues, feelings, behaviours, thoughts around alcohol -explored new ways of being since alcohol has been gone -removed alcohol symbol from room and discussed	-discussed learning about the power of alcohol and the intense hatred -discussed how it could come back and how would it be different	-debriefed the experience -therapist reinforced learning
6	Explored money and patterns of relating using a sculpt	-discussed the position in relationship to feelings, issues of trust and options -moved chair to be equal partners, a new way of being -brought up exploration about self devaluing patterns	-discussed learning about living with feelings even if they don't change but finding ways to listen and care for one another in the midst. -discussed how this session they experience a new pattern of equal partnership	--therapist reinforced and summarized pattern -congratulations of new pattern
7	Explored alcohol by reenacting a scene where Bill recently drank	-reexperienced in the here and now the feelings, thoughts and behaviours -brought in Bill's "child" spoke to him and loved him	-discussed understanding new reasons behind drinking -understood what needs to happen in the future to avoid this again	- therapist encouraged new experience of staying with feelings -therapist debriefed experience for Ann
8	Explored feelings of hopelessness and frustration	-a lot of feelings come up -expressing patterns of wanting to give up, taking things personally -positioned to goals brought up issue of fear of losing Sue -explored what one step closed to goals would mean	-discussed new way of staying with feelings -reinforced how Bill came back to conflict rather than avoiding it -took a small step towards goals each person found a way to honor it	-therapist impressed by new experience -encouraged them to do some homework -warned them that they are both vulnerable

9	Explored grief over losing identity using symbol of rock	-deep feelings of sadness around old identity and concerned for future patterns -visualized future,explored feelings and then positioned selves in the future Explored feelings	-discussed new way of feeling connected, lighter -a new symbol to be brought into therapy -each acknowledged the changes	-debriefing of session, and support of changes -clients made plan to change over week.
10	Explored changes in client's relationship and represented it in a sculpt	-explored new feelings to each other because of changes -sculpt of their relationship brought even more self-disclosure and intimacy	-discussed sculpt, this reinforced feelings -related new sculpt to symbols -celebrated this new way of being with words and a kiss	-debriefed and honored intimate session -reinforced their hard work and encouraged celebration -warned of sabotaging
11	Explored issues of weight over decisions using albatross symbol and two chair	-exploration of feelings around kicking Bill out and dealing with being alone lead to metaphor -metaphor brought out two parts - two chair explored , gave voice and practice	-two chair reinforced decision not to let Brian back -strong independent voice came through -discussion of how to keep using strong part	-debriefed and supported new voice -albatross gone -connected changes to in patterns
12	Explored drinking episode after session 10 using symbols of seal and alcohol	-exploration of feelings before, during and after slip -related patterns to family -bring in child, grieved loss -tried new ways to care for child -Ann expressed new strong voice that wasn't codependent	- seal was given a voice -ideas were generated to care for seal (Brian) -seal was placed back on track from being lost	-summarized learning and goals to reinforce changes -support and freedom expressed

13	Explored control issue by reenacting dancing evening	-exploration of feelings around that night revealed old pattern emerging -realization that alcohol gone but needed new way to relate without control -worked through that night and practiced validating feelings and differences	-summarized how old patterns were finding ways to emerge -connected this experience to the larger issue of staying with feelings and being congruent -discussed how this came up in relation to AA meetings	- summarized learning and supported -encouraged homework of staying with feelings
14	New changes and patterns were compared in relationship to symbols and goals	-old patterns were discussed new patterns were realized -symbols had changed and disappeared -relating on a different level	-physically moved in relation to the goals - extremely close -discussed new changes and feelings -symoblized this with a drawing	-honored changes -congratulated -discussion of vulnerable state and thus cautioned to stay with new patterns.

Table 8

Sessions with Clear Examples of the Pattern of Therapy from Case B

Session	Chose an issue	Explore and develop alternatives	Experience and reinforce new way of being	Conclusion
6	Explored the issue of "togetherness" through the symbol of a new ring	-discussion about changes made brought up an old pattern of relating- joking\ distancing - family issues- mothers are explored using empty chair -new way of relating explored using symbol of a new coat- protective with boundaries	-therapist integrated symbols and learning with larger context of life- work, family etc. -acknowledges new ways of setting boundaries- reframed	-debriefed and summarize -congratulated new place
8	Explored the issue of alcohol using externalization (Sam alone)	-discussion of its presence and pattern of falling back on it - Explored feelings,fears and options around letting it go or keeping alcohol- therapist challenged a lot	-reinforced options and moved to how to stick with goal -how to get help and what stopped Sam from getting close	-therapist supported any effort Sam made -therapist summarized
11	Explored the issue of closeness using the symbol of a wall	-explored all the dimensions of the wall and how it has stopped Sam from getting close -feelings of fear were explored -moved to describing wall in future- he drew a saloon gate	-supported wall as a boundary -encouraged the new gate and explored how this will be different -addressed the feelings connected	-summarized session -supported this new place for Sam & affirmed that people will be let in

13	Explored the issue of guilt using a box to symolize it	-related guilt to alcohol and sexuality and family -discussion of the power and control it had -explored ways to get rid of it and what it would feel like	-Sam talked to guilt and took control - he said good-bye and had it leave the room -exploration and debriefing of this experience	-summarized session and reinforced the connections of guilt to many areas of Sam's life -encouraged to bring in tangible symbol of guilt
14	Explored the issue of guilt using the symbol of a Ken doll	-intensive exploration of guilt and how it related to patterns in family and to childhood isolation -Sam took more power over guilt talking to him and saying good-bye to him	-Sam puts the doll in the bag and closed it -therapist reinforced that new patterns need to repeated over and over -challenged them both to be aware when old pattern tried to come back -clients come up with steps of what to do	- summarized old patterns reconnecting them to old issues -congratulated on hard work -warned of vulnerable state, encouraged new ways they chose to cope

Case B

Only five of the sessions in Case B followed the pattern of therapy (see Table 8). The other ten sessions had elements of the therapeutic story but did not contain the entire pattern. The establishment of an issue to work on seemed to take a long time to form, to not happen at all , or to include a number of different issues. Often patterns were explored and challenged but most of the time was spent on gaining an awareness of these rather than expanding alternatives or experiencing new ways of interacting. The new awareness was often summarised but the clients had not necessarily experienced a new way of feelings or being so integration of this was not necessary. The final phase of the session (conclusion) generally occurred by acknowledging and summarising the new awareness. The two main differences in some sessions (1,2,3,4,5,7,9,10,12) of case B were the lack of focus on one "story" or issue and a lack of experiencing alternatives which could allow clients a new experience during therapy.

Use of Symbols

The following section will describe the use of symbols in each of the cases and then give an analysis of the differences between cases.

Initial use of symbols

Case A.

A large part of the first session was spent writing up goals. The goals then became a symbol of what they wanted to be like in the future. The list was always present during the sessions and was often referred to in relationship to growth and other symbols. The therapist also symbolically represented alcohol as a bottle and had them place it somewhere in relationship to the goals. Bill removed it from the room completely. As well, during the first session of therapy the clients were asked to bring in symbols representing themselves as they were now. For the second session, Ann brought a rock and Bill brought a seal. Within the first ten minutes of the session these symbols were used to explore and intensify the couples feelings around fear of closeness and self preservation. These symbols were

worked with throughout the course of therapy. Often referred to as patterns, the symbols were explored,worked through and changed.

Case B.

Most of the first session was spent on the background history of the couple's relationship and their family of origin. No goals were set and no symbol was discussed. During the second session goals were written and these became a symbol that was used during therapy. The third session's focus was around alcohol, which was symbolically externalised in the form of a bottle. It was not until the fourth session that the therapist directed the clients to bring in symbols representing some aspect of themselves. Sam was invited to bring in a symbol representing his father and Donna was to bring in a symbol representing herself in the future. The clients never brought in these symbols, even after the therapist asked them to in the next two session.

Further interactions with symbols

Case A.

Throughout the course of therapy the symbol of the goals, the alcohol, the rock and the seal were worked with directly or integrated into the process that occurred. As well, other symbols were utilised to explored issues.

The Goals

The goals were used throughout the therapy session and in all but 4 session were referred to. The couple was asked by the therapist to place the symbols in relationship to the goals (session 2, 3, 5). In session 1, 2, 8 and 14, the therapist had the couple physically move in relationship to how far they were from the goals. In session 9, she had them move to sit by the goals so as to imagine what it would feel like to have reached them. As they explored the process of each of these experiences in the here and now, it deepened their experience.

The Bottle

The symbol for alcohol was brought into therapy numerous times. Sometimes the clients brought up alcohol, sometimes the therapist asked specific questions about it, however, the therapist was always the one who brought the bottle as symbol into therapy. In session one it was simply externalised as a bottle but removed from the room quickly by Bill. It was explored throughout session 5, as the therapist suggested they examine the role alcohol played in their relationship. Issues of co-dependency, power, hiding from pain, and self-esteem were explored with a high degree of intensity. Eventually, Bill removed the symbol from the room and this experience was debriefed. Session seven was an reenactment of a recent drinking incident, the symbol was present throughout and was referred to in exploring feelings and thoughts. The symbol was used to represent it's relationship to and distance from the goals again in session 13 and 15.

The Rock

In session one, Ann's internal feelings were represented as a rock. She brought a rough rock about the size of a football for session 2 and explored the feelings behind it. A lot of fear and anxiousness were connected to the rock. This came out clearly as the symbol of the seal got close to the rock. Bill said the seal wanted to climb on top of the rock and this felt to Ann like being invaded and taken over. A lot of deep feelings were expressed during this session. Throughout the course of the therapy the rock was present, at different times it got smaller and eventually left the room (session 10). During session 11, it seemed to over take Ann again but through further exploration the rock moved away again. In session 12, 13, 14, the rock basically disappeared and during the ceremony of session 15 it had lost all meaning and Ann wanted to give it away to the therapist.

The therapist often referred to the rock in therapy and often checked in with Ann as to where it was in relationship to the goals. As the therapist probed about the rock, she was often able to tap something deeper in Ann which then was represented by another metaphor (the ogre- session 2; the albatross- session 11, the fear chair- sessions 4, 6,7) and the exploration continued.

The Seal

The seal represented Bill throughout the therapy session. The seal symbolically represented Bill's growth. Initially, the seal wanted to get on top of the rock (session 2) but decided it would just look at the rock. Eventually, the seal was able to turn and look at the goals. Twice during therapy the seal was lost. During session seven, the seal went over to alcohol, representing the slip Bill had that week.The seal was explored intensely in session twelve in relationship to alcohol. It became a lost seal that was pulled into the fog by alcohol. This lost seal was Bill as a small, abandoned, unloved little boy. By the end of the session the seal was not lost but was put back on track and placed facing the goals. It was very symbolic that the seal went through a process of initially wanting to get on top of the rock (Ann), then turning just to look at the rock, then turning to look at the goals, then getting off track and wanting the rock to rescue the seal, but eventually getting back on track on his own and moving towards the goals until he reached the goals. The seal was used in a powerful way by the therapist to get Bill in touch with his immediate feelings and to explore some past experiences in the here and now.

The Ogre

In session two as the rock was being explored, the therapist had Ann symbolically externalized the intense black pain she experienced. It was represented as an ogre. The therapist helped Ann move through an empty chair process where she described it, listened to it, talked to it, gained insight about not giving herself patience or looking after self, and eventually Ann came to control the ogre.

The Wall

In the beginning 10 minutes of session 3, Ann joked about there being a wall between the seal and the rock. The therapist immediately got a cardboard box and used it as a wall. Exploration continued around the wall for the rest of the session. Towards the end the clients were directed to remove the wall, which they did, and then they explored the feelings around this new experience.

The Fear Chair

At the beginning of session 4, Ann arrived and expressed a need for space. The therapist intensified this boundary and challenged Ann about the fear of getting close. A symbol of Ann's fear was created by the therapist in session four. It was represented as a chair and was positioned in relationship to Bill. Most of the session was then spent exploring the feelings and thoughts around fear. Eventually, the therapist asked her to remove the symbol of fear and experience what this was like. This symbol came up again in session 6 and was used as a part of a sculpt to represent their relationship. By the end of therapy, fear had completely disappeared.

The future

During session 9, the therapist directed the clients to do a visualisation of the future and then physically move into the future by going near the goals. The therapist asked them to symbolize the feelings around this experience. Both of them thought of a feather and brought one in the following week. Session ten explored the feather and they both anchored it in relationship to the goals. In session 14, they moved towards the goals and symbolically represented their new future with a drawing. As this was explored, some deep feelings came out regarding the fragility of their relationship.

Case B.

The bottle

This was the one symbol that was used throughout most of the therapy. Session three was the first time symbols were worked with. The therapist symbolically externalised alcohol using a bottle and the clients referred to it as they processed an incident from the previous week where Sam drank. They were to place it where they thought it was in their relationship. The therapist tried to have them sort out how they felt, however, both of them had difficulty staying with feelings and continually moved to the story line. The therapist had Sam put the bottle in relationship to the goals, his father and himself. He put the bottle back in the trunk, completely removed from the picture. Issues were brought to awareness but not explored in depth.

During session 7, the therapist brought out the bottle symbol and asked Donna to

place it in relationship to the goals. Donna then told the story of the drinking incident and expressed a lot of anger. Both clients stayed with the story of the drinking incident rather than processing feelings, but some awareness arose. The therapist always reflected feelings around the story.

Session 8 was with Sam alone and the therapist asked him to place the bottle in relationship to the goals. It was still very present and the therapist confronted him on this. They spent a long time exploring the feelings and mixed messages he had around alcohol.

The ring

Session 6 began with the couple showing off the ring they had made for Donna as a Christmas gift. It was very significant because together the clients made this ring to symbolise the "we" of their relationship. Up until now, they felt like they were stagnant but now they felt this was a step forward. They were struggling to say we and ours, but this ring symbolised the new connection and relationship . The ring was also connected to Sam letting go of his mother. As they explored the ring, the therapist used immediacy to reveal an old pattern of distancing when it was too intimate. They were able to process this experience in the here and now. However, the rest of the session moved away from this symbol to exploring more issues about Sam's mother on a more cognitive level. The ring was mentioned only one more time in passing by Donna but it was not used again in therapy.

The wall

Sam came in alone in session 11. He began to talk a bit about the walls he had in his life and the therapist represented this by getting a flattened cardboard box. He put it between them and described the wall to the therapist. They explored how this wall had stopped him from getting close to people.He had always had windows and shades but was becoming aware that he was closing these off. The therapist was helping Sam get in touch with his feelings. He immediately switched to something else and admitted he interrupted people to avoid feelings. He was frustrated that he had wasted so much time and had been so afraid. However, Sam also stated that this distancing behaviour was improving as the

other day he saw an old friend and was honest about his recent problems and why he hadn't been in touch.

They continued to explore the wall but on a fairly cerebral level. The wall was described and so were some fears, but not with a lot of emotional connection. The therapist moved to talk more about how the wall would look in the future with the gate in it. He actually drew a picture on the wall of a saloon gate that opened both ways and was never closed. The gate was still joined to the wall but there was movement. However, he wanted to not leave it open too long, not let out too much hot air or bring in too much cold air but keep the opening under control. At the en, the therapist summarized the discussion about the wall and talked about boundaries being good. She also affirmed the fact that there was going to be a gate that let people in.

The wall was mentioned briefly again in session 12 and 15 but was not worked with.

The future

In session 4, the therapist had the clients visualise the future comparing where they were now and where they were going. After they processed this for a few minutes, she asked them for a symbol of who they hoped to be. They couldn't think of one at the time. The therapist did not pursue this and the clients started on a new story.

In the session 5 and 6, the therapist asked for their symbols of the future but they had not brought them in or even thought of something.

In session 7, the therapist asked again about the symbols and neither had brought them in. Donna described her symbol as a field of flowers, that represented actually being further away in relationship to their life together, but in her own personal life it represented how she was feeling great. Donna noticed the hurt in Sam's face as she expressed this picture. She then stated that telling the truth was hard but at the same time she felt better. This symbol was not explored in the session and was only mentioned once more in therapy.

Sam came in alone in session 8 and had brought a picture representing what he eventually would like to reach. It was a picture of his sister and him standing close,

without the presence of alcohol for Sam. The therapist engaged him in exploring the picture, however, Sam moved away from feelings and used a lot of story around his sister and money. The therapist didn't engage Sam experientially with the picture or explore the feelings in the here and now.

Guilt

The issue explored most in depth through symbol was guilt. Guilt was mentioned in session 1, 6 and 9 but was not worked with. In session 7 it came up again and the therapist represented guilt as a chair which Sam placed slightly away from him. Sam said his guilt had been leaving since quitting drinking. When asked where guilt was experienced on his body, he said he felt it in his throat. This was the end of the exploration and it only lasted about five minutes.

During session 13, when guilt was mentioned, the therapist externalised it as a Kleenex box and asked Sam where he would put it. The therapist engaged Sam in an exploration of guilt. At first there was a lot of story from Sam about where guilt came from but the therapist moved the discussion to exploring the dimensions of guilt. Discussion moved to how to get rid of it. Getting rid of it meant getting rid of part of himself. The therapist had him try to let go of the guilt. He spoke to the guilt and said good-bye. Sam didn't seem committed to letting go yet as he expressed how it would be waiting at home for him. The therapist encouraged him to bring guilt in a tangible form that he could get rid of.

Session 14 immediately started to address the issue of guilt as Sam brought in a Ken doll to symbolically represent guilt and he brought it out to show the therapist..The doll had a bottle around his neck and his hand was up waving good-bye. They explored the man and how each of them felt about him. Guilt was related to alcohol as Sam stated, "It had been a big stone around my neck for a long time". At the end of the symbolic exercise, the therapist summarized the connections between guilt and many other issues.

At the beginning of session 15 , the therapist was setting up for the closing celebration and summarized the use of the symbols used during therapy. The session continued by focusing on guilt (the doll). Sam wanted to get rid of it as he didn't want to

take it home. He had an earlier profound experience of doing a ritual burning at his treatment program and wanted to do something similar. Sam wanted to say good-by to this symbol by throwing it away. He placed guilt back in the bag. Sam admitted that it was hard to do but he did it. All three of them left and took the bag out to the dumpster. Upon returning they debriefed what had just occurred.

Attempts at symbols

The therapist attempted a number of times to either symbolize the clients experience or feelings but did not seem to hook the clients. At the beginning of session three, Donna expressed a lot of anger. The therapist attempted to have Donna look at her anger using a symbol but she didn't pick up on this. Again in this session, the therapist attempted to have Sam interact with the metaphor he used about getting back on the horse (sobriety). Sam talked a bit about his confusion around where to go from here, but he then moved away from alcohol and questioned the therapist about her methods of associating feelings and symbols. This moved the exploration away from his feelings. The therapist tried again to bring it back to anger and the symbol of anger, but this did not occur.

During session 4, the therapist had the clients place family members in the room using chairs. This was done but it was not processed with any depth or exploration. The clients themselves did not work with the symbols. Again in session 6, the therapist had them focus on their mothers as chairs in the room, but Sam and Donna represented them as being out of the picture and the exploration stopped there.

Analysis of the Differences of Symbol Use

The use of symbols in each of the cases differed significantly. Both the quantity and quality of the integration of symbols for Case A was greater than for case B. Symbols were referred to 65 times in Case A and most of these references involved working with symbols to get at some deep feelings and behaviours. In case B symbols were mentioned 31 times and a majority of the interactions with these were short and didn't move into any deep exploration. There were a few symbols in case B that were worked with in therapy: the

bottle, the ring, the wall, the future, and guilt. However, only guilt seemed to be a symbol that was processed and worked with in a way which lead to some deep exploration and change of the symbol. A few other symbols were mentioned by the therapist but these did not become part of the therapy. In both cases, when a clear connection to a symbol was made and it was worked with, the level of exploration seemed to deepen and move away from just storytelling but involved an exploration of feelings in the here and now. As well, with the use of a symbol the clients could experience change by moving the symbol and could represent change by changing the symbol or getting rid of it.

Experiential Techniques

The following section describes the experiential techniques used in each of the cases then gives an analysis of the differences between the cases.

Sculpting

Case A.

Sculpting was used six times during the course of therapy. Three of the six sculpts were intense and took up a majority of the session. During session 6, the therapist directed the couple to sculpt their relationship as they saw it now. Bill did one first using chairs. The sculpt represented the distance they felt and the fear that was between them. The therapist had Ann remove the fear chair and explore the feelings around this. Then Ann was asked to create a new sculpt of what she would like their relationship to be. Ann moved the chairs to represent equal partnership.

At the beginning of session 10, the clients talked a lot about the changes and the new sense of closeness they were experiencing. The therapist directed them to use a sculpt to demonstrate how they would like their relationship to look . Each client created a sculpt that demonstrated intimacy and independence. As the sculpts were explored a very touching moment was created.

In session 13 while reenacting an incident over dancing, the therapist directed them to do a sculpt about how they felt that night. Exploration centered around feelings and patterns that emerged. New awareness and understanding was gained.

In each of these sessions, the therapist directed them to enter into the sculpt and used empathy, explorations, interpretation and immediacy to explore the experience with them.

Case B.

Sculpting was used only once in the course of therapy. In session 7, the therapist had them do a sculpt of their relationship. Donna and Sam worked together to create a sculpt. This brought up a lot of feelings and a discussion about sex. They both began to express some deeper feelings but Sam got nervous. Sam tried to escape the sculpt but the therapist intensified the sculpt with questions, challenged with immediacy and then stated directly that they should stay with this. The sculpt was then explored further but as the discussion around the lack of sex in their relationship continued, they dropped the sculpt and sat down to continue exploring this issue apart from the here and now. The session moved into an emotionally detached discussion of their sex lives that didn't last long.

Reenactment

Case A.

Reenactment was used intensely two times during the course of therapy (session 7 and 13) as recent situations were brought up and explored. In session 7, the therapist directed Bill to recreate the drinking incident in the here and now. He physically, emotionally and cognitively relived the experience during the process. This took 30 minutes of the therapy and was debriefed after. A lot of connection was made between pain around his father and alcohol.

During session 13, the couple was directed to reenact the incident in which they went dancing. Again the therapist had them relive the situation physically and talk about their feelings in the here and now. The therapist also had them do a sculpt to represent how they were experiencing themselves.

Case B.

There was no reenactment used with couple B. They too brought up recent

situations that happened between therapy sessions (two drinking incidents that upset Ann, frustrations at work with a co-worker) but they were mostly recounted in story form. The therapist attempted to ask them questions about how they were feeling in the here and now but had not first set them up to be in the here and now.

Two Chair

Case A.

During session 11, a two-chair technique was used in a powerful way to allow Ann to experience that part of herself which had strength to assert her needs. Ann came in alone and was confused about many issues around kicking Bill out because he drank. The therapist identified three parts of Ann: (a) standing up for self , (b) giving into others and (c) complete apathy. Each was externalised, given a voice and explored. Eventually, the therapist directed Ann into a two chair with a women at work and this let Ann's "stand up for herself voice" speak strongly. Exploration of the feelings experienced with this new part of herself occurred. Ann liked this side of herself.

Case B.

There was no two-chair used with couple B. Sam and Donna often expressed different parts of themselves and the conflict between these but the therapist never directed them into a two-chair. Donna often talked about how her inside feelings didn't match her outside behaviour.

Artwork

Case A.

During session 14, the therapist had the couple move to where they saw themselves in relationship to their goals. They both moved very close to the goals. In this new spot, the therapist asked them to draw a representation of this new place. After they had drawn the pictures, they were explored, which brought out new feelings and fears. These were processed,worked with and resolved.

Case B.

There was no suggestion or attempt at artwork in any of the sessions of case B.

Analysis of the Differences Using Experiential Techniques

The differences between the two cases in regards to other experiential techniques were significant both in quantity and quality of use. Numerically, case A session comprised of over double the amount of artwork, sculpting, reenactment, rituals, burials and two chair work than case B. The therapist was quite directive with couple A and often suggested entering into an experiential technique. Couple A seemed ready and able to participate in the experiential techniques, which usually drew them to a deeper place of connecting with their thoughts and feelings. Couple B didn't appear as ready for exploration using these techniques but the therapist didn't direct them into these as readily either. When she did use them with Couple B, their level of experiencing and expression of feelings increased, even though it was hard for them and they put up some resistance. Again the interaction of these two factors impacted the amount and quality of use.

Intimacy Creation Within Sessions

There was a demonstrated difference in the couples' experience of intimacy in therapy. Two types of intimacy creation were evident in the sessions. One occurred as the couple expressed distance or frustration in their relationship and worked through it to a new place of connection during therapy (Intimacy process). The second type occurred when the couple expressed some positive changes in their relationship and the therapist drew them into an experience that deepened and reinforced this intimacy (Intimacy reinforcement). In case A, it was discovered that four sessions contained the first type called Intimacy Process (1,3,4,6) and three sessions contained the second type called Intimacy Reinforcement (9,10, 14, 15). In case B, it was discovered that only session seven contained the first type called Intimacy Process, although sessions 10 and 12 showed some attempt. The second type, Intimacy reinforcement started to happen in session 6 but didn't go to completion. A few other sessions from case B had the potential

to contain the intimacy process because the marker event was present (distance in the relationship or expressed positive change) but they didn't go anywhere. Following is a summary of the sessions stating the new place of intimacy or understanding they had reached.

Intimacy Process

Case A.

In session one, Ann expressed her concern over a decision Bill had made that didn't involve her. This lead to a deep expression of feelings, some conflict resolution guided by the therapist, and an eventual resolution with each other that lead to some new understanding.

T: (speaking to husband) I really appreciate this and I want to know how you are experiencing yourself right now, after this conversation.

B: Mmm. Well, honestly, o.k. I'm relieved. But I honestly don't see the reasoning for going through the dance to get to this result, like follow me?

T: It's a long way to go a long way around.

B: Ya, that's all but like I understand Ann's viewpoint now more anyway. I guess I just can't take what I consider little things for granted.

At the beginning of session three, Ann expressed that she felt there was a wall between the seal and the rock. Bill was surprised there was a wall. They were experiencing their relationship as distant. A cardboard box was put up by the therapist to represent this. There was a deep exploration of feelings,thoughts and fears around their relationship. Towards the end of the session, the therapist asked them to move the wall and they explored the feelings around this. Both expressed a new feeling in their relationship.

T: O.K. so if you are focusing on the goals then somehow you don't see the paths, blocked paths and those walls.

