

COMPREHENSIVE DISCOURSE ANALYSIS
OF SYMBOLIC EXTERNALIZATION

by

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ABSTRACT

The purpose of this study was to discover how therapist and clients co-create relational novelty using symbolic externalization intervention in successful Experiential Systemic Therapy (ExST) for marital treatment of alcohol dependence through a single case study design. A comprehensive discourse analysis method was used to study the therapeutic conversation within a 15 minute therapy episode in which therapist and clients externalized the problem of alcohol. The therapy episode was video-taped, audio-taped, transcribed and then analyzed according to the procedures of comprehensive discourse analysis. The analysis of the clients' and therapist's discourse revealed eight themes that contributed to co-creating relational novelty at the intrapersonal, interpersonal and symptomatic system levels. The themes co-constructed by the therapist and clients to attain relational novelty included: (a) creating and maintaining a collaborative atmosphere; (b) challenging propositions and competence; (c) reframing alcohol as a seducer; (d) moving from an individual to a relational understanding of the role of alcohol in the couple's relationship; (e) re-defining and accenting the couple's commonalities; (f) diffusing tension and defensiveness; (g) regulating the intensity of experiences; and (h) deepening contrasting experiences. The therapeutic process involved movement away from the old, restrictive story or meaning of the alcohol dependence toward a new

perspective while simultaneously moderating the atmosphere and character of the therapy. The outcome, the proximal in-session relational novelty, that the therapist and clients co-created using the symbolic externalization intervention demonstrated that therapeutic change is a dynamic, interactive, and context dependent process.

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CHAPTER I

INTRODUCTION

Origin of the Thesis Topic

Client changes within the therapeutic process are generally considered to be facilitated by the therapist's talk and use of particular interventions. It is, however, uncertain how this change actually occurs within the therapeutic context.

In the last decade there has been an influx of research examining the factors within the counselling process that lead to change. Gelso and Fassinger (1990), in their literature review, discuss studies that have examined counsellor techniques and constructs that are helpful in counselling. The studies cited examined client and counsellor responses, reactions, and variables, and constructs such as symmetry and complementarity to determine who controls whom in the counselling interaction (Gelso & Fassinger, 1990). Lambert, Shapiro, and Bergin (1986), in reviewing psychotherapy outcome research, indicated that the common factors across therapies associated with client improvement during therapy are interpersonal, social, and affective factors. They also stress the importance of the therapeutic relationship being characterized by trust, warmth, acceptance and wisdom. Pinsof (1991) reviewed studies that used family therapy process research designs and developed instruments to measure some aspect of the

therapeutic process. The empirically unsubstantiated findings failed to provide a clear and consistent body of knowledge about process-outcome links (Pinsof, 1991).

Although there has been a great influx of research studying the mechanisms of change in therapy, understanding what actually occurs in therapy to create change is still at an early developmental stage (Gelso & Fassinger, 1990; Pinsof, 1991).

Considering the numerous variables affecting the change process in therapy it is necessary to limit the scope of the present study and empirically examine a manageable aspect of the change process. Orlinsky and Howard (1986) identified five interrelated conceptual elements of a generic model of psychotherapeutic process which contribute to the effectiveness of therapy. These include; the therapeutic contract, therapeutic interventions, therapeutic bond, client self-relatedness, and therapeutic realizations. Due to the complexity of studying all five elements simultaneously the present study will focus only on one, the therapeutic interventions.

Therapeutic interventions constitute the most apparent substantive component in psychotherapy. Interventions are intentional in that the therapist must present specific tasks and procedures in response to clients' problems that will facilitate therapeutic growth. The diversity across psychotherapeutic theoretical orientations is often due to

use of different therapeutic interventions as well as how different client problems are perceived. "Yet no matter what the theory, therapeutic interventions presumably occupy the greater part of the time that [client] and therapist spend together" (Orlinsky & Howard, 1986, p. 313). The therapeutic interventions reviewed by Orlinsky and Howard (1986) were more generic across therapies and included the therapist using interpretation, confrontation or giving feedback, exploration and questioning, giving support, giving advice, reflection and self-disclosure. These authors also examined aspects of client participation in therapeutic interventions such as client self-exploration, affective arousal, discussion of problems, and here and now focus. Overall, the findings showed inconsistent association between client outcome and therapeutic interventions. The authors suggest that therapeutic interventions do not directly influence outcome because there must be "an 'open' state of [client] self-relatedness for this influence to become effective" (Orlinsky & Howard, 1986, p. 369). In other words, a strong therapeutic bond would provide a safe and supportive environment which would increase the client's willingness to participate in interventions. Again, it becomes apparent that there is little understanding about the impact of therapeutic interventions on the change process in therapy. More importantly, researchers have difficulty studying and

determining what is actually occurring within therapy sessions and identifying the mechanisms that facilitate therapeutic change.

A trend in the counselling profession has been to identify and outline therapeutic interventions and procedures for particular client problems. The treatment strategies for sexual abuse, for example, have been widely discussed and delineated in the literature with more emphasis currently placed on using a combination of individual and family therapy (Faller, 1988; Friedrich, 1990; Sgroi, 1989). However, considering the high prevalence of alcohol and drug problems, empirical studies investigating the efficacy of marital and family therapy in treatment of alcoholism and drug abuse are few in number (Gurman, Kniskern, & Pinsof, 1986). In their review these authors found that studies suggested the preferred treatment for couples with alcohol problems was group conjoint couples therapy. This format was more effective than individual therapy with the alcoholic spouse.

However, there has not been much mention or research in the literature as to what actually occurs in the context of a therapy session when the underlying principles of an intervention, which are based within an established theory, are implemented. This is largely due to the employment of conventional outcome research designs in marital and family therapy which focus on what occurs outside the confines of

the therapy session, particularly after termination of therapy (Gurman, Kniskern, & Pinsof, 1986). Movement from these traditional research strategies toward utilizing process research designs to study what occurs within the context of the therapy sessions has been recommended (Gurman et al., 1986; Pinsof, 1991; Wynne, 1988).

The intent of this present study is to comprehensively analyze the actual discourse that occurs within the context of a therapy session when a particular intervention is implemented by the therapist. The underlying principles of symbolic externalization intervention, derived from Experiential Systemic Therapy (ExST) model (Friesen, Grigg, Peel, & Newman, 1989), will be presented and analyzed through the use of a particular process research methodology. The study will examine how therapist and clients co-create relational novelty (change) using the symbolic externalization intervention in successful outcome marital therapy with a couple in which one partner is alcohol dependent.

Process Research

To understand how change occurs in the therapeutic process the emphasis in research must be primarily process research. Much of the research to date has evaluated the outcome of therapy without illuminating the process and theory of change. Outcome research is generally engrossed in studying the efficacy of a particular treatment as

compared to no treatment or an alternate treatment and fails to explore how therapy may be used to facilitate change in people or families. Comparative studies that examine outcome differences between different treatment approaches have little impact on clinical practice (Gurman, 1988). Clinicians and therapy trainers require information that can have an impact on their own behavior. Providing "detailed specifications and observations of the actual [therapeutic] processes" (Orlinsky & Howard, 1978, p. 310) and knowing what processes were associated with the success or deterioration of the treatment would be more relevant and meaningful to the clinician.

The process of testing clinical theory must then begin by investigating the actual events that occur in the therapeutic process. Otherwise, psychotherapy research would be thwarted as would be the specificity question - "What are the specific effects of specific interventions by specified therapists upon specific symptoms or [client] types?" (Bergin, cited in Pinsof, 1991, p. 700)

Family therapy process research is still at an early developmental stage and has generally been clouded by individually-oriented approaches that do not take into account concepts specific to marital and family therapy (Pinsof, 1991). Research methods and designs to be used by family therapy process researchers are continuing to emerge (Gurman et al., 1986).

Comprehensive Discourse Analysis

The present investigation is concerned with proposing an alternate methodology to assist in understanding the change process in marital and family therapy. This method is the comprehensive discourse analysis, developed by Labov and Fanshel (1977), which has been employed by these authors as well as Todtman (1990) to discover what occurs within a therapy setting. This comprehensive methodology allows researchers to analyze contextual interactions which is congruent with the systemic perspective of family and marital therapy. In general, this micro-analytical approach lends itself to discovering what occurs between therapist and client as well as how the therapist conducts the therapy. In addition, it also addresses the "relation between what is said and what is meant, and how things get socially accomplished with talk" (Grimshaw, 1979, p. 171).

The present study will use comprehensive discourse analysis to examine a therapy case in which the therapist implements a symbolic externalization intervention of the ExST model with a marital couple. This therapy case is considered to be appropriate for this type of comprehensive analysis for several reasons. First, ExST and its symbolic externalizing transactional class is a theoretically defined model of therapy. Second, the ExST therapist used this therapy model as well as the symbolic externalization intervention during the course of the therapy. Third, the

case was successful which was determined by both the therapist and the clients self-reports and the measurements of instruments used. Lastly, the therapy case was video-taped and thus providing the entire therapeutic context. The therapy segment of interest could then be contextualized within the therapeutic practice of the ExST model. The present study will provide the transcript of the segment in which the symbolic externalization intervention is used as well as a comprehensive analysis of how the therapeutic interactive talk is co-constructed.

Research Question

Externalization approaches have been used in various ways but there has not been any analysis determining whether it does what it purports to do. That is, does it create change and if so, how? The purpose of this study is to develop an understanding of the process of change that occurs through the implementation of a symbolic externalization intervention within the therapeutic context of successful therapy, with a couple where alcohol dependency is a problem. The question to be addressed is: How do therapist and clients co-create relational novelty with using symbolical externalization intervention in a case of successful Experiential Systemic Therapy for marital treatment of the husband's alcohol dependence? This research study is descriptive in nature with the central purpose of understanding the mechanisms used by both

therapist and clients to facilitate the co-creation of therapeutic change. It will also be possible to explore how the ExST therapist and the clients co-constructed the therapeutic conversation toward attaining change in the therapy.

The Significance of this Study

The symbolic externalization intervention of ExST was selected for this study because of its significance in the early stages of treatment of alcohol dependency. Davis, Berenson, Steinglass, and Davis (1974) state that there are adaptive consequences that maintain the alcohol problem within the family which need to be identified before therapy can be structured to learn effective alternate behaviors. Through using the intervention of symbolically externalizing the alcohol dependency and making it a separate entity, the couple will be able to discuss and directly relate to the alcohol and thereby create some change within the marital system of how they relate to each other and the alcohol. An exploration of what maintains and reinforces the use of alcohol by the husband can also occur.

It is anticipated that analyzing how this intervention does what it purports to do, that is, create relational novelty, will aid in understanding the mechanisms that facilitate therapeutic change when using the ExST symbolic externalization intervention. This will then lead to expanding and refining the theory underlying the ExST

symbolic externalization intervention. Clinicians and therapy trainees will also acquire relevant and meaningful information on how therapist and clients co-created proximal in-session therapeutic change when implementing this intervention. The how-to-do analysis of co-creating therapeutic change when using a symbolic representation of the alcohol dependency problem can provide valuable information for clinicians in all settings. Clinicians will be able to understand the actual proximal outcome that resulted in the therapeutic context when this particular intervention was used at that moment.

Additionally, the introduction of an alternate methodology, comprehensive discourse analysis, to family and marital therapy process research will enhance the development of the family and marital psychotherapy field. We will be able to more fully understand what actually occurs within the context of therapy to create change and how both therapist and client accomplish this task through use of language.

Limitations of the Study

This study does not propose that the implementation of symbolic externalization intervention will result in successful outcome in therapy. Applying this intervention is only one aspect of the treatment process. The ExST model is comprised of seven transactional classes that aid in facilitating therapeutic change. However, due to the

laborious nature of the methodological research approach employed in this study, the investigation of other elements that are integral to the process of change is beyond the scope and feasibility of this study.

The intent of this research is to study an episode of symbolic externalization that is grounded in the entire context of ExST and to carefully examine what actually occurred within the therapy. This careful examination will also need to occur with other transactional classes and their respective interventions. This change model of symbolic externalization will at best be only partial because it is unlikely that it alone accounts for all or most of the change in the course of marital and family therapy. Furthermore, other processes that may be equally or even more important for change are not included.

Organization of the Thesis

Chapter two will present a review of the literature on the process of externalization interventions and a review of both family therapy process research and discourse analysis research. The gaps found in family therapy process research will be identified and an alternate methodology, comprehensive discourse analysis, will be introduced to fill gaps in research design and method. Chapter three will delineate the methods of comprehensive discourse analysis used to analyze the segment of the marital therapy in which the symbolic externalization intervention is implemented.

Other methodological issues to be presented in this chapter include; the research design, procedures, and measuring instruments used to determine the successful outcome of the therapy.

Chapter four will present first the preliminary findings of the outcome of the ExST treatment and then the analysis of the therapeutic discourse in the marital therapy. Data for the analysis will be drawn from the transcripts of the conversation between clients and therapist during the symbolic externalization episode which will be included in chapter four. The final chapter synthesizes the results of the comprehensive discourse analysis and discusses the implications for understanding the therapeutic work of ExST as well as recommendations and conclusions for family therapy.

CHAPTER II

A REVIEW OF RELEVANT RESEARCH

In reviewing the literature on the use of the externalization interventions it became apparent that there has not been any research to date determining whether the intervention does what it purports to do. The externalization intervention used by both White and Epston (1990) and Perls, (1969) describe what the intervention is, when to use it, general procedures for implementation of the intervention, but they fail to put their interventions to test. This failure to test whether the intervention purports to do what it sets out to do may in part be related to difficulties in selecting research methodologies that can adequately assess the use of this intervention. That is, outcome research designs, often used in psychotherapy research (Gurman et al., 1986), do not lend themselves to illuminate the therapeutic process of change.

The first section of this chapter will present a review of the literature reflecting the use of externalization interventions used by both individual and systemic oriented psychotherapy approaches. An overview of Experiential Systemic Therapy will be presented to contextualize the therapeutic process of utilizing the symbolic externalization intervention. The next section will present a review of the methodologies used by family therapy process researchers and the strengths and limitations of process

research will be discussed. An overview of comprehensive discourse analysis will also be presented as a methodology to utilize in addressing gaps in the existing family therapy process research.

Review of Externalization Literature

Externalizing interventions have been used by various psychotherapy orientations. The introduction of the empty chair and two-chair technique was originally made by Gestalt therapy to resolve polarities and splits within individuals (Perls, 1969). The goal of this Gestalt experiment is for the client to identify and sense the opposing forces of the intrapsychic split and to integrate the conflict between the two parts through placing each side of the conflict in a separate chair and then proceeding to have a direct encounter between them (Greenberg, 1979).

Apart from experientially oriented therapy, externalizing has also been used by family systemic oriented therapies. White and Epston (1990) describe externalizing as

an approach to therapy that encourages persons to objectify, and at times, to personify, the problems that they experience as oppressive. In this process, the problem then becomes a separate entity and thus external to the person or relationship that was ascribed the problem. Those problems that are considered to be inherent, as well as those relatively fixed qualities that are attributed to persons and to relationships, are rendered less fixed and less restricting. (p. 38)

The method of externalizing used by White and Epston

(1990) involves first defining the problem and then asking "relative influencing questions" designed to assist in mapping the influence of the problem in the persons' lives and relationships, as well as mapping their own influence in relation to the problem. This is based on the premise that when persons describe their relationship to the problem; they can separate from the problem and review their relationship to it, which allows for unique outcomes to emerge.

Based on experience with using this approach, White and Epston (1990) conclude that externalization of the presenting problem assists family members to decrease unproductive interpersonal conflict, reduce a sense of failure for not resolving the problem, provide an opportunity for members to cooperate in resolving the influence of the problem on their lives, permit new possibilities for members to regain their lives and relationships from the problem, allow members to be more effective and less stressed when dealing with the problem, and to present opportunities for dialogue about the problem. Externalizing has been used with such problems as encopresis, schizophrenia, temper tantrums, communication problems, and other similar related problems (White & Epston, 1990). To date, these authors have not mentioned using this approach to address alcohol dependent problems. More importantly, there has not been research that analyzes

the effectiveness of externalizing interventions. White and Epston have not put their principles of this intervention to test and demonstrated how this process actually occurs in the context of a therapy session.

The externalizing approach used by White and Epston (1990) remains focused on a cognitive, verbal, and discursive level. Thus, this approach would not necessarily be as effective with clients who are more non-verbal and tend not to function predominately on a cognitive level.

A variation of the Gestalt empty chair intervention was used by Friesen and Goranson-Coleman (1987) in addressing alcohol dependency in families. The empty chair was used to represent the role of alcohol in the family. This separation of the dependent person from the alcohol allows the family members to confront and challenge the symptom rather than the drinker. In this externalizing approach the family bands together to aid the alcohol dependent person to let go of the alcohol. ExST adopted and modified this latter externalizing approach by Friesen and Goranson-Coleman.

ExST provides several reasons for extending both White and Epston's (1990) and Gestalt therapy's (Perls, 1969; Greenberg, 1979) approaches to include use of symbols in externalization. First, ExST proposes that it is possible to extend the externalizing process to access both digital and analogical information through the use of symbols

(Friesen et al., 1991). This is based on Bateson's (cited in Friesen et al., 1991) claim that "linguistic thought is structured in a digital code and perceptual experiences in an analogic code is communicated in the form of models, metaphors, analogies, stories and rituals" (p. 5). Two basic functions of symbols are abstraction and representation of meaning (Lusebrink, 1990). When the meaning of a situation or experience is unknown due to a direct expression not yet being available, the symbol is considered to be the best and most descriptive way to represent this meaning (Jung, 1964). "This symbolic approach can mediate an experience of something indefinable, intuitive or imaginative, or a feeling sense of something that can be known or conveyed in no other way, since abstract terms do not suffice everywhere" (Whitmont, 1973, p.16). According to Jung (1964), symbols had a life-sustaining function that expressed and transformed life. "Thus the function of symbols may be to reveal, to disguise, to mediate" (Lusebrink, 1990, p. 56).

In ExST, actual symbolic objects are used as a means to explore the client's inner world, to describe interpersonal relationships, and to represent symptoms such as alcohol dependency. Through the use of symbols, ideas are presented indirectly and experientially that results in them being more easily accepted and used. ExST considers what occurs in therapy as being symbolic of what occurs in other areas

of the client's life. Relational changes experienced within the therapeutic setting result in changes outside of the therapy room (Friesen et al., 1991).

The second reason for utilizing the symbolic externalization intervention, developed by ExST, is that it extends the use of Gestalt therapy's empty chair and two chair technique (Perls, 1969; Greenberg, 1979) to include not only enacting and interacting with various aspects of self, but to externalizing aspects of self that are in relationship to symptoms, problems, relational themes or relationship patterns (Friesen et al., 1989). ExST operates from a systemic perspective and is concerned with both intrapsychic and interpersonal dynamics which is in contrast to Perls (1969) who focused only on the individual's intrapsychic process of increasing awareness and contact. In ExST, internalized relational aspects of the clients' lives are externalized so that they may explore and change both their substantive relational themes and relationship patterns. By directly experiencing and intensifying aspects of self in relationship, there may be an increased awareness of self and understanding of alternative ways of being. The intent of this intervention is to give clients an opportunity to engage in relational novelty, which is the transformation of relationship patterns in the here and now (Friesen et al., 1989).

Relational novelty, a term coined by ExST (Friesen et

al., 1989), results from the enactment of alternate ways of being in therapy and includes a change in the substantive relational themes and relational patterns within intrapsychic and interpersonal domains. Relational novelty occurs not only on these two levels, but also occurs in relation to problems presented by clients in therapy. Clients have a relationship with the problem presented in therapy which requires the ExST therapist to bring this relationship with the problem into the clients' awareness (Friesen et al., 1989). For example, the clients' intensified experience of interacting with a concrete symbol representing the alcohol can create relational novelty. The problem is presented as alcohol creating distance between the couple and hence, it is possible to explore and change the relationship. When the couple experiences their respective relationship to the alcohol at the physiological, emotional, behavioral, and cognitive levels, they are able to broaden their perspective of the problem and one another. Relational novelty occurs in regards to the clients' presenting problem when they experience their relationship to the problem by interacting with it and exploring both their own and their partner's experience with the problem.

Relational novelty occurs at the intrapsychic level when clients experience aspects of themselves which were previously unacknowledged or avoided. Relational novelty may result in therapy when clients experience both unlovable

and newly discovered loving aspects of self.

Relational novelty occurs at the interpersonal level when a family or couple, through intensifying their relational patterns and interactions, experiences an alternate way of being with one another. They may experience being vulnerable and loving with each other rather than engage in their typical pattern of being angry and defensive. In short, relational novelty may occur within one or more of these domains.