B: Ya.

T: So you feel clearer?

B: Ya, much clearer

T: How's your body feeling now that you were clearer?

B: Much better, much better

T: What's that like, that better feeling, what's that like?

B: Ah, more relaxed

T: You feel more relaxed, right now.

B: Ya, loose, not rigid, and even that went away.

T: Oh, it went away, I see. What about for you, Ann?

A: The same, just letting go of the problem, focusing on the positive. And um, I'm just, that he moved, it just felt better. The ache isn't there anymore.

T: So what was there instead?

A: Kind of a patience I think. First of all I was going to say excitement, and there probably was some maybe there was some excitement but it's not real deep but there was some. I just kind of had this we can get over this hurdle and if something would change for the good, we'd get moving.

Early in session four, Bill noted that Ann had been quiet and he wondered why he felt distance. As this was explored it became clear that Ann was putting up boundaries because of a fear of being invaded. The therapist asked Ann to place fear in the room using a chair as a symbol. It was very close to Ann and was in between Bill and her. They explored many feelings around this fear. Eventually, the therapist asked Ann to remove the fear, face Bill and experience this. After much exploration around this, they both felt more connected to one another.

A: It felt like a release because I haven't wanted to tell you the truth. I just haven't wanted you to know. So it felt lighter, I'm really afraid of saying any of the negative thoughts I have.

...

T: ...So what you have done is move fear away and allow yourself to be connected to Bill in a way that felt scary to you because to move fear away was to get closer, and then you were able to share what was going on inside and you noticed that it changed as you were talking. So you did something which was different from when

you were fourteen, you felt isolated then and you didn't talk about it. So something was different here you were talking about it, and were not letting yourself be isolated.

A: I didn't ever talk about it at all...

T: So when you talked about it , (Uhumm) it changed you felt better and Bill took the Kleenex away.

...

T: You did it here today. How did you do it here today? You have done it here.

B: I don't realize how I've done it other than trying not to say as much, maybe just listen more I don't know.

T: You had been very successful here.

B:Ya

T: And she felt safe enough to share with you something that she had been afraid to say and when she said it, she felt better and you have some closeness. How did you make it safe for yourself Ann?

A: I took the fear away and just said it rather than.... just took the fear away. Mainly, just took the fear away.

In session six, after some discussion over the tension regarding finances, feelings of frustration emerged. The therapist asked the couple to sculpt their relationship using chairs according to how they felt right now. Ann sat in a chair with her fear beside her and Bill turned his chair so his back was to Ann. They discussed the feelings of being alone, distant and unequal partners. They spent most of the session exploring this. The therapist then asked them to move their chairs together to experience what it would feel like to be equal partners. At the end of the session, the therapist had them look at this experience and talk about their immediate feelings. Ann was feeling understood and beginning to feel like an equal partner. Bill also felt good and felt more equal to Ann.

T: What was it like to feel understood by Bill?

A: It felt like I'm an equal (laughs)

T: Now does this feel like a dream or does it seem to have a realistic base to it?

A: It felt real

T: It felt real and right now you feel understood by Bill. O.K. So was there anything you

want to say to him right now.

....

T: What does it feel like Bill, to be sitting here next to an equal partner? What does this mean to you? How does it feel?

B: Oh it feels good to have her back because I've always looked at Ann as an equal partner, and I don't mean 50/50 in everything we do, I just mean together that's an equal partner. Its not one side of the balance sheet or the other. It's together and it feels good.

Case B.

Session seven contained one of the only examples of the clients and therapist creating intimacy process in therapy. There is still some frustration in Donna at the end of the session, however, movement had occurred in terms of understanding each other. Sam had been drinking that week and Donna was mad. The first part of therapy explored the feelings around this incident. A lot of story came out but Donna did express how she felt when Sam drank. The therapist directed them to create a sculpt of their relationship. Sam set up the sculpt so that they were facing each other, holding hands and looking at each other. The therapist asked them to enter into the sculpt through describing it and exploring the feelings inside. This sculpt was explored in the here and now as the therapist asked questions and probed them to focus on the sculpt. She also had the clients focus on how the other might be feeling. The lack of sex in their relationship came up and the sculpt began to get harder for the clients to develop. When Sam wanted to move away from the sculpt, the therapist encouraged him to stay. The therapist had them talk to each other. The distance between them was revealed and feelings of frustration around sex emerged. At this point the therapist had them sit down and move out of the sculpt. They then explored the attempts and the feelings of failure around the issue. The therapist brought Sam's fears of failure and of being left behind to the surface. An attempt was made by the therapist to

move them from a feeling of distance to something different.

T: I wonder what information you have about this relationship right now. Is there something you need to do or say for this relationship?

S: All I can say is be patient and I understand what you are going through and I know that doesn't... but if I can't find it in time I don't know if I can put a time line on it. If I don't come up with it in that time its not going to work. That's what I feel. Hoping that what we have to together, it has worked well in the past. We work well together, I mean we are friends, we are good friends.

T: You are encouraging yourself. And do you think alcohol, we put alcohol here at the beginning of the session and I was wondering where it is now, if the two of you know where it is now.

S: It's between us

T: It's still between you. Is that right Donna? Has it moved at all?

D: No. I don't understand why he is drinking now but I don't think alcohol is going very far away. I don't think he is ready to give it up. I think he tried for me. I don't think he tried it for himself but for me because he knew he almost lost me.

The therapist brought the session to a close soon after this. The tension around alcohol and sex was still very present.

The couple's relationship was addressed again in session ten, and the therapist attempted to explore the feelings in their relationship. Distance and frustration was evident in Donna as Sam had been drinking the previous week. However, she expressed that she could live with it if it didn't interfer with their lives. The therapist challenged her on her own co-dependency. As the therapist explored the incongruency of Donna's statements, Donna's feelings of disappointment and confusion about their relationship came out.

D: Disappointment. Like I feel... I come to these meetings... I have great expectations things are getting better and ... then the thing in here is nudging , andthat thing is still here (the bottle) and you feel like you are getting better but that thing is still there. But things are getting better, money is getting better,

communication between us is getting better, being comfortable around each other is getting better but there is still that (points to the bottle) and there is no sex. It's normalcy put it that way.

....

D: I feel like my insides aren't matching the way I appear on my outside.

G: Have you had that feeling before?

Some exploration about how Donna was feeling around their relationship continued. Donna talked a bit more about sex but the questioning from the therapist moved to Donna's partner at work. A lot of time was spent exploring her feelings with the partner at work. The therapist also attempted to help Sam get in touch with his feelings about this partner. The focus of the session moved away from their relationship directly, however, the therapist tried to make the connection between these feelings and alcohol. Again some new understanding was gained but specific deep exploration about their relationship and movement to a new place was not evident.

In session twelve, the couple came in frustrated that Sam had been drinking again. The therapist attempted to move them into an exploration of alcohol's functioning of keep them distant from each other. This exploration brought up a lot of feelings, however no new place of closeness was expressed by the end of the session.

T: Alcohol is one way of keeping your distance.

S: Well, I don't use it to keep distance, is that what you are referring to?

T: Well, it certainly has that function, it is one way of keeping distance your distance from each other. I would think, that is just what I heard from...

S: Ya, she has a very keen nose.

Donna expressed that she was feeling distant from Sam . She was feeling like her confidence was shot and she was being controlled by her work partner. The therapist lead Donna in a exploration of this and a lot of story came out. When the therapist brought Sam in he expressed cognitively that they were working on things and often learnt a lot about their relationship but it was difficult to carry on at home. Sam moved this discussion

quickly to a story regarding his relationship to his children and a drinking incident. The therapist tried to relate it to a bigger pattern of Sam's need to control and fix. The therapist asked Sam to stay with his feelings and to focus on how Donna was feeling. The therapist directed them and focused them toward more exploration of when their distant and unsupportive feelings towards each other occured. The focus then turned to how Donna felt at work and in her family of origin, rather than the marriage relationship. This brought out a lot of emotion (tears) but Donna became concerned that too much focus was on her. When the therapist addressed how Sam felt about what was happening, the session moved away from Donna's emotions and the therapist spent about 15 minutes teaching about emotions, while the clients asked her questions. Feelings were explored more deeply for Donna but they did not make a connection with each other or work through the hurt, anger and pain. The focus at the end was to encourage the clients to continue experiencing their feelings.

The distance in couple B's relationship is mentioned numerous other times but not experienced in a new way during therapy. For example, at the beginning of session two, Donna came in and sat down. Then Sam came in and sat quite far from her. Donna commented on this and the therapist used immediacy to ask if they are sometimes too distant in their relationship. Donna acknowledged this distance but it was dropped, as the therapist asked them about their goals. During the discussion, Donna again stated that she felt she was moving further away from Sam, especially physically, however the therapist didn't direct them further in this issue and the client didn't continue this discussion either.

Session three also began with Donna talking about Sam's slip with alcohol from the past week. She was very angry and hurt and was even considering leaving over the incident. The therapist had the clients express their feelings around the alcohol but they had a hard time staying with feelings, often moving back into the story, which the therapist followed. Each of the clients were focused on themselves and their story, or their own past and had a difficult time entering into conflict resolution with each other. The therapist tried to have them look at how the other one may be feeling, however she never directed them to talk to each other. Sam admitted he was trying to just smooth things over rather than

discuss it and yet he realized this was not working very well. At the end of the session, the therapist asked them to move to a new place by saying something to one another about what had happened.

T: Is there anything you need to say at this time to Donna?

S: I can't thing of anything at this time

T: Ya , O.K.

S: There isn't just some work or phrase to sum up what happened.

T: Can you turn and look at her as you say this or anything else you have to say at this time.

S: I'm sorry , it won't happen again. She is going to think those words are all....

T: How do they feel to you . What do you feel inside?

S: I know they feel like I mean them but I know she is not going to believe them.

T: So as you say them feeling like you mean them in your heart, you also are kind of discounting them a bit.

T: Since I've heard you come in and acknowledge your achievement and acknowledge that your anger is bigger than just towards Sam, its more global than that because it is connected to your family of origin and never getting the recognition and appreciation from your mother. I'm wondering if from the context of your life what you need to say to Sam for his behaviour, his lapse. What is the essense of what you need to say?

D: I just wish you hadn't done it because it just reconfirms my past.

T: The past with your mother?

D: The past with my life.

The therapist affirmed that all of these patterns and issues were bringing up things from the past and this was a great opportunity to deal with them. Donna expressed that she still felt frustrated that she rescued Sam and martryed herself. The tension between them was still evident (difficulty in talking directly to each other, lack of clear resolution). Mostly the exploration from the session brought up more issues.

Session 13 began with an expression of Donna's anger around the drinking again.

Exploration of the pattern of co-dependency was the focus of the first part of the session, however,it moved to exploration of Sam's guilt using symbolic exploration. Again this session demonstrated feelings of distance from each other, however, there was no demonstrated reconnection by the end of the session even though each of them discovered and explored some new areas and new emotions separately.

Intimacy Reinforcement

Case A .

During session nine, they continued to explored the rock and the fear. These symbols seemed to be moving away from the goals and not blocking them as much. Ann was grieving the loss of this identity and was not sure what her new identity would be. They both felt somewhat optimistic about new changes. The therapist asked them to look at what it would be like in the future through a visualisation. Both of them expressed a new feeling of peace. They verbalized their desire for closeness and separation in their relationship. They moved their chairs to sit close to one another and to the goals. They discussed their feelings around this and expressed feeling lighter and more connected to one another.

B: It's surprising that a few steps can change the perspective so much that came to my mind I guess.

T: Your enjoying the change and you notice that you feel lighter and what is it like Ann to be sitting here next to Bill?

A: I was thinking (laughter) perhaps it really is this easy... This felt good, I feel taller, I feel a new desire.

At the beginning of session ten, the couple discussed changes in their relationship and the new patterns that were occurring. They were both optimistic and excited about the new relationship. The therapist asked them to do a sculpt of their relationship now. Both of them did a sculpt that showed them moving together but also being individuals. This was processed deeply as each of them expressed the feelings around what they were experiencing in the moment. Both of them expressed a new sense of connection and both

experienced intimacy.

T: As you feel trusted it kind of frees you to be what you want to be.So together with the trust and the honesty you are creating the freedom and health and intimacy and the opportunity to develop who you individually are as well as the opportunity to be powerfully connected.

...

A: And I feel like we are in partnership and we are both heading forward to what it is we want our lives, even though we were not sure what that is . It was just going to be forward movement... together.

T: As you look at him right now what do you see in him?

A: A few things... Umm He is still not really ready to take in how much I care about him. And umm... and that he is not ready to take in that he really deserves everything to be as good as it can be.

....

A: It's really funny that this has come up because I've been thinking, in me I guess I've known that something had really changed. It seems like a miracle.

T: You both have worked very hard. You have worked very hard. And this can be scary, the newness because you are not used to it can be scary. So I appreciate your hanging in here and telling your partner what is going on for you. So I think it is very courageous and important.

....

T: That is a very special kiss. It acknowledges a very special point in your journey. You have reached a point where you feel really intimate and connected and yet separate. And trusting of each other and it is powerful and freeing and very touching. You feel really connected to yourselves as well as to each other.

A and B: Uhummm.

In session fourteen, the couple came in and began to relate new changes to the symbols of the rock, the seal and the bottle. In each of these areas they expressed changes and discussed how they were operating with new patterns. They were expressing their

feelings and confronting issues more often. The therapist asked them to sit as close to the goals as they felt they were. They both believed that 90% of the goals had been reached. She directed them to draw a picture to represent this feeling and experience of being close to the goals. The pictures they drew were related to their relationship. Ann expressed how her picture of the sky demonstrated its fragility. It could change easily from a blue sky to a storm. With some tears she admitted her anxiety about the new place their relationship had come to. As she processed this, they both admitted that they felt connected in spite of the fear about these new patterns lasting.

T: And I'm wondering if you would be willing to say to Bill and Bill for you to say to Ann your commitment to the other person remembering all that we have talked about today and the beautiful symbols you have of the peace and security and the connection you have with your heart and the powerful statements you have just made about being separate and yet connected, caring and yet not taking responsibility for the other person. I wonder if you would very simply say to the other person what was the most important about all that that you want the other person to hear.

B: Like for me... I know how important it is for me to be me, whatever that is and not shaped or moulded when I'm me and doing what I had to do... then I can look after you.

A: Ummm... I know for me it is really important to like myself and I will continue to do that and I will continue to give our relationship our best.

Case B.

Session six began with an attempt to reinforce intimacy, as Donna was wearing the ring they had made, and they began to discuss what it symbolized. This is the closest any session got to deepening their connection. However, when this became too intimate, Sam withdrew and this lead the focus away from togetherness and into boundaries.

S: It puts a lot of feelings into something that you can see, you know what I mean, not each stone but a lot of years. It's like puttin a lot of paper in your box and stuff

and the papers are in here. And nothing negative has come out of it. I think we are prepared no matter what happens. It uhh, this is ours.

D: and the thing I didn't think about before was that these being mine down here and Scott's mom's ring being here, it's a we , it's not my ring, it's ours.

S: It's not the placement of diamonds because mine, the biggest ones, are on top. We didn't analyze that part did we, lets' not get into that (laugh)

D: No, but...

T: What happened just then (laugh)

S: I knew you would pick up on that (laughter)

T: You were both touching the ring and you were saying it symbolizes so many years of memories and you were saying it's not just my stones but it's a "we thing" and then you made a joke and you took it back and you folded your arms and I thought ahh...

S: I thought you might think there was something significant about what she said about my diamond being the biggest.

T: I heard the joke but somehow the joke took away from the moment.

D: We have talked about this together as being "our" thing because he has his private little bank account and stuff like that. I had mine and I was trying to show him that this was a "we" thing and he makes a joke when that get a little too close and uncomfortable.

T: Is that right?

S: Ya, I guess I do do that sometimes

T: Is that your way of kind of drawing a boundary when things get too close, too inimate?

D: That's right

S: So, I'll make a joke and it will stop.

D: and I move my finger and that's the end of the....

T: So it's very important that you recognize what you do and it's important to be able to draw a boundary and uh sometimes it hurts if you are getting closer and maybe you want to stay in that closeness a little bit more.

Donna went on to talk about her own distancing behaviour. The pattern, in their relationship, of pursuing and distancing, was explored through discussion and stories. Intimacy in the here and now was not focused on. The rest of the session worked on raising awareness.

Two other sessions addressed the client's relationship but neither the clients or therapist pursued these statements to any depth. Session four was mostly Donna and Sam taking turns talking about their own families and the therapist listening and reflecting their individual stories. The therapist then asked the clients to think about the future in relationship to themselves as a couple. After much story and probing both the clients expressed briefly what they would be like in the future but neither of them integrated this picture to include their relationship. The therapist didn't pursue this either.

Near the beginning of session five, the therapist asked the clients how their relationship was going. Sam stated that it was going better because they had been discussing financial things. They were getting a ring made from Sam's mother's ring and Donna's old ring. A lot of discussion occured regarding the ring and the therapist shook their hands and congratulated them on this new step. Donna talked positively about the things Sam was doing around the house and how they were talking more.

> D: We comunicate, we talk. I mean before we used to talk but not talk, now we talk. I don't know I feel like I'm changing. Everyday I find out something new about myself and I go like this and I feel really good, you know. And sometimes when Sam is feeling a little bit down, I'll say, "Well talk to me, just talk to me.", and he says, "No, no, it's not important." And I say get over here and talk to me and he does. And he starts to open up and the next thing I know we will talk about it.

Sam moved away from this comment by bringing up Donna's son's girlfriend. He began to give details and the therapist questioned him further. The rest of the session was used to explore the issue of money. Awareness and connections were made to money, the family, alcohol and other relationships. Their relationship and their interactional patterns

over money were only two focuses but these didn't have much depth.

Major Issues

There were similar major issues that continually arose during therapy in both cases. For both case A and case B, most of the major issues fell into one of three categories (a) alcohol, (b) fears and (c) co-dependency. Case B addressed the issues of sex in a way that separated them from the above categories, thus these will be discussed as a new category called (d) sexuality. Although there was some overlap between each of the categories, it was helpful to look at them separately to get a clearer sense of the process in therapy. Family issues relate to each of these categories in a way that didn't allow for a separate look at family but rather this issue is integrated with the others.

The Issue of Alcohol

Both cases dealt with alcohol, the past abuse of it and the present slips during the time period in which therapy occured. There were a number of client and therapist factors that impacted how alcohol was processed in therapy. Following is a summary of the client factors and the therapeutic process of dealing with alcohol.

Case A.

Client factors

Bill had been drinking heavily for about 20 years. Drinking was often done away from the home. At the beginning of therapy, he had been sober for 2 months. Bill had two slips with alcohol over the course of therapy. He drank once during week 7 and three times during week 11. One occured during week 7 precipitated by no AA meetings for three weeks, the strain and tension in their relationship regarding finances, and the banks rejection of their mortgage. The first time he was alone in the house and drank two glasses of wine. Each time he acknowledged it as a slip and didn't want this to continue.

Over the course of therapy, Bill attended 12 A.A. meetings. He went fairly consistently at the beginning, then missed four weeks in a row. It was the next week that he drank for the first time. Then he attended two meetings, missed a week, attended one more, missed two weeks and had another incident with alcohol. Over the course of

therapy, Ann became less and less co-dependent and finally kicked him out of the house when he had his second slip.

During therapy Bill indicated that he drank for the following four reasons: a) hopelessness about a situation, so what the hell; b) avoiding the past pain around his family ; c) avoiding dealing with feelings and conflict by pretending everything was alright; d) avoiding intimacy.

Therapeutic process

Over the course of therapy, the four reasons Bill drank were uncovered, explored deeply and new ways of coping were discovered. The next section will summarise how these four reasons for drinking were worked with.

During session 1, the therapist used probing questions to uncover Bill's feelings around alcohol. He admitted that when he experienced anger and depression he used alcohol to cover feelings up but now more feelings were coming out and it scared him. He expressed a lot of awareness about the above process occuring.

B: Ya... maybe it is because I'm becoming more aware that I am angry or what I am angry at. I definitely am a lot quicker to let my anger show.

T: You never used to let it show? I'm confused because you said you never used to hang on to it.

B: Ya... I used to bury it.

.....

T: But what you notice is that you are feeling angry and it is coming bursting out and it used not to do that when you were drinking, you used to just block it, you would block it. But now it was coming out.

B: Then I could just go and get drunk, because I could be anybody I wanted to be and so it didn't matter.

T: We know that anger is related to fear. Whenever you are angry, you are also afraid and I'm impressed that you are aware of that because you are aware of that and you are new in recovery and yet have a lot of awareness.

Alcohol was not mentioned again until session 5. As a focus for the session, the therapist suggested they explore the role of alcohol in their relationship. It was symbolically externalized with a large plastic bottle and the therapist used probing questions to get at what issues came up for them as they thought about alcohol. The talk revolved around past patterns and present feelings.

They had a sense that alcohol was gone from their relationship but a lot of the feelings were still present. Ann expressed that she was not angry at the alcohol and realised that her blame was directed towards Bill. Ann didn't have much to say to alcohol, she felt detached from it. But mostly she just wanted to kick it and get it out of the way. Bill didn't like the alcohol being around even in this exercise. He felt uncomfortable, "oppressed", that it was even here in the room. The therapist asked what this oppressive, black cloud would say to him.

Both the clients and therapist stayed with this exploration for most of the session. Ann began to express her pain around Bill's drinking quite emotionally.

A: Ummm...abandoned.... It wasn't nice. In the beginning I felt like it was my fault. And I learnt a long time ago that it wasn't. But I felt like there were times when I didn't feel like carrying on. I felt like why should I carry on with my life when I was feeling sad or whatever, but knowing that I had to because I was feeling responsible for me. Which was very lonely.

T: So you felt very lonely, very controlled and very sad.

A:... and abandoned

T: ... and abandoned...

A: ... and really angry, that somebody had the right to hurt me.

....

A: No, I don't feel that way right now because things have changed so much....

Bill pointed out that he thought Ann still held a lot of pain. The therapist challenged Ann on that and it brought her deeper into what the pain was about. The therapist expressed her own fear of the power of alcohol and that it could come back. She asked the clients if

they would like to remove the bottle from their relationship. Together they symbolically remove it from the room by putting it outside the door.

In session 7, Brian admitted, right at the beginning of the session, he had a slip with drinking that week. They both talked about the stress of finances and trying to remortgage their house. The bank rejected their request and Brian felt like he had no support anywhere in his life. The therapist moved Bill into a reenactment of that incident. They recreated the scene together, with the therapist asking clarifying questions. Once the scene was set up, the therapist directed Bill to go back to that moment. The rest of the session was spent helping Bill to get in touch with what lead up to the incident and what the feelings around the incident were about. A clear connection was made between alcohol, not feeling supported by Ann and the pain around his father. He processed the pain deeply with the therapist as she lead him through it and probed for feelings.

At the beginning of session 8, Ann expressed her frustration, because she wondered if Bill had been drinking and accused him of this. Bill denied this and expressed hurt at being accused. Both of them felt very hurt and discouraged and this feeling pervaded the whole session. The focus of the session was on these "here and now" feelings and not as much on alcohol. The therapist tried to relate the feelings to alcohol. Bill felt far away and distant and he didn't even want to be in the session. There was a desperation he felt, like he should just give up. He felt very weary and would like the pain to stop. The therapist used a lot of advanced empathy. She reaffirmed his learning from last week, but did teach that is was natural for there to be some fear and avoidance of pain for this week. He was not sure if he wanted to continue. It felt like the pain would never stop. The therapist asked him where the hopelessness was in his body. This moved into work with his family. Bill still had a lot of pain around his family and the lack of closeness that he experienced began to be expressed. Ann expressed with tears that her greatest fear was that she would continue to support Bill's behaviour in an attempt to be patient, until she was eighty just like Bill's mother did. Ann said she was starting to feel good about the relationship and had a lot more hope but was becoming suspicious of his drinking had put a kink in this.

A: (crying) And I wasn't, I haven't been all week. But my perceptions are that he was drinking and with everything that was going on with me..... You have seen that I have trusted you and I've just been feeling really good about our relationship and it felt like that was taken away from me. I feel good about our relationship and then he starts drinking again and then I don't feel good about it again.

T: So this has happened in the past.

S and B: Ya..

T: That you have stopped drinking and you felt hopeful and enjoyed being close to him and then the drinking has started again. And even in this very new time, where you are learning a new relationship the drinking comes back. So you are thinking is it all for nothing, dare I go on hoping and trusting. So you are very weary.

The therapist then moved away from their feelings at the present and asked them what they would like their relationship to be like. After exploring this, the therapist had them physically move to experience taking a step representing what they want to do. Ann wanted to stop supporting his drinking habit by paying half the bills so that he had to work harder. Bill's step was to start being responsible for himself, especially to find out what his own emotions were. This experience was debriefed after.

T: And so as we have been talking and you both have been experiencing a lot of despair and weariness and hopelessness and realise you don't want to continue with the old pattern that it's too painful. It's like you let yourself down all the time because you don't want to feel bad, you don't want to feel bad, phony or like you are faking it or committing yourself to something you don't want to do. As you have been saying this and feeling what it is like inside, I'm wondering if you don't want this, what would you like?

A: I'd like not... how do I put this in the positive... I would like to not be responsible for Bill. That's what I would like.

T: What would you like Bill?

B: I guess I would like to be responsible for me, you know.

T: So what would be the first step in not being responsible for Bill and for you being responsible for you. What would be your first step Ann?

A: ummm... I'd just pay half the bills.

T: That would be your first step, to just pay half the bills. That would be your first step if you really meant this.

A: Ya.

T: What would be your first step, Bill in being responsible for just you. Or being responsible for you, was what you said.

B: Uhhh... a lot of things, it's clouded.... I think for me... It has nothing to do with money or possessions it has to do with my own emotions. I want to find out what they really are, cause I don't really know. I want to find out.

T: It seems very wise to want to find out about your own emotions. And I noticed that when I asked the questions what would you like you turned to Ann and smiled and then you began to smile and it seems as though thinking about what you would like and being clear about that first step makes you feel very different inside. And I'm .... we don't have much time this is a short session but in terms of your goals....

Alcohol did not come up directly again, for three more session. The only time it was mentioned was in relationship to Ann as she explored not wanting to be co-dependent anymore. During session 10, the couple was involved in a sculpt that brought them to a particularly deep and intimate point. There had been a lot of changes in the previous weeks, such as Ann becoming clear about her boundaries and expressing them, including learning to say no, caring for herself and letting Bill look after himself. Bill had been able to accept Ann's and his own emotions. The pattern had been explored, perturbed and new ways of being were occurring. The therapist warned them that this was a vulnerable place and it could be sabotaged.

In session 13, they both came in together but Bill was still not living at home. The

session began with the therapist asking about the symbols of the rock and the seal. The rock was gone but Ann was not very hopeful about them being together as a couple because she reinforced her viewpoint that they would not get back together until she trusted that he was committed to not drinking. Specific things like getting a sponsor had not happened. Ann was feeling a bit hopeless and disappointed. Bill was trying not to take Ann's anger too personally. If Ann labelled him lazy or put him down he was trying to let go of his own pain. Often a so what voice came out that made him feel like wanting to give up again.

B: It's funny I can deal with it anywhere else in my life, except in our relationship because that's where it hurts the most.

The therapist asked how Bill was feeling inside at this moment. He was tired and angry. Bill felt ticked off and really mad when Ann demanded that his recovery did not look like how she wanted it to. He stated that he couldn't predict how his recovery was going to look. He felt like giving up when she was not with him in this. He felt very disappointed.

Bill had not been drinking since the last meeting because he had hope. He felt like he was dealing with things that were happening to him quickly and immediately, especially his feelings. They were spending some time together , he felt hopeful and then the hopes were dashed when she stated that she wouldn't have him back. Bill had been to three A.A meetings that week but he didn't really relate meaningfully to the meetings and stated, "There was not much there for me".

The therapist reflected how Bill was staying with his feelings and setting some boundaries. Ann was also doing this. The therapist then asked what they could focus on this session. Ann made the connection between alcohol and a pattern of control that Bill had. Even though the alcohol was mostly gone, he was trying other ways to control Ann

A: Well, I think one of the things is that Bill said is that he would had to learn how to be different when he was not drinking. And then the next day when I asked if that was the truth, he said no it wasn't. And one of the things that came up while we were at (the treatment program), was that he used his drinking or whatever to

control me. So I think that it's not dancing, because it wasn't one Saturday but two Saturdays, so I think he is using it to control me. I think he is still trying to control me in some way.

The therapist moved into the specific incident about dancing to explore this pattern.

T: So when you say you were set up...

A: ....when he didn't show up....

T: ...when he didn't show up twice. So you felt manipulated set up to be controlled in some way. And it seems today you are feeling very, very angry.

A: Ya... but I'm not necessarily angry at Bill , I'm just feeling angry. I'm feeling angry about ummm and sad ummm going away by myself because I wasn't supposed to be like that. Setting myself up , I thought I would be going away and my dad would be looking after me and taking me places and he is still in the hospital there so I am feeling disappointed. I'm still going it just doesn't fit my picture.

.....

A: So it just reminds me of times like that. When I would rely on him for something and he would be drunk . So it just reminded me of that. I don't know if he was drinking but that's just how I felt like I wasn't important and then the next day he can just say well I was really scared. Well, so what .So I think that was what had happened to the intimacy and that is where it had been jeopardised and that is what's happening. It's those control things, it's all those things. It's the set ups and all the control stuff.

T: .. and you are still connected to the control of all those years.

A: Ya, and like the dancing thing it is no big deal but it is like it was the control thing all over again.... it's like he holds back.

The therapist directed them to reenact the dancing incident in the here and now. During the exploration they used a sculpt to demonstrate feelings. A lot of feelings emerged and were connected to family issues as well as alcohol. The therapist had the two sculptures talk to each other. Bill was a cowering little boy.

B: Another thing in my recovery, I know one of the reasons I drink is because I do do so many things that I don't want to do and I get mad at myself inside for doing them for selling out or whatever you want to call it. And that is when the so what voice comes really strong. It is not any one thing, it's not one thing. I wish I could say it was one thing because then I could get rid of it. And I mean I'm just starting to realize all of this now. How long is it going to take? And that is why I say I don't get anything when I go to these meeting because nobody came even close to how I'm feeling. I can listen to someone speak and I can say, "O.K., I've had some of that in my life or whatever". But it didn't get my head working, or it didn't get me working, connected to my feelings, connected to why I am doing things.

T: Ya... and it is very important to you to accept and connect with your feelings at this stage. You said this several weeks ago (Ya, ya). And it takes courage at an A.A. meeting to share deeply at that level.

The therapist made the connection for Bill, why it was difficult for him to connect to the A.A. meetings for fear of getting close to people.

By session 14, some significant change had occurred for them in their relationship and with alcohol. There had been a three week break since last session because Ann was on a holiday. Bill made some decisions about wanting the relationship with Ann more than a relatonship with alcohol. He expressed an acceptance that he was an alcoholic and needed to get support to stay away from the bottle. Thus Bill had taken some clear steps to get help, including making an appointment with an alcohol counsellor about getting a sponsor. Ann had become even more committed to caring for herself and not falling into the codependent patterns.

T: If I was to ask Bill, "What is it that is making your relationship feel better at this moment," what would he say?

A: Umm... he would say because he is living at home and because we spent last

weekend in Washington together. And he would say ..... I don't know.... like I've just given something a rest, I've let go of stuff ummm..... I think I learnt a real lesson of how I don't look after myself when I'm real busy, when I'm working. And how when I'm away that I'm just real willing to do that, I'm just, it just seems so natural. And yet when I'm working. And I'm more likely and even though I'm really.... it's not a question of being happy or unhappy, I'm more accepting of things, I'm more accepting of being back at work, this was a means to an end. It means I can go away next year. I'm just more accepting, I think. And more clear about what I want.

T: ... and how about alcohol. I haven't asked you about alcohol. Where has this been in the last three weeks?

B: Well, it has been around as far as....uhhh... it is not totally out of the picture. I guess it never will be. I guess it will always be.

T: Have you been drinking?

B: No. What I mean when it's around is it's going to be around or I'm going to be around it all the time. It's not that it is part of my life but I guess somehow it is near me, just behind me that's all. (He places the bottle behind his chair). It's always going to be around. I'll always have a problem with it if I drink it. I can't fool myself anymore.

The therapist read the goals again and asked them to position themselves in relationship to the goals. Both of them moved very close to the goals. Ann moved first and sat across from them, about 90% there was what she expressed. Bill said he felt a bit nearer to the goals but wanted to stay beside Ann as he wanted the goals to be reached as us together.

B: Like Ann was saying earlier about her accepting things, I can accept things a lot ...for what they are now. That takes a lot of the frustration away. And the anger I'm dealing with as it comes up, I'm not holding it in. And that is a really big thing

for me because I did... I used to put all my anger... I held it all in. Then I'd get so angry at myself that that's when the drinking started happening bad. I just turned into someone I wasn't , kind of a real process there. So now I just shoot my anger off as it comes and it is not that bad.

T: And this morning you balked a bit and you were able to laugh about it I see, laugh about it.

B: Ya, I've been able to do that for quite a while, like at work my boundaries were really defined and uhh and I'm not afraid of holding back with people. I have been in our relationship but not so much now because I know if I just get these little spurts out, it's not that bad. And you can handle it and it will be better in the long run.

T: Well, I want to shake your hand. Can I shake your hand?

B: Oh, sure (they shake hands)

T: Well done. It is not easy to make personal changes like this, it is very difficult. As you know because you have struggled, the two of you have struggled.

In session 15, alcohol was mentioned as the therapist placed on the table all the symbols they had used in therapy. Bill was no longer connected to alcohol. He spent an hour and a half with an alcohol and drug counsellor. He realized that the reason he didn't want to go to A.A. was because he didn't want to admit that that was where he belonged. He was going to an A.A. meeting to get a sponsor, that night. As well, he had reached out to two of his friends and told them what was going on in his life. Ann asked him to go to A.A. five times a week and to get a sponsor, other wise they couldn't have much of a relationship. She had never asked this before but she insisted on it now. During the celebration, Bill expressed honestly that he knew it was not over and that he had a long way to go, but he wanted to be diligent.

After a lot of exploration of the changes, the therapist asked them to light a candle as an affirmation of what had happened and the growth that needed to continue. She asked them to each light the candle and tell each other what they were willing to do to preserve their relationship.

A: Bill, I will speak the truth, I will keep my self image high, I will continue to trust myself, I will continue to accept you and I will continue to have hope and patience.
B: Ann, for our relationship with you and for me too, I will stay dry, I will look after Bill and I will be there, with help.

At the end of the session the therapist acknowledged all that she had learnt through this time.

T: .... and you have reminded me of the tremendous power of intimacy and the competitive nature of alcohol and where you used to go to alcohol to feel intimate and without that you've got this wonderful connection. What you have now is challenging and rich and warm. And you have taught me more, what I knew before, about alcohol's desire to sabotage that. And I hear that you are not listening to that but are listening to your feelings .

Case B.

Client factors

By the third session, Sam had started drinking again. He drank heavily for two days the weekend Donna was away. He didn't drink again until before the seventh session. The drinking continued for three more weeks, usually a couple of beers once or twice a week. He then had another incident with drunkenness before session 13. He didn't drink the next week but continued to drink for the rest of the time in therapy. During session 15, he admited he had a few beers with some friends and felt guilty. He did not attend any support groups during therapy. He attempted to make one phone call for support to a member of his group from the rehab clinic, but discovered that they too had started drinking again. Over the course of therapy, Donna continued to show co-dependent behaviour.

As the issue of alcohol was explored, both from past situations and incidents that occurred during the time period of therapy, four distinct patterns emerged that seemed to

keep Sam dependent on alcohol: a) the family of origin dance; b) the avoidance of pain ; c) the relationship pattern with Donna ; and d) the fear of intimacy.

Therapeutic process

Session one and two both contain discussion over alcohol and its impact on their lives. The discussion mainly focused around recounting the past with some exploration of the reasons behind the drinking. Donna also brought up the lack of sex in their relationship and Sam revealed he struggled with being able to perform because of the alcohol.

Session three, began by Sam admitting that he was drinking on the weekend. Most of the discussion was recounting the story but during the session a pattern emerged. It was her graduation weekend and she was going away with some friends to celebrate. He decided to drink and Donna drove home early from Seattle when she couldn't reach him by phone. The old pattern of his needing to keep her dependent and her rescuing him was repeated.

> S: Things were going great until Friday after work while my wife was in Seattle. I thought I'd try just a little bit of rum to see if I'd be O.K. with it, I was doing alright I thought, just a couple of drinks, but by Saturday morning I still hadn't heard from her I went out and bought a 26oz. Feeling angry at the thought that she might have had too much to drink the night before to phone me. By noon I still hadn't heard so I drank the whole thing in less than an hour and passed out around 4:00 p.m. not realising she'd tried to call, but I guess I was a little more out of it than I thought.

It became obvious that he was jealous and fearful of her new career and independence. Drinking was a way of keeping Donna connected to him. However, he resisted exploration of this pattern when the therapist attempted this.

> S: Well, I don't know if it is a wall but it's a situation that is greater change. She is getting away from who used to bother her a lot, not so much the job as the people and she is coming to realise that people like her for what she is.
>
> T: and this makes you afraid of losing her.

S: Yes .... and I was trying to change myself. And uh this slip didn't help matters much at all. It's like spending months saving up for something and someone steals it and you didn't know someone was going to steal it and they just did.

During session 5, the pattern continued. Donna was pursuing a new career and was starting to feel more self-confident, but Sam's drinking seemed to cause her self esteem to go down and she lost her confidence. She then needed Sam more and he pursued her by being kind and buying her things. This pulled her back into the dance. However, if she started to get to close, Sam drank again to gain distance.

D: I feel sad because Sam has tried so hard to please me. He bought me two new skirts and two sweaters. I told him I would pay him back. He also put up some Christmas lights. He didn't want to put them up and I did. He was trying to get closer to me but for the first time I'm not ready.

.....

D: I feel more confident and I did talk with Sam the other night and he knows that if he continues to do this I won't put up with it.

T: You said that.

D: ya, Ya.

T: So there was some tightness in your chest and shoulders

D: Ya, and then I stop feeling not quite so confident , even in my job. And I can feel that coming over top of me each day . And then each night he came home from drinking which started the day my son and granddaughter went home for Christmas holidays he was drinking pretty heavy that day.

In Session 7, signs of the pattern continued. When the couple was getting closer, he used drinking to keep his distance. Sam drank after session six, in which they had processed the symbolism around the ring, and discussed the new "we-ness" they were experiencing. Donna was very angry and made threats about not putting up with it

anymore.

D: I feel sad as I am smelling more alcohol on Scott. Everything else around me is going better. I feel stronger within myself. I just don't understand how or why Scott is starting to drink again. We just had a ring made and I felt so close to him. This was the closest we had been in years.

In session 8, the therapist directed Sam to put alcohol on the table in relationship to the goals and Donna. It was still very present and the therapist confronted him on this.

S: I haven't had any drinks in the last little while..

T: How long?

S: Over a week.

T: I was impacted, when she sat here and said if you were to have another drink that would be it.

S: Basically, if I ever got the way I was before...

T: If you had another drink, I thought was what she said.

S: Ummm, ya..... She said that during the Christmas holidays and I still had a few beers after that. But she means what she says, if she sees a pattern developing again ....

T: I thought she said if you had another drink.

S: That's what I thought she said too.

T: Do you think she had changed her mind?

S: No, I think she was pretty serious.

The therapist stayed with this exploration and continued to challenge Sam.

T: I hear you saying right now

S: I'm saying that he

T: It seems like she had developed herself, so that if you did had a drink, she would

manage on her own.

S: Ya.. oh ya she had always done so. She had been working since she was fifteen.

T: And she was feeling better about herself and self esteem had gone up and she felt much more powerful in the world than she ever did.

S: Yes, this new career had really bolstered her confidence in herself. She was being liked for who she was. She had always had a feeling of inferiority and uhh and she felt years ago that she was slowly getting better. Ever since we broke up and she had her break down and she went to that place, I forget the name of it, what ever they do an out-patient kind of a thing.

As the discussion goes on it became clear that he was planning around alcohol wondering if he could be a social drinker and thinking of plans to live without Donna. Sam didn't want support, he distrusted that it would help.

T: Is that so... and also you also feel scared because so much of your relationship depends.....

S: So, I'm trying to think what would I be doing if I was on my own? Where would I go?

T: So, you had entertained the idea?

S: Oh, ya, I've thought about it

T: Have you?

S: The house would have to be sold, which would be too bad.

T: So you have considered it? Is that because you want that?

S: Well, I wouldn't be able to survive without it because most of my money is gone.

T: I'm curious about you considering the possibility of separating and selling the house, I'm curious about that because I thought you wanted to stay together.

S: I do, but I think of the what if situation. Alcohol might not be a factor in the future , we could just be drifting away naturally.

T: and in fact you have drifted a bit, (I think so) she have drifted. Have you

drifted?

S: I think, I'm trying to recapture some self-respect and get myself on some solid ground.

T: The ground became unstable and you drifted away on a sea of alcohol.

S: Ummm

T: She drifted away because she worked on her self-esteem and her skills.

S: Ya, but she was planning on this, she was doing all this real estate stuff during the time I was drinking and even during the time I was at de-tox and I was behind her then. To be honest, I didn't think she would make it because this real estate exam in B.C. was one of the toughest in North America. And she didn't make it the first time and I kind of felt bad but I also felt relieved because I thought she would go back to her old job.

T: She needs me, she needs me.

S: Ya

T: She doesn't need you as much anymore

S: ... ya not now..

T: .... and I can imagine that is pretty scary for you .

S: It is.

T: Part of me thought that if I were you I would be terrified.

S: Well, I have to think of myself too, if it came to it and alcohol is not a factor in the future. Like right now I can't afford to drink and if anything is going to happen it's going to happen on its own and take it's natural course.

T: How would it take it's natural course?

S: I don't know whatever happens between us.

T: If you drifted further apart and alcohol still stayed out of the picture and you drifted further apart.

T: So you arre trying to quit...

S: ya... where was I...

T: alcohol

S: Ya, I can't afford to even have a drink.

T: uhmmm... So this is the context you have drifted apart a bit, quite a bit in someways. And you have had several slips, and after the last slip Darlene said that's it if you do that again , that's it ..it's over, the relationship is over, we will always be friends but as significant others it's over, that's it.

S: I think so, ya.

T: And that leaves you scared knowing that the onus is on you, you can't afford to take one drink.

S: Also for myself and for the fact that if I do and she is aware of it then that's it.

T: You have to do it for yourself and for the relationship... and if she is aware of it. I suppose when you say if she is aware of it, you could do it secretly.

S: You can't really do it secretly because your actions and your breath give it away.

T: ...That's right...

S: ...Of course, I'm thinking in terms of time, if X number of time rolls by after a glass of wine or hard stuff. Each one had it's own dissipation period without you smelling it on your breath, or whatever. A few beers doesn't take as long, alcohol takes the longest.

T: And you might plan that...

S: The thought has crossed my mind, but I've got to kick that out of my mind too, there I go again planning around alcohol again. I have to pretend it's not even there and not think about that

T: It's very scary to let alcohol go completely.

S: Ya, but it's a fact of life, it has to be done.

T: You seem to be doing it on your own, you seem to do it on your own.

S: I don't really want the support of groups from outside. AA didn't really... it's a good group

T: It's hard for you to do it on your own but you don't really want to get close to anyone.

S: Ya, I because of the .... what happened with my friend there Louie phoning me up and that bothers me a lot.

T: It bothers you a lot..

S: But the counsellors at re-hab were great, great people. They don't phone but they were there whenever I want to phone, with or without a slip.

T: Twenty-four hours?

S: No, not twenty-four hours. But they give you a line called the twelve-steppers that you can phone.

T: Twenty-four hours?

S: Ya, so there are people you can call anytime.

T: I'm really glad about that because there are people who are there for you but you don't have to get too close because you can talk to them on the phone.

S: Ya, but they will come out and see you if that's what you need. There is a list, there are hundreds in whatever district, wherever.

In session 10, it came out that he was still drinking and Donna was still accepting it. The therapist challenged them on this but didn't have them experience any alternatives behaviours in the session.

T: As we finish, what do you need to say about alcohol. I'm very confused about alcohol.

S: I thought you might be.

T: I'm very confused.

D: Now you feel the way I do, I'm confused. (laugh)

S: I 'm trying not to confuse people but uh....

D: What about you. You. Don't worry about how you confuse other people, figure out how you can get rid of that confusion yourself.

T: I'm aware that confusion comes from not really being sure where we are going and alcohol....

S: Like are all these sessions pointless because I'm still drinking a couple of beers every once and a while.

T: Is that what you are feeling?

S: That is the impression I get this session.

T: Is that what you are thinking?

S: That is what I think you are thinking.

T: Oh, I'm not thinking they are pointless.

S: Not pointless, but we have come so far but we have gone back a few steps.

T: I'm curious about the presence of alcohol when you come up with this wonderful phrase here. I'm curious about alcohol coming back at the same time as you are becoming more in touch with your feelings.

S: I guess I'm poking more holes in the balloon but I guess alcohol is still in my life to a small extent. And uhh.... I just enjoy the taste of beer. I'd like to get rid of it altogether. I find I don't have any desire for anything else or for any more because I know what it does to me.

They discussed alcohol a bit more and then the therapist asked if he would still like to be at a place where alcohol was not in his life. He said he would but they don't explore this experientially. The therapist simply asked Sam to bring in a symbol of what he would like to be at the end of the therapy. He expressed that he would like to be free, without guilt and be able to express his feelings.

In session 12 it came out that Sam had been drinking to keep his distance from people.

D: Last weekend I noticed a smell of alcohol and I said, "Are you keeping your distance from me because you don't want me to smell the alcohol?" And he goes, "Yes". (laugh).. O.K. But I wouldn't have noticed it if I hadn't smelt it so I... it means he hasn't been actually drinking that much.

T: Alcohol is one way of keeping your distance.

S: Well, I don't use it to keep distance, is that what you were referring to?

T: Well, it certainly has that function, it is one way of keeping distance, your distance from each other. I would think, that is just what I heard from...

S: Ya, she has a very keen nose.

T: It has a very strong smell.

S: Ya, I can smell it on people if I haven't been drinking.

During session 13, the therapist attempted to gently challenge Sam about his denial of drinking being a big deal.

D: About his drinking (sigh). Last weekend I was really angry and I let him know that I was pretty angry. Because that night that he drank, my daughter was in a car accident and he didn't know anything about it till the next day.

T: Why was that?

D: Because he couldn't wake up.

T: So it was more than a couple of drinks?

S: Well, it was also 2:30 in the morning too. I'm not trying to make an excuse but I've been working hard lately and if I'm asleep, I'm asleep.

T: A car accident is a major event

S: Ya, I guess, I should have waken up for that.

T: So, do you think it was the alcohol that made it hard to wake up.

D: I think it had a factor in it

Often when the drinking incidents were brought up in therapy, both the clients bring in a lot of story. The therapist used a lot of reflection to hear the story, often trying to reflect the feelings behind the story. Once the story had been told, the therapist attempted to deal with alcohol using symbolic externalisation. The therapist again gently challenged Sam about choosing to drink again. Sam's response was to justify his drinking activities but the therapist continued to challenge this behaviour.

T: Alcohol was back. Where would you put it in relationship to the two of you?

D: (Places directly between them)

T: I'm curious about your decision not to keep your sobriety, I'm curious about that.

S: Me too, I guess. Just every once and a while, it just... the urge strikes and I act on it. Not much, not nearly as much as I used to.

T: But more than you did when you first came here.

S: Ya, it seems like I'm very slowly getting back into a situation, of course nobody wants that.

T: Well.... You're choosing it, so I have to think that you want it.

S: I think that I can become a social drinker and have an odd drink every now and then. But having just the one seems to cause problems.

T: Having just the one?

S: One or two... but I'm never incapacitated except that one night there where it was 2:30 in the morning. It was Friday night.

D: And I was late getting home from work, 12:30 in the morning. When I opened the bedroom door, I could smell the booze. Even if it was just one or two drinks, I can smell it like that.

T: Of course, alcohol has a very distinct smell.

S: Very...

D: And more so when he sleeps... I could smell it so I was angry when I went to sleep. And it was... With my job now and with real estate you can get yourself into some predicaments, like men coming through your open houses or men asking to look at houses and you have to take them in your car. I could be into a really dangerous situation and he wouldn't even know, he would wake up the next morning and still not find me home.

T: So you feel really angry that at night when an emergency occurrs, he is so fast asleep he can't wake up to support you.

D: (moved to story about a buddy system they set up at work because of this situation)

T: So, I don't know what we were going to do here.

S: (laugh) I know I am disappointing a lot of people.

The therapist attempted to intensify the exploration by asking about alternatives and feelings.

T: I feel powerless to do anything about this bottle because I'm not you and it's your decision. And I'm curious about how you feel about the alcohol right now. You are sitting very close to it, it's right between you.
D: I feel like kicking it over
T: You do..
D: Ya
T: You feel really angry, you are angry at it

The clients often moved the exploration away from feelings into more story and often the therapist followed the storyline by asking questions about the story.

D: Ya, but at the same time he is giving me more support since that day, but not because of that day. It's really hard to explain. I'm going through a lot of things at work trying to take care of the Bob problem. Last night when he came home, I was crying, I was upset, I was so upset that I didn't know when the garage got broken into during my transactions of the day.
T: Your garage got broken into?
S: Ya, Jackie's bike was stolen.
D: Right out of the garage... at the same time, I remember going to the bathroom and hearing a noise and I'm wondering if I'm so preoccupied with everything that I'm not paying attention. When he came home I was crying. And he said, "Oh, I guess you know about the garage" and I said, "No, what about the garage". " Oh, Bonnie's bike was gone. And when he realized it wasn't that, he kind of helped me with my situation. So he had been a little more supportive on that side of it. And that's .... I'm so tossed... I feel like I'm tossed at my work and I'm tossed at

home. One minute, I can be so happy and had so much support but then with Bonnie's accident he was not there.

T: When you really need him.

D: Uhumm... But I really needed him last night and he was there.

T:... and he was there. Were you drinking last night?

D &S: No.

The pattern of the clients and the therapists interaction was often the clients gave a lot of story, the therapist listened, gave an insight or interpretation and then more story came. Awareness seemed to be happening for the clients but they were not necessarily exploring alternatives or integrating new changes.

D: I have been very angry at myself since the last time I was here.

T: Why?

D: Because I want to be strong enough to handle situations when they come up and from that session I learnt a lot about Bob and the control he had over me was like my father (story continues about the details of her work partnership with Bob).

T: So you put him first before yourself.

D: Ya, and I don't want to do that .

T: You abandoned yourself.

D: Ya.

T: This was an old pattern you had had for a long time, taking care of other people even when they had treated you like shit.

D: That's right ... (more story about the situation with Bob)

.....

T: It is scary to make a full commitment . I thought you had made a full commitment to staying away from alcohol.

S: Ya, Ya (sigh) that's...

T: And I thought that you had made a commitment that you wouldn't live in a relationship with alcohol. I thought I heard you say that...

D:...I did..

T: ... I feel quite confused.

D: Me too. After I said that here he went for a long time without drinking, and then all of a sudden I guess he started to have little sips here and there . The little sips didn't bother me but then when Friday night happened that bothered me. So the rest of my week, from Friday till today, has been chaos, upside down all around me. And ....

T: Because...

D: Oh because of the meeting with Bob in the office and I've just been really tense and I've had a really bad rash for about eight weeks.

T: Where is it?

D: All through my hair and neck and down through my legs.

T: Stress?

D: Stress or I think that is what it is. The doctor said he didn't know what it was. The hairdresser said it looked like shingles, that's what she had one time. Anyway, ummm.... I just feel like sometimes I'm on such a high and everything is going so well and then something has got to happen. You know.

T: Something has got to happen?

D: Well, like yesterday, Bob and Friday, Sam. Yesterday the garage, Bonnie's bike.

T: Ya, it's upsetting when things were going well and then all of a sudden you experience the unkind things in life.

D: But I want to be able to handle things better. I should have been able to stand up in the office, turn around and say, "I think you are a jerk. All you have used me for is to get money and you were holding this over my head- 10th ave. , my mom's house. I'm not supposed to tell but you were dangling this over my head in this meeting." I should have been able to do that.

T: Well, given that you didn't and you have your colleagues behind you, what do you want to do.