ExST model strives to integrate various perspectives of alcohol related problems and thus, a multi-faceted, interactive model of alcohol dependence is proposed. Physiological, biogenetic, psychological, and socio-cultural processes are all interacting with one another (Friesen et al., 1989). The alcohol dependence model is relationally based and examines the patterned relationship that has developed, rather than emphasizing the disease entity of the behavior. From this perspective, the problem is not the alcohol or the alcoholic, but rather the relationship between the bottle and drinker.

The adaptive consequence model of alcohol dependency as presented by Davis, Berenson, Steinglass, and Davis (1974) examines the adaptive consequences of alcohol dependency and their reinforcing value. Davis et al. (1974) state that

these adaptive consequences are sufficiently reinforcing to serve as the primary factors maintaining a habit of drinking, regardless of what underlying causation there may be. The primary factors for each

individual differ and may be operating at an intrapsychic, intra-couple, or at the level of maintenance of homeostasis in a family or wider social system (p. 210).

Once the adaptive function of the alcohol dependence is determined, the emphasis in therapy is to assist the clients to manifest the adaptive behavior while sober and to learn effective alternative behaviors and relationship patterns. The goal is to make explicit the implicit role of alcohol to self and family relations. It is not only the once alcohol dependent person who must make changes and deal with redefining self, resolving unfinished issues from the past, and expanding to include alternate behavior, but other family members must also reorganize themselves and establish new patterns of relationship (Friesen et al., 1989).

The therapeutic setting provides a context for developing new behaviors and for both clients and therapist to co-create alternate ways of experiencing themselves. The therapeutic process of experiencing relational novelty implies that alcohol dependent clients and their family can directly experience and create non-dependent ways of relating to alcohol as well as reorganizing themselves in other significant contexts.

Overview of Experiential Systemic Therapy

To understand the rationale for employing the symbolic externalization intervention it is important to provide the theoretical framework and context in which the intervention

is embedded. That is, this intervention is not used in isolation from other processes occurring in the therapy. A brief discussion will ensue describing the process of ExST and how the transactional classes coincide with the therapeutic process, particularly symbolic externalizing transactions.

Phases of Therapy

The process of therapy in the ExST approach consists of four phases which include: (a) forming the therapeutic system and establishing a context for change; (b) perturbing patterns and sequences and expanding alternatives; (c) integrating experiences of change; and (d) disbanding the therapeutic system. These phases do not occur in a linear fashion from start to end of therapy instead, there is often a looping back and forth of phases over the course of therapy. These four phases also structure the process occurring within each session. That is, in each session there will be a forming and joining of the therapeutic relationship, perturbing patterns, integrating the changes, and ending of the therapy session. The first phase requires that the therapist and clients establish a bond and trust with each other. The therapeutic mandate is developed by assessing the nature of the clients' presenting problem and collaboratively creating the goals of the therapy. The second phase focuses on disrupting rigid and dysfunctional patterns and sequences in order that new patterns and

behaviors of relating to self and others can emerge. The third phase then strives to integrate and generalize the changes that have taken place in the therapeutic setting to the clients' life outside of therapy. The fourth phase is the termination of therapy and involves evaluating the therapeutic process and celebrating the changes made.

Transactional Classes

ExST developed seven transactional classes which describe the activities of the therapy and are related to and concur with the four phases of the therapeutic process just described. The following section will briefly describe the seven transactional classes.

Therapist-Client Relationship Enabling Class

The emphasis is on creating and maintaining the therapeutic alliance throughout the duration of therapy. Some of the transactions used are empathy, self disclosure, immediacy, and tracking.

Process Facilitation Transactional Class

The therapist observes the clients' relational patterns by having the clients directly engage with one another in the session. The therapist then uses particular techniques such as blocking, coaching, marking, role reversal, repetition, and expressing underlying feelings to shift the rigid and repetitive relational patterns.

Expressive Transactional Class

The focus is on assisting clients to make their

experiences public through exploring, naming and owning their experiences and by accessing both verbal and nonverbal expression. The use of such transactions as metaphor, sculpting, art, dance, and storytelling can provide an avenue of symbolic expression and move beyond just verbal expression.

Symbolic Externalizing Transactional Class

A symbolic representation of a central and problematic feature in the clients' life is created and brought into the therapy session. The interventions include empty chair work, two chair work, and symbolic representations.

Meaning Shift Transactional Class

The emphasis is on the therapist aiding clients in developing and expanding alternate views of the problem. The transactions include using reframing, normalizing, circular questioning, and regressions.

Invitational Transactional Class

The transactions are used to orient the clients to autonomous functioning outside of the therapeutic system and to enhance the work being done inside sessions. Some of the interventions used are prescribing symptoms, homework, journal writing, and self monitoring.

Ceremonial Transactional Class

To acknowledge the progress and change within clients ceremonies are created to demarcate endings, shifts in status, and changes in roles. The transactions may include

closing ceremonies, burials, confessions, and handshakes.

Due to the complexity and laborious task of intensively analyzing all seven transactional classes, the present study will only focus on examining the symbolic externalizing transactional class.

Symbolic Externalization Intervention

When working with clients who are suffering from alcohol dependency, symbolically externalizing the problem is often one of the first steps in understanding the relationship to the alcohol. Symbolic externalizing interventions offer clients an opportunity to gain distance from the problem of alcohol by creating a symbolic or metaphoric representation of this problem so that it is no longer perceived as a characterological trait residing within the client. For example, an alcohol dependent client's relationship to alcohol can be externalized by placing a beer bottle, which represents the alcohol problem, on a chair and having the client relate to it from a distance. Both the alcohol dependent client and his or her spouse can explore and discuss their relationships to the bottle.

Symbolic externalizing transactions can be used to address any problem, symptom, or relationship difficulty. When the symptom or problem is external and tangible and not fused with the person's identity, it allows clients to examine the many aspects and dimensions of this concrete

representation of their problem. Through this process a shift in the client's identity or relationship to the problem may occur and possibly alternate ways of dealing with it may emerge.

The symbolic representation of the problem or symptom may evolve in several ways. It may emerge directly from an expressive transaction (e.g. a metaphor) or attained directly from the therapeutic discourse. Another possibility is that the therapist introduces the symbol because it seems to fit with the client's experience. How the symbolic objects evolved is less important than the appeal of the symbols to the analogic mind (Friesen et al., 1989). If this does not occur than the work in relation to the symbols will not be useful to the client.

Beliefs and assumptions of symbolic externalization intervention. The beliefs and assumptions underlying the symbolic externalizing transactional class are many. First, ExST postulates that the client's presenting problem or symptom provides the source and often the solution to the problem. That is, the problem or symptom is perceived as a communicative act of existing relational difficulties. The problems and symptoms are messengers that something is amiss. For example, the alcohol dependent client who wants to stop unresolved pain and to detach from reality seeks the answer through drinking alcohol.

Second, intensifying the client's therapeutic

experience is important in facilitating change in therapy. "The deepest and the most profound form of knowing results from experience rather than dialogue or didactic instruction" (Friesen et al., 1991, p. 6). Therapeutic experiencing represents an integration of the holistic person which includes cognition, behavior, affect, perception, and expectation. Therapeutic change involves a deepening, enhancing and broadening of the client's experience through the use of action oriented interventions such as empty chair work, two chair work, enactment, and sculpting.

Third, communicating through metaphoric or symbolic means has the potential to move beyond usual defense mechanisms. The indirect and playful nature of the language used may result in the client not taking it seriously and thus immediately establishing defenses.

Fourth, due to symbols and metaphors tapping into analogic processes of the mind they are not easily forgotten or ignored. Andolfi, Angelo, and Nichilo (1989) found in their long term follow-up studies that images created and symbolic representations "have a remarkable capacity to persist and reverberate that is clearly superior to those produced by verbal exchanges and interpretations" (p. 74).

Process of utilizing symbolic externalizing transactions. The following steps demonstrate the process of this transactional class:

1. A therapeutic relationship of trust is first established. That is, a collaborative therapeutic alliance is created and maintained.

2. Through the client's discussion of his or her concerns, a metaphoric image becomes apparent to either the client or the therapist.

3. The therapist then helps the client to create a metaphor and then an external symbol which reflects the concern or symptom. The client's own words are used.

4. The client is asked to describe his or her relationship to the symbol and what he or she might like to say to it.

5. The client then engages directly in the relationship dialogue with the symbol or with each other about the symbol.

6. The experience of rigidity of the relationship is heightened or intensified.

7. Possible changes in the relationship to the symbol are explored.

8. Direct experience of relational novelty occurs with the symbol.

9. The therapist and client jointly decide what to do with the externalized symbol.

The function of the therapist while involved in this transactional class is to assist the client in clarifying the quality of the specific problematic relationship, to

explore the significance of the problem and to perturb relational novelty between the client and the symbol.

Process Research

To understand what occurs within the therapeutic context when implementing the symbolic externalization intervention, a comprehensive method of analysis that describes and analyzes the process must be utilized.

Relying solely on outcome research strategies could not adequately address the research question of this study. The nature of outcome research is to evaluate the effectiveness of a therapy by comparing outcome differences between different treatment approaches or no treatment. Consequently, it is unable to reliably describe what actually occurs in the course of therapy. Outcome research is not amenable to testing clinical theories about the process and effects of various interventions and treatment strategies. Instead, these tasks are best addressed within the field of process research. The process of testing clinical theory must then begin by investigating the actual events that occur in the therapeutic process.

Review of Family Therapy Process Research

In reviewing the family therapy process research to date, Pinsof (1991) stated that research has largely focused on evaluating the outcome of family therapy "but little has been devoted to systematically describing and evaluating the process of family therapy or attempting to relate process to

outcome" (p. 699). Pinsof (1991) claims the three factors responsible for the dearth of family process research are; the difficulty of the task, lack of adequate micro-therapy theory, and the individual orientation of researchers.

Pinsof (1991) stated that

this scientific isolation has retarded the speed with which the knowledge and skills offered by the field of psychotherapy research have infused the family therapy field. Simultaneously, it has permitted general psychotherapy researchers to remain enmeshed within a predominantly individual psychotherapy research paradigm (p. 701).

Other reviews of family therapy process research have also identified similar limitations (Gurman, et al., 1986; Newman, 1991; Wynne, 1988). There appears to be agreement among these reviewers that the areas that need to be addressed in family therapy process research are; use of adequate methods and measures, establishing clinical relevancy, incorporating a systemic perspective on the therapeutic process, and explicating the theoretical orientation employed. In the next section each of these four areas will be discussed as well as recommendations made for enhancing the quality of family therapy process research.

First, much of the earlier process research failed to utilize adequate methods and measures. Pinsof's (1991) review of family therapy process research identified research that focused on developing instruments to measure aspects of family therapy process. The emphasis of this

review was on enhancing the quality of family process research methodology.

The family therapy process research, reviewed by Pinsof (1991), focused on either self-report measures or direct observation measures of either the therapist or client's behavior using coding systems that describe and analyze behavior. These coding systems focused primarily on verbal behavior, disregarding paralinguistic, kinesics or proxemic behavior. In general, the findings obtained in these studies were often unclear or inconsistent.

Additionally, a major gap in the family therapy field noted by Gurman et al. (1986) was the lack of attention paid to nonverbal behaviors. They stated that "no one in the field has developed and implemented an empirical and quantitative methodology for studying paralinguistic... and kinesic... behaviors" (p. 598).

Most of the research studies reviewed by Pinsof (1991) focused on employing a complementary position in which the psychotherapy coding systems had different systems and/or categories for the therapist and/or family members. An exception was the study by Schefflen (cited in Pinsof, 1991) that adopted a symmetrical position that applied the same systems and categories to the behavior of the therapist and family members. This study used a context analytic approach addressing both the issue of cybernetics and communication theory (Bateson, 1972).

Scheflen's methodology is ethnographic and involves "an intensive, detailed description of every discernible (to the participants) behavior (verbal and kinesic) of every individual within a group during a transaction" (Pinsof, 1991, p. 721). This method of analysis derives specific codes and categories at various levels of a transaction. The advantage of this process analytical approach is that it is "the least reductionistic... [and] does minimal violence to the integrity and uniqueness of a given transaction" (Pinsof, 1991, p. 722). The limitations, however, include its complex methodology, the difficulty in applying it across different psychotherapeutic contexts as well as not being able to generate context specific therapeutic tenets (Pinsof, 1991).

In their review of family therapy process research, Gurman et al. (1986) state that the initial work done by Scheflen (cited in Pinsof, 1991) in this area has not been pursued or developed by others in the family therapy field.

Overall, Pinsof (1991) considers the family therapy process research to be exploratory. He found that the process analysis systems developed were tested in either one or several studies which did not utilize high quality methodologies. "A coherent body of findings has not yet emerged... Researchers need to follow through with more studies of their own and each other's coding systems" (Pinsof, 1991, p. 724).

Newman (1991), in reviewing family and marital therapy process research, agreed that at times the coding systems used by researchers were "too crude to capture the important nuances of interpersonal interaction and, as a result, the conclusions were clinically redundant" (p. 6).

The overreliance on extensive analysis methodologies by early marital and family process researchers to understand the therapeutic change process has contributed to inadequate use of methods and measures (Newman, 1991). The appropriateness of using extensive analysis research and confirmatory paradigms for investigating the therapeutic process was previously not challenged due to funding being given for studies that incorporated this methodology (Stanton, 1988). Exploratory research that include intensive analysis research designs such as small n, single and multiple case studies, are not regarded or funded in the same way as conventional research paradigms (Stanton, 1988). The preferential bias toward extensive analysis methodologies has contributed to early researchers not utilizing more exploratory research paradigms.

The two research strategies often used in conventional process-outcome studies also contribute to the utilization of inadequate methods and measures (Gurman et al., 1986). The first strategy focuses on the entire course of therapy and attempts to relate the final outcome measured at termination to some client and/or therapist variable or

experience measured at a particular point in the therapy. The second strategy consists of first obtaining averages of specific variable measurements over the entire therapy and to then compare these averages to client outcome at the conclusion of treatment. This emphasis on long-term process-outcome links has resulted in a failure to identify any consistent process-outcome patterns. Long-term links may surface at some future point but "they must evolve out of the accumulation of knowledge about the smaller, short-term links" (Gurman et al., 1986, p. 600). It would thus seem that researchers have been too ambitious, at this stage of development in family therapy process research, in trying to find process-outcome links. It is not likely that a statistically significant relationship will be found "between either an aspect of process at some point in treatment or an aspect of process that spans the whole course of treatment and the final outcome (at termination or follow-up)" (Pinsof, 1988, p. 167). For instance, the likelihood of what occurs in the first few sessions being directly related to the outcome after 20 sessions is not great. There may be a variety of intervening variables affecting the outcome. A fundamental problem with these two conventional research strategies is that the outcome is viewed as a "simple, static phenomenon that is best measured in some definitive sense at the conclusion of treatment and/or at some follow-up point after treatment" (Gurman et

al., 1986, p. 599).

Rice and Greenberg (1984) suggest adopting more of a process orientation in which outcome is perceived as an ongoing change process with a series of "small-o" outcome measures. This would result in the outcome not being measured at one best point.

However, it is essential that researchers identify the significant relationship that links the process being observed to the outcome when attempting to understand the client change process. Pinsof (1988) claims that:

Substantive (content-oriented) process is meaningless without an immediate or remote link to outcome. Linking process to outcome makes process research the study of the process of therapy. Its primary task is elucidating the mechanisms and processes of change. Process research ultimately attempts to reveal how therapy works (or fails) (p. 161).

Previous psychotherapy research has failed to consistently find links between process and outcome variables (Orlinsky and Howard, 1978) which has resulted in clinicians not gaining understanding of the interactions of therapy that can have useful impact on clinical practice.

The solution to the problem of long-term process-outcome links is to focus on smaller units of analysis of the therapy (Pinsof, 1988; Rice & Greenberg, 1984; Wynne, 1988). The purpose of using the episode or small-chunk strategy is to explicate the connection between process and outcome variables that are closely linked in time. The intent is to link the particular therapy moment or unit

studied to client change. This would allow for investigation of the outcome of specific interventions within a session, after a session, and within a series of sessions. The emphasis being on "proximal" outcome rather than "distal" outcome (Pinsof, 1991). The two assumptions underlying this method are that "process-outcome linkages are best discovered in smaller units that do not obscure the phases or vicissitudes of therapy... and that such small-chunk results are meaningful and valuable" (Pinsof, 1988, p. 168). This strategy can be utilized to replace the method of randomly or arbitrarily sampling therapy sessions (Pinsof, 1988).

Newman (1991) challenges the strategy of separating therapy into clinically meaningful units because this process "removes these change moments from the context in which they occurred and the clinical problem of summing and comparing de-contextualized therapy chunks remains" (p. 12).

Although the problem of de-contextualizing therapy units currently exists, this may be rectified by adhering to the recommendation made by Wynne (1988) to use smaller, within-model, intensive single and multiple case research designs. This shift in examining smaller units of therapy will require that researchers do not narrow the focus too much resulting in the essence of the therapeutic process being lost. It is important that researchers ensure the process-outcome link is still present. Newman (1991) found

that some researchers were narrowing the scope of the studies, as recommended, and shifting from examining broad theoretical orientations and arbitrarily categorizing and coding therapy units to investigating specific constructs and change moments in therapy. However, these research studies cited by Newman (1991) continued to employ "traditional research paradigm that reduces therapy to a mechanical act [and] inevitably generates methodologies that warp the process being studied until it is unrecognizable to practitioners" (Newman, 1991, p. 11).

A comprehensive process analysis requires that the participants' (including both therapist and client) experience of therapy, their thoughts and feelings as well as their observable behaviors are included. The methodological implication is that the combination of both self-report methods and naturalistic observational methods is legitimate and valuable (Gurman, 1988; Pinsof, 1988). This permits the researcher to acquire information about both the client and therapist's perspectives and the actual process of the therapy.

Clinical relevancy, the second criteria pertinent in process research, is considered to be of central importance in efficacy research (Gurman, 1988). Gurman (1988) suggests that priority be given to conducting research that will have direct meaningful relevant impact on clinical practice. This requires identifying the specific and important

elements and mechanisms of change in effective family therapies as well as identifying the elements that do not result in clinical effectiveness (Gurman, 1988). The result of such studies would allow for examination of specific interventions and provide information about how these interventions interact with such variables as therapist and family characteristics and treatment setting characteristics. Understanding how specific family therapy methods work with specific clinical populations is invaluable for clinicians. This information can also be used for refining or abandoning specific methods with specific clinical populations.

An influx of clinically irrelevant family therapy process research studies has emerged from utilizing extensive analysis research designs to examine the therapeutic change process (Gurman, et al., 1986; Newman, 1991; Pinsof, 1991; Wynne, 1988). The result has been the marginalization of the significance of the therapeutic context and providing support for the myth of homogeneity (Newman, 1991). Early process research studies described the therapist and/or client behavior and/or experience in isolation from their context (Gurman et al., 1986). The search for a representative sample of the variable being studied resulted in sampling within and across sessions without regard for the role of the context in which the variable occurred.

Much of the earlier process research was based on the underlying assumption of homogeneity of process (Rice & Greenberg, 1984). The approach involved selecting and rating samples from one or more sessions and then averaging the ratings across samples or across sessions. "Aggregating process though all process during therapy is the same involves a uniformity myth from which psychotherapy research has been suffering" (Rice & Greenberg, 1984, p. 10). The assumption is that all therapeutic process is the same and thus can be sampled. This contradicts the premise that therapy is a change process. Rice and Greenberg (1984) state that:

Different processes occur at different times in therapy and have different meanings in different contexts. It is more the pattern of variables than their simple occurrence that indicates the therapeutic significance of what is happening in therapy (p. 10).

Randomly selecting therapy segments and disregarding their context fails to provide little information on the process of change in therapy. The essence of the therapeutic process is misconstrued when there is rigid adherence to utilizing conventional or extensive analysis research designs.

The third criteria for improving the quality of family therapy process research is to adopt a systemic perspective of the therapeutic process. Historically, psychotherapy process research has been individually-oriented and failed to include dimensions of family systemic therapy (Pinsof,

1991). One factor contributing to the lack of family therapy research paradigms is the added difficulty in studying the therapeutic process when there are more than two participants in therapy (Gurman et al., 1986).

Investigating the therapeutic process in individual therapy is a complex task in itself. Family therapy research methodologies have to account for the various subsystems in the therapy setting and how each family member is impacted by an intervention, for example. In reviewing family therapy research studies, Newman (1991) found that there continues to be an emphasis on studying only one client's behavior in therapy rather than focusing on the family interactions.

Therapy is regarded as an interaction between client and therapist which implies a reciprocal influencing relationship between therapist and client subsystems (Pinsof, 1988). Thus, it is important to investigate how therapist and client interactions create client change. This requires developing methodologies for family therapy process research that accommodate the theoretical concepts of circular causality and cybernetics (Gurman et al., 1986; Pinsof, 1988).