Another interaction pattern that was common in the therapeutic relationship was the therapist did a lot of summarising and teaching and the client agreed with it. The client rarely expressed the learning but just agreeed. This section of session 15, demonstrates this.

> T: And for you, if you are willing, it will be very important to give yourself lots of practice in staying away from alcohol so that you can learn to care for this lonely part of yourself. There was a real lonely, empty part there..
> S: Uhumm..
> T: ... that needs some caring and you abandon that part , you abandon that part, you abandon that part when you drink . I learnt that earlier on in the therapy.
> S: Ya, O.K.
> T: When you drink you are joining your sister and your dad and others who have neglected you. You are joining them when you drink because you abandon that part... I mean there is a momentary sense of taking a break or feeling better but really that part of you stays very lonely. So this is a chance for you to nurture yourself and care for that part . It's so important that part.
> S: Without using anything else?
> T: Yes, so this is a chance for you to practice that and it will be hard for you. It will be a real challenge.

The Issue of Co-dependency

Both cases dealt with co-dependency at various points in therapy. A number of client, therapist and technique factors interacted with co-dependency in therapy. Following is a summary of the client factors and the therapeutic process of dealing with co-dependency.

Case A.

Background

Ann and Bill came into therapy with some awareness of their co-dependant

patterns. Typically, Ann abandoned her needs and her sense of self to care for Bill, especially in the past when he would drink. While this was in the process of changing, it still came up during therapy. The therapist used symbolic and experiential techniques to move Donna into a deep exploration of this pattern. Donna was also given opportunities to experience new ways of interacting with Bill in therapy and discovered how not to abandon her feelings and needs for the sake of Bill's.

Therapeutic process

In session one, Ann begins to talk about her pattern of caring for Bill at all costs to herself. This was a transitional stage where she was just coming to understand that she had not stood up for herself, had sacrificed her own needs and had not expressed her true self for fear of being disliked. These patterns had underminded her self esteem and had provided "support" for Bill's alcohol.

A:.....He said if there was any confrontation he doesn't want me to back down, he wants me to continue with the confrontation when... because this was what I always used to do, I would walk away and come back happy.

....

A: If there was any addiction that I had it would be something that I am changing now. It was that I would always do for others before I did for myself, I never took care of myself. I looked after everybody else.

...

A: I was always put in that place. That was my role in the family to look after everyone else from the time I was about a year old.

T: I wonder how that must had fed your self-esteem.

A: It was... That was one of the reasons I was so devastated last year when we had to face Bill's alcoholism because that was where I got my self worth from, was from being needed and I felt that I had failed. So it had been a journey this year to learn how to look after me.

...

A: One of the most difficult things for me to learn has been to say no.

The first time this pattern is explored deeply is in session two as they are working with the symbols that the clients brought. Ann expressed how she is afraid to not be the caregiver because she doesn't know what her new role will be. The therapist directed the clients into an intensification that gave an opportunity to see where the pattern stemmed from.

T: And you feel little.

A: Little, ya.

T: So right now you feel pretty little. I wonder if we might stay with this for a little while. Is that O.K. with you Bill? (Ya). So there is a sense that you feel really little and not knowing what this is all about. So can you think about yourself in the context of your life when you might have been very little. You might be connecting with one of those times right now. You might be connecting with part of yourself historically a long time ago.

A: The only thing I can think about and I don't know if it is about being little is just that ummm... If part of my need is to be a caretaker and I get part of my self worth from being a caretaker then if Bill is better....

T: Do you think Bill is better? In what ways is Bill better?

A: Ummmm.... I think he is pretty healthy, right now.

T: So it is scary to think of Bill being healthy and not needing you as much. That is really scary because you don't know what your role is going to be.

A: (Crying) ... because I just don't know. I just don't know... I don't want to be the caretaker, I just don't know.

T: What would you like to be?

A: I don't know.... an equal partner.... but not even that because that sounds really masculine. I said that before... I want to be taken care of. Ummm... I want to feel special and I think I want to even enjoy being little, you know, instead of always fighting for myself.

B: Do you have to fight for yourself with me or with other people or other things...while you are being small.

A: With you too... (Ya, ya)

T: So part of you wants to go on being taken care of and feeling special and you also want to feel equal ....

A: ... like a grown up.

T: ...like a grown up (ya). So inside you don't feel like a grown up. How old do you feel inside?

A: Ummm.... The age that came up is ten.

The therapist stayed with Ann and explored more of the pain. Most of the pain and the pattern of caregiving and abandoning her own needs, came from her family and the fact that she had to look after her sick mother. However, nothing she did was good enough. Her father always expected the best and never praised her when she did anything. She was always given more responsibility then she should have and no decision could please anyone. The therapist explored the feeling and asked where it was in her body. This pain became symbolically externalized as an ogre that subtly controlled and spoke to her. They interacted with it, moved it and talked to it. She eventually moved it behind a chair. Over this process a new lighter voice emerged. Bill said Ann seemed alive when she was in this space and he really liked it. Bill stated that Ann needed to come to an acceptance of people, of her family, of his family and of him. Some of the insight Ann came to was that she gave no patience to herself, but was very patient with others. She realized she needed to accept herself, to learn when she had given enough. The therapist pushed the learning to the next place by asking specifically how she could learn that enough was enough. They had a three-way conversation about this, bringing Ann to more awareness, through clarifying, questioning and feedback. The therapist tried to break down a situation where Ann had stopped. The therapist also congradulated Bill on his ability to let Ann have these emotions without trying to stop them or fix them.

T: So when Ann is hard on herself , you feel helpless and then you feel frustrated because you don't know how to fix it and this kind of grows into anger. So what I really appreciate here is that you are sitting here and not trying to fix it. Because Ann will fix it by herself and what you are doing is something wonderful , you are

listening to her, you are adding information about her family background that is helping me to understand, and being patient and it is hard for you. And I appreciate you valuing the lightness of Ann because it is a really beautiful thing.

The therapist then summarized how Ann could be aware of her feelings to lead her and to help her establish clear boundaries.

Session five again dealt with Ann's pattern when the therapist specifically directed them to look at the role alcohol played in their relationship. They spent the session interacting with symbolically externalized alcohol. They both interacted with alcohol as if it was something gone and in the past. Anger was expressed by both of them. Ann's anger was directed at Bill but she didn't feel that as much now. The therapist asked Ann about a statement Bill made, "I think you are still hurting from those thirteen years." So Ann was able to do some grieving over the pattern she was part of .

A: Ya maybe, some things.... And maybe not so much from what he did but the choices I made in those thirteen years (cries) .

T: What hurts you?

A: Ummm.... that I didn't care enough about me, that I didn't look after me.

T: You abandoned your own needs.

A: That I was such a martyr and didn't reach out for help for myself sooner. And I did a bit but I didn't feel worthy enough to have what I wanted in life. Mostly just that.... And I always knew what Bill was capable of. I always believed I had really high self-esteem when I married him but it looks to me like I couldn't have because if I did ummm... why did I jeopardise so much of myself.

It was clear that she had moved into a stage of realizing her part in Bill's alcohol dependency through her co-dependency. Which opened her up to deal with her own issues around Bill's alcohol.

At the beginning of session eight, Ann expressed a suspicion that Bill had been

drinking that day. He stated that he hadn't. The therapist empathized with both of them and their frustrations but she pointed out the pattern they fall into of avoiding rather then understanding emotions, either through drinking or just avoiding relationship. In this session she was able to move them past some of the emotions around the drinking and to a future picture of what they wanted to be like. Ann was able to state clearly how she didn't want to stay in the co-dependant pattern. As well, Bill was able to state how he too wanted to get out of the pattern.

T: And so as we had been talking and you both had been experiencing a lot of despair and weariness and hopelessness and realize you don't want to continue with the old pattern that's too painful. It's like you let yourself down all the time because you don't want to feel bad, you don't want to feel bad, phony or like you were faking it or committing yourself to something you don't want to do. As you had been saying this and feeling what it was like inside, I'm wondering if you don't want this, what would you like?

A: I like not... how do I put this in the positive... I would like to not be responsible for Bill. That's what I would like

T: What would you like Bill?

B: I guess I would like to be responsible for me, you know.

T: So what would be the first step in not being responsible for Bill and for you being responsible for you. What would be your first step Ann?

A: ummm... I'd just pay half the bills.

T: That would be your first step, to just pay half the bills. That would be your first step if you really meant this.

A: Ya.

T: What would be your first step, Bill in being responsible for just you. Or being responsible for you, was what you said.

B: Uhhh... a lot of things, it's clouded.... I think for me... It had nothing to do with money or possessions it had to do with my own emotions. I want to find out what they really were, cause I don't really know. I want to find out.

T: It seems very wise to want to find out about your own emotions. And I noticed that when I asked the questions what would you like you turned to Ann and smiled and then you began to smile and it seems as though thinking about what you would like and being clear about that first step makes you feel very different inside. And I'm .... we don't had much time this was a short session but in terms of your goals....

The therapist had them position themselves in relation to the goals. Ann and Bill both put themselves at the opposite end of the room. Each of them were asked to take a step towards the goals. They processed how this position felt in the here and now.

Ann processed her feelings of being Bill's mother and how she had decided that she no longer wanted to play that role. When Ann talked about this, Bill sat down. However, the therapist used immediacy to keep the exploration of breaking this co-dependant pattern going.

A: Ya and the part about being the mother was something that had always been there in our relationship all along and I'm really struggling not to be his mother. I don't want to be his mother and yet as soon as I say it , it's also a struggle for me. I mean part of the reason I married him was so I could look after him. But I don't want to do that anymore.

T: So the whole basis for your being together is shifting. And there are parts of you both that want to keep it the way it was because I notice you go right back to how you felt as a child when you couldn't do it right and I noticed that it was really... when she says she doesn't want to be your mother it was hard to accept that and uhh... you sit down again and it was hard to accept how she felt, it was really, really hard.

This session was significant in that they both took steps forward, Ann standing firm on not wanting old patterns to repeat and Bill as he expressed emotions. Ann was learning to step out of the co-dependent role even though it was difficult.

Eventually, by the ninth session she had some courage to change old patterns which in turn improved her self-esteem. She continued to grieve the loss of an old identity but was doing things differently. Ann was caring for herself and less for others, even accepting that she couldn't do everything. As well, she had taken the step of putting away money for herself and not letting Bill have it all.

T: Another thing that connects you is a really strong need to be taken care of. Somehow to get from the other person what you didn't get from your parents. That's really important. The danger is to expect the other person to give you that.

A: And what I am learning now is that I have to take care of myself and be responsible for me. It's hard (laughter).

T: Yes. You can get a little of that from the other person but you do need to be responsible for yourselves. In a way for you, Ann is the nearest thing to mothering you have had because your mother was kind of not there.

In the eleventh week Ann came in alone because Bill drank and she told him to leave.

A: I think we are still pretty close... but we are.....I don't know.... You know last week when Bill said he felt kind of relieved because he wasn't playing games any more and he wasn't lying and making up stories anymore and it just felt like .... you know last week you talked about how we could really sabotage the relationship during this time and that felt... that's been happening.

T: So you really sabotage the closeness if you are not used to it.

Ann goes on to tell the story of how he drank this week. Her reaction was numbness, she wasn't angry or anything but she knew she couldn't put up with this. The denying and the lies and the old pattern came back. She asked him to leave calmly and knew she would not accept him back until he reached out for help beyond her.

T: The difference this time was you had reached a boundary. You were not willing to tolerate him if he had been drinking. Is this the first time that you had asked him to go?

A: No, no but this was the first time he has left.

.....

T: And when you said you wanted some decisions from Bill about whether he is going to drink or whether he gets support, is there a chance he can come back if he goes on drinking or is that completely out.

A: No..

T: So you were really clear about that.

A: Ya... I'm really clear about that, that is absolute.

Ann was demonstrating a new pattern of strength and resisting the need to be co-dependent. The therapist helped her process the confusion and emotions that go along with standing strong in this new pattern. It was difficult for her but she talked about the difficulty and the therapist used two chair work to help her process the two opposing voices within her- one which tried to please people and one which stood up for her own needs.

A: And the stand up for me, would have been asking Bill to leave the other night. Just saying I've had enough of that.

T: And that was what you did. So you brought that, that part of yourself into your relationship with Bill...

A:....not very often

T: .... not very often but the other night you did. And so that stand up for yourself part took care of you and your need for a break from that repetitive pattern back to alcohol.

A: Ya, Ya... and the other thing it did for me, was it got me to a place where I was going out, so I just got ready and went and didn't fret about anything because I was really clear.

T: You said you were really calm too.

A: Ya and I was really clear with myself and it wasn't planned. So it was very clear and straight forward. Whereas other times it would be planned and ....

T: So how do you feel as you say that?

A: Powerful.

T: You feel powerful. Ya.. So giving room to that voice that stands up for you makes you feel powerful when you actually express that and take action from that place in here.

A: Ya. Ya.

In the thirteenth session, they came in together and Bill hoped to come to resolution and be allowed back into the home. However, Ann didn't think he had made enough steps to prove to her it would be different. They were spending time together as a couple and he had attended three A.A. meetings this week. However, Ann wanted to see him with a sponser and be convinced that he was giving up alcohol for their relationship.

The fourteenth session was conducted three weeks later because Ann had been on a two week holiday by herself. They were back living together. Bill was going to A.A. meetings consistently, he spent an hour and a half talking to a drug and alcohol counsellor. He realized that the reason he didn't want to go to A.A. was because he didn't want to admit that that was where he belonged. He was going to an A.A. meeting that night to get a sponsor. As well, he had reached out to one of his friends and told him what was going on in his life. Ann was insisting that he go to A.A. five times a week. She had never asked this before but she insisted on it . Ann had also returned to ALANON.

In the last session, during the debriefing of the entire therapy, Ann expressed what she had learnt from the therapist's modelling. No longer did Ann need to be co-dependent or a victim but she could still care for Bill in a healthy way.

A: I want to thank-you for teaching me patience. I don't think I would have learned it without you. Each time I came in and... not each time.. but times I've come in and been so frustrated, especially that first time Bill had had a drink, and you just sat there very calmly and listened, there was something in me that said, "Well, if she can do it, I can do it." Not as a competition but just really listened to you and watched you and just really saw your patience. And I don't think I really would have learnt that because I saw your patience as a strength and it wasn't.... I've seen other women at ALANON that were victims. It doesn't seem like patience to me, it

felt like something else to me. And with you it truly felt like patience and acceptance that was not judgmental. (Crying)

Case B.

The Background

Throughout therapy the issue of Sam's use and abuse of alcohol emerged. Sam drank at numerous points during the time period of therapy and was always apologetic and extremely nice to Donna in an attempt to "smooth things over". Donna's pattern of feeding into this drinking was evident during therapy as she (a) would give up what she was involved in to rescue Sam, (b) would lie for him and (c) would state that she would leave if he drank again, but didn't. The therapist used mostly reflection of feelings and behaviour whenever Donna admitted this. Donna was not given a chance in therapy to practice a new experience or to explore alternatives.

Therapeutic process

Session three, was the first time co-dependancy came up directly in therapy and a clear pattern emerged. Donna went away the previous weekend which she hadn't done for a long time because of the fear of leaving Sam alone. That night and the next day Sam got drunk. When she couldn't reach him on the phone, she panicked and drove home to check on him. She then stated, "I can't be his babysitter anymore, that's it, I drew the line months ago when I said that's it". However, her behaviour from the weekend showed the opposite as she drove home early when she feared something was wrong. The therapist used empathic responses to listen to the story. She attempted to have Donna explore the anger using a symbol but it was not intensified because the client moved back to story and the therapist followed her. Donna then stated again how disappointed she was.

D: I am very angry and I feel hurt. My husband has hurt me deeply and I don't know if I can get back what I thought we were working for. He drank and used me as an excuse. He said and did things that disgust me deeply. This was my grad

weekend with my friend , and I allowed Sam to take it away. I am so disappointed. I am thinking of moving out on my own. I think it will be better for both of us

Sam responded by admiting he blew it, trying and be nice and keeping the peace for a while. The therapist used the technique of reflection of description and feeling. Donna did not move out at any point in therapy even though there were at least 8 other incidents of drinking.

Session 5 revealed more of the co-dependent pattern from the past as they explored money. Donna admited that when he drank and spent money on alcohol , she would help by freely giving money to him. He never had to pay it back directly. Sam's response to money was the opposite and more controlling. Donna always felt like she was begging if she asked for money no matter how little and always felt like she had to pay it back. The therapist continued to use restatement of description and reflection of feeling throughout this session.

During session 6, Donna told the story of how they both went out Saturday to make the ring and then that afternoon Sam drank. She continued to make statements that she did not follow up on. The therapist's response was to reflect feelings.

D: I am really confused and I am getting mixed feelings about Scott. He is not sharing why he drank. He said it's because of the pain in his shoulder. I don't believe that. If he continues to drink I am going to leave him. This will really hurt me and it will destroy him I'm sure.

During session 7, the couple was discussing another incident with drinking. Donna lied to Sam's boss when he asked how Sam was doing even though she admitted she had promised she wouldn't do this again. However, she knew the boss had said if Sam was drinking again, his job would be lost. The therapist again used empathy and reflection of feeling but few other techniques.

Later in the session, Donna was discussing a conversation she had with Sam. The therapist gently pointed out the discrepancy between her talk and her actions.

D: I feel more confident and I did talk with Sam the other night and he knows that if he continues to do this I won't put up with it.

T: You said that.

D: ya, Ya.

T: So there is some tightness in your chest and shoulders.

D: Ya, and then I stop feeling not quite so confident , even in my job. And I can feel that coming over top of me each day . And then each night he comes home from drinking, which started the day my son and granddaughter went home for Christmas holidays. He was drinking pretty heavy that day.

T: ... and this was something you say you were not prepared to put up with but you have been since before Christmas.

Donna continued to justify why she was not following up on her statements. The therapist did not challenge her again.

During session eight, Donna talked again about smelling alcohol on Sam.

D: I'm a bit disappointed in Sam as I smelled alcohol on him. I just pray he doesn't start again. I know I could not live like that again.

Later in the session, she stated again that if he were to have another drink that would be it for her. This is not challenged or picked up on by the therapist.

Session 10 revealled how confused Donna was, as in the same sentence she justified Sam's behaviour and stated that she would not accept it.

D: Christmas was great. My granddaughter my son and his girl friend arrived and it was the best Christmas ever. Scott drank only today because my son was going home today. Scott feel's as close to them as I do. Scott drank more today than he

had in the past six months. I sure hope he gives it up as I can not put up with it again.

The therapist pointed out this discrepancy and challenged Donna on co-dependency. Donna stated that she was willing to have alcohol but not drunkenness.

T: How was that for you? Last time you were here you were really clear about if there was anymore drinking that would be it. I'm wondering what that has been like for you.

Donna went on to describe how she could smell a faint smell of beer but that she didn't mind that, as long as there was no wine or intoxication. She was willing to live with alcohol as long as it didn't interfere with their life. The therapist challenged this as opposite to what she expressed before. Donna admitted she would like it not to be there. However, she felt guilty that she had the right to drink a bit at a wine and cheese party and he didn't. Sam had gotten upset when that happened before. The therapist used a gentle challenge.

T: I'm not sure what interfering with your life means?

Donna talked about not wanting to be out with Sam when he was drinking. The therapist continued to point out that Sam was still dependent on the alcohol. She then challenged Donna that she had not followed through with her conviction. Donna seemed to justify his behaviour by stating that , "compared to her uncles who were fall down drunk, Sam was not too bad." As well, she stated that she didn't want to abandon him.

D: If he was like that type of person, I wouldn't be in the relationship we were in. Now he has so many qualities that I admire and there are some that I wish he could.. just like there are things in myself.....There are so many things I love about him and drinking is one thing I don't like and the second thing is I think he could do so much better for himself. I've seen him improve so much over the last few

months that I just can't walk away from that. Mass improvements and I can't walk away from that.

She said she was comfortable with the relationship but they still had no sex and alcohol was still present. Donna felt her insides were not matching her outsides and she feared that alcohol might take over before a break through came.

Session 13 revolved around another incident of drinking, where Sam was so passed out that he was unable to wake up, when Donna needed him. Donna expressed a lot of anger around this situation . However, she moved back into a place of confusion quickly as she talked about another incident that week where she felt so supported and listened to by Sam. She expressed feeling confused because Sam was there for her, then not there for her and this was very inconsistent. The therapist began to make interpretations to point out the pattern of her interactions as they related to a specific incident at work.

D: I have been very angry at myself since the last time I was here.

T: Why?

D: Because I want to be strong enough to handle situations when they come up and from that session I learnt a lot about Bob and the control he had over me was like my father (story continued about the details of her work partnership with Bob).

....

T: So you put him first before yourself.

D: Ya, and I don't want to do that .

T: You abandoned yourself.

D: Ya.

T: This is an old pattern you have had for a long time, taking care of other people even when they have treated you like shit.

D: That's right ... (more story about the situation with Bob)

The therapist challenged them again about what kind of commitment did they have as Sam wasn't going to drink and Donna wasn't going ot live in an alcoholic relationship.

She stated that she was quite confused. However, the clients continued to justify their behaviour and the session moved away from this pattern to story about work and sex. This brought up the issue of guilt which was explored a bit.

Donna's pattern of co-dependency is not brought up directly in therapy again.

The Issue of Fear

This section looks at each client separately and how their fears were or were not dealt with in therapy. An analysis of the differences in each of the cases follows.

Case A.

Bill

For Bill the biggest fear was of his own emotions including anger and pain. Bill discussed some of the fear he had around the expression of his emotion in the first session. He worried about how to cope with frustration, anger and depression without drinking. There was a part of him that wanted to learn how to express negative emotions and not bury them. One of his goals was to learn to handle frustration so it lead him further and further away from alcohol. Self-disclosure was a risky process for him.

B: Not so much cravings as what I've noticed the last few weeks was I seem to be getting angrier than I ever used to and that scares me. It doesn't bother me, it scares me.

T: Ya..

B: And today, I was giving it quite a bit of thought and I think when I get frustrated now I can get down and depressed and before when I would get depressed it would last a day or two at the most and I could always bounce out of it and I think what happens now is if I get depressed it feels or I get a sense that it is going to be for a longer period of time. That's where I ... I don't know...

T: So, you get scared when you get depressed, you are not sure how long you were going to feel this.

B: Ya, whereas before I was able to say, " I feel depressed right now". Then I would do something to get out of it. Now maybe I'm just more aware that I'm

depressed now that's it and that's why it's bothering me.

T: It may well be. Uhh... So you were feeling really threatened that you are getting angry.

B: That part , ya. Because I know I am hanging on to my anger more than I used to.Whether that's good or bad I don't know.

T: Longer than you used to?

B: Ya... maybe it was because I'm becoming more aware that I am angry or what I am angry at. I definitely am a lot quicker to let my anger show.

T: You never used to let it show? I'm confused because you said you never used to hang on to it.

B: Ya... I used to bury it.

.....

T: But what you notice is that you are feeling angry and it is coming bursting out and it used not to do that when you were drinking, you used to just block it, you would block it. But now it is coming out.

B: Then I could just go and get drunk, because I could be anybody I wanted to be and so it didn't matter.

T: We know that anger is related to fear. Whenever you are angry, you are also afraid and I'm impressed that you are aware of that because you are aware of that and you are new in recovery and yet have a lot of awareness.

During therapy, Bill is given numerous occasions to express his emotions and work through them. This often happened as the couple dealt with a specific conflict in the session (session 1, 5, 6,7,9) and the therapist helped them stay with it expressing emotion and coming to a resolution. Another example, was when feelings around issues are evident in therapy, Bill learnt to express them and stay with them. Session six involved Ann expressing a lot of negative emotions and Bill being able to express his emotions of feeling alone, overwhelmed with the negative stuff and a lack of hope about where they were going. The therapist listened with empathy through out the session and helped them move to a new place in there relationship where they experienced a sense of togetherness.

Bill felt good about staying with his emotions.

Bill was also given an opportunity in therapy to discover where a lot of his fear came from, especially in relationship to his father. For example, during session seven, Brian expressed a lot of his feelings and emotions around alcohol and his father. This uncovered a lot of pain.

The therapist also helped Bill work through the pain rather than avoid it. During next session (8), he came in feeling distant and wanting to give up. He felt weary and wanted the pain to stop. The therapist used a lot of advanced empathy. She taught and reaffirmed his learning from last week, but stated it was natural for there to be some fear and avoidance of pain for this week. He was not sure if he wanted to continue, it felt like the pain would never stop. The therapist focused on Bill and the hopelessness he expressed . She asked Bill where the hopelessness was in his body, focusing on the here and now. This moved into more work with his family. Bill still had a lot of pain around his family and the lack of closeness that he experienced began to get expressed.

In the midst of his expressions of emotions, another fear emerged. It was the fear of abandonment. In therapy, Bill attempted to avoid conflict but the therapist had them walk through it. Ann often brought up her desire to change the role of mother she played. Bill initially seemed to get frustrated that she insisted on that role. Eventually, as the therapist confronted him when he sat down in the midst of a discussion around this issue his fear of losing Ann came out.

A: No, no I don't... But I feel like for me to not feel that way, he needs to be ahead of me or equal with me.

T: So if you are not the mom what will you be?

A: Here? I feel like I am... but I don't want to be ... but I am.

(Bill sits down)

T: I noticed that he sat down. He had taken a step but now he sat down. I'm curious to know about your choice to sit down, what does that mean?

B: It was probably out of frustration.... Like I have heard this before and it's not like I hold it against Ann it's just that umm.... I feel it is something that Ann is kind of stuck on. So for me it was just kind of sitting down.

.....

T: So the whole basis for your being together is shifting. And there are parts of you both that want to keep it the way it was because I notice you go right back to how you felt as a child when you couldn't do it right and I noticed that it was really... when she says she doesn't want to be your mother it is hard to accept that and uhh... you sit down again and it is hard to accept how she felt, it was really, really hard.

.....

B: It's not that... it's not so much that I expect you to be my mother because my mother never did whatever it was you think you are doing anyways. But what I'm afraid of is losing you period. Like you say... it's being my mother. To me it's feelings... the one person who accepts me, I'm losing. That's how I see it.

A: But that's not necessarily so. (crying)

B: Ya... but that is how I feel. I get very uhhh.... afraid and uhhh.... all kind of things.

T: So Bill what you are doing right now is experiencing your feelings and knowing who you are so even though you sat down you are really in touch with your feelings. (Uhumm) And you are really afraid of losing Ann, you are really, really afraid. And so who you are at this moment is someone who cares very much for Ann. When she said she didn't want to be your mother you felt fear of being abandoned. After all your mother didn't really protect you and give you the chance you deserved as a child. So what Ann has given you is acceptance and you have never felt accepted by anyone before. And it must be a little scary to think if things continue the way they are she may run out of patience. So I think that even though you sat down, you somehow got up , even though it doesn't look like it right now. But at some point you got up because you stayed with your feelings.

The therapist also gave Bill an opportunity to reaffirm his desire to understand rather than fear his emotions. At the end of session eight, the therapist had them look at the future and express what they would like.

T: What would you like Bill?

B: I guess I would like to be responsible for me, you know.

.....

T: What would be your first step, Bill in being responsible for just you. Or being responsible for you, was what you said.

B: Uhhh... a lot of things, it's clouded.... I think for me... It has nothing to do with money or possessions it has to do with my own emotions. I want to find out what they really were, cause I don't really know. I want to find out.

T: It seems very wise to want to find out about your own emotions. And I noticed that when I asked the questions what would you like you turned to Ann and smiled and then you began to smile and it seems as though thinking about what you would like and being clear about that first step makes you feel very different inside.

Bill was also given the opportunity to work through a situation where he had been true to his emotions but it backfired. He had not wanted to dance when Ann and he were out, so he said no. During session thirteen, a sculpt was created where he was a cowering boy trying to say no but he worried about the implications. The therapist pursued this feeling as a little boy, Bill talked about saying no to himself and denying who he was when he was younger. He was attempting to say no and to listen to himself and do what he wanted to do.

B: Another thing in my recovery, I know one of the reasons I drink is because I do do so many things that I don't want to do and I get mad at myself inside for doing them for selling out or whatever you want to call it. And that was when the so what voice came really strong. It was not anyone thing , it's not one thing. I wish I could say it was one thing because then I could get rid of it. And I mean I'm just starting to realize all of this now.

By session fourteen, there seemed to be a clear expression of changes in this area as well as a demonstration of this in the client's relationship. Bill expressed that he was much more able to be direct with his emotions.

B: Like Ann was saying earlier about her accepting things, I can accept things a lot ...for what they were now. That takes a lot of the frustration away. And the anger I'm dealing with as it came up, I'm not holding it in. And that was a really big thing for me because I did... I used to put all my anger... I held it all in. Then I'd get so angry at myself that that's when the drinking started happening bad. I just turned into someone I wasn't , kind of a real process there. So now I just shoot my anger off as it came and it was not that bad.

T: And this morning you balked a bit and you were able to laugh about it I see, laugh about it.

B: Ya, I've been able to do that for quite a while, like at work my boundaries were really defined and uhh and I'm not afraid of holding back with people. I had been in our relationship but not so much now because I know if I just get these little spurts out, it's not that bad. And you can handle it and it will be better in the long run.

T: Well, I want to shake your hand. Can I shake your hand?

B: Oh, sure (they shake hands)

T: Well done. It was not easy to make personal changes like this, it was very difficult. As you know because you had struggled, the two of you had struggled.

By the end of the therapy he was able to thank the therapist for her part in helping him to get over his fear of facing and expressing his own emotions.

B: You definitely made it easier for me to get in touch with my feelings. In the beginning, I didn't think I could but thank you for it , I appreciate it.

Ann

Ann expressed and worked with the fear of being abandoned and the fear of intimacy. The first fear was that of being abandoned. Abandonment was related to her fear of intimacy. Both came up in the first session. Bill's drinking in the past had taken him away from the home for days at a time and she feared this happening again. She didn't want to risk becoming emotionally connected with Bill again if he might leave. Ann was fearful when he got frustrated because she wondered if he would get the help he needed or

if he would go back to old patterns and start drinking again.

B: A couple of weeks after we got back, I can't remember the particular incident or whatever, but we went through some emotions and we both realized how fragile this really is.

A: Because there have been times, we have been together for thirteen years, and there have been times in the past where our relationship has been really, really good and it doesn't last. Like it is just for a short period of time and then it just dissolves again. And ummm (cries), it is really scary for me.

T: You feel pretty vulnerable right now.

A:... that it will just go away.

The therapist gave Ann opportunities to explore the fear of intimacy deeply through symbols and symbolic externalization. During the second session she expressed a fear of losing her individuality as they interacted with the symbols (the rock and the seal).

A: The first thing that goes on for me is that the front of the rock is really jagged and rough...

T: This side or this side?

A: This side (pointing to the side that faces the seal)... so if I was coming up against it, it would be painful because it is not smooth. And when he talks about... when he said the seal will get on top of the rock, I ummm..... had this feeling of being taken over... it's not mine ... it's not mine anymore.

T: I see that you really hurt when you think of that . So if the seal were to get on top of the rock you would feel it wasn't yours anymore. (Ya) You would feel controlled (Ya) and that is scary to think of being taken over. (Ya)

A: Yup.... and I have this feeling that that is what I'm feeling right now. That I'm not in control and I'm not me anymore.(crying). Which may not be a bad thing it's just really scary for me.

B: That was what you were saying last night too.

A: Ya, Yup...

T: So I'm not sure how you got this symbol, where it comes from. What is

happening in your relationship?

A: Well, I think because we are getting closer, it is so different now. I feel like I'm... like I'm going to lose me and I don't want too. Like last week when Bill talked about him being tall and he sort of pushes away short people ummm it's kind of funny that I would marry someone that was tall because I'm afraid of tall people and ummm yet I always wanted to be tall but it didn't quite scare me. I don't know why. (crying)

T: You feel pretty vulnerable right now as you say that.

A: And I think I've just realized it now, but I think it's been going on for a number of weeks or three weeks. I'll just get a Kleenex (she stands to get one) . Since maybe just before we came here or the week we came here around there anyway. I didn't know what was going on in me.

The therapist asked permission to stay with this and the rest of the session was spent exploring her fears. Related fears were brought to awareness such as not knowing what her new role would be if Bill was better and she didn't' need to be the care giver . The therapist gave her an opportunity to dream about what she would like to be. She wanted to be an equal partner but also to be cared for.

The therapist asked questions to illicit where a lot of these fears were coming from. Eventually, they explored where the role of care giver in her family originated. An ogre symbolically appeared as controlling her, telling her she was not good enough. After interacting with it, she was able to feel a lightness.

Ann was also given an experience in this session of articulating setting up boundaries to not give up herself and yet to be cared for by others.

Fears came up in the third session again and were represented as a wall between them. The wall for Ann was the fear of trusting again. When Bill was frustrated she was afraid he was going to go away and start drinking again. The therapist lead them through a process of sharing honestly some hurts and frustrations.

The therapist then gave Ann an opportunity in the safety of therapy to remove the fear and experience what that was like. Thus in session three after exploring the fear, the

therapist had them remove the cardboard wall and see what it would feel like. They physically moved the wall and then explored how this felt. There was a relief that came and a joy they both expressed in being able to see the seal, the rock and the goals.There was a deeper sense of being connected that was expressed.

Ann began to explore boundaries and the therapist helped to clarify which were walls that kept distance and which were boundaries. In session four, Bill was concerned about Ann's quietness all week. As this was explored it became clear that she was putting up boundaries so as not to be invaded. Ann was an hour late in getting home from work. Bill asked what was going on. She didn't want to talk about it.

> A:... but I'm finding that I don't want to give everything about me, I want some things that are mine and I could have told him, I was just talking to someone, it was personal. I just felt like I was being invaded, not questioned, just that he had to know. And it was not that it was Brian but just that I wanted that for me, it was mine and it was something I really enjoyed.

The therapist intensified this boundary by acknowledging that it was good but that there was also a fear in getting close. Ann put fear in the room using a chair. It was very close to Ann, between Bill and her. They began to explore the feelings around the chair and eventually the chair is moved and a new experience was created that felt good to both of them.

Ann was also able to grieve the relationship they had when Bill was drinking, which was full of the fear of abandonment and was lacking in intimacy.

> A: Ummm... abandoned... It wasn't nice. In the beginning I felt like it was my fault. And I learnt a long time age that it wasn't. But I...like there were times when I didn't feel like carrying on. I felt like why should I carry on with my life when I was feeling sad or whatever, but knowing that I had to because I was feeling responsible for me. Which was very lonely.
>
> T: So you felt very lonely, very controlled and very sad.
>
> A: ...and abandoned.
>
> T: ... and abandoned...

A: and really angry, that somebody had the right to hurt me.

....

T: So when John says, "I think you are still hurting for those thirteen years."...

A: Ya maybe, some things... And maybe not so much from what he did but the choices I made in those thirteen years (crying).

Fear came up again in session six and was externalized as a chair again during a sculpt. The fear is named. This lead to working through some issues around money and self disclosing their emotions. After this process, the therapist asked Ann if the fear was still there. She said the fear wasn't, and she moved the chair. The fear had changed to frustration and anger, which they continue to work with.

After Bill's first slip with alcohol, fear emerged again and during session eight it was given a chance to be expressed and worked with. Ann expressed with tears that her greatest fear was continuing to support Bill's behaviour under the guise of being patient.

A: (crying) And I wasn't, I haven't been all week. But my perceptions that he was drinking and with everything that is going on with me... You have seen that I have trusted you and I've just been feeling really good about our relationship and it feels like that is taken away from me. I feel good about our relationship and then he starts drinking again and than I don't feel good about it again.

T: So this has happened in the past.

A and B: Ya...

T: That you have stopped drinking and you felt hopeful and enjoyed being close to him and then the drinking has started again.And even in this very new time, where you are learning a new relationship the drinking came back. So you are thinking is it all for nothing, dare I go on hoping and trusting. So you are very weary.

During this session, the weariness and hopelessness is explored deeply and the therapist directs them into a experience where they physically take one step forward.

By session ten, they were experiencing a new relationship which they sculpt. They were able to sculpt their relationship in a healthy way without fear.

T: You can both be moving in the same direction but you don't have to be side by side all the time. You can be your own individual person (Ya) What do you think it is like for Ann when you acknowledge that you can be your own individual person and you don't have to be right next to her all the time.

B: I thinks she likes it but I think it scares her too (laughs).

T: Is that true?

A: I like it, I feel relief and it doesn't scare me.

T: It is my expectation that so often with couples when they have been doing everything together and suddenly acknowledge each others individuality and set their sights in a way away from each other and yet still in relationship to each other and still moving toward their goals, it can be scary for one or the other that you might feel abandoned initially or scared and then relieved and know that it is a good thing. But I hear that you feel relieved and encouraged in a way.

A: and I don't feel like his mother.

In session eleven, Ann comes in alone because Bill drank and she kicked him out of the house. This is the first time she has ever done this and she feels very convicted about it. The fear of being abandoned is growing smaller in light of not wanting to support Bill's habit.

Over the course of therapy she came to trust Bill as they worked through specific conflict (session 1, 5, 6,7,9) and other issues rather than walking away from them. She experienced Bill listening to her and acknowledging her feelings during therapy, with the help of the therapist. As well, her own sense of self increased to the point where when Bill drank, she made him leave and it wasn't devastating to her. Eventually, her sense of trust increased and the symbol of fear never came back to therapy after session eight. As well, the rock (which also represented some fear) disappeared by the end of therapy.

Case B.

Sam

Sam had a fear of being abandoned. He felt abandoned by his father and often felt

like he had a hard time getting close and being honest with anyone. He also feared the pain that came from trying to get close and be vulnerable. A past relationship he had with another women really hurt him and he learnt to not trust. Another fear was exposing his weaknesses and failure to Donna especially in relationship to his sexuality.

Sam was given a opportunity in therapy to name his fears, however, they were not explored with any depth. For example, in session two, as they were discussing their goals, the lack of sex in their relationship came up. It had been two years since they have had sex. Sam stated that he struggled with being able to perform and was scared to try for fear he would fail. About ten minutes was spent gathering information around this issue. The therapist used empathy and validation during this time but the discussion stayed at a cognitive level and was not explored deeply.

In session three, it became clear that Sam feared losing Donna and feared her new job which was improving her self esteem and confidence. The weekend she left to celebrate graduation and her new job, was the weekend Sam had a slip with alcohol and Donna came running back. He wanted to just avoid the fear and smooth things over.

T: How do you think Donna is feeling right now?

S: Hurt, and distrust. And she is probably feeling I've been through this before, I've had this career change and I'm not going to let this happen again.

T: So she has that wall there that protects her...

S: Well, I don't know if it is a wall but it's a situation that is greater change. She is getting away from people who used to bother her a lot, not so much the job as the people. And uh she is coming to realize that people like her for what she is.

T: And this makes you afraid of losing her.

S: Yes... and I was trying to change myself. And uh this slip didn't help matters much at all. It's like spending months saving up for something and someone steals it and you didn't know someone was going to steal it and they just did.

T: Is this how Darlene feels?

S: I think so, I stole something from her umm the glory of the moment I guess and I'm trying to be real nice and not pretend it didn't happen but let's work things out slowly. Let's not try and bring up too many subjects that would make someone

upset, whether it's a T.V. show or something in the news or whatever. Just talk about ... not nice things but things that wouldn't make you mad or her mad. So I'm watching everything I'm saying...

T: You're watching everything you are saying?

D: Yeah, it's like he is on guard.

The session moved away from this fear to Donna's patterns of being martyred and how these patterns were coming out in her relationship to Sam.

Sam's fear of intimacy came up in therapy. His awareness was raised about an avoidance pattern but it was not worked with directly. In session six the clients came in with a ring that they had made to symbolize their new relationship. The therapist attempted to have them focus on the ring and what it meant to each of them. However, soon into the exploration, Sam broke the moment with a joke and physically moved away from Donna. The therapist used immediacy to point this out. She did not make him go further into this fear but simply stated that he may want to stay with it a little bit more.

T: What happened just then?

S: I knew you would pick up on that (laugh)

T: You were both touching the ring and you were saying it symbolizes many years of memories and you were saying it's not just my stones but it's a "we thing" and then you made a joke and you took it back and you folded your arms and I thought ahhh...

S: I though you might think there was something significant about what she said about my diamond being the biggest.

T: I heard the joke but somehow the joke took away from the moment.

D: We have talked about his together as being our thing because he has his private little bank account and stuff like that and I had mine and I was trying to show him that this was a we thing and he makes a joke when that gets a little too close and uncomfortable.

T: Is that right?

S: Ya, I guess I do that sometimes.

T: Is that your way of kind of drawing a boundary when things get too close, too

intimate?

D: That's right

S: So, I'll make a joke and it will stop.

D: and I move my finger and that's the end of the...

T: So it's very important that you recognize what you do and it's important to be able to draw a boundary and uh sometimes it hurts if you are getting closer and maybe you want to stay in that closeness a little bit more.

The rest of the session is spent talking a bit about some of the changes and the tension of growing apart and together. Sam's mother is discussed. As well, Sam's awareness around boundaries and not letting people in was heightened.

Sam's awareness of fears was heightened as therapy goes on. His fears were also connected to past relationships and patterns around money. In session eight, Sam is in alone and they are exploring how money is connected with being rejected and betrayed.

T: There is something that happened with Susan (past girlfriend) that make you learn not to give your money and things away.

S: Ya, not to be so free with my feelings and along with that went money. I guess it was a natural progression, I don't know.

T: So you were afraid to give gifts in case you were betrayed. So at that time, at the age of sixteen being let down and betrayed or rejected or however, you saw it, was connected with giving gifts of yourself.

S: Ya, I guess in a way. I didn't want to share my feelings, I didn't want to share my feelings. I didn't want anyone to get the wrong impression. So I guess it started from there and went on.

The therapist asked Sam to put alcohol on the table in relationship to the goals and to Donna. This moved therapy away from Sam's fear of giving parts of himself to challenging Sam about his drinking behaviour. As the therapist was challenging Sam, his fear of Donna not needing him and leaving because of her own independent growth came up. However, Sam avoided entering into a discussion about this fear.

T: So what is it like for you to know that she can survive without you?

S: Ummm... It bothers me, not in the sense that she will fall apart cause she always

was that kind of person who could survive under almost any circumstances.

T: What bothers you ?

S: In a way because I'm the male and she should be depending on me for a lot of support. Whether it's money or emotions or what. She is going to feel totally crushed, I don't think she will feel crushed, she will feel hurt. (If Sam leaves).

T: She will or she would feel hurt? There is a difference.

S: She would be hurt but she is a survivor.

T: So in a way when you think she will be shattered but she will survive, you feel badly, because you would like her to depend on you because you are a male and in a way you feel abandoned knowing that she could survive with the skills she has because she has a lot of skills now.

S: Well, I kind of admire that .

T: Is that so... and also you also feel scared because so much of your relationship depends.

S: So, I'm trying to think what would be doing if I was on my own, where would I go?

.....

S: Ya, but she was planning on this, she was doing all this real estate stuff during the time I was drinking and even during the time I was at de-tox and I was behind her then... to be honest, I didn't think she would make it because this real estate exam in B.C. is one of the toughest in North America. And she didn't make it the first time and I kind of felt bad but I also felt relieved because I though she would go back to her old job.

T: She needs me, she needs me

S: Ya

T: She doesn't need you as much anymore

S: ...Ya, not now.

T: and I can imagine that is pretty scary for you.

S: It is.

T: Part of me thinks that if I were you I would be terrified.

S: Well, I have to think of myself too, if it comes to it and alcohol is not a factor in the future. Like right now I can't afford to drink and if anything is going to happen it's going to happen on its own and take it's natural course.

The session moved to what could happen to their relationship with the presence of alcohol. This lead to the therapist pointing out his fear of giving up alcohol completely. However, he didn't explore this fear or the feelings behind it. Sam stayed detached and intellectual about the fear, and eventually the therapist supported him in it.

S: The thought has crossed my mind, but I've got to kick that out of my mind too, there I go again planning around alcohol again. I have to pretend it's not even there and not to think about that.

T: It's very scary to let alcohol go completely.

S: Ya, but it's a fact of life, it has to be done.

T: You seem to be doing it on your own, you seem to do it on your own.

S: I don't really want the support of groups from outside. AA doesn't really... It's a good group

T: It's hard for you to do it on your own but you don't really want to get close to anyone.

S: Ya, I because of the .. what happened with my friend there Jack phoning me up and that bothers me a lot.

T: It bothers you a lot.

S: But the counsellors at re-hab are great, great people. They don't phone but they are there whenever I want to phone, with or without a slip.

T: Twenty-four hours?

S: No not twenty-four hours. But hey give you a line called the twelve-steppers that you can phone.

T: I'm really glad about that because there are people who are there for you but you don't have to get too close because you can talk to them on the phone.

Sam continued to make connections between his fears as therapy progressed. In

session 11, he expressed that he believed his inability to be open and honest in expressing his feelings was connected to his frustration with sexuality. The therapist then gave him an opportunity for the first time in therapy, to explore this inability and fear of letting people know his feelings. Sam used the metaphor of a wall and the therapist got a flattened box to represent this. The rest of the session was spent exploring the wall. They discussed how the wall kept people out and he wished it could have a swinging gate in it. He expressed his fear but also said that was changing. Most of the exploration was on a intellectual level and he didn't appear to be processing his feelings deeply. The therapist does ask him to draw the swinging gate on the wall as a representation of the future. They spent some time debriefing this.

During session thirteen, two fears that were named previously in therapy came up, (a) Sam's fear of losing Donna and (b) Sam's fear of leaving alcohol completely. Both are stated again but not worked with.

T: So there are a number of things that go on for you when I ask what it is like that Donna is involved in her work and doing well, and feeling supported and well-liked. And you say you feel threatened or you used to..

S: I still do to a certain degree..

T: You still do to a certain degree.. In what ways do you still feel..

S: That she is going to find somebody else with a lot more money and decide to leave me. There the bottom line.

T: You are afraid of losing her.

S: Ya, we talked about that some session back.

.....

T: It is scary to make a full commitment. I thought you had made a full commitment to staying away from alcohol.

S: Ya, ya (sight) that's....

The rest of the session was spent exploring the issue of alcohol, co-dependency, guilt and their sexual relationship. The therapist attempted to connect these issues and used confrontation a lot to point out discrepancies in their words and actions.

Session fourteen did not address fears directly, but the depth of processing was increased and Sam was given an opportunity to express some deep emotions about his family and do some self disclosure around pain. This process moved him past the fear and allowed him an experience of connecting to pain in the presence of others without alcohol.

T: ... and sometimes you (Sam) resort to the old way of being . Because that is the way you survived by isolating, by acting out, by trying and trying to get what you needed from people who couldn't give it to you. And you may still find yourself trying in those ways because it helped you survive but it didn't work. And you may still find yourself resorting to the old ways. And I encourage you to do two things to acknowledge how you feel and to connect. To connect with each other and extend your support system so that if the other one is not available you have other people. You need a lot of people to support you.

S: I guess my biggest problem is letting someone else know I have a problem.

T: We are all human. we all have these old ways of being. We are not accustomed to talking about...

S: The first problem was admitting to myself that I have a problem.

T: Yes, and so now that you have gone such a long way beyond that and you have connected alcohol with guilt and brought your dad in here and experienced that lonely, lonely sadness that you have in your throat. I wonder what you are going to do differently this week or so?

S: Uhhh... put together a lot of things I have talked about over these many months. I honestly thought today was the last session and I was kind of sad about that.

Donna

One of Donna's biggest fears was Sam going back to drinking and the impact that would have on their relationship. Out of this came the fear of being abandoned and not cared for. Another fear for Donna was drifting apart from Sam, especially sexually and never regaining that aspect of their life.

During session two, while stating their goals, Donna expressed a fear of moving further away from Sam because of the lack of physical closeness. The topic was discussed

briefly, but quickly moved to Donna's family background.

During session ten, Donna is exploring a feeling inside of her in the present. It is acknowledged and named, however, it is only discussed briefly.

T: Have you had this feeling before?

D: Not when things were going well but when things were going bad. Like I knew my mom was going to tell my dad something bad that I did and I knew I was going to get a licking when I got home. It's the same feeling... It's a fear.

T: Kind of a dread And the fear of alcohol coming back into your life is scary. (More summary and teaching from the therapist, however the tape is unclear.) What do you think Donna is thinking right now Sam?

S: That is a good question....What is she thinking... I think she is thinking that things are going well but there is still that chance that they might not, that alcohol might take over before there is that break through.

The discussion moved to talking about their sex life. After a few speaking turns, Donna said the same thing was happening to her at work and the session moved to more storytelling and feelings about her partner at work.

Session fourteen was the only session where Donna explored at a deep level the root of her abandonment fear. Although this was not stated directly in the session, the theme of Donna's exploration in this session focused around the pain of her father's neglect. This pain was related to how she felt with Sam when he is drinking.

Analysis of the Differences Between Cases in Dealing with Fears.

An analysis of the process of therapy, while looking specifically at fears revealed four major differences between the two cases: (a) the couple's readiness to work through fear; (b) the amount of therapist direction in processing fears, (c) the depth of experiencing around their fears, (d) and the number of times they had a therapeutic experience that moved beyond their fears.

First, couple A demonstrated more readiness to work through their fears as they entered into exploration of fear with the therapist without too much resistance or change of

topic. Couple B however, often avoided the direct statements the therapist would make about their fear. They also would move away from discussion of their fear by storytelling.

Secondly, the therapist directed couple A into exploration of fear using symbols and symbolic externalization many times in therapy, but only used this technique once with couple B. When couple A's fears were raised to awareness, the therapist directed the couple to explore fear by addressing it and staying with it. Couple B seemed to bring up fears or the therapist would interpret actions and statements as fears, however, these were not focused on or taken to a different level of processing.

Thirdly, because the therapist moved the session into a further exploration of these fears with couple A, the depth was increased compared to couple B. For couple A, these explorations often allowed a clearer and fuller understanding of where fears came from and a process of grieving the losses involved. This working deeply through fear in the process of other therapeutic issues allowed fear to lessen and change by the end of therapy. For couple B, the fears were named but without a depth of exploration were still very present in session 13 and 14. By session 15, the couple expressed a clearer sense of awareness about these issues but the fears were still present.

Finally, the therapeutic process allowed couple A to move beyond their fears and experience something different in the safety of the session, more often than couple B. Both men in each of the cases, feared the expression of emotion. Bill often expressed emotion as the therapist gently probed deeper, challenged him to stay with it and helped him find ways to say what he needed to. Sam expressed deep emotion less and only towards the end of therapy. The therapist attempted to probe deeper but Sam often used humour or storytelling to move away from depth and the therapist often followed. On two occasions the therapist challenged him directly about these behaviours. Both of the couple's feared intimacy, however, couple A was given more opportunity to experience intimacy in the session and to enjoy those experiences. Both the men expressed a fear of losing their spouse. Bill was given an opportunity to process this fear deeply as it related to his family and sense of abandonment. Even when Bill wanted to escape the intensity of this emotion, the therapist directed him to stay with it. Sam on the other hand, mentioned his fear of losing Donna three times in therapy but it wasn't processed much further. One time when he admitted

this fear, he covered it up by talking about leaving himself. It didn't move much beyond that in the session. Donna's fear of drifting apart because of the lack of physical closeness was addressed directly twice and mentioned three other times in therapy. However, each time their sex life was addressed, it stayed fairly cerebral and often moved to other issues fairly quickly. The therapist encouraged them not to put pressure on themselves regarding sexuality and that after this project they could go see a sex therapist. From the beginning of therapy to the end, it seemed that Donna's fear had come true, as they were further apart according to self description and marital measures.

The Issue of Sexuality

The issue of sexuality is obviously an area which could impact any couple. However, in these two cases it was approached differently. Couple A were sleeping in the same bed after a few years apart and they made comments about it being a great improvement in their relationship. Other than a few comments is was not mentioned directly or dealt with in therapy. Couple B on the other hand had not had sex for two years because according to them Sam struggled with impotency. This was on the top of each of their goals for therapy. However, sexuality was not focused on in therapy with any depth and their sex life did not show any improvement by the end of the entire therapy. The researcher assumed that the health of couple A's sex life was not a major issue for therapy in improving their relationship. However, for couple B it is a major and goal issue that was valuable to analyze how it is processed throughout therapy.

Background to Case B

The couple came to therapy not having had sex for almost two years. There had recently been two attempts but they were unsuccessful because Sam was unable to perform.

In a WSD written before therapy began, Donna wrote: "Sam is really changing. He is treating me different. He talks to me differently He seems very proud of me. He tried to have sex with me but he couldn't complete. Maybe we need to talk about this."