Gurman et al. (1986) encourage research that is discovery-oriented and is of the new 'process perspective' that is derived "from family therapy theory and represents a significant contribution from the family therapy field to

the general field of psychotherapy research" (p. 596). Progress in the process research field is slow as a result of researchers needing to "deal with all the problems involved with individual therapy process research as well as those unique to the family therapy context" (Gurman et al., 1986, p. 597).

The fourth criteria of family therapy process research is to develop a clear theoretical approach of the change process. The theoretical orientation of the therapist is often not stated in process research studies or in any of the reviews mentioned earlier. Developing theories of change that can be tested allows for the emergence of clinically meaningful research questions, designs, and methodologies (Wynne, 1988). Explicating a theory of change that is clinically relevant will result in conducting process research that is also clinically relevant. Reiss (1988) noted that the many highly abstract and unarticulated family system theories are inadequate for generating specific hypothesis and for applying to research methods that would inform us about the change process.

The testing of clinical theories is important because it can result in clinicians refining and modifying their practice. Both Gurman (1988) and Epstein (1988) recommend that at this stage of family therapy research it would be more fruitful to delineate and study family therapy interventions within specific approaches since we are not

yet able to investigate common elements across approaches. Dismantling the components of interventions of specific family therapy models aids in the refinement of practices of specific models by identifying the clinically meaningful components as well as minimizing or avoiding neutral or harmful variables (Gurman, 1988). The study of common effective elements and change mechanisms across family therapy models can be examined more prolifically after specific therapeutic approaches have been delineated (Wynne, 1988).

Gaps in Family Therapy Process Research

In reviewing the literature on the family therapy process research conducted to date, it is apparent that this field is at an early developmental stage and is struggling between which research method and design to use to capture the essence of the therapeutic change process. Utilization of conventional and extensive analysis research paradigms results in acquiring information that does not have direct impact on clinical practice, a distortion of the therapeutic process, and instruments that produce clinically irrelevant results. Prematurely categorizing and classifying the therapeutic discourse into nominal scales tends to result in the meaning of the therapeutic process being lost. In addition, studies that do not clearly articulate the theory of change and fail to take into account the accumulative effect of small outcomes of the therapy limit our

understanding of the change process in therapy. Our understanding of this process is further reduced when researchers fail to contextualize the therapeutic change moments and do not study the multiple levels of interactions occurring between both therapist and clients and between family members. Intensive analysis research strategies that involve using single and multiple case study research designs have generally been ignored by family therapy process researchers.

The shifting emphasis towards exploratory, discovery-oriented, hypothesis-generating research (Gurman et al., 1988; Rice & Greenberg, 1984; Wynne, 1988) and the notion that "family therapy research should be theory-based and theory-driven" (Wynne, 1988, p. 250) will likely result in more clinically meaningful and relevant contributions of the therapeutic change process. The discovery-oriented approach is compatible with the intensive analysis procedures which entails measuring or analyzing a phenomena so that the shift can be "from description to explanation of phenomena, model building, and finally prediction" (Greenberg, 1986, p. 712). Since process research is not yet at the stage of predictability we need to begin the process by investigating what was really said and done in therapy. When the goal of the research is to understand what and how change occurred in therapy, it is premature to categorize the phenomena observed. The intensive analysis of a phenomena begins with

the laborious task of generating hypotheses from the micro-analysis of individual cases and thus calling for the employment of single and multiple case study research designs (Wynne, 1988).

Further investigation by family therapy process researchers is needed to explore the therapist and client interactions and to study both verbal and non-verbal behaviors of the therapist and clients using a combination of naturalistic observations and appropriate questionnaires and self-reports. Clearly articulating the theoretical framework may elucidate the therapeutic change process within the specific therapy model. Priority should be given to efficacy research that is clinically relevant and meaningful to practitioners and to research strategies that can reflect the change process.

Based on the limitation of previous research methods, such as coding mechanisms, it is important to broaden the family therapy process research perspective and examine what actually occurs in therapy by using a discourse analysis methodology.

Discourse Analysis as a Method for Analyzing Therapy

Discourse analysis provides an alternate methodology for studying the change process in therapy. This new methodological perspective has implications for studying many socio-psychological topics and social texts as well as challenging conventional research. Typically, a single case

research design is used to analyze the contextualized discourse occurring in a naturalistic setting. In using this approach to study the change process in therapy the focus would be on understanding what is actually occurring in therapy, what are both the clients and therapist doing, and how is change accomplished. Discourse analysis allows researchers to move beyond the constraints of coding system research and instead, to examine the actual interactions between therapist and client. This approach, as will be demonstrated, fits with the earlier recommendations of using a discovery-oriented intensive analysis, single case study design and it also addresses the concerns of incorporating a systemic perspective in the therapeutic process, clinical relevancy, articulation of theoretical perspective and adequate methods and designs.

To aid in understanding the purpose and implications of using a discourse analysis method the following section will include; a rationale for studying discourse, theoretical roots of discourse analysis, and a review of different methods of discourse analysis.

Integral to psychology and to the understanding of human communication is the study of language because it is the most fundamental, influential, and widespread type of interaction that occurs between people. Activities are generally performed via language; "our talk and writing do not live in some purely conceptual realm, but are mediums

for action" (Potter & Wetherell, 1987, p. 9). Discourse analysis is concerned with how language is used in organizing people's perceptions and making events, things, and experiences happen. The premise is that language is used to construct social interaction and varying social realities. Discourse analysis, as defined by Potter and Wetherell (1987), is the analysis of any type of discourse such as spoken interaction, formal and informal, and written texts with the emphasis on understanding the nature of social interaction through studying social texts.

The study of how people actually use language with each other in different types of interactions has its roots in several theoretical traditions with the first one developed within speech act theory. The underlying premise of this theory "is that all utterances state things and do things. That is, all utterances have a meaning and a force... People use language, like a tool, to get things done" (Potter & Wetherell, 1987, p. 18). Speech act theory identified that a particular sentence or group of words can be used in various ways to give an order, a question, or a request. This theory also stresses gaining awareness of how aspects of the social context are associated with language use.

However, the limitation with this theory is that it fails to provide methods for applying it to the vicissitudes of everyday talk in naturalistic settings. It is able to deal with simulated sentences or actual exchanges that are

ritualized as in wedding ceremonies. In everyday talk interactants' speech acts are often more implicit rather than explicit. For instance, we may indirectly request a ride by asking "Are you going downtown?" Although the request is framed as wanting information, the action desired is a ride. Speech act theory is problematic when it is used to categorize discrete speech acts of a conversation through sequencing rules because utterances may perform more than one act (Cicourel, 1980; Corsaro, 1985; Labov & Fanshel, 1977; Potter & Wetherell, 1987). That is, there may be multiple messages associated with the utterance. Another problem is that the act being performed is often determined by the response, not aspects of the utterance itself (Potter & Wetherell, 1987). Focusing on only rule-governed features of speech acts provides little understanding of the methods used by interactants to interpret their experience.

In contrast, ethnomethodological research, the second theoretical tradition of discourse analysis, studies the methods used by ordinary people to understand everyday situations and how they then produce appropriate responses. Ethnomethodologists identified the reflexive features of talk. That is, talk is not only a description of a rule about particular actions, events, or situations but "it is also a potent and constitutive part of those actions, events and situations" (Potter & Wetherell, 1987, p. 21). The talk formulates both the nature of the action and the

relationship between the interactants as well as having many consequences within that situation. Another premise underlying ethnomethodology is that many utterances are indexical (Potter & Wetherell, 1987). The meaning of the utterances is attained through acquiring knowledge of their context.

The problem with using ethnomethodological research is that the empirical basis is unclear. The data consists of field notes made by the researcher and thus the data is based primarily on the researcher's interpretation and analysis. Another difficulty in evaluating the research results is that the assumptions underlying the investigation are not clearly delineated. To alleviate these problem, some ethnomethodologists have incorporated an alternative analytic method known as conversation analysis (Potter & Wetherell, 1987). The empirical data consists of the verbatim transcripts of interactions.

Both speech act theory and ethnomethodology claim that talking involves action which suggests the study of language also be viewed from a social perspective, not just traditional psycholinguistics. Potter and Wetherell (1987) state:

When language is conceptualized as a form of action performed in discourse between individuals with different goals we are forced to take the social context into account, likewise, with the notion that a web of felicity conditions or a system of distinctions is required for language to be used meaningfully (p. 28).

Considering that the predominant feature of therapy is the talk between therapist and client and that the therapeutic interview is a social occurrence, it is only appropriate that the study of language should be considered when attempting to understand what actually occurs within the process of therapy. At present there are a few studies that have employed the study of language as the basis in marital and family therapy process research (Gale, 1989; Todtman, 1991). To know how language is actually operating it is important that researchers not just focus on traditional psycholinguistics but begin to include examination of social psychological issues.

In essence, both speech act theory and ethnomethodology argue that people use language to perform an action such as ordering, persuading, accusing, and requesting. This emphasis on language function is a fundamental concept in discourse analysis. The analysis of function cannot be conducted in a linear fashion in which speech acts can be mechanically categorized because language function may vary depending on the context and as well, people often use indirect methods for persuading, for example. "A person's account will vary according to its function. That is, it will vary according to the purpose of the talk" (Potter & Wetherell, 1987, p. 33). This will require the analyst to contextualize the language function. For instance, two students may describe a teacher's formal and structured

lecture in very different ways which are in accordance with their own respective preferred style of teaching and learning. The person who prefers organized, formal, and didactic teaching may speak about the positive aspects of the lecture. Whereas, the other person, who prefers unstructured and informal teaching, may emphasize the negative aspects. Another example is that the information people choose to discuss with others will vary depending on whether they are speaking with an acquaintance or an intimate friend. Thus, understanding the meaning of utterances requires that it is embedded within its context.

These examples demonstrate that people, in general, use language to construct their version of the world. The fundamental premise of "discourse analysis is that function involves construction of versions, and is demonstrated by language variation" (Potter & Wetherell, 1987, p. 33). The concept of constructionism is pertinent for several reasons:

First it reminds us that accounts of events are built out of a variety of pre-existing linguistic resources, almost as a house is constructed from bricks, beams and so on. Second, construction implies active selection: some resources are included, some omitted. Finally, the notion of construction emphasizes the potent, consequential nature of accounts. Much of social interaction is based around dealings with events and people which are experienced only in terms of specific linguistic versions. In a profound sense, accounts 'construct' reality (Potter & Wetherell, 1987, pp. 33 - 34).

This constructing process is not always intentional. A person may not be consciously aware of constructing while speaking, but construction occurs through the process of

attempting to understand a particular situation or through unconsciously entering in accusatory or defensive behavior (Potter & Wetherell, 1987).

The emphasis of discourse analysis approach is not on revealing underlying entities, events, beliefs, and cognitive processes from the discourse rather, it looks analytically at how discourse or accounts are created. Two key questions are "How is participants' language constructed, and what are the consequences of different types of construction?" (Potter & Wetherell, 1987, p. 55).

Although several strands of research have emerged from the discourse analysis approach, conversation analysis as first developed by Harvey Sacks, Emmanuel Schegloff, and Gail Jefferson (cited in Potter & Wetherell, 1987) and comprehensive discourse analysis (Labov & Fanshel, 1977) are of primary importance for the present study. Conversation analysis investigates how speakers contribute to producing and managing such actions as blaming, greetings, refusals in everyday conversation (Potter & Wetherell, 1987). The procedure is to study a few occurrences of a phenomenon in its natural occurring context, especially the embedded sequences of the talk, and to then explicate its systematic properties. The basic sequential properties include turn taking, adjacency pairing, and preference structure.

Turn taking research investigates the principles and rules involved in how speakers alternate between talking and

listening when engaged in a dialogue. These changeovers in conversation operate in an orderly way with speakers knowing when the utterances by the other is finished (Potter & Wetherell, 1987). Another structural feature found in conversation is adjacency pairing which includes such pairings as questions and answers, greetings and return greetings, and offers and acceptance. Research on adjacency pairs involves investigating the rules that determine how the second part of the adjacency pair (e.g. acceptance of an offer) is produced by the first part of the adjacency pair, the offer, and the social context. Preference structure research entails understanding whether the second part of the adjacency pair is rated as a preferred or dispreferred response. A preferred response is acceptance of an offer while a dispreferred response is a decline. "The concept of preference is used to indicate a normative ranking of different responses exhibited in the organization of talk" (Potter & Wetherell, 1987, p. 83).

The objective of conversation analysis "is to describe the procedures by which speakers produce their own behavior and understand and deal with the behavior of others" (Heritage, 1988, p.128). In conversation analysis each speaker's turn is understood in relation to the sequence in which it is embedded (Potter & Wetherell, 1987). The assumption underlying sequencing rules is that there is a relationship between utterances and the actions performed.

That is, the rules state a possible set of relations between a question such as "Are you doing the dishes?" and the subsequent speech acts it suggests such as a request for information and a challenge.

In reviewing several approaches to discourse analysis, Corsaro (1985) criticizes the conversation analysis approach developed by Sacks, Schegloff, and Jefferson (cited in Corsaro, 1985; Potter & Wetherell, 1987). He claims that "the autonomous nature of the turn-taking system and the invariance of the rules are not made clear" (Corsaro, 1985, p. 172). The procedure used is to first take segments from the data, interpret the meaning of the segments, and then to classify the utterances into speech acts categories or a set of rules that appear to be operating. The problem is that this conversation analysis model cannot account for variations across cultures, different types of conversations, and variations of rules in different types of informal conversations (Corsaro, 1985). Classifying and quantitatively coding speech acts and sequencing rules is as interpretative as the coding procedures discussed in the previous section on process research. At this preliminary stage of analyzing what and how change occurs in the therapeutic context, it is premature to form a succinct number of categorizations.

There are real limitations when research focuses primarily on verbal structuring and organization of a

conversation in its natural setting. For instance, in conversation analysis the emphasis is on identifying the structural properties of the conversation at any given point but is not interested in addressing what is actually occurring in the moment (e.g. a therapeutic change moment). This approach fails to provide reasons for why a particular question or response occurred at a particular point. The concern is not with such questions as "What is taking place in the therapeutic interview? or, even more to the point, 'What should I, as a student, attempt to do in a therapeutic interview?'" (Labov & Fanshel, 1977, p. 24). Additionally, much of the conversation analysis research has focused primarily on the sequencing of individual speech acts and has not queried about the influence of roles and status on speakers in conversations (Labov & Fanshel, 1977). Labov and Fanshel (1977) argue that when the contextual information in which the discourse is embedded is lacking, researchers imagine it. Consequently,

the construction of such imagined context is an uncontrolled variable in the study, so that rules that appear to be quite general are, in fact, limited by those conditions that we necessarily construct unconsciously as we imagine how we would interpret the utterances in general (Labov & Fanshel, 1977, p. 73).

Research on turn taking and adjacency pairs can be appropriately used when analyzing short strings of sequential utterances. However, these methods of analysis, due to their narrow focus, cannot be applied to whole or longer conversations (Bilmes, 1986; Grimshaw, 1979; Labov &

Fanshel, 1977).

In contrast, comprehensive discourse analysis, developed by Labov and Fanshel (1977), is capable of addressing larger units of conversation. According to Labov and Fanshel (1977) conversation is "a matrix of utterances and actions bound together by a web of understandings and reactions" (p. 30), not a group of isolated utterances. These authors applied this method to a detailed investigation of fifteen minutes of interaction between a client who suffered from anorexia nervosa and her therapist.

The reviews of theoretical discourse models (Cicourel, 1980; Corsaro, 1985; Potter & Wetherell, 1987) underscore the significance of studying discourse in naturally occurring settings, contextualizing the discourse, and having awareness of the multiple levels of information processing. Cicourel (1980) found that the studies he reviewed "invariably recognize that the surface features of language use are inadequate if we want to address the meaning of the utterances as recorded in context" (p. 111). Thus, utterances are to be expanded to gain a more thorough understanding of language use in social situations. This requires that the cultural basis and context of the interaction be explicated as well as clearly identifying the relationship between the interactants. Considering that interactants often operate under a common knowledge base resulting in aspects of the conversation not being stated,

this would require making the unsaid explicit. It is also important to take into account the multiple functions of contextualized speech acts which can have either a past, present, or future orientation. Cicourel (1980) stresses the importance of using an expansion model to analyze discourse because it is

particularly concerned with the relationship between what is actually said, including paralinguistic and nonverbal activities, the expansions that are part of the researcher's analysis, the attribution of intentions, and the way the interaction unfolds because of locally generated conditions and the broader socio-cultural context in which local talk is embedded. In all of these activities the participants continually benefit from reflexive feedback from their own actions and the actions of others (p. 111).

The expansion model, comprehensive discourse analysis, developed by Labov and Fanshel (1977) is able to accommodate these recommendations. Their expansion model is able to "synthesize all information that will help in understanding the production, interpretation, and sequencing of all utterances in discourse materials" (Corsaro, 1985, p. 183). The central goal is to expand what is said in the actual text to what is meant. This is done by using information from other parts of the therapy sessions and other relevant knowledge acquired by the analyst. This approach permits moving beyond actual utterances to explicating underlying propositions and to describing how the interaction is accomplished in therapeutic discourse.

The open ended process of comprehensive discourse analysis has benefits to the study of discourse analysis.

Labov and Fanshel (1977) presented their data and interpretations in a comprehensive and explicit way which allows for critical evaluation and challenge from others (Cicourel, 1980; Corsaro, 1985). Challenging the interpretation of the data "result[s] in the expansion and refinement of discourse models and lead[s] us toward more integrative approaches to discourse analysis" (Corsaro, 1985, p. 184)

The difficulty of acquiring "correct interpretation" (Labov & Fanshel, 1977, p. 73) cannot be completely resolved because analysts do not have total knowledge about what is shared between interactants. Grimshaw (1979) suggests that:

Closer approximations to a solution are possible, however, if we: (1) recognize the seriousness of the problem and the concomitant necessity to (2) study conversational interaction in maximally known context with speakers well known to the analyst... and (3) subject the conversation to explicit (in the sense that "procedures are stated as plainly as possible so that anyone else who would like to use them may find it possible to do so" [p. 354]) and comprehensive (in the sense of making the analyst[s] "accountable to an entire body of conversation, attempting to account for the interpretations of all utterances and the coherent sequencing between them" [p. 354]) analysis. (p. 171).

A criticism of this method of analysis is the manner in which Labov & Fanshel (1977) obtained hierarchical levels of information (Corsaro, 1985). The concern is that the researchers relied on their own interpretations and the therapist's reactions to playback segments of the session when they went beyond the immediate text and paralinguistic cues to past and future episodes to aid in contextualizing

the data (Corsaro, 1985). The criticism is that discourse material is limited because neither the client nor other family members were consulted to increase the validity of the interpretations (Corsaro, 1985). The other concern is that when these researchers acquired information about status and roles operating within the client's family, they relied only on the client's references to her family in the therapy sessions rather than also using ethnographic observations of the family's daily interactions (Corsaro, 1985).

In the current investigation these two concerns raised by Corsaro (1985) would not be relevant. The focus of this study is on the therapeutic process of how the therapist and clients use a particular therapeutic intervention to co-create relational novelty which means that the therapy session in which this process occurred would be the naturalistic setting. For the purpose of this study, it is more problematic to include both the couple's and therapist's reaction to playback segments because the therapy sessions occurred quite some time ago and thus in playback both the therapist and client would be interpreting what they thought had occurred. The problem of making abstractions about status and role without using naturalistic observations of daily interactions is rectified in the present study by observing the couple's interactions within the counselling setting.

Filling the Gap of Family Therapy Process Research

Many theoretical orientations of psychotherapy exist but few studies investigate how social interaction is accomplished. The early developmental stage of family process therapy research requires a direct investigation of how change in therapy is produced. To understand the process of change in marital and family therapy several authors recommended moving toward intensive, discovery-oriented research (Gurman, et al., 1986; Pinsof, 1988; Wynne, 1988).

The method that lends itself to examining the change process in family and marital therapy is comprehensive discourse analysis which is an intensive micro-analytical approach. This methodology could be employed to develop an understanding of how abstract interventions and constructs such as symbolic externalization and relational novelty are "articulated with contextual features of real-life interactive settings" (Corsaro, 1985, p. 185). After this expansion method "uncovers propositions (recurrent communications), they could then be compared to the general assumptions and predictions of the various theoretical perspectives." (Corsaro, p. 185).

Comprehensive discourse analysis is able to accommodate the four criteria of utilizing adequate methods and measure, establishing clinical relevancy, incorporating a systemic perspective, and articulating the theoretical orientation of

the change process. The methods and measures used by comprehensive discourse analysis are not reductionistic and do not de-contextualize therapeutic change moments. The expansion process of this method attempts to connect the utterances with the background and contextual aspects of the interaction in which it is embedded. Various parts of the therapy sessions are used to help clarify specific sequences of talk and to explicate what is actually intended by the participants. This method uses the empirical data (recording and verbatim transcripts) to understand how clients and therapist construct and use their context. Overall, comprehensive discourse analysis is a naturalistic approach that examines naturally occurring discourse, takes into account verbal and nonverbal behavior and paralinguistic cues, does not disrupt the discourse being studied, and is sensitive to the context explored.

Comprehensive discourse analysis is also able to address the systemic notions of circular causality and cybernetics that are particular to marital and family therapy. The reflexive dimension to talk, as identified by ethnomethodologists, permits examining the recursive nature of the talk and its connection to the context of the conversation. That is, the reciprocal influencing relationship between therapist and client subsystems can be studied to determine how therapist and client interactions prompt client change.

Due to the comprehensive and intensive analysis of this approach clinicians can gain valuable and relevant information about the mechanisms of change of the therapeutic process. Identifying how specific family therapy methods work with specific clinical populations will allow clinicians to refine their strategies. This approach also lends itself to studying various psychotherapy theoretical orientations. It can be used to test theoretical orientations which can aid clinicians in refining and modifying their practice.

CHAPTER III

METHODOLOGY AND PROCEDURES

The present study is concerned with understanding and analyzing how therapist and clients interact with each other to co-create relational novelty through using the ExST symbolic externalizing intervention in therapy. This chapter will first delineate the research design and the procedures used in this study. The next section will present salient features of the comprehensive discourse analysis methodology. The measuring instruments used to determine a successful case of ExST marital treatment will follow.

Research Design

To address the present study's research question of how therapist and clients co-create relational novelty through implementing the symbolic externalization intervention, a single critical case study research design (Yin, 1989) was employed. Yin (1989) suggests using a single case "when it represents the critical case in testing a well-formulated theory" (p. 47). The theory must explicate "a clear set of propositions as well as the circumstances within which the propositions are believed to be true" (Yin, 1989, p. 47). The ExST model concurs with this suggestion in that it has clearly articulated the theoretical underpinnings of and rationale for using the symbolic externalization

intervention with such problems as alcohol dependency. When conditions for testing a theory exist in a single case, this case may be studied "to confirm, challenge, or extend the theory" (Yin, 1989, p. 47). The knowledge attained from this particular single case study can contribute to theory-building of ExST and its symbolic externalizing transactional class.

For the purpose of this study, the conditions for testing the theory underlying the symbolic externalization intervention of ExST in this critical single case study require that the marital therapy was successful, the symbolic externalization intervention was used to address the problem of alcohol dependency, relational novelty occurred after the intervention was used, and that the therapist operated within the ExST model when working with this couple.

The case selected for this study met these four conditions. First, successful outcomes based on the results of the instrument measures and personal reports by both clients and therapist were attained. Client goals of abstinence from alcohol intake were maintained at follow-up. Second, the symbolic externalization intervention was used to address the alcohol dependency and the criteria for implementation of the intervention was met. Third, the criteria for experiencing relational novelty was also met when using this intervention. Fourth, the therapist

regarded her counselling in this case as being within the ExST model. Considering that the selected case meets these four conditions of successful outcome and adherence to aspects of ExST theory, it serves as an exemplary critical single case to be studied.

The rationale for a single case study design is twofold: First, each case of co-creating relational novelty using the symbolic externalization intervention contains its own unique characteristics and complexity. A comprehensive single case study can provide the detail presumed essential for a fuller understanding of this phenomena. Second, this information gained can then contribute to future multiple case study designs on this topic.

Criteria for Judging the Quality of Research Designs

To determine the quality of a single case study design it must be subjected to four logical tests which include construct validity, internal validity, external validity, and reliability (Yin, 1989).

Construct Validity

To establish construct validity operational measures must reflect the concepts studied. Construct validity may be enhanced through using multiple sources of evidence, establishing a chain of evidence, and having external researchers review the analysis (Yin, 1989).

The constructs in this study that must be operationalized and analyzed through appropriate measures

and procedures include; symbolic externalization intervention, relational novelty, and a successful case of ExST marital treatment of alcohol dependence. The method, Comprehensive Discourse Analysis (Labov & Fanshel, 1977), clearly delineates the procedures to analyze therapeutic discourse and thus, it will be used to analyze both symbolic externalizing intervention and relational novelty. A chain of evidence, used to increase construct validity, is obtained by providing the relevant data in such a way that an external observer "should be able to trace the steps in either direction (from conclusion back to initial research questions or from questions to conclusions)" (Yin, 1989, p. 102). The data to be analyzed in this study is presented in its entirety in chapter four to allow for establishing a chain of evidence. A successful case of ExST marital treatment of alcohol dependence will be determined through multiple sources of evidence such as client and therapist self report measures.

Internal Validity

Internal validity requires establishing a causal relationship wherein particular conditions are inferred as leading to other conditions (Yin, 1989). Internal validity may be increased by utilizing pattern matching, explanation-building, and time-series analysis (Yin, 1989). However, considering that the present investigation is a descriptive study examining how clients and therapist used the

intervention to co-create relational novelty and is not concerned with causal inferences, establishing internal validity is inapplicable (Yin, 1989).

External Validity

External validity is achieved when the findings of the study can be generalized beyond the case studied (Yin, 1989). Generalizability occurs through replicating studies and using the clearly stated research questions, design and method of the case study. The present study clearly delineates both the relevant aspects of the ExST theory as well as the research question, design, and methods used, which allows for further testing and refinement.

Reliability

Reliability is enhanced when it is demonstrated that the procedures of a study can be repeated and the same results are obtained (Yin, 1989). Increasing reliability requires clearly stating the operations and procedures utilized. The comprehensive discourse analysis method used in this study requires that the transcripts of the data and the analysis are presented to allow other researchers to determine their own analysis.

Procedures

Participant Selection

Participants were recruited through newspaper and television advertisements and community and personal referrals. The requirements to participate in the research

project were that the male, of a hetero-sexual marital couple, experienced alcohol problems and was trying to recover from this dependency, the spouse was not an alcoholic, and the couple experienced marital problems. The level of alcohol problems was determined by the male participant scoring 5 or higher on the Michigan Alcohol Screening Test (MAST) (Selzer,1971). The male alcoholic also had to be either sober for 3 months or still currently drinking. The Shipley Institute of Living Scale (Zachary, 1986) was administered to couples to determine whether they both had the verbal and abstract reasoning skills to be able to complete pretest, midtest, posttest, and follow-up questionnaires. Participants in the research project received an honorarium for their time in completing questionnaires of the study.

Identifying information about the participants selected such as names, ages, dates, locations, occupations and activities have been changed to protect their confidentiality. The selected participants for this present study were a couple, both in their late thirties, who had been married for over 8 years and had 2 children. The couple was of a white racial background and reported a middle income level. Both spouses identified that the husband's alcohol dependency was a problem in their marriage. This couple who volunteered to participate in marital therapy with the research project met the screening

criteria.

Therapist Selection

The therapist selected for the present study was employed at an alcohol and drug clinic and had completed an 8-week ExST training program and received ongoing clinical supervision within the ExST model. Identifying information about the therapist was changed to ensure anonymity.

The Origin of the Data Record

The data for this investigation were video-taped recordings of the 15, one hour per week, therapy sessions with the selected couple collected from the alcohol and drug program that sponsored the research project in which the ExST model was used in treatment. Video-taped recordings of all the therapy sessions were collected, with client consent, resulting in the entire therapeutic context being made available for study. For the purpose of this present study, audio recordings of the video-taped sessions were made to aid in transcribing the verbal dialogue. The recordings in which the symbolic externalizing intervention occurred were transcribed, and included verbal, non-verbal, and paralinguistic cues, and edited for accuracy. Although there were 15 hours of therapy sessions, only 15 minutes that were directly related to the intervention being studied were transcribed. However, to provide a context for the analysis of the symbolic externalization intervention the video tapes of the entire 15 therapy sessions were viewed

and described in the analysis.

The methodology used depends on the analyst being familiar with the theory of ExST and having an ability to derive meaning from the data. Due to the analysis being augmented by having familiarity with the data, it is appropriate to have the analyst type and edit the transcript.

Throughout the duration of therapy the couple was also required to complete questionnaires that dealt with personal and marital functioning. The questionnaires were completed by each spouse at pre-treatment, mid-treatment, post-treatment, and follow-up to assess the clients' progress at these different points of treatment. The follow-up questionnaires were completed 15 weeks after the 15-session treatment period. In addition, both spouses and the therapist were asked to complete post-session reviews after each session. The couple was also asked to complete 'weekly situation diary' forms on a weekly basis over the duration of the 15 therapy sessions.

Unit of Analysis

A case study must delineate the necessary criteria in the unit of analysis (Yin, 1989). Clearly defining the unit of analysis aids in limiting the data collection and analysis of the research question. Both the couple and the particular therapy segment selected for the present study were based on specific criteria which are as follows:

1. The couple met the screening criteria to be included in the research project.

2. The couple selected in this study demonstrated a successful case of ExST marital treatment. This was determined by the clients attaining their therapy goals, measurements on instruments indicating success in abstaining from alcohol intake as well as measuring a decrease in personal and marital difficulties.

3. The therapist also perceived her therapeutic approach in this therapy case as following that of the ExST model and demonstrating good quality work.

4. It was important to select a marital therapy case in which the alcohol dependency was symbolically externalized. In the selected therapy case, the symbolic externalization intervention was used with the couple to address the client's alcohol dependency in the second therapy session. The intervention was viewed as successful by both the therapist and couple which was based on the couple's reference to the effectiveness of the intervention in later sessions.

The therapy segment transcribed in this study begins with the discourse leading to the implementation of the symbolic externalization intervention in relation to the alcohol dependency and ends after the therapist and clients debrief the intervention. The total segment to be analyzed is 15 minutes in length and is included within the analysis

in chapter four.

The criteria for using the symbolic externalization intervention was determined by meeting the following conditions:

a. A collaborative therapeutic relationship of trust is established and maintained.

b. Through the clients discussion of their concerns, a metaphoric image becomes apparent to either the clients or the therapist.

c. The therapist then helps the clients create a metaphor and then an external symbol which reflects the concern or symptom. The clients own words are used.

d. The clients are asked to describe their relationship to the symbol, and what they might like to say to it.

e. The clients then engage directly in the relationship dialogue with the symbol or with one another about the symbol.

f. The experience of rigidity of relationship is heightened or intensified.

g. Possible changes in the relationship to the symbol are explored.

h. Direct experience of relational novelty occurs with the symbol.

i. The therapist and clients jointly decide what to do with the externalized symbol.

4. It was also important to select a case in which

relational novelty was achieved through the use of the symbolic externalization intervention. This required that the substantive relational patterns or relational themes associated with the alcohol dependency problem were intensified with self, their spouse and/or the presenting problem. Through the intense encounter with the alcohol dependency problem the clients identified and experienced something new or different about self, their spouse, and/or the alcohol dependency in the therapy setting.

Method of Analysis

Comprehensive Discourse Analysis

The comprehensive discourse analysis of Labov and Fanshel (1977) is an approach that analyzes contextual patterns and has been used by psychologists and linguists to understand how interactants produce and interpret their own and other people's actions. To discover what happens in therapeutic discourse it will be necessary to analyze data that consists of much detail. Comprehensive discourse analysis makes it possible to analyze various units of discourse including single words, groups of words, behaviors exhibited, both short and long episodes of talk, and takes into account the whole text.

Cross-Sectional Analysis

Labov and Fanshel (1977) provide a framework in which the conversation studied forms a matrix of utterances, propositions, and actions that indicate two types of

relations. The first relation is "between surface utterances and deeper actions which are united by rules of interpretation and production" (Labov & Fanshel, 1977, p. 37). The second relation is "of sequencing between actions and utterances which are united by sequencing rules" (Labov & Fanshel, 1977, p. 37). The discourse is analyzed through cross sections in which elements of small units are studied, identified, and the internal relations delineated. Labov and Fanshel (1977) suggest that the cross sections should not be perceived as ends in themselves because understanding what occurs in therapy sessions "necessarily presupposes a longitudinal study of the sequencing of these verbal actions" (p. 37).

The components of the cross sectional analysis presented by Labov and Fanshel (1977) include four stages; transcription of the text, text expansion, analysis of propositions, and analysis of interaction. The text, non-verbal and paralinguistic cues, the expansion, and the propositions formulate "what is said" while the interaction component determines "what is done."

The text, nonverbal behavior, paralinguistic cues.

The first stage is to accurately transcribe the recorded data which involves presenting the words spoken as well as the false starts, hesitations, interruptions, and nonverbal behavior. The modified notation system used in the present study is a combination of the systems used by

Labov and Fanshel (1977) and Gale (1989) (see Appendix A). The notation system takes into account the following: speech tempo; inhalations; exhalations; interruptions; loudness and emphasis of words; and timing of pauses. For instance, pauses in speech are demonstrated by using one dot for each 1/2 second of pause. An abrupt termination of speech is signified by a dash. The hyphen is used to represent sounds that are less than a word. Underlined characters are used to indicate stress. When words are not discernable the symbol "xxx" is used.

Identifying volume, pitch, voice qualifiers (e.g. breathiness, whine), and significant changes in breathing such as laughter or suppressed laughter augments understanding of what is being said and meant by the interactants. When paralinguistic cues contradict what is said directly there needs to be a way to interpret their implicit meaning. The process and terms used for deriving meaning from paralinguistic cues is not generally agreed upon (Labov & Fanshel, 1977). These authors restricted their interpretation of paralinguistic cues to limited meanings. The cues they identified in their study communicated, tension, tension release, exasperation, mitigation, aggravation, sympathy, derogation, neutrality, and reinforcement (Labov & Fanshel, 1977). Attributing meaning to paralinguistic cues enhances the coherence of the therapeutic discourse for the interactants as well as for

the analyst.

In the present study, the paralinguistic cues and non-verbal behavior are placed within the body of the spoken text. The emphasis is on presenting words spoken as well as noticeable paralinguistic cues and nonverbal behavior derived from both the audio and video tape recordings. Examples of these kinesic cues or physical movements by the clients and therapist included in the transcript are head nods, noticeable body gestures, and shifting body positions observed from the video-tape recordings.

Expansion of the text. After separating the text and paralinguistic cues and non-verbal behaviors, the next stage is synthesis. All the information obtained so far is synthesized to facilitate "in understanding the production, interpretation, and sequencing of the utterance in question" (Labov & Fanshel, 1977, p. 49).

The crucial phase of the analysis is the expansion. The process of expansion involves expanding the text to what is unsaid in the original conversation to describing more explicitly what was implied. Various sources of information derived from the verbal text, paralinguistic cues, material presented in earlier or later conversations, and shared knowledge of participants are synthesized to discover what is actually being said. Expansion permits going beyond speech acts to identifying implicit or underlying propositions and to describing how an interaction is

accomplished in discourse while taking into account the background and contextual elements of the discourse (Labov & Fanshel, 1977).

The concept of indexicality identified by ethnomethodologists is incorporated into comprehensive discourse analysis. Thus, it is important that the contextual information in which the conversation is in embedded be examined.

According to Labov and Fanshel (1977) expansion of the text includes the following process:

1. The meaning of the paralinguistic cues and nonverbal behavior are expanded to communicate their textual terms.
2. The referents of pronouns to other situations and time periods are made explicit.
3. Factual material occurring before and after the utterance and from other parts of the therapy sessions are provided.
4. The shared knowledge between the therapist and clients which is obtained from studying the therapeutic process in its entirety is made explicit.

Expansion of the text is an open-ended process and is unlimited in explanatory facts that could contribute to understanding the utterances. To demonstrate the expansion process an example will be taken from the work of Labov and Fanshel (1977):

Text: Client: I don't..know, whether...I--think did--
the right thing, jisttalittle..situation

came up...an' I tried to uhm.....well try to.....use what I--what I've learned here, see if it worked (p. 119).
 Cues: Tension: hesitation, self-interruption; uneven tempo; condensation and long silences, 3 and 4 seconds (p. 119).
 Expansion: Client: I am not sure I did the right thing, but I claim that I did what you say is right, or what may actually be right, when I asked my mother to help me by coming home after she had been away from home longer than she usually is, creating some small problems for me, and I tried to use the principle that I've learned from you here that I should express my needs and emotions to relevant others and see if this principle worked (p. 119).

The next stage is to identify the implicit propositions which "build the fabric of conversational interaction" (Labov & Fanshel, 1977, p. 51). The expansion of the text "provides a context for these propositions" (Labov & Fanshel, 1977, p. 51).

Propositions. Once the text is expanded, propositions are extricated. Labov and Fanshel (1977) define propositions as agreements between interactants of what is being talked about or recurrent communications which may be linked to specific social relationships, role definitions, or personal attributes. Propositions may either be local (i.e. specific to events being discussed) or general and may arise throughout the therapeutic sessions. They may be stated explicitly or referred to indirectly. The specific nature of therapy is that both client and therapist join together to make particular propositions explicit.

Labov and Fanshel (1977) identified a set of

propositions which include:

1. General therapeutic propositions relate to underlying therapeutic assumptions and processes. A proposition such as, "Clients should express their needs and emotions to significant others" is central for most therapeutic orientations and is often made explicit in therapy.

2. Psychological propositions characteristic of therapy involve asserting certain emotions. For example, "Kate feels frustrated."

3. Status propositions accent the roles and expectations of the participants' social life. For example, "Kate is in charge of the household." Statuses may carry a set of role obligations and criteria for adequate performance of the role.

4. Performance propositions criticize or support the activities in the role that a person's plays. For example, "Kate never helps out with the chores."

5. Constitutional propositions focus on particular characteristics of people. For example, "Kate is thoughtless."

The analyst cannot start the process of analyzing the discourse with an established set of propositions. The recurrent themes embedded in the particular discourse under investigation must be studied. Examining one sentence after another will not explicate what the speaker means. It is

only through an intense analysis of what was said before and after that will provide the external analyst with knowledge seemingly equivalent to that of the participants. Comprehending the point being made by the speaker requires that both the listener and the analyst gain some level of awareness of the underlying propositions used by the speaker.

The propositions Labov and Fanshel (1977) found in the example cited on page 77 include:

1. The client thinks she did the right thing as suggested by the therapist.
2. The therapist's suggestion was that the client express her needs and emotions to significant others.
3. The client requests that her mother come home.
4. The client questions whether the therapist's suggestion was appropriate.

Analysis of Interaction. The analysis of the interaction between speakers attempts to understand the way in which speakers use utterances to produce responses from each other. Labov and Fanshel (1977) define "interaction as action which affects (alters or maintains) the relations of the self and others in face-to-face communication" (p. 59). The goal is to understand what speakers are doing and what they mean when they interact in discourse. This analysis may rely on information from previous parts of the text and the analyst's knowledge of the context.

Labov and Fanshel (1977) consider that "actions are more important than utterances, since it is actions that have consequences and affect people's lives" (p. 59). Interaction may also be defined as what is meant by a particular statement. "The action is what is intended in that it expresses how the speaker meant to affect the listener, to move him [or her], to cause him [or her] to respond" (Labov & Fanshel, 1977, p. 59).

The interactional statement is a summary of the utterance stating the result of the analysis. Using the same example as in the previous section, the following illustration of an interaction is based on the work of Labov and Fanshel (1977):

Interaction:	[The client] initiates the session... by referring to the previous suggestion of the therapist and an incident from everyday life and asserting that she did right in carrying out [the therapist's suggestion]. She simultaneously expresses uncertainty about her assertion, ambiguously questioning that she carried out [the therapist's suggestion] correctly and questioning that [the therapist's suggestion] is appropriate, thereby challenging the competence of the therapist (p. 126).
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Rules of discourse. Labov and Fanshel (1977) state that the rules of discourse "bridge the gap between what is said and... the actions performed by those words" (p. 71). The rules these authors identified in their study include how speakers challenge each other, make requests for information, present narratives, and dispute assertions.

The discourse rules for the present study will be elucidated as they appear in the particular text analyzed. The discourse rules used in this study and their definitions are outlined in Appendix C.

Synthesis/Episode Summary

The cross sectional analysis suggested so far presents a static view of utterances, that is, a still picture of social interactions which allows for understanding and analyzing each utterance with the inclusion of assumptions and implications that preceded and followed. Labov and Fanshel (1977) state that the "primary interest must be in the coupling of one utterance with another, in the succession of cross sections, in the assembly of still frames into a moving picture" (p. 69). To accomplish the goal of connecting the cross sections in a matrix of action and response, a summary including the observations of the overall structure of the therapy episode and the general direction of the therapy session will be presented in this study. More specifically, the succession of interactional statements elucidated in the cross sections of the therapy episode will be synthesized and summarized. The subsequent step will be to identify and describe the mechanisms or themes that contribute to the therapist and clients co-constructing therapeutic change. The emphasis of the summary will be on describing how the therapeutic discourse flowed throughout the therapy episode and how the therapist

and clients co-created relational novelty using the symbolic externalization intervention.