In a WSD written before therapy began Sam wrote: "I've got some bad sexual

problems: the more I drank the less I could perform, now that I'm sober I still can't preform, thinking I won't be good enough for either of us, my wife wants to talk, but I can't."

Therapeutic Story of Sexuality

Donna first brought up the sexual difficulties in session 2 when the therapist asked what one of her goals was for therapy. This was one of her top goals and was the one Sam mentioned second. The therapist then asks about the area of sexuality. Each one of them talk about the lack of sex in their relationship very objectively. Sam discussed how he was unable to perform and was scared to try for fear he would fail. Donna feared she was moving further away from Sam but she wanted physical closeness. They had great sexual relationships for the first number of years. Sam's sexual desire had gone down hill for years, the more he drank the less fulfilling sex was. Soon he had to have one or two drinks because he couldn't perform while sober. Now he had anxiety about being able to perform when sober. He believed he thought too much about it and then got anxious. About 10 minutes was spent on this, as the therapist mostly used empathy and validation of their experience

This was a constant tension in their relationship while in therapy and they were unable to resolve it. It was obvious that this was a concern for both of them. It was always mentioned when the therapist was checking in with their relationship. As well, in the WSD's Donna mentions it more than any other issue. In WSD #1 Donna writes : We are closer in all senses but not sexually. We are closer in everything else. Feel like it's my fault. In WSD # 3 Donna writes: Still have a sexual problem. It's been absent for 1 year eleven months. In WSD #8 Donna writes: I tried to reach out to him about our no sex life and he talked to me about it openly. I feel stupid about trying to have him get interested with me. I think I embarrassed him and myself. He has been drinking ever since. In one of the last WSD's Sam writes: Planning more things for the future but I'm not sure what the future's going to be with my wife, we've become even better friends, but the sexual desire

on my side has all but faded.

However, there are only three other occasions where it was was actually discussed in therapy with both clients. In all cases Donna brought it into therapy and the therapist picked up on it. Most of the discussion focused on awareness of feelings and patterns around the issue. But the discussions never lasted more than 5-10 minutes.

The first time it was brought up was in session 7, during a sculpt of their relationship. This was the deepest exploration of the lack of sex in their relationship. Most of the exploration was focused on expressing feelings and bringing to awareness the connection of sexuality to alcohol. During the sculpt Sam was asked by the therapist to express what Donna would need to believe Sam that things would change.

S: We both know

T: Oh, you both know? Do you think she agrees with you that you both know?

S: Uhhh

T: Is that something private between the two of you.

D: It's called the lack of sex.

The therapist starts asking questions and Sam starts to get uncomfortable and attempts to break the sculpt. Sam is encouraged to stay with it even though it is hard. Donna talks about how Sam doesn't like her talking about it.

D: He doesn't like me talking about it.

T: Uhhh. And you are so very sensitive and conscious about his feelings that you pull back and are dishonest with yourself.

D: That's right.

T: and you lose your integrity and then get mad at him. You have a choice, you can pull back at this point, there is no right or wrong here.

D: I get angry when I don't hear him say anything about love.

The therapist goes with Donna's feelings and has her express these to Sam. She has a hard time doing this. They talk about other ways she was filling that gap. The questioning goes to how Sam was feeling. He expressed some of his frustration and inability to perform. The therapist encouraged and supported his willingness to talk about

this vulnerable issue. She also used empathy during this moment. Sam moved it away from the intense feelings within a few speaking turns, to discussion at a more cognitive level. The therapist had them sit back in the chairs.

T: I heard you say, I'm not ready and I felt respectful when you said that. And I heard you say it doesn't matter if you fail or can't perform.

D: What I meant by it not mattering is the part that if we try and fail, that's O.K. I understand. The part that is not O.K. is that there is no attempt.

The therapist had Sam sit outside of the interaction and look in at what he saw of their relationship.

T: and there is part of you that is really afraid. So not only do you have part of you that is afraid of failure...

S: But a part of me that is afraid of being left behind as well

T: Fear of failure, fear of being left behind, fear of losing her. A lot of fears and they are important and they are there for a good reason. And I'm impressed that you are willing to acknowledge them. Very impressed.

The therapist asked him in this place to say something to Donna. He asked her to have patience. The therapist asked where alcohol was, but it was still very present. Donna was then asked to sit outside of the relationship. She saw Sam with his bottle and Donna going the opposite way. Donna expressed her confusion about whether she could hang on to this relationship because alcohol had come back. She also talked about her experience with Sam tensing up at physical touch and her frustration at this. The therapist supported Sam and encouraged Donna to be patient. Normalization of these sexual experiences was then presented by the therapist. She did challenge Sam that with alcohol the progress will be slower.

T: Without alcohol we can do a lot.

S: But there is more involved in my life then just alcohol

T: That's right, but if alcohol comes back then it protects you from dealing with other issues in your life that you need to deal with.

The session ended with the therapist, stating that when alcohol is removed completely from their relationship, perhaps they could go to a sex therapist. As well, she encouraged them to refrain from all sexual contact just to take the pressure off in this area. The clients asked if she suggested this for reverse psychology purposes. She said no, she just wanted them to not focus on this area.

> T: It is to be expected the that the sexual connection would improve very, very slowly. This is normal when alcohol has been a part of any relationship for a long time. This is not uncommon by any means, not uncommon. So if the alcohol keeps coming back, the sexual relationship ... well, very often it doesn't come back until your insecurity, your self esteem changes, until you learn to accept your fears.
>
> .....
>
> T: I want to tell you when alcohol is right out of the picture and you've moved nearer to these goals and are feeling a lot more self respect, which you will do if you mean to keep alcohol out of the way. When a certain amount of time has gone by, there are some really good sex therapists, I know a very good sex therapist that we could refer you to. But not yet , not just yet.
>
> S: Ya...(clears throat)
>
> T: And it would be a very gentle process...And so after the therapy is finished and after the post therapy period, 15 weeks more have gone by , it you are still interested and have managed to keep alcohol out of your life that might be a good time to consider going to a therapist to deal with that area. But I think it may get better by itself, I think it will as you feel better about yourself. But we can't do much when alcohol keeps coming back.

It was not mentioned again, until session 10. They discussed the fear that the alcohol may take over before they have the break through that they are looking for. This moved into a discussion about sex. Donna felt like she had initiated at times but it never went anywhere and then she felt foolish. The questioning moved quickly away from that to Donna's partner at work.

During session 13, connections are made between alcohol , sex and guilt. Donna

started by talking about how they were the "best of buddies" but are still missing a few things in their relationship, like the sexual thing. The therapist attempted to have Donna make connections with sex and alcohol , she had a difficult time doing this. The therapist also had her explore the alternative of never having sex in their relationship. This discussion doesn't last long and Sam moved it back the the present difficulty of guilt.

T: How do you connect the sexual thing with alcohol, Donna?

D: At first, I thought it was because he drank too heavy or would pass out or whatever. Now I don't understand, I have no understanding. I don't know of anyone that is going through what we have, and yet we keep it a secret. Nobody knows that there was no sex with us, but it's been well over a year. It's like you are always playing games. My best girl-friend thinks we have such a fantastic marriage. When we are out we have fun, we laugh, everything was normal.

....

T: What if the sex never came back. What about that scenario? I don't believe that, I'm just curious about what that would be like.

D: It would be really hard for me. It would be really hard for me. .... It's hard for me now.

T: It's hard for you now.

D: Because I don't feel, it's not the act of sex, it's being close. When you are close you can feel and think what the other person is feeling and thinking. Sam and I don't have that. Sometimes I get funny and I go up and tickle him on the neck or under his arm and he laughs so hard he can hardly stand up and I like that. It's really funny, it's just like he was a little boy then (laughs).

T: So you have this dream of being able to know what he is feeling and thinking and you think you can get that through sex.

D: No, but the closeness would be there. I think in every other aspect, except for that and the alcohol, we do have a good marriage.

T: Sounds like you do have a wonderful marriage, friendship and good marriage and are hanging in there. Are you hanging in there?

D: Huhuh.

S: She was... I feel like I've done some damage to myself years ago, I don't know if I can blame it on the alcohol. It was psychological too. But it brings me so I can't perform sex. I still feel guilty about having sex, even when I'm sober. My little libido isn't ...isn't as active as it used to be.

T: Which was normal.

S: When I see a good-looking woman on the street, the little thing, the little things aren't there. The other guys are (thumps foot on ground). Of course that's mostly how guys are.

T: So it is normal for libido to lessen with age.

S: I don't know, I don't know. I don't want to think about my age. There are lots of people my age and older who are very sexually active. There is an old saying - What you could do all night long, takes you all night to do when you get older. Uhhh, but it's taking me all year to do. The longer the abstinence is the harder I'm making it on myself. I used to ... it used to be so spontaneous.

T: Does this have anything to do with the alcohol?

S: Oh, there was guilt written all over that bottle.

T: Ya, Ya. So guilt, had to do with....

S:... a lot of things in my life.

T: So guilt had to do with alcohol. Guilt was connected with sex. If this was guilt, where would you put it in your relationship now. Here is alcohol and here is Donna. Where would you put this (Kleenex box).

S: Well, first and foremost guilt is first . There are other reasons guilt was in there.

T: Why is guilt there?

S: Well, I felt guilty about my past relationships.

The therapist queried about past relationships and then a lot of story about how they met, and had an affair came out. The rest of the session focused on guilt but didn't relate it back to sex.

In session 11, Sam came in alone but brought his goals from the rehab center. One of his goals was to be more comfortable and happy with sex. In the papers are notes he

took from the sexuality seminar at rehab and he read them aloud, but there was little interaction over them. There were some very blunt notes. He was a little embarrassed about even reading them. The therapist affirmed him reading them. Sam admitted that he was feeling vulnerable, the therapist encouraged him and told Sam that she appreciated him bringing them in. Sam deflected from the embarrassment of the moment by commenting on how most people don't talk about their sexuality, except for in Europe. The therapist followed the story by asking details about his Europe trip. Sam goes off on a lot of story about his trip in Europe twenty years ago. The therapist brought him back to sexuality by asking him to place the sexuality notes in relationship to the goals. He placed them on his goals as part of the goals. He expressed that he wanted to be comfortable and relaxed about his sexuality. Sam believed that his inability to be open and honest and express his feelings was connected to his frustrations with sexuality. Sam was surprised how long it was taking to see changes in the area of sexuality. He thought their sex life would fall into place. Discussion moved to looking at the walls Sam used to keep people out. This symbolic exercise had more depth but they did not relate the wall back to sexuality.

Analysis of the issue of sexuality

The couple and the therapist displayed some discomfort discussing the issue of sex in the therapeutic context. The only time feelings about sex were focused on was in session 7 and this only occurred because the therapist intensified the interaction. However, the therapist ended with the statement that perhaps they could deal with their sexuality later with a sex therapist. This communicated that the problem of their sex life was not an integral part of the healing for this particular therapy. It seemed that sexuality was a central goal for the couple but the therapist only directed the discussion around this issue once. The other times it came up the therapist didn't pick up on it and deepen the exploration and the clients also quickly moved away from it. This issue seemed to be a big wall in their relationship that was not dealt with adequately in therapy.

Part four

Part four presents the results of the analysis of the "best" and "worst" sessions in

four sections: a)the Qualitative Clinical Analysis; b) the Counsellor Verbal Response Category System and the Client Behaviour System and c) the Sequential Analysis.

The qualitative clinical analysis

The following section gives a descriptive summary of the best and worst session of each case, then the differences were compared. The best session for case A was number 12 and for case B was number 14. The worst session for case A was number 8 and for case B was number 2. The focus of this analysis was to look at broad differences rather than distinct behavioural differences because these showed up in the coding of the transcripts using the CVRCS and the CBC.

The "Best" Sessions

Case A .

Prior to this session, Bill had a slip with alcohol and Ann kicked him out of the house. They were living apart ever since but had seen each other. Ann stated he was not coming back unless he left alcohol completely. The session began by the therapist asking if they could update her on where they were currently. Bill was obviously in deep thought and had a lot of hope that this session would be a reconciliation. Ann told the therapist about a dream she had and in recounting it seemed to reinforce her ability to stand up for herself and to not take Bill back for the wrong reasons. Within the first five minutes the clients expressed a lot of deep emotion as they checked in. The therapist directed therapy by asking them to put alcohol (symbol of bottle) in their relationship now. Both of them placed it right between them. The therapist then asked Bill to talk about the drinking incident and relate the symbol of the seal to alcohol. Bill stated that the seal "went on a tangent" and "was lost". The therapist used empathy and interpretation to draw Bill further into exploration of this metaphor and the seal then became a lost child. She also asked how this situation was different from the experience with his parents. After some exploration, the therapist asked Bill what he was feeling right now. A few speaking turns later she asked the seal to say something to alcohol. They spend some time exploring the voice of the seal, alcohol and his father. Some deep emotions were expressed about the hurt he felt as his father dismissed him. The therapist asked him to bring these feelings up through time and

experience them . Some time of grieving occurred as he explored the pain around his father in the here and now (tears were evident). The therapist used empathy and gentle probing to help Bill go deeper. The therapist then made the connection between all these issues.

> T: So when someone says something negative to you now, that you feel useless and worthless and unloved and no good, you just feel really bad, then you hear the voice of your father, "So what", which you heard when you were five and the lost child went to alcohol and joins....

After more exploration, where Bill continued to express emotion, the therapist brought Ann in and asked her to talk about the pattern. At first Ann expressed resistance, " I don't know. I think he sometimes blames it for the choices he made. It doesn't make...", but the therapist asked her to allow her thoughts to enter into the situation and focus on the triangle. After some further exploration of the pattern, the therapist asked Bill where he would put the seal now. He chose to leave the seal "lost" near the alcohol but looking at Ann. The therapist asked Ann what she had to say to the seal. With tears she expressed that she wished she could fix his pain but she couldn't and she refused to rescue him. Bill got very upset ,"I'm a mess right now". He felt abandoned just like he did when he was a child and his mother and father abandoned him. The therapist had him place his father and mother in the room using chairs. When she asked where the seal would be in relationship to them, he placed it in his lap. The therapist directed the seal to speak to his mother, this took them further into exploring the hurt and anger. Then she directed him to speak to his father and more emotional exploration occured (tears). The therapist then stated:

> T: ...I've seen so many feelings since then and I hear so many feelings today and I see how committed you were to getting to know yourself and now today you've been connecting with a five year old boy and gaining some understanding about the so what voice and uh, the voice that said you could do it by yourself, you don't need help and the seal. And I wonder if you could, this person that you were, that's learning to be with your feelings, I wonder if from that position , you could just speak to the seal right now.
>
> Together Bill and the therapist moved through a dialogue in which, Bill expressed

love for the seal and a willingness to care for it. The therapist pushed Bill further by asking how he could protect the seal. At first he was unsure and said he couldn't do a lot but the therapist gently pushed him. Bill came to new understanding about listening to his feelings, and believing in himself. The therapist brought Ann in through immediacy and the experience was debriefed through her perspective. She was much more willing to understand Bill's pain then at the beginning because she connected to being abandoned by Bill's mom, however, she continued to stand up for not accepting alcohol. The session was then brought to a close as the therapist questioned Bill about seeking out AA this week and made him make a firm commitment. She then asked where the seal was in relationship to the goals and Bill stated that it moved back on track, facing the goals. Bill placed it there and the session ended.

Case B.

Prior to this session, the therapist had asked Sam to bring in a symbol of his guilt. The session began with the therapist asking how they were. Both of them gave superficial accounts of their weeks. Sam initiated a transition by asking if the therapist wanted to see his little suitcase. The conversation was light with laughter as Sam talked briefly about the development of the symbol. The therapist said directly to Donna, " And for you, guilt could be a fear too, kind of a hidden threat." However, Donna went into a story about work, which the therapist followed and used empathy and questioning to explore it more for about five minutes. Sam again made the transition in therapy by asking after a brief silence, "Would you like to see my suitcase". Sam had brought a bag (that used to carry his alcohol) containing a Ken-doll with a bottle around his neck. They explored the symbol in a descriptive format and eventually saw if he could stand on the table. The therapist moved the therapy deeper by asking Donna what went on for her as she looked at the doll. She just saw Sam. More exploration of what the symbol represented occurred and then the therapist challenged a statement Sam made about guilt being a nice guy. Sam admitted this did not make sense. The therapist then asked Sam to let the whole of his past be with him and then explore which part of his past guilt he was most connected with. Sam connected with a time when he was young. The therapist used empathy and probing to help Sam

explore his pain deeper. She also asked about how this time was connected to guilt. Sam often went to the story line but the therapist's initial responses were mostly interpretations and open ended questions about feelings. She affirmed him whenever feelings came out. Sam continued to talk about his dad and moved into the story of meeting him when he was sick as a young child. The therapist continued to explored with Sam but started to get trapped in the story with Sam by asking questions about details such as , "tell me about the scary moment ", or "who was with you at this moment?". The therapist tried to go deeper after a lot of details were recounted by summarising:

> T: So it was another time when you were isolated and so there was many times that you felt isolated even when the family was together at the bird sanctuary -there was a kind of a sense for you to be careful... Dad shuffling around and looking at the ground.

The last part of her summary seemed to take Sam back into the story. They stayed with the story for a number of speaking turns and then the therapist asked directly how it was inside right now as he talked about it. Sam's initial response was to describe the weather, so the therapist asked it again with emphasis. Sam expressed some feelings and the therapist asked where about he felt this. When the therapist reflected the fear, Sam resisted by saying, "Oh that's basically what TB was like way back then". Sam moved back to story and the therapist followed. She didn't intervene to bring it back for quite a while, but then summarized and interpreted, "That fear was accompanied by a sense of isolation of not really being close to your Dad". The story continued about his father and eventually moved to when his dad died. The therapist tried to reflect feeling and asked twice, "How was that for you?". Sam gave more details and the therapist followed by asking more closed questions. Then she made the connection from guilt to his father's death asking him why he felt so guilty. This seemed to move Sam into a deeper level of experiencing as he expressed, with tears, his guilt around his father's death and his mom's reaction. The therapist interpreted and made connections between all these issues. This moved to sadness and he wished he could jump back in a time machine to talk to his dad. The therapist stated that he can't do that and then summarised and supported his feelings. After a bit more

discussion, the therapist supported Sam for doing something very different today.

> T: So what you're doing in this room is something very different and it probably felt strange to you, you are talking about a very deep sense of isolation and hurt and pain and you're doing it not in isolation not only with Donna here and I know that you two had talked a lot but you are doing it with a stranger. You're doing it not in isolation you're experiencing a pain and doing it without the isolation and without alcohol and maybe the alcohol took you away from your guilt took you away from your pain but it also perpetuated that pattern of thinking there's something wrong.

Donna agreed with the therapist and talked about her perspective of the issues. She began to make connections to her own father and spent a few minutes with the therapist exploring this. The connection was made between the "trap of abuse" she experienced as a little girl and the experience she had of being trapped when Sam drank. This was new insight for her. The therapist tried to bring the session to a close by saying there's lots more work to be done. She then summarized the new awareness they both had. The therapist encouraged Donna to do something to affirm herself in those moments of being trapped. More exploration occurred as Donna seemed eager to discuss all this but the therapist said the session had to end and she asked Donna what she would do for herself in the next couple of days. The therapist also asked Sam what he would do differently in the next couple of weeks. The sessions ended by discussing some of the details of the TARP. The doll was simply put back in the bag and Sam made a joke about perhaps having a ritual burning.

The "Worst" Sessions

Case A.

The previous session was one in which Bill had his first slip with alcohol, and a lot of pain was revealed to be connected to his was father and alcohol. The session began with the therapist asking how they were. Ann came right out and said what was on her mind. She believed Bill had been drinking and was very upset. This in turn caused Bill to be angry and hurt because he said he had not been drinking. The therapist explored both their

feelings around this accusation using empathy and open ended questions. Both clients expressed a lot of hopelessness, weariness and frustration about the pain that did not seem to stop. The therapist went deeper into Bill's pain asking him to describe it and explored it in his body. It moved a bit away from the actual pain when the therapist asked Bill to tell her something about his family. The therapist drew Ann in at one point by asking how she was feeling as she listened. Ann talked about feeling sorry for the pain he had experienced but as the therapist reflected and probed her feelings Ann said tearfully, "That's the trouble I'm really afraid". "What were you afraid of ?", the therapist asked. Ann expressed that she feared supporting Bill just like his mother did with his dad. The therapist directed her to tell Bill this. The therapist continued to explore both their feelings and she summarized after a while:

> T: Ya, so you're feeling really tired you're both feeling weary and tired and very fed up with the patterns and you're feeling this. It seemed to take a big toll.

A few speaking turns later she asked, "If you don't want this what would you like?". Each of them talked about what they want and the therapist asked them what the first step in doing that would be. After some exploration of this, the therapist directed them to place themselves physically in relationship to the goals and had them literally take a first step. Ann wanted to pay only half the bills, Bill wanted to be responsible for himself. The therapist explored Ann's feelings around this experience, mostly related to her not wanting to be Bill's mom and in the process, Bill sat down. The therapist used immediacy to explore what just happened. Both of them expressed a lot of frustration and anger at the return of an old pattern of avoidance. The therapist interpreted and asked what the connection was to their childhood. As they explored, this Bill was able to come to an understanding of his own fear of losing Ann. The therapist affirmed that at this moment they did something different from the old pattern.

> T: So what you were doing right now Bill was experiencing your feelings and knowing who you were so even though you sat down again you were really in touch with your feeling.

The therapist then asked them what they were going to do to honour the steps they had taken when they leave. More feelings came out and Bill expressed how he was protecting himself and was also shocked that he was saying how he felt. He expressed his frustration in knowing that he couldn't predict the future or know exactly what recovery would look like. Both the clients still seemed caught up in frustration, sadness and helplessness but the therapist affirmed that they were able to experience something different and stay with their feelings. The therapist then spent a lot of time summarising and directing them as to how to cope in the next little while. The clients did not express much. At the end, the therapist summarized that she was scared for them because they seem depleted and so she encouraged them with ideas of how to break the pattern of Ann not putting herself first, and of Bill trying to fix Ann or draw her into caring for him.

Case B.

Note: Session 2 was listed as the worst session in terms of making changes, however, it was a session where goals were being formed, which was an essential part of the therapeutic process. Thus again it may not have created changes but it was not necessarily unhelpful in the therapeutic process.

The session started by the clients coming in and debating about where to sit. The therapist used immediacy to ask Donna if Sam was sitting too far away. Donna responded that sometimes it was. The therapist didn't follow this up but moved to noticing a badge on Donna representing her new job. During this discussion, the therapist used immediacy to point something out again but did not pursue it. They spend a few minutes talking about this and then the therapist summarized the last session and asked them if they had thought about their goals of therapy. Donna immediately stated her goals as wanting to get rid of the problems with money , sex and fairness. The therapist picked the first one about money and asked Sam what he thought she would like to see happening at the end of the fifteen sessions. Again the therapist used immediacy to point out that Donna had something more she wanted to say, however, this was joked about by Sam and not followed up on. The issue of money was explored as the therapist used mostly closed questions to get the details around this issue. Donna stated that she felt guilty if she didn't pay for more than her share.

The therapist asked more questions about the guilt. She then attempted to symbolically externalize guilt with chairs, but does not correctly help the clients to use this technique. She simply brought in a chair to represent guilt. The therapist then asked Donna to place it in relationship to herself. It was very close to her. Discussion moved away from this and then the therapist asked Donna what would be happening when she had cleared up the money problem. Donna hesitated at first by saying, "I don't know" but the therapist stated, " We need to know so we know what we were aiming for". More details about money and how it could change and was changing were given. The therapist asked if one of Sam's goals was to be more giving. Sam expressed his guilt in this area as well. The therapist had him position a chair representing guilt. The therapist pursued this by asking ,"Where about inside do you feel it, the guilt?". They explored this feeling in his body but Donna interrupted the process by moving to a story where she felt guilty. After some exploration with this story another goal of taking less responsibility was written down. The therapist then moved to ask about Donna's sexual goals. A discussion occurred about the lack of sexual closeness in their relationship, it was focused on information. A few feelings emerged as the therapist interprets Donna's story.

> T: So you really felt shut out and really excluded pushed away and really isolated in your relationship in spite of the fact that was seemed really easy and close on the surface for you. There's a lot of emptiness inside and you live alone.

Some exploration of Sam's feelings occurred next when the therapist asked Sam if he would like the intimacy back. Throughout the discussion, the therapist affirms any closeness , any sexual feeling, any sexual attempt that they expressed. This seemed to move the discussion away from the pain around this issue and the therapist summarized that she was sure successful sex would happen sometime. Donna seemed to want to bring it back by stating, "But I feel that I'm getting further away ..." and then went on to a talk about how her new job was making her feel successful and distancing her from Sam. When Donna talked about needing to look after herself, the therapist asked who taught her that. This lead to a discussion about her family and the therapist spent a long time gathering information about Donna's family. The therapist seemed to focus on a lot of

details especially as Donna started to talk about a history of abuse with her ex-husband (including getting last names). This exchange went on for about 20 minutes. As Donna continued to talked about other people and their control, the therapist asked her if she was a controller. This lead to a discussion about some of the patterns in their relationship. The therapist pointed out a statement that demonstrated Donna's co-dependency but Donna continued to stay with her point. The therapist then became more complementary and supported her by saying, "You had faith" (that he would stop drinking). Donna responded with story about her past work situation and how hard it was. The therapist followed this with reflection and questions. The therapist then stated that they needed to stop soon but she read the goals that had been written so far. Sam and Donna moved to what some of the changes were already and Donna talked about the hopeful feeling she had inside that they were going to do something. When the therapist asked how Sam felt inside, he again talked about some of the changes he saw with himself. This brought out some more of Sam's goals as Donna pressed him on these changes. At the very end, the therapist reflected back and supported the commitment to each other and the good things in their relationship. The therapist also asked if one of Sam's goals was to stay sober. He said yes but he also said he would be a liar if he didn't admit that he thought about drinking again. A few responses go around this and then at the conclusion the therapist put the goals on the table and they signed them.

Analysis of the Differences Between Best and Worst sessions

The clinical qualitative analysis showed some clear differences in the sessions. Most of the differences occurred between cases rather than between the best and the worst sessions. As well, both sessions (best- #12, worst- #8) from case A and the best session (14) from case B had more similarities with each other then case B's worst session (2).