The data analysis of the present investigation will utilize similar strategies as just presented. The format will consist of presenting the text transcription, the expanded text with the paralinguistic cues, nonverbal behaviors, and propositions, the interactional statement, and finally the episode summary.

Measuring Instruments

A variety of instruments were used to measure and describe both client behavior and change in relation to the alcohol dependency, intrapersonal and marital functioning, and the therapy process. Measures were first used for the purpose of screening participants to determine their appropriateness for the study. Other measures were then used to determine client changes during and after treatment. Client demographic information and the degree of alcohol dependence and marital problems were obtained through administering a series of questionnaires.

Questionnaires were completed at four different intervals to determine pretest, midtest, posttest, and follow-up measures. The results of these measures were used to determine the success of ExST marital treatment in this case study.

Alcohol Dependency Measures

1. Michigan Alcoholism Screening Test (MAST; Selzer, 1971)

This instrument is used to detect alcoholism and was used as a screening device in the present study for the purpose of including alcohol dependent participants. Respondents answer yes or no to the 25-item questionnaire and those who score 5 or more are considered to have alcohol dependent problems. Skinner and Sheu (1982) report test-retest reliability of .84.

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

This 39-item measure is used to determine the level of alcohol dependency, ranging from mild, moderate to severe dependence. The frequency of an event or situation is identified on 4-point Likert-type scale ranging from "Never" occurs to "Nearly Always" occurs. In this study, the ADDQ was used at pretest, posttest, and follow-up.

3. Drinking Pattern Assessment Scale (DPAS)

This 19-item self-report questionnaire was designed specifically for the research project. It was administered only at the pre-treatment period in this study to assess the participants' alcohol consumption pattern and consequences of alcohol consumption.

4. Alcohol Dependence and Treatment History (ADTH)

This measure was designed specifically for the research project to gather information about the history of the alcohol dependence and subsequent treatment. The 17 items of the ADDQ are comprised of questions relating to when the

drinking began, periods of abstinence, alcohol treatment received, goals for treatment of alcohol, and family of origin alcohol problems. This measure was administered only to the male alcoholic.

Intrapersonal Measures

1. Shipley Institute of Living Scale (SILS; Zachary, 1986)

The SILS is used as a screening device designed to measure the level of intellectual functioning and to assist in discovering cognitive impairment. The revised normative sample of the SILS consists of 290 psychiatric patients, including an even distribution of males and females, with a mean age of 34.9 years (Zachary, 1986). The author reports that the SILS has construct and criterion-related validity as well as reliabilities ranging from .60 to .82 for the Total score (test-retest) and .92 (internal consistency) indicate temporal stability and internal consistency. Both the Vocabulary and Abstraction subtests were administered at screening to determine whether the participants had the verbal and abstract skills required to complete the pretest, midtest, posttest, and follow-up questionnaires.

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

The SCL-90-R is a 90-item self-report symptom inventory designed to identify psychological symptom patterns of psychiatric and medical patients (Derogatis, 1983). Items are rated on a 5-point scale of distress. Reliability coefficients ranging from .77 to .90 (internal consistency)

and .80 to .90 (test-retest) as well as evidence of content, concurrent, and construct validity were reported by the author. The SCLS-90-R is able to provide information about 9 primary symptoms and indices of distress on three levels; global, dimensional, and discrete symptom. Derogatis (1983) recommends that when a single global measure of distress is needed the Global Severity Index (GSI) should be used because it represents the best single measure for identifying the current number of symptoms and the level of distress experienced. The GSI was used in this study for the purpose of identifying psychiatric symptomatology. The SCL-90-R was administered at screening, posttest, and follow-up.

3. Beck Depression Inventory (BDI; Beck & Steer, 1987)

The BDI is a 21 item inventory designed to assess the severity of depression in adolescents and adults. The items are rated on a 4-point scale, ranging from 0 to 3. Beck, Steer, and Garbin (1988) report that the BDI has high internal consistency ranging from .73 to .92 (coefficient alpha) and test-retest reliability ranging from .60 to .90 with 15 nonpsychiatric samples. These authors also found that the BDI has high concurrent, construct, and discriminant validity. The BDI was used in this study at pretest, posttest, and follow-up periods to assess the participants' progress throughout therapy.

Marital Measure

1. Dyadic Adjustment Scale (DAS; Spanier, 1976)

This 32-item self-report questionnaire is an extensively used summary measure of marital adjustment. Spanier (1976) reports that the DAS has both high reliability ($r=.96$, Cronbach's coefficient alpha) and validity (content, criterion-related, and construct validity). Most items are rated on a 5- or 6-point Likert-type scale indicating the amount of agreement or frequency of a situation. The norms for married and divorced couples have mean total couple scores of 114.8 (S.D. 17.8) and 70.7 (S.D. 23.8) respectively (Spanier, 1976). In this study, the total scale score of the DAS was used as a screening measure as well as a measure of outcome at post treatment and follow-up.

Therapy Measures

1. Post Session Review (PSR)

The PSR, created for the research project, is comprised of seven items relating to the process of change in therapy and is completed at the end of each session by both client and therapist. Respondents rate their agreement or disagreement, on a 7-point Likert-type scale, to items pertaining to the following; changes made both within the session and in personal relationships, and degree of openness and awareness with respect to feelings and thoughts and how they connect to the problem. The last two items of

this instrument require short answers describing the most significant part of the session and giving a title the session.

2. Post Therapy Evaluation Form (PTEF)

The PTEF is a 9-item measure designed specifically for the research project to assess the effectiveness of the therapy and was completed at the conclusion of therapy by both clients and therapist.

3. Weekly Situation Diary (WSD)

The WSD was also designed for the research project and was completed by both the husband and wife at the end of each week. The WSD consists of the following five sections. Part One pertains to changes made, level of satisfaction, and level of closeness in relation to self and others. Part Two is concerned with specific activities such as alcohol consumption and attendance of support groups, for example. Part Three, for the alcoholic, is a record of the amount and type of alcohol consumption. Part Four is also only completed by the alcoholic and the type and quantity of drugs taken are recorded. Again the non-alcoholic spouse does not complete this form. Part Five of the alcoholic's form is the same as the non-alcoholic spouse's Part Three form. This section is optional and any additional information can be listed.

Summary

This chapter provided an overview of the approach used

in the present study to analyze the therapeutic discourse. A description of the research design, the procedures involving participant selection, how the transcript data was collected, and determination of the unit of analysis, the data analysis strategy, and the measuring instruments used in this investigation were also provided. The following chapter will present the results of the screening and outcome measures and the analysis of the therapy discourse in which the symbolic externalization intervention was used.

CHAPTER IV

RESULTS AND DATA ANALYSIS

In this chapter both the results of the preliminary analyses and the discourse analysis of a therapy episode in which the symbolic externalization intervention are presented. The first section consists of the preliminary analyses and results of the screening and outcome measures that were used to determine a successful case of ExST marital treatment. The analysis of the therapeutic discourse will begin with a brief introduction to the case. This is followed by a description of how the analysis is presented, the analysis of the conversation within the therapy session and the summary of the analysis.

Preliminary Analyses and Findings

Screening Measures

Alcohol Measures

1. Michigan Alcoholism Screening Test (MAST; Selzer, 1971)

The criterion level for identifying respondents with alcohol abuse problems is a score of 5 or more points on the MAST. The female participant in this study scored a total of 2 points placing her in the non-alcoholic range. The male participant's score of 21 on this measure placed him in the alcoholic range.

2. Alcohol Dependence and Treatment History (ADTH)

This measure was designed specifically for the research

project to gather information about the history of the alcohol dependence and treatment. The male participant in this study identified himself as being alcohol dependent who thought he could stop drinking with assistance. He had stopped drinking alcohol several times in the past due to marital and financial problems and the challenge to overcome his dependency. Since becoming a regular drinker, a 24-hour period has been the longest abstention time. A few months prior to participating in this study he had quit drinking alcohol. The male participant's goal for treatment of his alcohol problem was to stop drinking completely. He was willing to undertake both individual and marital therapy.

3. Drinking Pattern Assessment Scale (DPAS)

This self-report instrument was used to attain a descriptive assessment of the husband's pattern of drinking. The husband identified that drinking alcohol had been a problem for more than 6 years with him stopping and starting drinking 4 to 6 times during this time. In the last year, he drank 7-12 beers and a half bottle of wine on a typical drinking day. Once the drinking started he frequently continued until intoxicated. He tended to drink in bars with friends, but rarely drank alone or with his spouse. Work related problems due to the drinking were rare. Other problems related to his drinking included verbal fighting with spouse, relatives, and others and driving while intoxicated. He had not caused physical harm to himself or

others.

Intrapersonal Measures

1. Shipley Institute of Living Scale (SILS; Zachary, 1986)

Both the Vocabulary and Abstraction subtests of the SILS were administered at the initial screening period to determine whether the participants had the verbal and abstract skills required to complete the pretest, midtest, posttest, and follow-up questionnaires. The overall summary score for the raw scores of both the vocabulary and abstraction subtests were converted to normalized T-scores. The male participant's summary score of 62T placed him in the above average range. The female participant had a 60T-score which placed her in the high average range. Both participants scored high on the Vocabulary (57T-score) and Abstraction (male 63T-score and female 60T-score) subtests which indicates that they had good vocabulary skills and high abstract reasoning skills, resulting in them being included in the study.

Marital Measure

1. Dyadic Adjustment Scale (DAS; Spanier, 1976)

The DAS was completed at screening to determine whether the couple met the criteria of experiencing marital problems. At screening, the DAS total couple score for the husband was 96 and the wife scored 79. These scores were below one S.D. of the mean (114.8) for married couples which would indicate marital distress.

Outcome Measures

Alcohol Measure

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

The ADDQ was administered at pre-treatment, post-treatment, and follow-up to assess the severity of alcohol dependency. The findings are graphically displayed in Figure 1. At pretest the husband's score of 62 indicated severe alcohol dependency. The posttest score of 5 fell within the mild dependency range. However, at follow-up the husband scored 0 indicating no alcohol dependency. These findings suggest that the marital therapy was successful in decreasing the husband's alcohol dependency. That is, the outcome of ExST marital treatment was successful.

Intrapersonal Measures

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

The Global Severity Index (GSI) raw scores were referred to gender-appropriate norms (e.g. non-patient) and converted to standard T-scores. The normative sample is comprised of 478 non-patient females and 482 non-patient males. The participants' scores are graphically presented in Figure 2. The results show that the T-scores for the wife fall consistently within the mean range throughout screening, posttest and follow-up periods. This indicates a normal (moderate) level of psychological distress and symptomatology. However, the husband's T-scores show a

Figure 1. Alcohol Dependency Data Questionnaire Scores

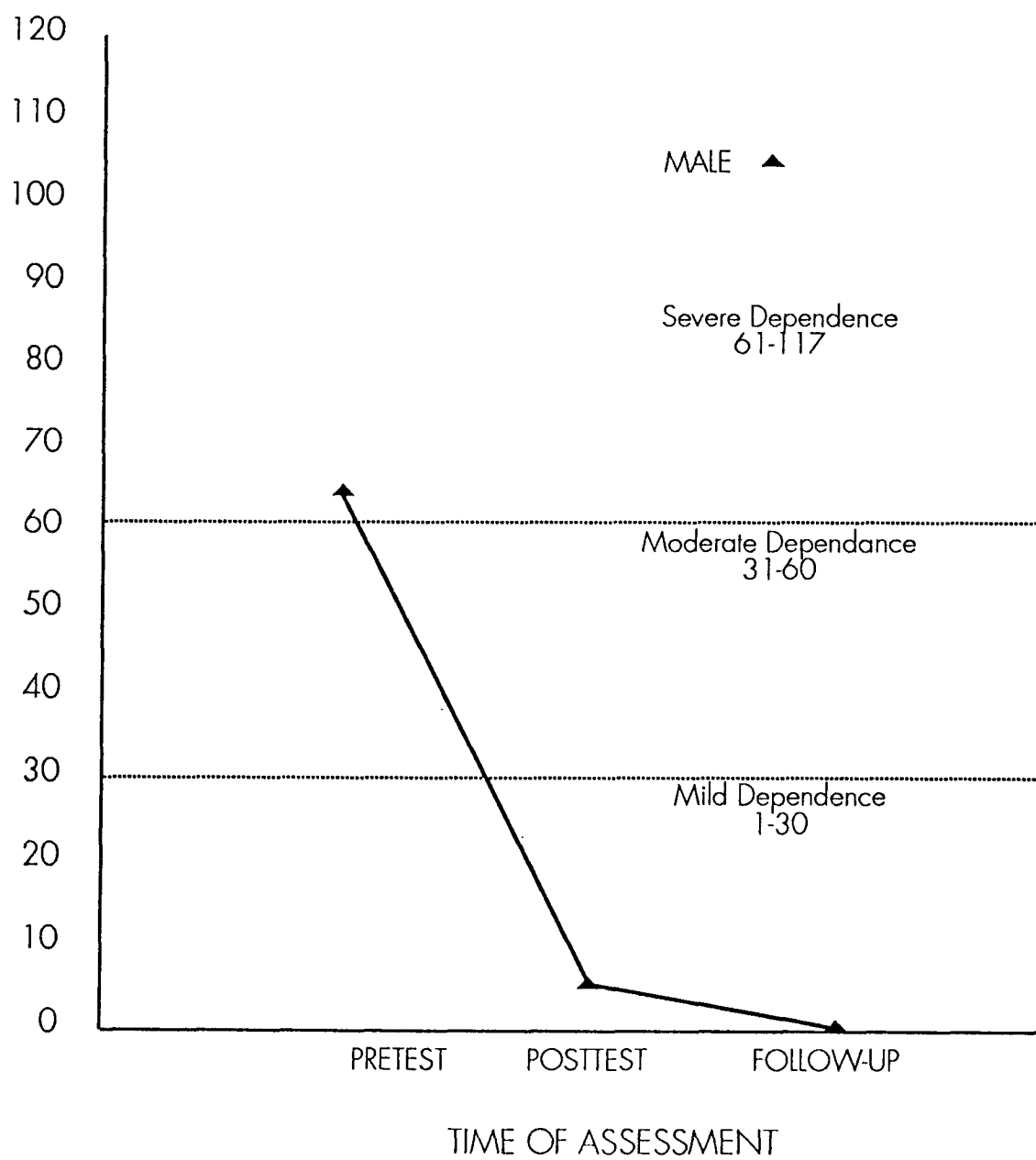
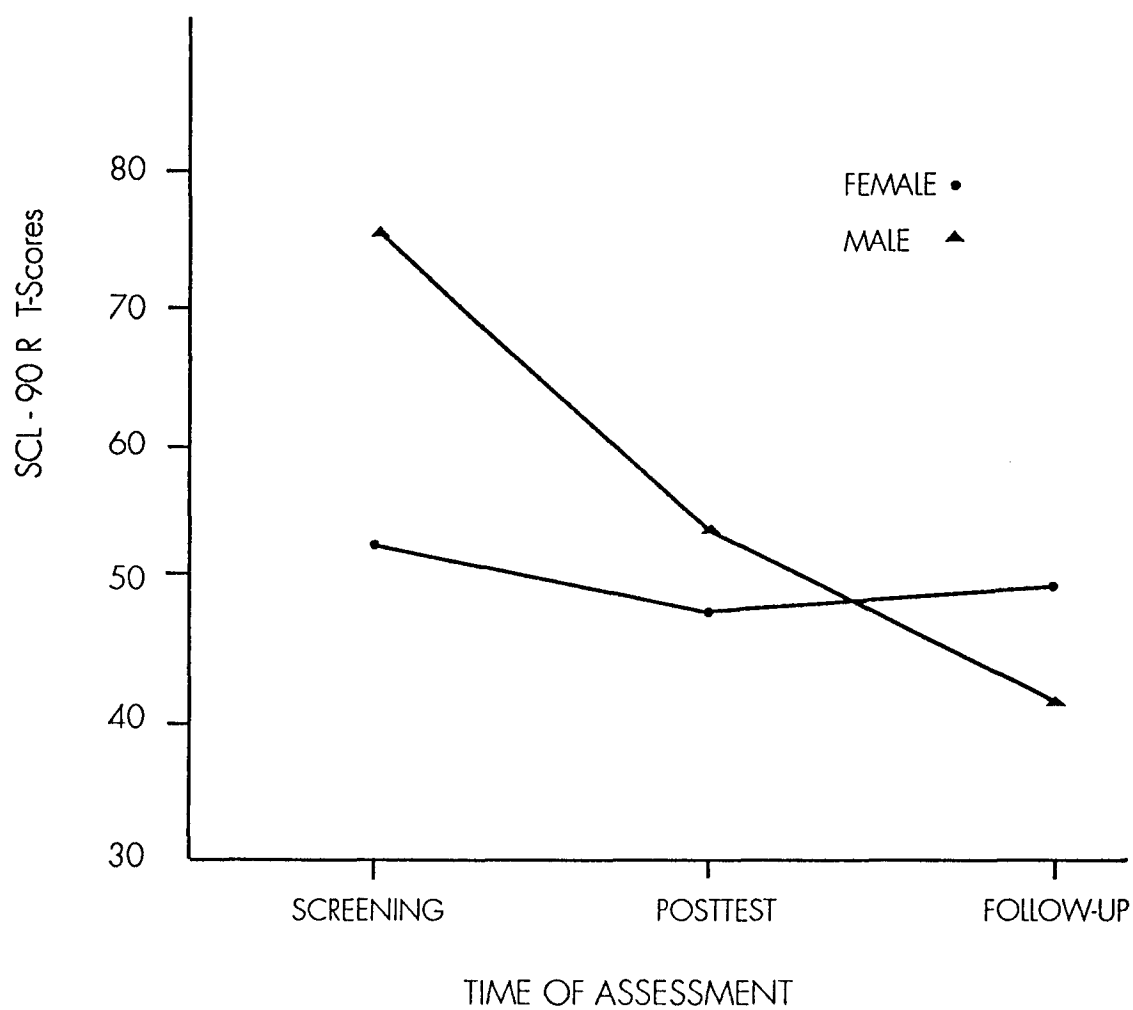


Figure 2. Global Severity Index Scores on the SCL-90R



dramatic decrease in the GSI from the screening period to posttest and follow-up where his scores fall below the mean range of the normative sample. This finding suggests that prior to treatment he experienced a high level of symptomatic distress which then decreased, revealing little evidence of psychological distress at the end of treatment.

2. Beck Depression Inventory (BDI; Beck & Steer, 1987)

The BDI was administered at pretest, posttest and follow-up to assess the severity of depression throughout the course of therapy. The findings are graphically displayed in Figure 3. At pretest the wife's score indicated mild-moderate depression and at both posttest and follow-up she scored within the normal or asymptomatic range. The husband, on the other hand, indicated moderate-severe depression at pretest but at posttest and follow-up he also scored within the normal range.