Differences across best and worst sessions.

Best sessions involved a depth of exploration and emotion that included tears of grief. The worst session of case A involved a lot of emotion but it was more frustration and anger. The worst session of case B did not involve a depth of exploration and few emotions were experienced in the here and now.

Differences across cases.

Case A did not have a lot of story at the beginning but moved quickly into the issue as the client brought it into the therapy. In both session 12 and 8, the therapist picked up on the issue and drew them deeper into an exploration of it. Case B, sessions 2 and 14, had more storytelling at the beginning of the session. Even though in session 14, Sam brought up his symbol of guilt immediately, it moved away from this to Donna storytelling. The therapist seemed to follow the story line of the client for a while and Sam then intervened to bring it back to a focus on his symbol. Session 2, was mostly storytelling and fact finding as the therapist attempted to help them clarify goals.

Case A explored an issue and then gave the clients an experience of practising something new. Session 12 explored alcohol and its hold on Bill through the use of the symbol of the "lost seal" having moved to alcohol. The therapist helped Bill explored alcohol deeply, to bring up the pain connected to his parents. This was related to the pattern in the couple's relationship. The session allowed Bill to grieve and let go of some of his pain and then helped Bill find and practice new alternatives for caring for the seal's feelings. There was a transformation in Bill as the symbol of the seal was placed back on track with the goals at the end of the session. Session 8 also explored an issue and brought up a lot of feelings. Even though the same kind of depth was not present nor was the obvious transformation, feelings were explored and a new experience of staying with them and expressing them occurred. As well, they experienced doing something different by taking a step out of the hopelessness. By the end of the session, their awareness was deepened. Session 14 allowed Sam to explored some of the pain and guilt around his fathers death. There was a new experience of staying with his feelings and this brought some new awareness but he didn't go the next step of experiencing transforming these feelings (via talking to his father or doing something with the symbol of guilt). The focus was on awareness but not moving to a new place of caring for self. Session 2 was a lot of storytelling with little exploration into issues or any opportunity to experience a different way of being.

Session 12 and 8 used symbol more than session 14 and 2. Session 12 used symbol throughout in a very powerful way. The seal and the alcohol were used to explore

and transform Bill's experience. During session 8, the symbol of the alcohol and the goals were integrated throughout therapy, although not explored with the same depth as session 12. Session 14 began with the symbol of Sam's guilt which drew them into some deep exploration of the pain around his family, however, it was not integrated after about the first five minutes and was not used to summarise any transformation. Session 2 only briefly involved symbolising guilt as chairs but it was not explored beyond a couple of responses.

In session 12 and 8, the therapist had the couple experience their feelings in the here and now. In session 12, the therapist specifically asked Bill to bring his feelings from the past up into the present. She also asked numerous times, how he was feeling right now. Session 8 also had the couple talking about feelings they were experiencing at the moment in the therapy session. The therapist used a lot of immediacy to get them to this place. Session 14, explored emotions from the past but the therapist never asked them to bring them into the present. A few times, she asked how they were feeling in the present and where they were experiencing this bodily, but this never went very far. Session 2 had little exploration of feelings at all, with only one brief dialogue about Sam's experience of guilt in the present.

The Counsellor Verbal Response Category System

The results from the Counsellor Verbal Response Category System are presented in the following section. Table 9 lists the results according to the proportion of response units in each of the categories. Statistical analysis is not appropriate because of the limited sample. However, a comparison of these proportions show four major differences between the "best and worse" sessions as cases were coded with the Counsellor Verbal Response Category System: a)the amount of silence, b) the amount of closed questions, c) the type of paraphrasing, and d)the amount of interpretation.

The first major difference was the amount of silence present in case A vs. case B. For both the "best" (12) and "worst" (8) session of case A approximately 8% of the counsellor responses were silence. For the "best" (14) session of case B only 1% of the

Table 9

Counsellor Responses in the "Best and Worst" sessions

	Session			
	Best		Worst	
Therapist Response	12-A	14-B	8-A	2-B
Minimal Encourager	.13	.12	.07	.09
Silence	.09	.08	.01	.00
Approval	.10	.10	.06	.09
Information	.05	.09	.13	.04
Direct Guidance	.07	.04	.07	.05
Closed Question	.08	.10	.06	.26
Open Question	.13	.06	.11	.09
Paraphrase	.23	.26	.29	.27
Interpretation	.10	.06	.12	.06
Confrontation	.02	.04	.03	.00
Self Disclosure	.00	.05	.03	.01
Other	.00	.00	.02	.04

counsellor responses were silence and for the "worse" (2) session 0% of the counsellor responses were silence. The second major difference was seen in the questioning category. Both sessions of case A and the best session of case B showed between 6-10% of responses being closed questions. The worst session of case B (2) showed 26% of the responses as closed questions. The third major difference was seen in the type of paraphrasing used in each session. Looking at paraphrasing as a whole there were not huge differences between sessions. However, by breaking paraphrase down into its types while

working with the transcripts, the researcher discovered that the counsellor used more reflection of feelings and immediacy in both session 8 and 12 than in session 14 and 2. Session 2 especially had more restatements of clients response than any of the other sessions. Finally, the fourth difference came in the amount of interpretation used. Interpretation occurred 10% and 12% in the best sessions, 12 and 14 respectfully, as compared to only 6% in the worst sessions of both cases.

The Client Behaviour System

The results from the Client Behaviour System are presented in the following section. Table 10 lists the results according to the proportion of response units in each of the categories. Statistical analysis is again not appropriate because of the limited sample. However, a comparison of these proportions shows three major differences between the "best and worse" sessions as cases were coded using the Client Behaviour System: a) the amount of recounting, b) the amount of exploration both cognitively and affectively, and c) the amount of insight.

The first major difference showed up between cases more than between sessions. Case A showed significantly less client recounting (Session 12-9%, Session 8-13%) than Case B (Session 14-45% and Session 2-61%). The second major difference showed up again between cases. In both the best and worse session of case A, the amount of cognitive-behavioural (Session 12-45%, Session 8-38%, Session 14-26%, Session 2-16%) and affective exploration (Session 12-22%, Session 8-26%, Session 14-8%, Session 2-7%) was higher than in either session of case B. The final major difference was the amount of insight experienced by the clients. The best session of case A showed 6% insight behaviour. Only 2% was shown in both the best session of case B and the worst session of case A. The worst session of case B showed only 0.4% insight.

Looking at all these results one can see that differences between cases were almost stronger than the differences between best and worst cases.

Table 10

Client Behaviours in the "Best and Worst" session

	Session			
	Best		Worst	
Client Behaviour	12-A	14-B	8-A	2-B
Resistance	.02	.02	.05	.02
Agreement	.13	.13	.14	.09
Appropriate Request	.02	.04	.02	.01
Recounting	.09	.45	.13	.61
Cognitive-Behavioural Exploration	.45	.26	.38	.16
Affective Exploration	.22	.08	.26	.07
Insight	.06	.02	.02	.00
Therapeutic Changes	.00	.00	.00	.02
Other	.01	.00	.00	.02

Summary

The results from this case study revealed numerous differences between the successful and unsuccessful case. To discover how and why change occurred analysis was done in the context of the entire therapeutic story as well as exploring a smaller contextualized episode. How client factors, therapist factors, technique factors and the interaction of those may have influenced the process of change were analyzed using qualitative measures, scales and coding systems.

In summary, change occured as an interaction and interweaving of numerous

variables that seemed to be present in the successful case and not as clearly evident in the unsuccessful case. These variables influenced one another to create or stop immediate outcomes from occurring and thus impacting the final outcome of therapy overall. The following chapter will integrate the results into clear themes associated with change.

CHAPTER FIVE
DISCUSSION

This investigation has examined all the therapy sessions of ExST couples therapy from two cases using case study methodology. By analyzing the differences between these two cases with opposite outcomes using multiple assesment levels (Pinsof, 1989), factors can be identified that are associated with change. A review of family therapy process research and specifically case study research demonstrated the need for exploratory studies to illuminate the change process in therapy. The successful and unsuccessful case were thoroughly analyzed using numerous techniques to reveal how the client factors, counsellor factors and the interaction of therapy may have contributed to the Big "O" outcomes and the little "o" outcomes. This chapter focuses on the major findings,the implications of findings for practice, the limitations of this approach and the directions for future research.

Findings

Numerous differences were discovered in the two cases as they were explored and analyzed. Researchers have demonstrated that change throughout therapy is a complex process of how the preexisting variables and the contextual variables moderate and interact with the process variables to create immediate and final outcomes (Hill, 1992). Jacobson (1993) states that exploratory comparison within models lends itself appropriately to ask questions such as : Just why was one case successful and one case unsuccessful? What are the conditions under which a treatment effect is maximized? To what extent is the theory of change implicit in the treatment confirmed or disconfirmed by the results? Thus, the results from the previous chapter have led the researcher to synthesize the findings as to why and how change occurred with case A and not case B. These findings are integrated with other current research and the theoretical perspectives of ExST. The results are discussed with the understanding that these are only inferences and it is impossible to achieve certainty on how the changes came about. As well, the evidence used to establish the findings is often

correlational in nature and thus further research would need to be done to establish the validity of these findings.

The first findings relate to the preexisting factors that influenced change. The next group of findings address why change occurred. The final group of findings address how change occurred.

Preexisting Variables that Impact Change

Finding # 1

Greater change was associated with some preexisting client variables that moderated the therapeutic interactions.

In this investigation, many preexisting variables were held constant, such as choice of therapist, client demographics and diagnosis. However, each couple demonstrated differences in personality, motivation, presenting problems and supporting network.

Personality.

The two couples showed some similar personality traits. Neither couple was highly negative or hostile. Each client was pleasant and likable. Generally, each client was able to enter into a relationship. However, two main differences between the clients were noted. First, Sam tended to be less susceptible to interpersonal influence, he acted as a bit of a loner and found it harder to enter into emotional interactions. Sam often used humor to divert intense interactions. Another big difference between the couples was in their psychological distress level. Both on pretests and from client expression, couple A showed higher levels of distress. Therapeutic differences are supported by other research as being important factors for success.

Highlen and Hill (1984) reviewed five personality factors that have been found to be determinants of successful outcome: (a) the client must be susceptible to interpersonal influence, get along with others and form a relationship with them; (b) the client needs to be upset and in psychological distress vs. having mild, vague dissatisfactions; (c) if the

distress is interpersonal rather than physical or somatic prognosis is better; (d) the client should have some coping capacity; and (e) the client's attractiveness and likability sometimes predict success. This study demonstrates that all of these factors were more evident in the couple that succeeded. For the unsuccessful couple, factor a and b were not as strongly evident. As well, Sam (couple B) presented distress in the physical area (impotency).

Highlen and Hill (1984) also noted specific skills involved in being a good client: verbal ability, capacity for self-understanding, and an ability to self-explore and focus. The clients all showed good verbal ability and were able to engage easily in conversation. Couple A seemed to come to therapy with a clearer understanding of their patterns and the also seemed more capable of self-understanding. Couple A also had a much higher ability to self-explore and focus during the session. Couple B often explored other people and had a difficult time staying focused during therapy. Gomes-Schwartz also (1978) found that the most consistent predictor of outcome was the patient's willingness and ability to become actively involved in the therapy interactions.

Motivation.

Both couple's came to therapy, expressing a high degree of motivation to see changes continue. However, couple A demonstrated more motivation to work by the way they did their homework and by the way they entered into therapy quickly in the first session. Couple B seemed more cautious and avoided changes at different levels.

Presenting problem.

The presenting problems were very similar in both couple's, except in the area of sex. Each couple wanted the male to stay sober and they wanted to work on restoring their relationship. However, couple B had not had sex for over two years. Couple A were back sleeping together after some time apart. Couple B's sexual difficulties were just barely touched on in therapy and still remained at the end of therapy. This is a major issue in couple's therapy and the fact that couple B's relationship did not improve during therapy could have been linked to this. Researchers have shown that outcome is less likely to be

positive when frequency of sexual intercourse is low (Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984).

Supportive network.

Another variable that may have accounted for success in one case over the other is that couple A seemed to have a family structure (Ann's family) that supported Bill's recovery. Bill didn't seem to have contact with his family during therapy. As well, Bill was attending AA meetings fairly regularly throughout therapy and had a sponsor by the end of therapy.

Couple B, however, mentioned numerous times that their interactions with Sam's family were not helpful to his recovery. They seemed to be in denial about his alcohol and often offered him drinks. Sam also never attended AA meetings and felt he could recover on his own. This supports research that discovered the difference in outcome was due partially to the fact that the more successful client had a supportive network (O'Farrell et al., 1986).

Finding # 2

Greater change was associated with a preexisting stage of change that moderated the therapeutic interactions.

Several studies explore the stages of change construct (Prochaska & DiClemente, 1992; DiClemente & Hughes, 1990; DiClemente & Prochaska, 1985). This research has been ongoing for 12 years and has been integrated with processes of change. Most of their work has been related to change from addictive behaviours. Prochaska , DiClemente, and Norcross (1992) used cluster analysis to discover five stages of change: (a) precontemplation, (b) contemplation, (c) preparation, (d) action, and (e) maintenance. A clear criteria for each stage is given. These stages occur in a spiral pattern, relapse and recycling through the stages occur quite frequently, especially with addictive behaviours. Research on a large sample size (N=570) demonstrated that the amount of progress clients make following interventions tended to be a function of their pretreatment stage of change

(Prochaska & DiClemente, 1992). The only other variable that outperformed the stages of change as outcome predictors were the processes of change the clients used early in therapy.

The present study noted differences in the client's motivation and readiness to eliminate alcohol. Bill and Sam came to therapy in the action phases with regard to alcohol because they had both successfully abstained for over two months prior to entering therapy. In relationship to filling the void created by the absence of alcohol, however, Bill and Sam were at two different stages. Bill was in the preparation stage and ready to take action to explore his feelings and his relationship with Ann. Sam, however, was more in the contemplation stage as demonstrated by weighing the pros and cons of his behaviour and by avoiding feelings and conflict. When Sam had his first slip with alcohol, he seemed to move back into the contemplation stage regarding this as well. Even in the fifteenth session, Sam admitted that alcohol was still a factor and he had not decided to get rid of it altogether, thus he seemed to be in the contemplation stage by the end of therapy, even though he had cycled through some of the other stages. His continued use of alcohol drew him back to this stage. By session fifteen, Bill on the other hand seemed committed to leaving alcohol and getting the help needed to do that. Thus he moved to the maintenance stage. Bill had also moved through the preparation, action and maintenance stage in a spiral fashion throughout therapy regarding his relationship with Ann. He ended therapy in the maintenance stage.

This study also noted the differences in Ann and Donna's willingness to confront situations. Ann had been to counselling prior to the start of the TARP project and she seemed to be in the preparation stage as far as readiness for therapy (confronting issues and expressing her feelings). Donna on the other hand came to therapy more in the contemplation stage, as she was keen to see changes, but more cautious to initiate feelings or bring up conflict and often engaged in the weighing of the pros and cons of a problem and its solution (Prochaska, 1992).

Thus change could have been impacted by the fact that Bill and Ann came to therapy in the preparation stage and the therapist was able to help cycle them through the other phases. Sam and Donna on the other hand were more in the contemplation stage and thus it

took longer to move them out of this stage, thus slowing the change processes.

Finding # 3

Greater change may have occurred if case B had more therapy sessions.

A condition of this project was the time limitation of only providing fifteen sessions of treatment. To expect change in a limited time frame, doesn't take into account individual clients pacing, pretreatment stage (Prochaska, 1992) and process. As both couples only received 15 therapy sessions, it is possible that more change would have been shown had couple B been able to continue therapy. Couple A seemed to come naturally to the end of their therapeutic story. They were fearful but hopeful and expressed a clear sense that change had occurred in a deep way.

Couple B on the other hand were anxious and wishing for more sessions. Many of their issues were just beginning to come to awareness and to be processed. As stated by Donna in session 15:

> D: But we talked and we feel it's gonna be, or at least for me I feel that I'm just getting on the tip of what bothers me and I'm afraid to let this go. And I've been really sad about this all week. In fact my sleeping habits everything have been....you know because I know I won't really have anyone to talk to and I feel like I'm just beginning to talk about my dad, not from a joking point of view but from everything I've been hiding. And that scares me, it scares me to death because I feel like I'm just starting to get into it.
>
> T: It is really important that you take good care of yourself in the next twenty weeks.

Evidence showed that for couple B, therapy was somewhat helpful according to their ratings and according to the researchers assessment. During the last few sessions, the couple became more engaged in symbolic and experiential work. Couple B made some changes over the course of therapy as evidenced by less recounting, expression of more feelings and increased awareness. These did not impact the outcomes measures but it does

bring into question what is "success" and if it takes longer for some is it less "successful".

This finding supports other research that states it is possible that technique variables might have been more salient if treatment were of longer duration or if only patients "appropriate" for brief dynamic therapy were included (ie. those with sufficient motivation and ego resources) (Gomes-Schwartz, 1978; Kohut, 1971; Lambert & Cattani,1996) .

Process research that attempts to get at change theory should allow for the variable of time to be factored in. As some of the same process variables may create change but may not be evident within the same time framework for each client.

Why Change Occurred

Finding # 4

The impact of the therapeutic alliance on treatment outcome was not as significant to change as other factors.

Therapists of most theoretical orientations tend to agree that without a strong relationship between the therapist and patient, the most likely outcome is premature termination from psychotherapy or very little if any positive change (Garfield, 1990; Strupp, 1973; Strupp & Binder, 1984) Empirical research also demonstrates that therapeutic alliance is the highest correlate of outcome among the process variables investigated in several studies (Horowitz, Marmar, Weiss, DeWitt & Rosenbaum, 1984; Lambert, Shapiro, & Bergin, 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

The present researcher supports the view that therapeutic alliance is an essential element for change. Without a good therapist/ client relationship, therapy would have a hard time proceeding. However, numerous cases in research state the reason one case succeeded and not the other was almost solely because of the lack of therapeutic alliance (Strupp, 1980). Unfortunately, these studies did not tap other subtle process variables

because the lack of relationship gets in the way. In this present study, the therapeutic and working alliance was fairly consistent across cases. This leads the researcher to assume that therapeutic alliance is a necessary but insufficient condition for therapeutic change in this study. Thus with alliance being relatively consistent other process variables have an important impact on change.

Garfield (1990) criticizes the emphasis on the therapeutic alliance as the main or primary variable of change as it brings into question our rationalizing of the use of various techniques as being change agents. His concern is with the current proliferation of therapeutic approaches, various procedures and techniques, all supposedly capable of producing positive results, although few have been adequately evaluated.

A strength of this study is that both cases had a strong therapeutic alliance. Thus other process variables, such as techniques, may be indentified clearly as having an impact on change. Evidence for this strong alliance came as both couple's verbally expressed numerous times their appreciations for the therapist, rated the therapist with high scores on any of the process measures, and demonstrated a high quality of relationship in their interactions with therapist. Couple B, even presented the therapist with a present in session six in appreciation for her caring. The therapist demonstrated a caring, respectful, nurturing style towards both couples and often expressed her enjoyment of therapy and her encouragement to the clients.

Finding # 5

Therapeutic experiences that addressed intimacy issues deeply were associated with greater change .

Couple A had more experiences in therapy that improved their lack of intimacy (intimacy process) and reinforced their increased intimacy (intimacy reinforcement) than couple B. Each of these experiences were a small "o" outcome and the culmination of them over time seemed to impact the strength of couple A's relationship. This is supported by research and theory as demonstrated below.

First, research has shown that intimacy is a significant factor in marital satisfaction.

Researchers have also demonstrated that the best predictors of satisfaction in marriage were strong senses of intimacy in the marriage (Merves-Okin et al., 1991). Tolstedt and Stokes (1983) found that three types of intimacy- verbal, affective and physical- were highly predictive of perceived marital satisfaction. Verbal and affective intimacy measures showed an even stronger contribution to marital satisfaction than did physical intimacy. Couple A experienced more verbal and affective intimacy in the sessions than Couple B.

Secondly, research supports the need to work at intimacy issues with alcoholics. Alcoholics are one particular group often in psychotherapy that have been shown to have difficulty with intimate relationships (Kaplan, 1979; Coleman, 1982). Often, alcoholics will receive treatment to help them stop the actual drinking behaviour, but the treatment doesn't go on to deal with and teach skills related to intimacy. The issue for marital therapists then lies in working through intimacy issues in conjunction with the cessation of alcohol. This present study demonstrated both couples had difficulties with intimacy, but only couple A was given opportunity to express it and deal with it at a deep level and to learn some skills to get to a new place of intimacy when distance is felt. This present study also demonstrated the value in reinforcing growth of intimacy in a relationship by intensifying it and celebrating it.

A number of theories support this present study's findings. Schrefer and Olson (1977) lists six types of intimacy: emotional, social, intellectual, sexual/affection, recreational, and spiritual. One key difference of Olson's definition of intimacy is his distinction between intimate experiences and intimate relationship. An intimate experience is a feeling of closeness experienced with another person in one of the seven areas. An intimate relationship is where individuals share intimate experiences in several areas and there is an expectation that the experience will persist over time (Schrefer & Olson, 1977). Couple A was given the opportunity for intimate experiences during therapy more than Couple B, thus there level of intimacy and satisfaction increased.

Kelly (1993) looks at intimacy as something that develops in the process of a dyadic relationship as a result of the dynamic interplay of the innate affects. "The more skilled two people become in maintaining an interpersonal environment that supports interactions that consistently maximize positive affect, minimize negative affect, and

minimize affect inhibition, the more intimate they become" (Kelly, 1993, p.557). With the help of the therapist couple A were able to maintain an interpersonal environment that consistently maximized positive affect, minimized negative affect, and minimized affect inhibition.

More recent theory on intimacy criticizes the above concepts because what "makes a relationship intimate or not involves more than the pattern of interaction" (Schnarch, 1991, p. 93) but must include the concept of self intimacy. Schnarch (1991) talks about the sense of self one needs to enter into or to experience intimacy. Waring and his associates have developed the Waring Intimacy Questionnaire (Waring et al., 1986). The eight facets of intimacy measured include conflict resolution, affection, cohesion, sexuality, identity, compatibility, autonomy and expressiveness. Identity refers to the couple's level of self-differentiation and self-esteem.This has been shown to be a significant factor in the couple's ability to develop intimacy. Autonomy refers to the couple's success in gaining independence from their family of origin and their offspring. Certainly, this present research demonstrated that as Bill and Ann became more self-differentiated and improved their self esteem through practice of looking after themselves. As they did so their feelings of intimacy increased. Sam and Donna gained more awareness about their connections to family, their lack of self-differentiation, and their attempts to sabotage their own and their partners self esteem. However, they had not made significant changes in these areas by the end of theapy and they also had decreased their level of intimacy.

Stauffer (1987) lists a number of fears related to developing intimacy: fear of loss of individuality, fear of merging and becoming fused with another person, fear of the vulnerability, pain and loss that comes from closeness lost, fear of exposing weaknesses and imperfections to another, fear of attack, fear of abandonment, fear of internal destructive impulses and loss of control. Often these fears are unconscious but often if they break into conscious awareness, people will use distancing techniques to decrease the threatening intimacy level (Feldman, 1979). In case A, the fears were addressed openly and processed. The couple's distancing techniques were challenged. They were given opportunity to interact without fear and without distancing techniques. Couple B had less opportunity for any of these things.

Although a lot of theory exist about intimacy formation little empirical research has been done about how intimacy is formed in therapy. One researcher (Newman, 1995) in a case study of successful ExST, demonstrated that couple intimacy was developed, where initially there existed disparate beliefs and behaviours, through the syncretic change process. This change process has two parts: (a) initial disagreement and conflicting belief, and (b) transformation (via therapeutic system efforts), which lead toincreased mutuality a of belief and practice in the relationship. The findings in this present study regarding intimacy process support Newman's (1995) concept about syncretic intimacy, and give further evidence about its connection to positive change.

This study's discovery about intimacy process, which in essence represented a lot of conflict resolution, also is supported by evidence from research done in this area. Recent work (Gottman & Krokoff, 1989) on conflict avoidance indicates that conflict engagement is predictive of longitudinal increases in marital satisfaction, whereas conflict avoidance leads to decreases. Frey et al. (1979) conducted a study that furthered the idea that intimacy is achieved through the resolution of conflict . Frey and his associates looked at three models of conflict resolution said to increase levels of intimacy. In the two studies they conducted, it was discovered thatthe 'fair-fighting approach' and the 'calm, rational discussion approach' were the most favorable, but that the 'sharing of hurt feelings approach' was rated as the most intimate. Sharing hurt feelings was the most intimate and therefore the most risky and vulnerable as it got at the causal level of the conflict. In this present study couple A, engaged in the sharing of hurt feelings more often than couple B. This leads the researcher to assume that the more intimacy process within sessions (little "o" outcomes) the greater the intimacy in the final outcome (big "O").

A few other studies have explored specific factors in the process of intimacy development. Self-disclosure is the most researched aspect of intimacy development and has shown a high correlation to marital satisfaction (Navran, 1967; Burke, Weir, & Harrison, 1976; Hendrick, 1981; Chelune, Waring, Vosk, Sultan & Ogden, 1984; Prager, 1989). Couple A demonstrated a higher quantity and quality of self-disclosures than couple B.

The limitation of most of these studies is that it is unclear whether self-disclosure is an antecedent or a consequence of marital intimacy. This raises significant questions in looking at the process of intimacy: Can one self-disclose without a secure sense of self?; Can one have a secure sense of self without self-disclosing to another person?; Which comes first intimacy or the ability to engage in honest self-disclosure. In this present study, the process of therapy allowed some of this to happen simultaneously. In the safety of therapy, the clients self-disclosed, were supported and thus increased their sense of self. At other times the clients spoke out of their increasing sense of self and thus felt safe to self disclose. This was then worked with and processed to a new point of intimacy.

Finding # 6

Practicing new ways of being in relationship during therapy was associated with greater change .

Couple A was given more opportunity to try out a new way of being in relationship during therapy than Couple B. This occurred mostly through symbolic and experiential techniques. The therapist would direct an interaction with a symbol for example. This would lead to a deeper exploration of feelings and an identification of the origins of patterns. After some processing of this, the therapist would ask the couple to move, change or talk to the symbol. Thus in the safety of therapy the clients were given an experience of trying new patterns of interaction. Often this lead to an expression by the clients of feeling different. These experiences occurred while processing issues such as fear, alcohol and co-dependency. Again each of these experiences represents a positive little "o" outcome and the culmination of them contributed to the positive Big "O" outcome.

This finding supports the ExST theory of change as represented in the construct of Relational Novelty. Relational Novelty is referred to as "the enactment of an atypical way of being in therapy which alters the substantive relational themes represented in rigid cognitive,emotive and behavioural ways of being with self, others and the presenting problem" (Newman, 1995, p.9). ExST believes that these episodes are significant factors in the process of change in therapy and that without them, change is less likely. These

episodes of relational novelty follow a pattern the begins with the therapist focusing on the client's narrative and then collaboratively delving into a salient aspect of the narrative through a therapeutic transaction. The client's consent and the therapist guides them through a deep, intense and novel encounter with self, other or presenting problem. This experience is debriefed by the therapist marking client change, congratulating the client, summarizing the process or asking the client for their views of the experience. Relationally novel experiences were much more common in case A that in case B.

From an ExST perspective, it is important to stress that client experiencing is meant to be an immediate, here and now phenomenon. Relational novelty seldom arises from talking "about" the relationship or problems. It emerges out of the intensity of being "in the relationship" and acting out new, often unexpected behaviour from within this context. Couple B spent a lot more time talking "about" the issues then couple A. Clients favorable response to experiential techniques was obviously a factor here that lead to the appropriate and valuable use of these thechniques.

How Change Occurred

Finding # 7

Deeper levels of experiencing and processing was associated with greater change.

Both the holistic analysis and the embedded analysis showed that case A had deeper levels of experiencing and processing than case B. Findings from the holistic analysis showed that the clients from case A were more emotionally involved in their process, were more focused and were more involved in working through issues. These experiences occurred as the therapist directed them deeper via an experiential technique where she used empathy, immediacy and probing of feelings in the here and now.

Findings from the embedded analysis, show that the successful sessions from each of the cases involved more cognitive-behavioural exploration than the worst session from the unsuccessful case. The worst session from the successful case also showed more

cognitive-behavioural exploration. Affective explorations occurred more frequently in the successful case, irrespective of the best or worst session. This supports research that states clients are generally more productively involved when engaged in cognitive-behavioural and affective explorations (Hill et. al., 1992) Insight and change behaviour were also discovered to be associate with clients who were more productively involved (Hill et al. 1992), however this present study showed no consistent difference of these behaviours with any one of the sessions. Only insight was shown to be slightly higher for the successful session of case A.

Clients in case B were significantly more active in recounting (storytelling) . This supports the research that reveals clients are less involved and productive when responding with recounting (Hill et al., 1992) . Hill et al.'s study (1992) also stated that client behaviours like resistance, agreement and request were associated with less client involvement. This present research does not reveal any differences with the behaviours of agreement or request between cases. However, case B does show slightly more resistance by staying with story, avoiding feelings and using humor to deflect the intensification.

Other research supports the finding that deeper experiences led to change. Researchers (Klien, Mathieu-Coughlan, and Kiesler, 1986; Strupp, 1980) concluded that client involvement and experiencing was a major predictor of success.

Merves-Okin et al. (1991) discovered a consistent relationship between verbal expression of feeling and marital satisfaction and therefore, suggest that chances for fulfilment in the marriage will increase in direct proportion to the frequency or quantity of verbal expression present. Greenberg, James and Conry (1988) used critical change incidents with couples to sort change processes into five categories. Two of the categories discovered to relate to change are also supported by the above finding: (a) expression of underlying feelings by one of the partners leading to change in interpersonal perception, and (b) expressing feelings and needs. The first category is supported by the findings from this study as couple A demonstrated a deeper level of expression of underlying feeling and needs than couple B.This occurred numerous times throughout the process of therapy and was co-created as the client and therapist entered into conflict resolution, a symbolic exercise or an experiential technique.

The second category of change process was the change in interaction that occurred as the underlying feelings were expressed. " Partners who had observed their spouses express underlying feeling or who expressed underlying feelings reported feeling more understanding and accepting of their spouses, feeling closer to their spouses, and behaving differently toward their spouses. In other words, expressing underlying feelings seems to elicit new, more supportive interactions in the relationship" (Greenberg et al., 1988, p.21). This suggested to Greenberg et al. that the communicative and interpersonal aspects of expressing underlying feelings are as important as the intrapsychic aspect. This was true in the successful case as the results demonstrated that one partners expression of underlying feelings allowed for a process of understanding and change of perception in the other partner. This process of change occurred numerous times in case A's therapy through experiences of intimacy creation and conflict resolution.

Frey, Holley & L'Abate (1979) calls genotypic intimacy the sharing of hurt feelings and makes the recommendation that therapy must facilitate clients being vulnerable, sharing their hurts and fears not just their anger. If therapy doesn't do this it will miss the deepest level of intimacy development. Specifically, during conflicts in therapy couple A, had the opportunity to do exactly this via the intensification process of therapy. There were few conflicts in therapy that were processed at a deep level for couple B.

ExST also postulates that intensifying and deepening experience is a process that creates change. " Intensifying and deepening experience is the means by which clients fully embrace their experience such that different ways of being with themselves and others are made possible both in the deepened moment and after it "(Newman, 1995, p.10).

Finding # 8

Therapist techniques are associated with greater change.

Hill (1989) states that she "believes that therapist techniques are responsible for client change. Above and beyond being a nice person, a therapist must do something to help a client to change" (p.13). The present research also supports this proposition.

Obviously, whether a technique is helpful depends on client and therapist characteristics, the therapeutic relationship, the timing and the appropriate use of technique. Thus there are variables that moderate the effect of a technique (Hill, 1989) but it doesn't change the fact that a technique can be used to significantly impact change.

Two levels of techniques were analyzed by this study. The first level involved the therapist directing the clients into symbolic and experiential techniques. The second level occurred within speaking turns as the therapist used different responses as measured by the CVRCS. The results from this study show that when the counsellor utilized certain responses within the context of a symbolic or experiential experience the greatest change occurred.

The first level of techniques that are correlated with outcome are the symbolic and experiential. Case A had a higher quantity and deeper quality of these techniques during the course of therapy than did Case B. The starting point for these techniques was initiated by the therapist. She took the initiative a lot more with couple A than with couple B. The couple then agreed to enter into the process. The use of these techniques deepened the processing of issues and allowed new creative experiencing for the clients. Case B spent more time dialoguing over similar issues whereas Case A spent more time in an experiential or symbolic interactions. When the therapist did initiate an experience with couple B (as in the "best" session), the couple moved to greater experiencing and less description. This suggests that therapist direction was necessary to alter the couple's behaviour. Couple B also was limited in entering into these experiences by the fact that they didn't bring in symbols to the therapy until the seventh session, whereas couple A brought them in second session. The the analysis of the worst session from case B and observation of the other sessions indicated that supportive and passive listening by the therapist did not lead the clients out of their storytelling. Directive methods were necessary to break through the clients style of description and avoidance of feelings.

This finding supports ExST theory and research. ExST theory postulates that the representational symbols touch deeply the client's sense of personal meaning and significance (Friesen, 1991). This process of distancing from the problem through engaging in a symbolic representation of it, allows clients to examine other aspects of their

relationship to it. Through the process of symbolic externalization and experiential techniques, a holistic integration of the client's world can occur including cognition, behaviour, affect and perception. This intensifies and deepens the clients experience in relation to the symbol or experiential activity in a way that dialogue alone can not do. Action oriented techniques are utilized to broaden a clients experience by offering a new way of being (or interacting with the symbol for example) rather than engaging in a didactic discussion of what "should" be done. (Newman, 1995). The theory states that this can lead to a shift in the client's identity which leads to new ways of being (Friesen et al. 1989).

Recent research done specifically on one case of symbolic externalization (Wiebe, 1993) demonstrated how representational symbols aid in intensifying and deepening the clients experience. It was also shown that only after the client's symbolically externalized and intensified their experiences that relational novelty occurred. This symbolic exercise took place in a successful case of ExST and was said to be a contributor to outcome. Another case study of relationally novel events (Newman, 1995) demonstrated that the use of symbolic externalization allowed for intensification of the issue of alcohol and helped facilitate the creation of relational novelty. She also demonstrated that the use of an experiential techniques called reenactment also allowed for intensification of feelings in the here and now, awareness and cognitive understandings, evoking of relational themes and new shifts in relating. Relational novelty was created in this intensified reenactment episode.

The second level of techniques that are correlated with positive outcome are specific responses the therapist gives. Results of the CVRCS demonstrate that silence, paraphrase (specifically reflection of feelings and immediacy) and interpretation were more frequent in the best sessions as compared to the worst session of case B. This supports the research by Hill, Helms, Tichenor et al. (1988) that used a similar system and also discovered that interpretation and paraphrase were perceived as quite helpful. Closed questions were demonstrated to occur at a higher frequency in the worst session of the unsuccessful case than all the other sessions. This is supported by Hill et al. (1988) who discovered that closed questions were not very helpful to the sessions. Their research also categorized self-disclosure and approval as being quite helpful. This present research found

no consistent difference in the amount of each of these responses in any of the best or worst sessions. Hill et al. (1983) also discovered that interpretations were the most helpful intervention in moving the client out of story telling behavior and they concluded that counsellor interventions do indeed have an impact on clients, over and above the relationship and client variables.

These responses in and of themselves are helpful in facilitating change but they become even more useful in the context of a symbolic or experiential technique. Once the therapist directed the clients in this study into a symbolic or experiential technique the task was to use it at a deep level. The skills of silence, paraphrase (specifically reflection of feelings and immediacy) and interpretation were used in the best session of case A, during a symbolic exercise which helped to intensify the interactions.

Finding # 9

Opportunities for clients to work through issues using a process that has a beginning, middle and end are associated with greater change.

Couple A had more experiences in therapy that seemed to represent a complete cycle of working through an issue than did couple B. The advantages of these steps for change seemed to be four fold: (a) a clear focus was established for the session or the experience; (b) opportunities to explore and understand the issue were given but then movement away from just awareness to trying something different was also given; (c) these steps allowed for a deep intensification of an issue; and (d) a debriefing time allowed for reinforcing learning and establishing a goal for the week. This finding supports the ExST theory of the phases of therapy.

According to ExST theory, (Friesen et al. , 1989) therapy has a present tense focus on the here and now. Thus difficulties from the past are brought into the present and integrated in to the therapeutic story of therapy. This story includes four phases: (a) forming the therapeutic system: establishing a context for change (introduction); (b)perturbing patterns and sequences and expanding alternatives; (c) integrating experiences

of change: reorientation (action and climax); and (d) disbanding the therapeutic system: termination and acknowledging accomplishments (denouncement and resolution). These phases can take place within the sessions or can represent the overall story of therapy .

The essential components of each of these stages and the necessity of them for change to occur will be discussed in the following section as it relates to the present research.

Forming the therapeutic system is the first phase and it entails setting the stage for the action to occur. This necessitates the establishment of a bond between client and therapist, an assessment of the nature of the troublesome human dilemma brought to therapy and the development of a commitment to the goals agreed upon by all the members of the therapy system. Both case A and B completed this phase of therapy for the overall therapeutic story. However, case A seemed to work through this phase in the first session and had moved to the next phase by the second session. Case B, however, took almost three sessions to complete the first phase. At an individual session level, case A also was able to enter into phase one more quickly. Within the first few minutes of most sessions, case A had established a therapeutic mandate.This was typically stated and agreed upon as something to focus on for therapy. Case B, however, did not find a focus as early and often seemed to lack a focus. In more than half the sessions no mandate was articulated. This seemed to be a function of the client's story telling behaviour, which the therapist often followed, and a function of the client's inability to stay focused especially on feelings, which the therapist challenged on occasion.

The second stage of perturbing patterns and sequences and expanding alternatives, is an essential component of therapy where change can occur because of clients experiencing creative shifts in rigid behaviour, patterns or views. During this phase of therapy the therapist strives to perturb relational patterns and therein directly affect clients' static sequences of behaviour and expand alternatives. The focus in this phase is on the here and now experiences. Case A demonstrated evidence of being in this phase throughout therapy as patterns related to the rock, the wall, the seal, the bottle were being perturbed throughout the course of therapy. Specifically, during each session, through symbolic externalization and/or experiential techniques the therapist would lead them

through an exploration of patterns and then provide opportunities for expanding and practicing alternatives. Case B showed less evidence of being in this phase throughout the course of therapy. Two factors that seemed to hinder entering into this phase was the lack of symbols to work with and the focus on talking "about" issues but not bringing them into the here and now. Specifically, during each session, this phase was evident in part. The therapist attempted to have them focus on patterns, however, most of the sessions were spent on raising the awareness of patterns rather than trying to perturb them.

The third stage of integrating experiences of change is essential to reinforce and validate any changes that may have occurred for the client. The therapist aids the clients in generating novel experiences that validate their changes and simultaneously helps them to release, albeit sadly, old patterns of relating. This can be achieved through the creation of rituals (burying symbols or a simple handshake) or transformational markers designed to ensure that the changes made can be absorbed into the client's lives. For case A, this occurred in the overall process of therapy as old symbols (rock, wall, alcohol) were removed, thrown away or given a new place of existing and new symbols (feathers, artwork and candle celebrations) were used to represent changes. Specifically, most sessions took time to debrief the experiences, reinforce any new experiences, adjust or establish new symbols and congratulate the clients. For case B, the integration of change did not occur as readily, because the number of changes were not as evident. The most significant time this occurred was in the last few sessions when the client worked with the symbol of guilt and eventually threw it away.

The final phase is disbanding the therapeutic system: termination and acknowledging accomplishments in therapy. The importance of this phase of therapy is to dissolve the therapeutic journey in order to bolster client independence. On an overall level each of the cases showed clear evidence of this stage. As in the last session, both cases reviewed the journey and shared pivotal moments. For case A, they expressed a lot of changes that had occurred and they stated clearly that the goals had been met. For case B, some changes and a lot of new awareness was expressed. The therapist reinforced the new changes and awareness and helped them to establish how to care for themselves after therapy. Case A had a clear final closing ritual (involving the expression of a commitment

to each other (the couple) and a blowing out of a candle) and an evaluation of the process, which was clearly directed by the therapist. Case B did not have a clear closing ritual (more discussion and less symbolism) and only evaluated briefly the therapy.

These are preliminary findings on a small sample and will need replication. This study is correlational in nature and thus does not offer evidence on the causal effects of these processes of change, but it does offer evidence supportive of the hypothesized process of change in these cases of ExST. This study suggests that change in case A was co-created by clients and therapist, moderated by preexisting client variables, increased as clients were given an opportunity to work through issues, to experience intimacy and to practice new ways of being using symbolic and experiential techniques that were deepened and intensified by the therapist. This study suggests that change in case B was not as evident because it was impacted by some preexisting client variables, by the fact that the clients did not have as many opportunities to work through issues, to experience intimacy and to practice a new ways of being using symbolic and experiential techniques that were deepened and intensified by the therapist.

Limitations of the Case Study

Three major criticisms of case study methodology as stated by Yin (1994) are: (a) lack of rigor; (b) lack of generalizability; and (c)large unreadable results. This study acknowledges these criticisms but also attempts to address them in the design.

The first criticism has to do with the lack of rigor in case study research which could result in the possibility of researcher biases influencing the direction of the findings. Such concerns include researcher bias influencing the direction of the case study, which as Yin points out is also present in experiments and survey research designs. Obviously, as the present researcher had training and was in support of the theoretical propositions of ExST, the possibility of this is present. This process is personal, therefore, the study is limited by the researcher's observations and interpretations.

The researcher attempted reduce bias in a number of ways. First, to give some focus to the observations the researcher chose a specific case study protocol and laid it out clearly in the study. The internal validity is a concern because of attempts to observe behavior and make inferences. Inferences occur when the direct observation of an event is not possible. The concern around inferences could have been improved if clients could have been interviewed, however, this was not possible within the ethics of the TARP project and would not been valid given the years of lapse between videotaping and thisresearch. In the present study, the ability of the researcher to go back and look at events until saturation point reduces the concern over inferences. Looking at the holistic case-study and also analyzing the embedded units of therapeutic episodes strengthened the study as well.

Secondly, the researcher endeavoured to reduce the bias by attempting to report all evidence fairly and in full detail. A data base was established in which all results are available for perusal and thus reliability is increased. As well, the "best" and "worst" sessions were transcribed in their entirety. All parts of the sessions that related to the significant differences between cases were transcribed and some sections included in the results. The complete transcripts of the "best and worst" sessions are available for perusal.

Thirdly, an attempt was made to look at the data from a number of different angles, both holistic and embedded and with qualitative measures, scales and coding systems. One of the major limitations of this study in attempting to get rid of researcher bias, was that no opportunity was available for triangulation of the data with the client (Stake, 1994). As well, the covert processes to which clients do not give expression during the therapy hour are not going to be accessible from the examination of therapy transcripts. However, the clients thoughts and ratings of change were included through the Post Session Reviews and the Weekly Situation Diaries.

The fourth attempt to reduce bias happened by including inter judge raters on the Counsellor Verbal Response Category System, the Client Behaviour System and the Vanderbilt Process Scale.

Finally, the theoretical underpinnings of ExST were stated clearly and thus the researcher was able to become sensitive to her biases.

The second criticism about case studies are that they provide little basis for scientific generalization. However, the purpose of the case study is not to generalize to "sample" populations (statistical generalization) but to expand and generalize to theories (analytic generalization). The purpose of this case study was to explore the differences between a successful and unsuccessful case of therapy, in order to extend further research directions and create hypothesis regarding change mechanisms arising from this investigation. Given that the focus of this study is on the outcome of the overall therapy sessions of only two specific cases with a focus on the proximal outcome of two therapy sessions, generalizing to another therapy case would not be appropriate. This present study works with ExST couple's therapy and therefore can only be generalized to ExST theory. The results may be of help to other therapy theories that fall in to the broader field of experiential therapies. The study was strengthened in it's ability to make analytic generalizations by doing a multiple case study design looking at a successful and unsuccessful case as well as the best and worst session of each case. It may be possible to generalize, with further research, some of the findings identified and their significance to creating change.

The third major criticism has to do with the fact that case study research often results in large unreadable documents. The thorough and varied approach to the cases in this study assured that the data would be readable and functional. As well, the massive amounts of transcripts and field notes were shifted, sorted and grouped into clear variables that allowed for a more readable text. The presentation of the results were laid out clearly into four parts, utilizing charts and graphs and when applicable further worked into major findings (as in the holistic analysis). This was a long and laborious task which took many hours, however, the richness of the data supports this methodology.

Future Research

This research has begun to explore the differences in ExST couple's therapy as it relates to big "O" and little "o" outcomes. From a general perspective, this study

complements and furthers the development of research in the area of ExST, process research and change theory. As Van Kaam (1966) states, " research performed in this way is pre-empirical, pre-experimental, and pre-statistical; it is experiential and qualitative. It sets the stage for more accurate empirical investigations by lessening the risk of premature selection of methods and categories; it is object centred rather than method-centered. Such preliminary exploration does not supplant but complements the traditional method of research available to me" (p.295). Thus in taking an exploratory holistic look at the entire therapy session, numerous questions arise for future research.

Research which has conducted multiple case studies of successful and unsuccessful cases using similar methodology would enhance the present findings and increase generalizability. More of the same studies would increase the ability to make correlations between the findings and the outcome. Furthermore, if multiple researchers were used to analyze the present data as thoroughly as the first researcher, the results could be expanded and a fuller understanding of the therapeutic change process would occur.

One of the main recommendations for future research is the further testing and refinement of ExST family therapy. This study demonstrated that in the two cases the more consistently the therapy was followed the more improvement was shown. Recommendations are for a move from this exploratory study to a more explanatory study which would build hypothesis based on ExST and then test them using multiple case studies.

Another recommendation, would be to research the effective utilization of symbols, both in terms of what kind of client can engage in this work, how can a therapist engage a client in symbolic work and how do they co-create depth around this.

A significant area of research could be in the whole area of intimacy. Intimacy is an experience long been sought after in our society. The popular press and self-help books are full of ideas on how to improve intimacy. It is an essential component of most satisfied relationships (Merves-Okin et al. 1991) and thus is a central issue in marital therapy. From a clinical standpoint, problems with intimacy are some of the largest cluster of problem behaviours for which individuals seek psychotherapy (Horowitz, 1979). This study raises questions about the experience of creating intimacy in therapy and the impact on the overall

improvement of a couple. However, further research will be needed to clearly lay out effective models which will increase intimacy in couple's therapy.

Related to intimacy more specifically, is the whole area of sexuality and couple's therapy. This study suggested that avoiding bringing the couple's sex life into the workings of therapy could be extremely detrimental to the health of the couple. Further research could look at the impact on change as the couple's sex life is addressed or avoided.

Considering the importance of stage of client involvement, as identified by this study and some of the research done in other areas around this, further research on the impact this has on the process of therapy and the techniques utilized would be fruitful to understanding the significance of "successful" therapy. This could entail grouping couples according to stages, applying appropriate techniques and then looking at outcomes according to each group.

The present study attempted to take a broad, holistic and thorough look at two cases of ExST couples therapy to begin to explore the variables that may be correlated with change. Much more research needs to be done in process research regarding the direction of correlation as stated by Jacobsen and Addis (1993). They believe that there is a perennial problem in psychotherapy process research that continues to interfere with interpretation of most interesting empirical findings:

> It is the issue of interpreting the direction of the correlational relationships. Whenever a correlation is found between an outcome and a process variable, the possibility exists that the process variable is the result of improvement rather than a mediator of improvement. Thus, for example, when it is found that the tendency to communicate vulnerability rather than hostility is more likely to occur in improved couples later in therapy than in unimproved couples earlier in therapy, it is often implied that the communication of vulnerability mediates relationship enhancement. In fact, it is equally plausible that the communication of vulnerability is an outcome of an improved relationship that has in turn been mediated by other factors. Until this correlational relationship is disentangled, it will be difficult to distinguish process markers of change from process mediators of change". (p. 88)

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Appendix A

Emerging areas for further investigation.

Client Issues
- Sexual
- Family of origin
- Grief
- Financial Stress
- Repressed pain
- Abuse
- Self Esteem
- Fears
- Wall/Boundaries
- Alcohol
- Guilt
- Abandonment
- Intimacy
- Presenting problems
- Goals of Therapy
- Support systems
- Avoiding conflict

Client Variables
- Resistance
- Avoiding Feelings/Topics
- Humor
- Distracting
- Story-telling
- Triangulation
- Patterns of dependency
- Stage of readiness

Therapist/ Technique Variables
- Facilitating client relationship
- Use of Symbol
- Externalization
- Two-Chair
- Art Work
- Conflict Resolution
- Deepening Experiences
- Practicing alternatives
- Directiveness
- Transitions
- Metaphors
- Empathy
- Ceremonies

Therapist/Client Interaction
- Therapist Alliance
- Sustaining engagement of issues
- Individual therapy/couple therapy
- Resistance/ challenge
- Question/Avoidance
- Directiveness/ Control
- Speed of sessions-first session

Appendix B

Data Analysis- Categories for indexing purposes

1. Alcohol
    - 1.1 Reasons for drinking
    - 1.2 Patterns of drinking
    - 1.3 Impact on relationship
    - 1.4 Therapeutic process

2. Self Concept
    - 2.1 Self Image
    - 2.2 Self Differentiation
    - 2.3 Patterns
    - 2.4 Therapeutic process

3. Sexuality
    - 3.1 Issues in relationship
    - 3.2 Patterns in relationship
    - 3.3 Therapeutic process

4. Conflict
    - 4.1 Patterns in relationship
    - 4.2 Reasons behind it
    - 4.3 Issues avoided
    - 4.4 Issues worked through

5. Fears
    - 5.1 Fears
    - 5.2 Reasons behind fears
    - 5.3 Patterns in relationship
    - 5.4 Therapeutic process

6. Self Disclosure
    - 6.1 Level of intensity
    - 6.2 Amount of disclosure
    - 6.3 Subject areas
    - 6.4 Therapeutic process

7. Phases of therapy
    - 7.1 Completed stories
    - 7.2 Incomplete stories
    - 7.3 Techniques utilized

8. Techniques of the therapist
    - 8.1 Empathetic responses
    - 8.2 Facilitating client relationship
    - 8.3 Intensifying and deepening experiences of therapy
    - 8.4 Challenging client variables
    - 8.5 Use of symbols
    - 8.6 Use of experiential techniques
    - 8.7 Experiencing and practicing future goals/patterns
    - 8.8 Homework follow through
    - 8.9 Ceremonies

Appendix C

Data Analysis-Example of Indexing according to Categories

8.2,8.1 T: I heard you say, it sounded like you hadn't been consulted about it.

J: About the plan, no.... because when I talked to you, I said I would bring this and the other thing and then I saw the couples plan and I thought I would bring it.

4.1 S: ..... But I wasn't consulted and one of the things in the couples plan is how we would discuss anything

4.2 that is important before one of us makes a decision.

4.2 T: Maybe you need to do that and you are not ready to have me see this.

4.2,4.4 S: No, no that's fine, I don't mind you seeing it at all. It's just that this is another time that John has

6.3 chosen to do something that involves me and he has controlled it.

8.1 T: So you felt excluded from the decision.

6.1 S: Ya, excluded and controlled. That I'm not capable of making my own decisions. That I'm not trusted.

6.4 That you don't trust me to say. " Yes, John it is O.K. to give it to Gillian".

....

4.1 T: So this seems to be something that is a pattern in your relationship. He doesn't mean to discount you but you feel discounted.

6.1 S: Ya because he knows I'm going to say yes, so he doesn't ask. I mean... or on the other hand he knows there are times when I'm going to say no so he doesn't ask either way.

8.3,8.2 T: Is that your perspective John?

6.2 J: No, maybe in the past but not in this.

4.4 S: So, why didn't you ask?

J: Because you weren't there and I didn't even think about it. I just threw it all together.

4.4 S: But that's what you do it alone when it involves me and you don't even think about it. I'm just asking that you do.

8.1 T: So it kind of hurts inside that you are not in John's mind at that moment when he makes a decision

8.2 that involves the two of you....

S: Right....

8.3 T: .... You feel kind of hurt at that and kind of unimportant to him.

.....

8.3 T: So, ummm.... maybe a part of you is feeling a bit angry when such a big deal is made of this and you just wanted to help.

J: Ya.. I'm really...ya, I am.