Marital Measure

1. Dyadic Adjustment Scale (DAS; Spanier, 1976)

The DAS was used as a screening and pre-treatment measure and as a measure of outcome at termination and follow-up. The findings are graphically displayed in Figure 4. As stated earlier, both spouse's scores at screening indicated marital distress. The total couple scores at posttest for both the husband (114) and wife (112) were within one S.D. of the mean (114.8) for married couples. This pattern was continued at follow-up at which time the

Figure 3. Beck Depression Inventory Total Scores

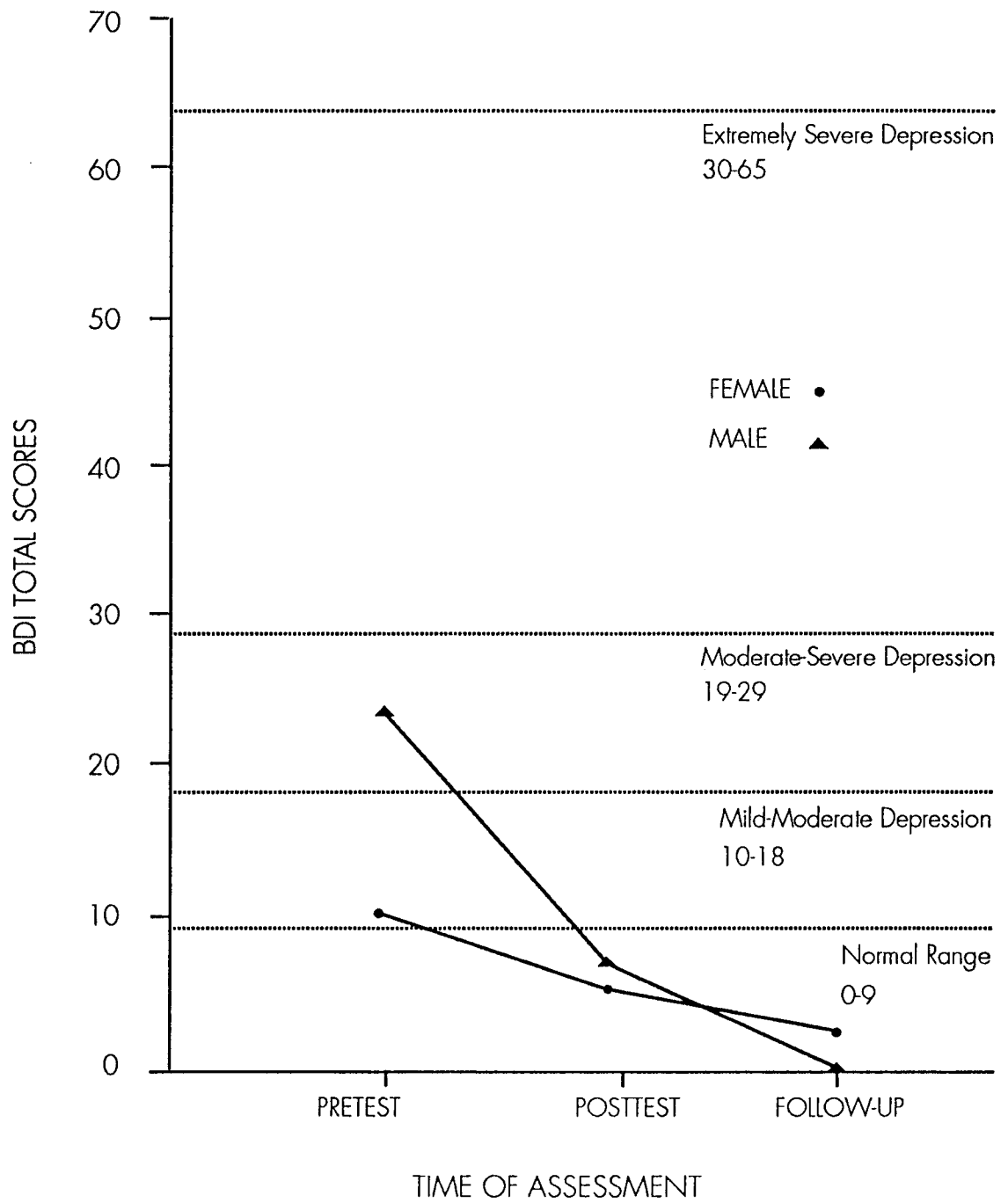
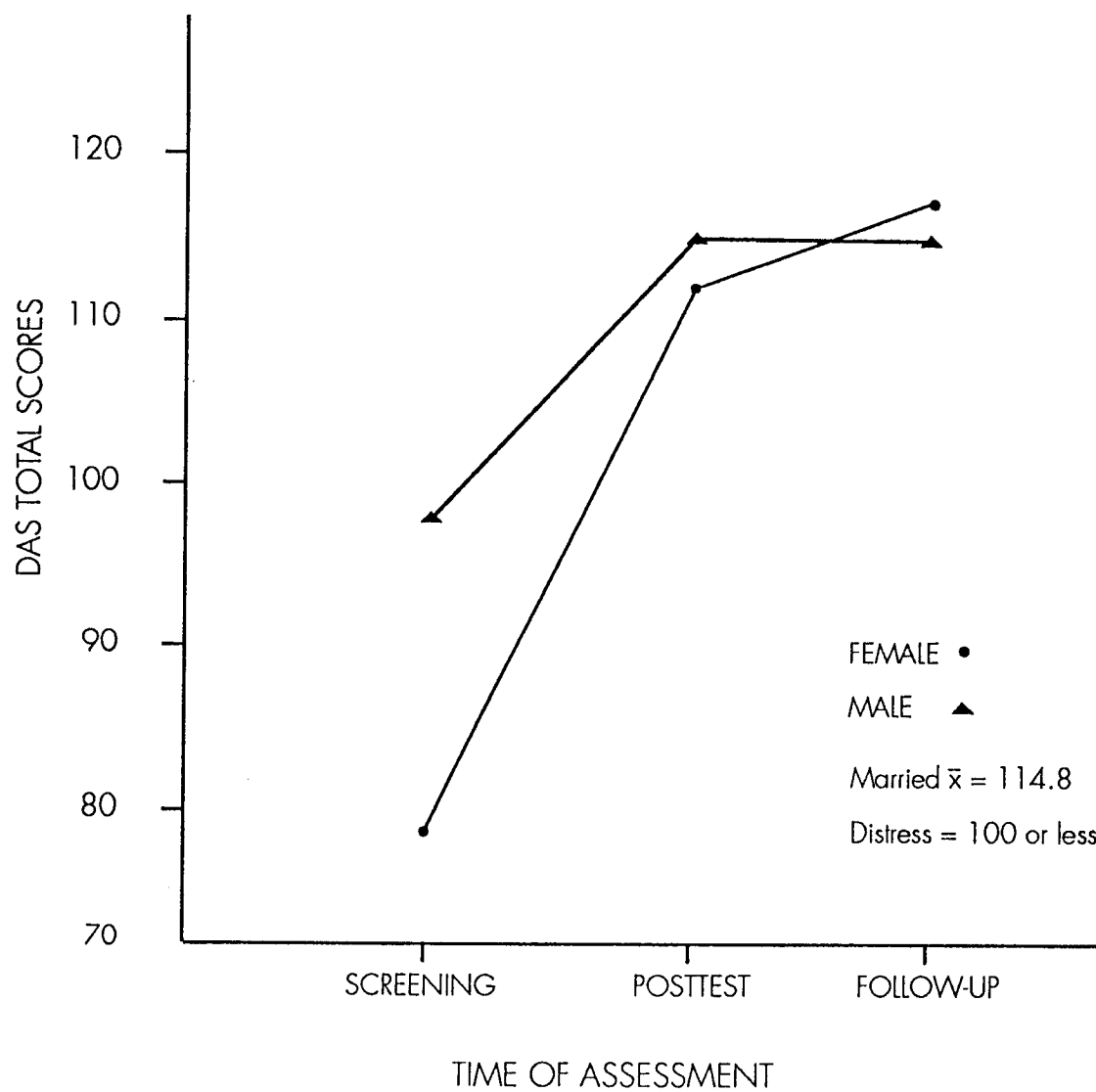


Figure 4. Dyadic Adjustment Scale Scores



husband scored 113 and the wife scored 115. The increase in total scores at posttest and follow-up intervals suggests that there was much less marital distress experienced by both the husband and wife leading to the conclusion that the outcome of ExST marital treatment was successful.

Therapy Measures

1. Post Session Review (PSR)

After each of the 15 therapy sessions both the clients and therapist completed the PSR to aid in assessing dimensions related to the process of change in therapy. The findings for both the wife and husband were generally consistent with minor variations in scores. For instance, the wife's scores tended to fall more in the "completely agree" or "strongly agree" categories while the husband's score were generally more in either the "strongly agree" or "agree" categories. The wife indicated that in 12 of the 15 sessions she strongly agreed that she had made some valuable changes in that particular session. The husband agreed that he had made some valuable change in 12 of the sessions. In relation to their level of openness with feelings and thoughts in the sessions, the wife either agreed strongly or completely to being open in all 15 sessions. The husband responded that he strongly agreed that he was open with his feelings and thoughts in all the sessions. The wife also completely or strongly agreed, in all 15 sessions, that she was more aware of how her usual ways of feeling, thinking,

or behaving were connected to the presenting problem. The husband, in turn, agreed that he had become more aware of how his usual ways of feeling, thinking, or behaving were connected to the presenting problem. Both the wife and husband agreed that each session helped them to make significant changes in their personal relationships as well as helped them to deal more effectively with the problem in their everyday life.

The therapist's rating of each of the sessions tended to be slightly lower than both clients' scores. In two-thirds of the sessions (10 out of 15), the therapist agreed that the husband was making some valuable change in the session. The therapist, however, agreed that the wife made some valuable change in 87 percent of the sessions (13 out of 15 sessions). In most of the sessions, the therapist perceived both husband and wife as being open with their feelings and thoughts as well as becoming aware of how their usual patterns of feeling, thinking, or behaving were connected to the problem. Additionally, the therapist indicated that most sessions helped both clients make significant changes in their personal relationships as well as helped them 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 the clients and the therapist.

2. Post Therapy Evaluation Form (PTEF)

To evaluate the effectiveness of the therapy both clients and therapist completed the PTEF. The scores were generally quite consistent between both the clients and the therapist.

Both the husband and wife were "very satisfied" with the therapy received and described their present condition as "excellent". The wife responded that overall she had changed somewhat for the better since therapy began and attributed this change to the therapy. The husband's response was stronger; claiming that he was "much better" since therapy began and that this change was "definitely related" to the therapy. Both partners strongly agreed that the therapy was particularly helpful to them individually as well as to their marriage. There was slight to moderate agreement that the therapy was helpful to their family. They both disagreed that aspects of the therapy were harmful to them. Both were interested in pursuing further therapy sessions in the near future.

The therapist was also "very satisfied" with the therapy the clients received. She described the clients' present condition as "very good" and that their overall change for the better, since beginning therapy, was "definitely related" to the therapy received. She strongly agreed that the therapy was particularly helpful to them individually as well as helpful with respect to their

marriage and immediate family. She strongly disagreed that aspects of the therapy were harmful to the clients. She indicated that the clients would benefit from further therapy sessions in future.

These consistent findings indicate that the therapy was perceived by both the clients and therapist as effective, highly satisfactory, and helpful in creating change.

3. Weekly Situation Diary (WSD)

On a weekly basis, the clients were requested to rate whether they experienced change with respect to self, marriage, family, friendships and work as being worse or better in the past week. In the first 6 weeks of therapy the wife rated her marriage as changing "somewhat better". In relation to herself, the wife indicated that she "somewhat worsened" in weeks 6, 12, 13, and 15. Apart from these scores, the wife generally rated "no change". The husband, on the other hand, identified more changes for the better in relation to self, family, and to the marriage. The change in his work was "somewhat better", but often there was "no change" in either his work or friendships.

In regards to the wife's level of satisfaction of herself, her marriage, friendships, and work she generally rated all these categories over the course of therapy as ranging from "somewhat satisfied" to "extremely satisfied". In other words, she was generally satisfied with her life. However, the husband's satisfaction scores in these same

categories were lower, ranging typically from "somewhat dissatisfied" to "somewhat satisfied".

Each week participants were requested to rate how close their marriage, self, family, friendships, and work came to their ideal on a scale of 0 to 10, with 10 being ideal. During the course of the therapy the wife rated her marriage as ranging from 6 to 9, family ranging from 8 to 10, friendships ranging from 7 to 9, work ranging from 5 to 8, and herself ranging from 5 to 9. Her family ideal score remained fairly consistent at score 9 and as well, her friendships tended to be scored at either 7 or 8. The husband's ideal scores were considerably lower, ranging from 1 to 6. The work category was the lowest for him and the scores often fell between 3 and 4. Both his family and marriage scores typically ranged from 4 to 6 while self scores generally ranged between 4 and 5.

Part Two indicated that the husband did not consume any alcohol during the course of therapy suggesting that the therapy was successful in decreasing alcohol dependence. He did not partake in any support group meeting during the course of therapy.

Data Analysis

The Therapy Case

The therapy case began when Sam Laney made a telephone call to the research project office. Both Sam and his wife, Jill Laney, were invited to complete screening measures to

determine their appropriateness for the study. Once this was assessed, the couple was contacted by the therapist and a therapy session was scheduled for the following week in which the clients' goals for therapy were explored.

Fifteen therapy sessions were conducted over a 17-week period. The conclusion of the therapy case was successful; Sam had abstained from drinking alcohol, their therapeutic goals had been achieved, and their marital relationship improved.

Context

It is important to contextualize the utterances and actions of all three members of the therapeutic subsystem in the therapy episode before proceeding with the analysis. The therapist, for instance, was recently trained in the ExST model to be used in a large programmatic research initiative combining both outcome and process research methodologies. In outcome studies there is often a tendency for the therapists involved to take a great deal of responsibility for efficacious outcome of the research which may lead to nervousness and hesitancy (Newman, personal communication, 1992). Hesitancy may also be exacerbated by this being one of the therapist's first ExST cases of the larger research study. Furthermore, the session studied, was only the second session of this therapy case which may result in the therapist exercising clinical judgement in regards to matching the intensity level of the session

number with the clients' comfort level. The expectation of the therapist was to also adhere to the principles of the ExST model in conducting the therapy. According to the ExST model, the first phase of the therapeutic story is the forming of the therapeutic system which requires establishing a bond between the therapist and clients, assessment of the current problem, and to develop and commit to the goals, that is, the therapeutic mandate of the therapy.

Sam stated in the first therapy session his goal was to abstain from drinking forever. He had quit drinking more than 5 times, but each time he resumed. The on-off again pattern of drinking resulted in self-doubt and feeling scared that he could not permanently quit drinking. Sam asserted at the outset of the therapy that he should be in charge and in control of quitting drinking and handling alcohol related concerns in his own way, otherwise, he and others (Jill and therapist) would perceive him as being weak and a failure for not being competent and effective in dealing with his battle with alcohol. He also interpreted attending therapy and seeking help with his alcohol dependence as indicative of him being weak and a failure for not quitting drinking on his own. Subsequently, Sam's focus in the therapy was to attempt to lessen his feeling of being weak, worthless, and a failure.

Jill's agenda for the therapy was also for Sam to quit

drinking and to take responsibility for alcohol related decisions. She was concerned and fearful about interfering with alcohol related issues because Sam could become defensive and be mean toward her, which she wanted to avoid.

Arrangement of the Analysis

The segment of therapeutic discourse analyzed in this study consists of the 15-minute therapy episode in which the problem of alcohol dependency was symbolically externalized. The intervention was introduced in the beginning of the second therapy session after the therapist summarized the couple's understanding gained in the previous session about their experience with alcohol and how alcohol had affected their marital relationship. She then began the process of establishing the therapeutic mandate by reiterating Sam's goal of wanting to permanently quit drinking alcohol and stating that alcohol is a relational experience which has affected them individually as well as affected their marital relationship. The therapy episode analyzed was chosen because it was the beginning of a new topic of conversation (Labov & Fanshel, 1977) that led to the implementation of the ExST symbolic externalization intervention and subsequently, co-creating relational novelty.

The analysis of the therapy episode is arranged according to the conditions set in the previous chapter. Each speech turn will result in a cross-sectional analysis and will begin with the original text, including non-verbal

behavior and paralinguistic cues, then the expansion and interaction. After the entire speech turns in this episode have been analyzed, an episode summary describing how relational novelty was co-created by the therapist and clients will follow. When not obvious inferences are made in the expansion an explanations will be provided. The propositions will be embedded within each of the text expansions and will only be introduced and explained when they first appear in the therapy episode. The propositions are enclosed in parenthesis in both the text expansion and interaction sections. A complete list of the propositions identified in the episode is in Appendix B. A description and definition of the discourse rules used in the interactional statements is in Appendix C.

Analysis of Therapy Episode: Getting Rid of Alcohol

Text

1 Th: So it will be interesting to know if-if you want to
 2 continue that talking that you began last week. ((hand
 3 gestures)) You shared.. ah some feelings and ah you
 4 did too. (Sam: Yeah) You also let me know that fear
 5 was in the room. (hhh) A:nd I appreciate knowing that
 6 and I know that fear is here (Sam: Yeah xxx) and it-it
 7 is very important to acknowledge it (hhh) and fear will
 8 ((hand gestures)) continue to be here from time to time
 9 and I appreciate that even ((sharp gesturing with
 10 clenched fist)) when fear is here you can be ((leans
 11 slightly forward; gestures with fist)) here (Sam: Yeah)
 12 and that means to me that ah ((Sam rubs neck)) you're
 13 willing.. to cope ((open hand gesturing)) with change
 14 while you're here. (Sam: Yeah) That you stay here.
 15 [xxx]

Expansion

Th: Last week in our therapy session you both began the process of disclosing feelings, not previously spoken,

to one another {S-Share}. I am wondering whether you are willing to continue sharing more feelings in today's therapy session {S-Express}. Jill, last week you disclosed some feelings of fear {E1-J} and anger {E2-J} in relation to how alcohol has affected you, your family, and your relationship with Sam which you have never verbally stated to Sam in the past. Sam, you also disclosed feelings such as fear, worry, and apprehension {E1-S}. In our last session, Sam, you talked about feeling fear and apprehension {E1-S} that you will again fail in your goal to quit drinking alcohol {~2} and that your commitment to your goal to quit drinking alcohol forever {1} will wane resulting in you resuming your repetitive pattern of quitting drinking for a while and then starting drinking again. You stated feeling fearful {E1-S} that the alcohol will kill you if you continue drinking. You also talked about knowing that when you do not drink you are much more aware of your feelings and this feels scary to you {E1-S} and thus, this is one reason why you like a lot of stimulation, things going on, and challenges. Jill, you also talked last session about feelings of fear {E1-J} you have felt in the past regarding Sam's drinking getting worse and fear {E1-J} of knowing what lies ahead in the future when Sam drinks. You also said that you are bothered by the patterns repeating themselves and cannot endure the repetitive pattern continuing anymore. I appreciate being informed about your feelings of fear {S-Express} because this information helps me to understand what you are currently experiencing which is part of the therapeutic process and my task as a therapist. I want you to know that I am aware of and understand that you are both experiencing fear {Convey} presently in this session. Acknowledging feelings of fear as they emerge within you is an important therapeutic process {S-Express}. Part of the therapeutic process is to become aware of feelings such as fear and to then directly express the feelings {S-Express}. During the course of the therapy you will feel fear from time to time because there are some painful issues from your past that you have not addressed due to your emotional growth being stopped when you started drinking. Considering the disasters you experienced in relation to alcohol, there will be painful experiences which may feel scary to talk about and this is normal {Convey}. I appreciate and am aware that even when such a strong emotion as fear is felt within yourself Sam {E1-S}, you can allow yourself to stay present with this feeling and directly experience the feeling in the here and now {A-Feeling}. By being able to experience the fear, I interpret this to mean that you are expressing a willingness to cope with and

make changes {3} while in therapy. Your staying here in therapy even when you feel fear informs me of your commitment to make change within yourself, your relationship with Jill, and with alcohol {3}.

Expanding the text. In this particular speech segment, as in most of the other therapist's utterances in this episode, the therapist uses gestures to support her verbal message. For example, the therapist uses clenched fist to accent how difficult it is for Sam to stay present when he experiences intense emotions. When contrastive stress is used, as was done by the therapist, this "forces us to locate the implicit proposition that is being used as a point of contrast" (Labov & Fanshel, 1977, p. 117). For instance, the stress placed on the words "be here", which is a euphemism for being present in the here and now, can be contrasted with dissociating from what is actually occurring in the here and now.

The expansion included referring back to session one to understand what feelings and information each spouse had disclosed to one another and what the therapist had said. The original text in session one was condensed and included in this segment. The following discussion will delineate the propositions revealed.

Propositions. A recurrent theme of this entire episode is; {S-Express} In therapy clients should express their feelings. This general proposition is considered to be a fundamental assumption underlying most individual and family psychotherapy theories and approaches and is often made

explicit in therapy. Another general proposition pertinent to family systemic therapy is; {S-Share} Spouses should share feelings and needs with one another.

An essential theme for the ExST model is that "change occurs through increasing the client's awareness of their present condition" (Friesen et al., 1989, p. 3) which then suggests that clients must develop awareness of their feelings, cognitions, physical sensations, and behavior. The proposition reflecting this theme is stated as; {Awareness} Clients should develop awareness of their emotions, cognitions, bodily sensations, and behavior. For the purpose of the present study, this general proposition is broken down into more specific propositions for each of the dimensions of emotions, behavior, cognition, and bodily sensations. For instance, the assertion in therapy is that clients should become aware of feelings they experience. That is, if a client feels angry then he or she should be aware of it. A goal of therapy would then be to develop this awareness. The proposition is stated as; {E} Client feels an emotion.

The therapy episode revealed that there were specific emotions experienced by both Sam and Jill and they are delineated as;

{E1-S} Sam feels fear and/or apprehension. {E1-J} Jill feels fear and/or apprehension.

{E2-S} Sam feels anger. {E2-J} Jill feels anger.

{E4-S} or {E4-J} Sam or Jill feel relaxed, calm and easier.

{E5-S} Sam feels tentative, anxious and unsure.

{E6-S} Sam feels less apprehension.

Another underlying assumption of the ExST model is that the therapeutic process involves the clients becoming aware of feelings and then experiencing these feelings in the here and now (Friesen et al., 1989). The proposition relates to the dimension of therapeutic experiencing and is stated as; {A-Feeling} Therapeutic process involves becoming aware of feelings and experiencing them in the here and now.

Another related dimension in ExST is that clients are to become aware of bodily sensations and to directly experience them in the here and now. The proposition is; {A-Bodily} Therapeutic process involves becoming aware of bodily sensations and experiencing them in the here and now.

Furthermore, clients are to become aware of their cognitions in ExST and thus, the proposition is; {A-Cognitions} Therapeutic process involves becoming aware of cognitions and experiencing them in the here and now.

The proposition relating to developing awareness to behaviors reads as; {A-Behavior} Therapeutic process involves becoming aware of behaviors and experiencing them in the here and now.

Other propositions underlying the ExST model are as follows:

{Here} ExST focuses on the here and now experiences.

{Mandate} A therapeutic mandate must be established in ExST.

{Experience} Heightening and intensifying experiences is important to aid in gaining awareness of internal process and to create change.

{Novelty} Direct experiencing in therapy deepens and expands alternate ways of being, that is, relational novelty.

{Safety} Pacing the therapeutic work is important.

{Split} A conflict/contradiction is brought to clients' awareness.

Other psychological propositions involve the therapist's role and her tasks as a therapist. The therapist is required by most theoretical orientations to convey understanding of clients' feelings and experiences and to normalize the therapeutic process for clients. The proposition is stated as; {Convey} Therapist conveys understanding of clients' feelings and experiences.

A method that the therapist uses to aid in establishing safety and acceptance of the clients' experiences in the therapeutic relationship is tracking. Tracking can lead to exploration of new ways of being in relationship to oneself and others. Tracking is utilized by most schools of psychotherapy to "discover explicitly and in detail a specific pattern of behavior, thought, or feeling in its systemic context" (Sherman & Fredman, 1986, p. 120). The therapist follows the clients' experiences by noting and highlighting their experience, asking clarifying questions,

encouraging further talk, repetition of client's words, and invoking amplification of a point (Minuchin, 1974). This method is a non-intrusive approach and one in which the therapist does not challenge what the client has said. The proposition is stated as; {T-Track} The therapist notes and highlights clients' experiences.

In most therapeutic orientations the therapist highlights both clients' strengths and difficulties. The proposition is stated as; {T-Highlight} Therapist highlights clients' strengths as well as difficulties.

The general underlying premise of marital and family systemic therapy is that the therapist recognizes the commonalities between the spouses and family members. For instance, both spouses may have in common their desire to be rid of the alcohol dependence problem and may argue with each other about it, rather than acknowledging their common goal. This proposition reads as; {T-Common} Therapist accents couple commonalities.

A proposition, related to the general proposition {Safety}, emerges in this therapy session in regards to the role of the therapist. The therapist is respectful of the clients' therapeutic process and does not intrude when the subject matter results in intense emotions and experiences. The proposition is stated as; {Non-Intrusive} Therapist does not intrude upon clients when intense experiences emerge.

The recurrent theme that emerges in the course of this

episode, and in the therapy as a whole, is that Sam's goal is to quit drinking alcohol forever. He explicitly stated this goal in session one. The proposition reads as; {1} Sam's goal is to quit drinking alcohol forever.

A related proposition, which is repeatedly expressed as well as challenged in this episode, is that Sam deals with his alcohol dependence in a competent and effective way. The proposition is stated as; {2} Sam is competent and effective in dealing with alcohol. However, Sam also expresses feeling weak, worthless and a failure in how he deals with alcohol. He fears he will fail in his goal to quit drinking alcohol forever. The local proposition is; {25} Sam feels weak, worthless, and a failure.

Sam stated both in session one and in this episode that he made the decision to commit to The Alcohol Recovery Project which signifies to him that he is committed, willing, and motivated to make changes in regards to his relationship with alcohol, his marriage and within himself. This local proposition is stated as; {3} Sam is motivated, willing, and committed to make changes.

In regards to general propositions related to alcohol dependence a few themes emerged. In ExST, client problems and symptoms such as alcohol dependence are considered to be a relational experience affecting all family members. The therapist introduced this explicit underlying assumption in the first session and again mentioned it in the beginning of

this session. The proposition reads as; {Relational} Alcohol dependence is a relational experience. A local proposition, related to this general proposition, that emerges in this therapy case is as follows; {16} Jill is, and should be, a part of Sam's alcohol recovery process.

Interaction

The therapist redirects the conversation to the topic of {S-Share} both clients disclosing feelings and needs not previously shared before. The therapist then uses the rule for indirect request, referring to the third precondition of rule of requests: The couple's willingness to carry out the action of {S-Express} sharing more feelings with each other (See Appendix C). She also refers to the time referent for indirect request which is, "in today's therapy session." The therapist uses an indirect request to assert {S-Express} both clients should express feelings in therapy. The therapist then continues speaking as she summarizes what {E-S;J} feelings both clients shared in the therapy session last week as well as the {Awareness} awareness that they both developed about their feelings, cognitions, and behaviors in relation to the alcohol. After presenting the events that occurred in last session, the therapist gives an evaluation of the importance of these events by asserting {S-Express} that expressing emotions is an important task performed in therapy. She continues speaking and asserts {Convey} her understanding that Sam may experience {E1-S}

feelings of fear. The therapist acknowledges the clients' feelings and normalizes both the feelings and the therapeutic process for the couple. She then interprets Sam's {A-Feeling} feeling and experiencing of fear {E1-S} in the therapy session as {3} his willingness and commitment to making therapeutic change and thereby {Highlight} highlights this as a strength. The therapist repeats part of the last statement which again emphasizes the importance of her interpretation. That is, by {A-Feeling} Sam feeling {E1-S} fear in the therapy session, he is demonstrating {3} his willingness to make change. Sam reinforces what the therapist says. The therapist's words become inaudible and Sam interrupts.

Text

16 Sam: [I enjoy challenge ((leans to the right)) so
17 its

Expansion

Sam: Your emphasis on my feelings of fear results in me feeling uncomfortable and hence, I rub my neck and shift position and interrupt you. I want to shift the focus from intense experiences and emotions, which results in me feeling not in control of my battle with alcohol {~8} and thus, feeling weak and a failure {25}, to feeling in control and strong. I will say that the reason I stay in therapy and experience my feelings of fear is because I perceive this to be a challenge for me. I will also tell you that I enjoy challenges because I believe that challenges help me to maintain my sobriety. As I explained to you both last week, I have a problem with experiencing dullness and I feel afraid that when I feel dull again I will drink. In previous periods of sobriety I have reverted back to drinking alcohol when I felt dull, no stimulation and my interests were not peaked. Considering that I know what I need to not drink, which is have my interests peaked, to feel stimulated, and be challenged, I can

save face and say that I am still in control of my battle with alcohol {8}. Thus, I do not expose my feelings of being weak and a failure {~25} as you talk about my fear and for being in therapy.

Expanding the text. Pro-forms which are "anaphoric elements that refer to unstated objects, facts, or propositions" (Labov & Fanshel, 1977, p. 117) were located and expanded. For instance, the reference to "its" clearly refers to the fear that Sam feels. This is determined by the topic of conversation of the previous utterance made by the therapist as well as the sentence that follows in which Sam says, "you know fear is a big challenge".

To understand and explicate what Sam's fear is about, it will be necessary to refer back to the first session. He stated in session one that his fear is that he will revert back to his repetitive on-off again drinking pattern. Since he has not been able to quit drinking permanently and be in control of alcohol, he renders himself weak and a failure. Overcoming the fear is a big challenge because he has not ever been able to quit drinking permanently. As well, he talked in session one about how he ended periods of sobriety because of feeling dull and lack of stimulation. He fears that he will feel bored and dull during this period of sobriety and resume his repetitive drinking pattern. The therapist concluded in session one that when Sam does not drink, he is much more aware of his feelings which is scary for him and hence, is one reason he wants much stimulation and challenges. That is, he feels dullness when he is less

stimulated which then results in him becoming aware of experiences he has not resolved.

Another recurring theme that exists throughout the duration of this therapy is that Sam thinks he should quit drinking on his own and that to seek help from either Jill or a therapist means that he is weak and a failure.

Propositions. The propositions identified include:

{5} Sam is challenged to keep the top on the bottle of alcohol.

{6} Sam's goal is to confront and handle his fear that he will revert back to his repetitive drinking pattern.

{7} Client tends to analyze and explain behavior.

{8} Sam is in charge and in control of his battle with alcohol.

Interaction

Sam interrupts the therapist and indirectly expresses feeling uncomfortable with the therapist's expression of intense emotions because it results in him feeling {~8} not in control of his battle with alcohol and hence, feeling {25} weak and a failure. Sam indirectly asserts that {8} he should be in control and in charge of quitting drinking on his own {17}. Since he feels he is {~8} not in control, he then {25} feels weak, worthless, and a failure. Sam then deflects from the intense emotions expressed by giving information as to the reason for staying in therapy and thereby regulates the intensity of his experiences in

therapy. To save face for feeling the fear, which results in him {~8} not feeling in control and in charge of quitting drinking on his own, and for attending therapy, Sam asserts that challenging himself, and not feeling dull, helps him to maintain his sobriety. Having this self-awareness helps him {8} re-gain control and {~25} not feel weak and a failure.

In his next utterance, Sam refers to the previous session when he says, "you know fear is a big challenge". He is reminding the therapist and Jill that the reason he stays in therapy is because of needing challenges to help him remain sober and that it was dullness in his life that was responsible for him resuming drinking. He asserts that {1} his goal is to quit drinking alcohol forever and what helps him to achieve this goal is being {5} challenged to keep the top on the bottle of alcohol.

Text

18 Th: Yeah I hear that

Interaction

Therapist provides reinforcement.

Text

19 Sam: you know fear is a big challenge (hhh)

Expansion

Since I have been able to save face by not feeling weak and a failure {~25}, this then allows me to concede that I feel fear {E1-S} about being able to keep the top on the bottle of alcohol {5}. Confronting and overcoming my fear that I will drink again and revert back to my repetitive drinking pattern {6} is a big challenge for me.

Interaction

Sam continues expressing that since he has saved face by demonstrating he is {8} in control of his battle with alcohol and thus {~25} does not feel weak and a failure, he can concede to feeling {E1-S} fear and doubt about not attaining his {~1} goal to quit drinking alcohol forever, and thereby he regulates the intensity of his experience. He simultaneously asserts another challenging goal, {6} which is to confront and handle his fear that he will revert back to his repetitive drinking pattern.

By using the discourse marker of "you know", which "represents an appeal for solidarity or support" (Labov & Fanshel, 1977, p. 185), Sam is reminding the therapist of and explaining the reason he stays in therapy. He is possibly recognizing that he is entering in an area of disputable statements and thus, wanting support from the therapist based on what he said last session.

Text

20 Th: Yeah. So you know something ((outward hand
21 gesturing)) about facing the fear that is in-in
22 challenge (Sam: hmhm) and you will feel challenged as
23 we move through this process (hhh)

Expansion

Th: Yes I heard you say last week that you like to be challenged, stimulated, and to have your interests peaked. You also said that confronting your fears {6} of not quitting drinking alcohol forever and of reverting back to your repetitive pattern of drinking alcohol in a therapeutic setting is a new experience as well as a scary challenge for you. When you do not drink alcohol you are more aware of your feelings which is scary and is one reason you like much stimulation

and challenge. You are wanting me to know that you have analyzed yourself {7-S} and thus, have gained some awareness {Awareness} about confronting your feelings of fear {E1-S} that are associated with taking on the challenge of staying sober and keeping the top on the alcohol bottle {5}. As well, I acknowledge that you want me to know that you have some control over what happens with you {8} and therefore you are {~25} not weak and a failure. One way you feel in control, Sam, {8} is by analyzing and telling me about your awareness. Having awareness of your behavior, thoughts, and emotions is one way you get control. Again, I want you to know that you will feel challenged and not dull as we go through the therapeutic process {Convey}.

Interaction

The therapist interrupts and acknowledges that she heard Sam's proposition; {6} that his goal is to confront his fears of reverting back to his repetitive drinking pattern. The therapist then interprets Sam's preceding response as being {7-S} analytical and acknowledges that he has performed the proposition {Awareness} of developing awareness of what challenges represent for him. She asserts that analyzing his experiences also serves to demonstrate that he is {8} in control over what happens to him regarding his quitting drinking and thereby asserts that he is {~25} not weak and a failure which simultaneously helps regulate the intensity of his experience. She then re-assures Sam that he will feel challenged during the therapeutic process and thereby asserting that he will not experience the dullness that he fears will result in him drinking again. Sam reinforces what the therapist says.

Text

24 Sam: (hhh) I just wish I could handle it better. (Th:
 25 ah ((nods yes))) you know that's I mean I:[((shakes
 26 head))

Expansion

Sam: Since you are allowing me to save face by not challenging my competence {~?2}, therapist, I will admit that I feel weak, worthless, and a failure {25} because of how I handle not being able to quit drinking alcohol forever {~2} and because I feel fearful that I cannot succeed in staying sober. I fear that I may possibly revert back to my repetitive on-off again drinking pattern making me incompetent in dealing with alcohol {~2}. I just wish that I could take charge and be in control {8} which would mean that I would handle my quitting drinking better. If I could better handle my fear about starting drinking again {6} then I would not feel weak, worthless, and a failure as I presently do {25}. I am beginning to feel uncomfortable about admitting what I just said and, so, I am wanting to explain and analyze what I meant. Analyzing will allow me to feel like I have control {8}.

Expanding the text. The pronoun "it" refers to Sam quitting drinking which is based on his preceding utterance as well as the reason why he is in therapy. The expansion includes information from session one at which time Sam described his fear of failing to quit drinking forever and reverting back to his on-off again drinking pattern. The self-interruption and shaking of his head accent him feeling weak, worthless and a failure for not quitting drinking.

Interaction

Sam indirectly asserts that the therapist's response helped him save face and {~25} not feel weak and a failure. Hence, he is willing to venture forth and concede to both {25} feeling weak and a failure for not {~2} being competent

in dealing effectively with his battle with alcohol and feeling fear about not {~1} achieving his goal to permanently quit drinking. He then gives a self-critical evaluation of his behavior regarding proposition {1}, which is his goal to permanently quit drinking alcohol, and thereby asserts he is not {~2} competent and effective in dealing with alcohol and thus, he feels {25} weak, worthless, and a failure. The therapist reinforces and supports Sam by nodding yes. Sam then expresses wanting {8} to control his quitting drinking and feelings of fear and reduce his {~25} feelings of being weak and a failure. He then expresses feeling uncomfortable and begins to gain {8} control by explaining and analyzing.

Text

27 Th: [So
28 ((reaches and gets note pad)) that may be something
29 that ah xxx xxx

Expansion

Th: So, based on what you are saying Sam, I identified another goal. This then brings us back to my original goal for today's session, which was to establish a therapeutic mandate {Mandate}. One therapy goal for you Sam may be to learn how to handle your fear of not quitting drinking alcohol forever and resuming your repetitive on-off again pattern in a better way {6}.

Expanding the text. To understand the meaning of "that" and "something" it is necessary to contextualize these pro-forms in the preceding and subsequent statements made by both Sam and the therapist. The therapist began the therapy session by saying she would like to establish a

therapeutic mandate (i.e. goals of therapy) in this session. The word "that" refers to Sam's last utterance in which he talked about wanting to better handle his quitting drinking as well as better handle his fear. Sam's fear of not quitting drinking is made explicit in this speech turn.

Interaction

The therapist interrupts Sam and re-directs the topic of the conversation back to her original task of the session which is {Mandate} establishing a therapeutic mandate. Focusing on establishing therapy goals rather than Sam's experience contributes to regulating the intensity of Sam's experience. The therapist asserts that another goal for Sam is to {6} handle his fear in a better way. Through the use of mitigating forms such as, "may be" the therapist permits the client to either agree or disagree.

Text

30 Sam: Very rarely have I shied away from things.
 31 Whether-I usually walk through the situation that I-I
 32 am aware of what to expect or how to.. you know address
 33 it.

Expansion

Sam: In continuing with my last statement, what I mean to say is that I am usually in charge and in control {8} and therefore, I am not {~25} weak, worthless and a failure. I have rarely avoided challenging situations. How I do this is to rehearse in my mind what I might expect to occur and what I can do to handle the situation so that when the situation actually occurs, I am in control and aware of what to do {8}.

Interaction

Even though the therapist interrupted, Sam continues

with his explanation and {7-S} analysis regarding handling his fear in a way that he would prefer and thereby asserting that he is not {~25} weak, worthless, and a failure. He gives information about how he deals with challenging situations so that he can maintain {8} control of his surroundings and not {~25} feel weak, worthless and a failure and thereby, indirectly asserting that {8} having control will help him achieve his goal of quitting drinking forever. To feel in control {8}, Sam must have information about what is happening otherwise he feels {25} weak and a failure. Throughout this speech turn, Sam also regulates the intensity of his experience.

Text

34 Th: ((sits back; begins writing on note pad)) *OK* So
 35 one of the things you want to ah..ah accomplish here
 36 ((briefly looks up at Sam; then resumes writing)) is..
 37 learning to handle fear ((looks up at Sam; then writes
 38 again)) and confront it.

Expansion

Th: OK I want to make sure that we are in agreement with our therapeutic mandate {Mandate}. I have heard you say Sam that one goal you want to accomplish in therapy is to confront and learn how to handle your fear {6} of not being able to quit drinking alcohol forever. Is that a correct statement of one of your therapeutic goal Sam?

Interaction

The therapist does not directly respond to Sam's last utterance, instead she repeats her earlier assertion {Mandate} of establishing a therapeutic mandate which concurrently serves to reduce his intense experience of not

being in control and feeling weak and a failure. She then interprets and summarizes what she understood Sam to say about his goal of therapy {6} and requests confirmation that she correctly interpreted his goal.

Text

39 Sam: Ye:ah. I: (.hhh) like I have I mean I have
 40 cravings for alcohol all the time (Th: *yes*)
 41 ((therapist continues writing))) and that scares the
 42 hell out of me because uh (hhh) I mean we ((gestures
 43 to the left)) have=we don't have liquor cabinet full
 44 but there is alcohol in the house. ((therapist looks
 45 up at Sam then looks at Jill and back at Sam)) (hhh)
 46 And uh.... to me... ((therapist moves her chair
 47 back)) once I have ((sharp downward hand gesture; then
 48 gestures to the left and right)) made that decision
 49 that I'm not going to do it it's not a problem. (hhh)
 50 But.. I go through: periods of pondering ((therapist
 51 nods yes)) where. I wonder ((tilts head to the right))
 52 we::ll what the hell. ((hand gestures to the right))
 53 You know I'm having a coffee throw some rum in the
 54 coffee=I'm ((gesture to the left)) having this=I'm
 55 having you know (hhh) ((gestures to the right)) I'm
 56 gonna have a pop or something=we'll throw some rum into
 57 the pop you know or-or a dozen beer ((rubs his head and
 58 therapist shifts position)) or something you know.
 59 ((leans to the right)) Oh what the heck one is not
 60 going to kill me but (hhh) ((picks lint off his pants
 61 and drops it)) I-that.. sometimes lasts.. you know
 62 sometimes ((sharp downward hand gestures)) that is
 63 two minutes that I think about it ((holds hands open
 64 and then gestures downward)) and sometimes it's half a
 65 day I think about it. ((holds hands open)) (hhh)
 66 And I still have not.. since the first day quit, gone
 67 done anything about it. You know I have not been
 68 active. I have not gone and opened anything or had a
 69 drink. So, (hhh) you know, I'm always c-concerned and
 70 worried that I might=and ((spreads hands out and then
 71 drops them on his lap)) it's not a fact like=I mean it
 72 is in the house but it is more of a direct..
 73 presentation to me but that's (hhh) I mean=its the pub
 74 is not far away and uh I know half the people=I know
 75 all the regulars in there. You know that sort of thing
 76 and it would be easy. So it is not a [fact its just is
 77 in the house

Expansion

Sam: Yes one of my goals in therapy is to learn how to handle and confront my fear that I will repeat my drinking pattern {6}. Considering that my fear is very big, that is, I have cravings for alcohol all the time {14} which terrifies {E1-S} me, then coming to therapy and admitting that I have a problem controlling alcohol seems more acceptable and does not suggest that I am {~25} weak and a failure. But if I talk about why I have this fear then I might reveal that I am {25} weak and a failure which is not something I want to do. Therefore, I will not talk about my fear and, instead I will begin analyzing {7-S} and attempting to understand my feelings and behavior associated with these alcohol cravings. Actually, I do not know what triggers the alcohol cravings, but I do know that the alcohol cravings are not triggered by the fact that alcohol is in our house or in close proximity such as at the pub. Jill and I have some alcohol in our house {10} and I am not bothered by having it there {9}. Once I have made the decision to quit drinking alcohol I do not drink {11} and therefore the presence of alcohol in our house {10} is not a problem that triggers the alcohol cravings {9}. But the problem that concerns me in regards to my goal of how to handle my fear of reverting back to my drinking pattern {6}, is the periods of time when I ponder and wonder whether to have a drink of alcohol {12}. At times I feel afraid that I might drink which would make me incompetent in dealing with alcohol {~2}. I rationalize to myself by saying, "Well what the hell, since I'm having some coffee I may as well pour in some rum." Or I might say to myself, "I'm having this particular beverage which would taste good if alcohol was added so I'll pour in some rum. Or I'll drink a dozen beer." I try to convince myself that drinking alcohol will not harm me by saying to myself "Oh what the heck one drink of alcohol will not kill me as the doctors threatened" {12}. This rationalizing and convincing myself that one drink of alcohol will not harm me {12} can sometimes last either two minutes or half a day. The frequency of the thoughts makes this a big problem for me and really scares me {E1-S}. However, as I admit this fear to myself and both of you I begin to feel weak and a failure {25}. So, instead, I will change the topic and tell you about my success which would negate my weakness and failure {~25}. Even though I have these thoughts about drinking alcohol, I still have not had a drink {2} since the first day I quit drinking alcohol. That is, I have not been active in pursuing drinking and have not opened a bottle of

alcohol or had a drink. This illustrates that I am competent and effective in how I deal with alcohol {2}. But, as you both are aware, based on my past behavior, I am always concerned and worried {E1-S} that I might break my goal to quit drinking alcohol forever and have a drink, resulting in me being {~2} incompetent in dealing with alcohol. Again, as I admit my fear I begin to feel weak and a failure {25} and thus, I will say that I am in control {8} of my battle with alcohol. This is verified by the fact that when I see a bottle of alcohol in the house, for instance I perceive the bottle as it is, a direct, actual presentation of a bottle of alcohol {9}. Similarly, the pub is a direct presentation of where drinking alcohol occurs, but the pub also does not trigger my alcohol cravings {9}. The pub that I used to frequent with other regular customers is not far away and if I wanted to have a drink of alcohol I could go to the pub and drink {11}. The point that I am making is that alcohol is accessible in other places besides our home and if I wanted alcohol I could get it from the pub. Having alcohol in our home or being in the presence of alcohol is not what creates my problem of having constant alcohol cravings {9}.

Expanding the text. The stress placed on the word "hell" is used to emphasize intense feelings of fear. The euphemism "scares the hell out of me" is generally associated with feeling terrified. Thus, Sam is stressing that his fear of having frequent alcohol cravings terrifies him. Throughout this speech turn Sam self-interrupts which indicates his uneasiness with discussing his alcohol dependency.

The decision that Sam speaks about making on line 48 is the decision to quit drinking alcohol, which is the focus of the therapy. When he says on line 49 "its not a problem", it is necessary to refer back to both the preceding and following sentences in which he talks about the alcohol in the house not being a problem.

A proposition not yet mentioned in this episode reads as; {14} Sam craves alcohol almost on a constant basis. Sam discusses this proposition throughout the course of therapy and identifies the alcohol cravings as the problem for him, not the alcohol. As stated in his previous speech turn, Sam wants to be in charge and in control of his battle with alcohol. Perceiving the alcohol cravings as the problem to control is Sam's way of maintaining control over alcohol.

In the alcohol dependency literature (Brown, 1988; Steinglass et al., 1987), alcohol is the central organizing principle for the alcohol dependent person. The alcohol and drinking behavior become the primary focus in the family while the denial of this behavior becomes the primary cognitive focus (Brown, 1985). Such defenses of denial, rationalization, and minimization are essential to maintain the alcohol dependent person's belief in self-control. Each family member develops similar behavioral and thinking disorders to the alcohol dependent person. That is, they are controlled by the reality of alcohol dependency and must at the same time deny the reality. They then adapt their thinking and behavior to accommodate the family's story or explanations that allow the drinking behavior to be simultaneously maintained and denied. The alcohol dependent person and other family members make adaptations in their perceptions and logic to maintain the belief that the alcohol dependent person has the ability to control his or

her drinking, often through use of denial and rationalization. Incoming information that challenges this belief must either be altered to accommodate the belief, ignored, or denied.

In the family environment, the alcohol dependent person is number one, setting the changing rules and tone to which other family members must adjust and respond. The organizing function of alcohol, its denial, and the need for a focus of control are central concepts in working with couples where one spouse is alcohol dependent. The beliefs that the dependent person does not have a drinking problem and that he or she has self-control, the ability to control the drinking behavior, forms the dependent person's identity and structure, and interpretations of self and others. Furthermore, these beliefs are also central to the dependent's family when denial is present. That is, there is no alcohol problem and no lack of control. The chaos, inconsistency, and unpredictability in the family are either denied and become part of the family's normal functioning or are projected onto another problem.

It is evident in the present study that Sam's belief in self-control, the ability to control alcohol related problems, and the denial and rationalization of alcohol related problems are paramount. For instance, in session one Sam minimizes the extent of his drinking problem even though he had been drinking "heavily" on a daily basis, that

is, 7 to 12 beers on a typical drinking day, according to his self-report on the DPAS instrument. Each time he began his pattern of drinking he would say to himself, "I don't see [my drinking] as a problem. I think it is normal and my mindset changes. I focus it and change to either I do [drink] or I don't." Jill states that she recognized that Sam denied the drinking problem to himself and "justified drinking through [his work], saying he had to drink with clients." Sam tended to drink during the day and by the next morning the alcohol problem was forgotten. Jill said when Sam stopped drinking for a while the memory of drinking slid away and she had more trust for Sam, felt at peace, at rest, and did not doubt him. They both said that neither one talked about the drinking in either sober or drinking states because their motto was to "let sleeping dogs lie". This is in effect a denial and belief in Sam not having an alcohol problem and that he can control it.

However, it is important to acknowledge that Jill's silence about the alcohol problem was not necessarily a denial or minimization. Throughout the course of the therapy Jill talks about how she stopped raising her concerns about the alcohol and Sam's alcohol dependency because he became either defensive and mean or deflected her concerns through use of humour. In session four, Jill talks about feeling intimidated by Sam because he would get angry and aggressive by throwing objects in her direction, for

example. To protect herself from Sam's intimidating and aggressive behavior she withdrew from him. Thus, it is essential to acknowledge that Jill's fear of Sam's intimidating behavior does not mean she has been denying and minimizing the alcohol problem. It was safer, and in her best interest, to remain quiet and let him deal with the alcohol as he chose.

Based on the preceding discussion, the following propositions, not previously mentioned, were identified:

{9} Presence of alcohol does not bother Sam, making it more difficult to abstain from drinking alcohol or triggering alcohol cravings.

{12} Client rationalizes, minimizes and justifies behavior.

{17} Sam is responsible for quitting drinking and dealing with alcohol related concerns on his own.

{10} Alcohol is in the clients' home.

{11} Sam's decisions are final and absolute.

{15} Sam gets defensive when alcohol concerns are raised.

{4} Jill feels afraid and intimidated by Sam's aggressive behavior.

Other general propositions are beginning to emerge which relate to the obligations and status of each spouse. Labov and Fanshel (1977) suggest that much of what occurs in the therapy discourse is concerned with the social life, particularly the statuses of each person and their accompanying set of role obligations and requirement for

competent role performance. To maintain a particular status requires the person to act in competent and appropriate ways in accordance to the social norms of the family. Minuchin (1974), as well, emphasizes that the family structure consists of both universal rules governing family organization (e.g. the family may have power hierarchy with different levels of authority for each family member) and idiosyncratic mutual expectations of family members, which involves implicit and explicit negotiations among family members in regards to small daily events.

Throughout the course of the therapy, Sam often, either explicitly or implicitly, states that males, the husbands, are the head of the household. For instance, in session three Sam refers to males as, "we're strong, we're tall, we're the breadwinner, the ones to stand alone". In session eight Sam discusses how he has 51% and Jill has 49% of the decision-making power because he is the man of the household. Jill does not dispute this split. He also states in the first three sessions that his decisions are final and that when it comes to alcohol related decisions he does not involve Jill in the decision making process. For instance, in session one Sam says, "When it comes to alcohol I deal with it the way that I wish to deal with it, and frankly it has always been if I wanted a drink I would have one." Considering that both Sam and Jill have accepted that husbands are the head of the household, the husband's status

carries certain implications such as, the duty and role obligation of the husband to have authority, be responsible for making decisions, act responsibly in his decision-making, and reserve the right of final decision.

When the husband is head of the household this means that he must be competent to perform the obligations and duties of that status. The general proposition is stated as; {H-Head} Husband is a competent head of the household. The local propositions, {11} and {17} are related to {H-Head}.

In session one Jill clearly asserts that she supports and respects Sam's decisions and does not interfere because when Sam makes a decision it is final and her input does not influence him. Moreover, she is afraid of his defensiveness because he acts mean and aggressive toward her resulting in her feeling intimidated. For instance, in session five Jill states, "Arguing with Sam is not easy. You don't get your say with Sam. Lots of things I didn't say because I'm afraid of him leaving". She continues to say that since she did not get her say in arguments she gradually gave up letting Sam know what she felt. She also felt frustrated at not getting her say and feared him either leaving or exploding. She also realizes in session five that she leaves the initiative to Sam which stems from childhood experiences of being told her opinions were not worthy. She says, "When you are silenced a lot you end up being silent."

The general proposition, which is either implicitly or explicitly negotiated, for the wife's role is stated as; {W-Supports} Wife is a competent support to husband.

This last proposition requires that the wife supports her husband's decisions and performs the necessary tasks which support him. It also requires that she not challenge him and not do anything that may result in him becoming defensive. Related local proposition include; {23} Jill is caring and attentive to Sam. {20} Jill does not interfere with alcohol related concerns.

Interaction

Sam confirms that the therapist has correctly stated {6} one of his goals for therapy. He then gives information about his feelings of {E1-S} fear, the intensity of his problem {14}, which he identifies as the constant alcohol cravings, and as well he expresses the intensity of his {E1-S} fear associated with {6} his goal of handling the fear and thereby asserting that he is not {~25} weak and a failure for attending therapy to deal with his alcohol dependence. That is, he asserts that his problem is big, requiring outside help and thereby not rendering him {~25} weak and a failure for not {~8} being in control of his battle with alcohol. The therapist acknowledges what Sam said about having the frequent cravings by nodding her head yes. As Sam is about to give an interpretation or explanation for having {14} the constant alcohol cravings,

he begins to {25} feel weak and a failure. Consequently, he re-directs the topic of conversation and asserts that {9} the presence of alcohol does not bother him and thereby indirectly asserting {8} he is in control of his battle with alcohol and simultaneously reducing {~25} his feeling of being weak, worthless and a failure. In other words, to resume his position of {8} being in control, Sam deflects by {7-S} analyzing and explaining what he knows does not trigger the alcohol cravings. He then proceeds to assert that {9} the presence of alcohol in or near their home is not what triggers the alcohol cravings. By asserting this proposition {9}, Sam presents a disputable event (D-event) which is an event that both speaker and listener know that the truth of the proposition cannot necessarily be assumed (See Appendix C). Sam acts in such a way that indicates he is aware that disagreement may occur. Before either Jill or the therapist speaks, Sam supports his assertion with subsequent evidence and argument. That is, Sam asserts that he knows he is not affected by the presence of alcohol {9} because he has proven this by not being bothered by the alcohol that already exists in their house. To ward off possible criticism for having alcohol in the home he also defensively asserts that there is not a large quantity of alcohol in their home. While continuing to provide support for his proposition {9}, Sam asserts another proposition {11}, which is that his decisions are final. Hence, if he

decides to quit drinking, nothing, including the presence of alcohol, will deter him from his decision. Sam then re-directs the topic and gives information about {6} his goal to handle his fear which is an A-event; information known to A (Sam) and possibly not known to B (either Jill or the therapist) (See Appendix C). Typically A has privileged knowledge about these events and can expect to address them as an expert without facing contradiction. Sam has information about the alcohol cravings and thoughts about whether or not to drink which no one else would know unless he provides this information. Sam orients the therapist and Jill to the behaviors and thoughts he experiences when he questions whether or not to drink alcohol. The orientation he presents is about the connection between his fear and his tendency to {12} rationalize and justify drinking. As he admits {E1-S} feeling fear, he begins to {25} feel weak and a failure. He then re-directs the topic by giving information about incidents of success which then renders him {2} competent and effective in dealing with alcohol and thereby reducing his {~25} feelings of being weak and a failure. He again admits {E1-S} feeling fear and {~2} possibly being incompetent in dealing with alcohol which results in him {25} feeling weak and a failure. To prevent feeling {25} weak he re-directs the topic by giving information about {9} not being bothered by the presence of alcohol and thereby indirectly asserting that {8} he is in

charge and control of alcohol battle. He ends his speech turn by re-asserting {9} that the presence of alcohol does not bother him.

Essentially, what is occurring in this speech turn is that Sam feels he is weak and a failure for not being in control of his alcohol battle and for being in therapy. He fluctuates between perceiving alcohol as a problem and not perceiving it as a problem. He also fluctuates between admitting he is incompetent in handling his alcohol dependency and consequently feeling weak, worthless, and a failure and being competent and not weak and a failure in handling the alcohol. To Sam, being competent means that he is in charge and in control of his battle with alcohol without the help of anyone else.

Sam appears to be functioning in more of a defensive mode and explaining and analyzing much of his behavior and thoughts. This may be a result of denying the effect alcohol has on him. Sam stated at the end of the therapy session that he was defensive during this episode.

Text

78 Th: [It is within walking
79 ((gestures outward)) distance=

Expansion

Th: Alcohol is so close to you that alcohol is just within walking distance from you...

Interaction

The therapist interrupts Sam when he begins to repeat

his explanation and rationalization that {9} the physical presence of alcohol is not a problem for him. The therapist repeats part of Sam's preceding utterance, by paraphrasing, that the alcohol is in close proximity to Sam and thereby using {T-Track} the method of noting and highlighting Sam's experience of alcohol. The therapist heightens the proximity of the alcohol which would make it difficult to not drink.

Text

80 Sam: (hhh) Oh yeah! ((nods yes))

Expansion

Sam: Oh yes I agree, alcohol certainly is in close proximity.

Interaction

Sam agrees with the assertion that the alcohol is in close proximity.

Text

81 Th: =Alcohol is within reach ((grasping motion)) (Sam:
82 yeah) even within your house (Sam: yeah) (hhh) and you
83 feel tempted constantly ((back and forth hand
84 gestures)) (Sam: Yes. ((nods yes))) many=many times
85 (Sam: yeah) throughout the day (Sam: Oh yeah!) you feel
86 really drawn [to ((leans forward and uses grasping
87 gesture))

Expansion

Th: I recognize Sam that you are not weak and a failure {~25} because the problem is that alcohol is a very powerful seducer {13} that tempts you to open it and drink it. Alcohol is so seductive {13} and by it being in such close proximity as in your home {10}, it constantly tempts you to drink it many times throughout the day, making you feel compelled to reach and grab it {~9}.

Expanding the text. Through the use of grasping motions and leaning forward the therapist accents the ease in which the alcohol can be reached and how it draws Sam to it. The therapist accents the frequency of the temptation to drink by repeating, "many=many times". The phrase, "feel really drawn" is defined more precisely to mean that Sam feels compelled to drink alcohol. In session three Sam states, "I feel incredibly compelled to drink" which is how he thereafter describes his experience with alcohol. The proposition identified is; {13} Alcohol is seductive in tempting Sam to drink.

Interaction

The therapist continues speaking after being interrupted by Sam. She then gives an interpretation, or reframe, of the function of alcohol as {13} a seducer and thereby, asserting that Sam is not {~25} weak and a failure, but rather, the problem is that {13} alcohol is seductive. She simultaneously asserts that {10} the alcohol in their house aids in increasing the intensity of the {13} seduction and temptation for Sam to drink. The therapist is indirectly challenging proposition {?9} and thereby questions Sam's assertion of {9}. When the therapist uses the rule for challenging propositions regarding Sam's assertion of the proposition {?9} that the presence of alcohol does not bother him, which is supported by Sam's status {?H-Head} of being a competent and responsible person

to deal with such problems as alcohol dependency, then she is heard as challenging Sam's competence in his status {?H-Head} (See Appendix C). Sam reinforces what therapist says.

Text

88 Sam: [(hhh)
 89 ((holds neck, uncrosses legs, shifts position, folds
 90 arms over chest, leans to the left)) Well=no I.
 91 usually go through one sequence... you know ((Jill
 92 moves hands)).. but.. as I say it can last for like 2
 93 minutes ((lightly claps hands)) or a-a thought will go
 94 through my mind YEAH I want a drink ((forward hand
 95 gesture)). (hhh) And I'll sit there and say or
 96 rationalize we:ll no I shouldn't because I-I've come so
 97 far I've gone ((Jill scratches face)) three and a half
 98 weeks or four weeks at this point ((alternates left and
 99 right hand gestures)) (hhh) um.. and it would j-just
 100 set me back again so::... (hhh) I just put it aside
 101 ((flicks hand to the left)) but some days it's
 102 stronger.. ((gestures back and forth)) than other days
 103 and ah for what reason I don't know ((shakes head))
 104 (hhh) I haven't seen trigger points or anything like
 105 that that-that prompt me to-to feel that way. (hhh)
 106 But it's.. you know.. it's something that I have to
 107 address and deal with.. Al-almost (Th: *yeah*) on a
 108 constant basis.

Expansion

Sam: Well, in regard to alcohol being close by me {10} and craving alcohol constantly {14} I do concede. But I do not feel compelled to want to reach out and grab the alcohol because then I would be admitting that I am weak and a failure {25} and not in control of battle with alcohol {~8}. In order for me to be strong and in control, I must analyze my experiences {7-S}. I do not want either one of you to think of me as a failure, so I will tell you about how I am in control {8}. As I have said earlier, the problem is my cravings for alcohol, not the alcohol. There is one particular sequence that I usually experience in relation to my alcohol cravings, but what varies is the length of time of the sequence. For instance, the sequence can last for 2 minutes or momentarily like a thought such as "Yeah I want a drink of alcohol." What typically happens next is that I sit and rationalize {12} by saying the following statement to myself, "Well, I want a drink of alcohol, but I shouldn't have a drink of alcohol because I have made great strides in my

sobriety by having quit drinking alcohol for 3 1/2 or 4 weeks. I know that if I have a drink of alcohol I would just set myself back again and repeat my pattern of quitting drinking and then slowly starting again which would eventually lead to drinking alcohol more frequently." When I say the above-mentioned statement to myself {12} I can put thoughts and cravings of alcohol out of my mind and be in control {8} of my battle with alcohol. But some days the thoughts about alcohol and the alcohol cravings are stronger and I do not understand the reason for this. I have not been able to identify what triggers me to feel such strong alcohol cravings. But, as I have said previously to you both, my alcohol dependency problem is mine to resolve {17} and as you know, based on what you said earlier, I will have to address and deal with these thoughts and cravings for alcohol on an almost constant basis {14}.

Interaction

Sam interrupts and disagrees with the therapist's interpretation that the {10} proximity of alcohol {~13} compels and seduces him to drink the alcohol and thereby, attempting to deflect from his {25} feeling of being weak and a failure for not being in {~8} control of his battle with alcohol. He indirectly defends against the challenges to the proposition {?9} that the presence of alcohol does not bother him and to {?H-Head} him not being competent as head of the household, by giving information to the therapist and Jill about his alcohol cravings to help them understand what he means and experiences. Sam heard the therapist's last comment as her not understanding that although he has alcohol cravings, he controls {8} them and is successful {2} and competent in dealing with alcohol which then results in him also being competent {H-Head} in his status. This preceding interpretation made by the

analyst is based on the information that Sam then gives. That is, Sam gives information about his alcohol cravings which he describes as lasting briefly and then he evaluates the success {2} he experiences in using self-talk to manage/control {8} the cravings. Considering that he has been successful in controlling his cravings, then he is actually competent in {H-Head} his status as head of the household. Sam then re-directs the conversation back to his original concern which is not understanding what triggers the strong alcohol cravings. Simultaneously, Sam evaluates that most days he is {2} successful in controlling the cravings but "some days" he is not as {~2} successful. In other words, most times Sam is competent {H-Head} in carrying out duties and obligation relegated to his status as head of household, but some times he is not as competent {~H-Head}. Since these latter incidents occur only "some times", overall he is still competent {H-Head} in his status and is {8} in control of his battle with alcohol. Sam again re-directs the conversation back to the proposition of his status {H-Head} and asserts the local proposition {17} of being the one responsible to quit drinking alcohol and to deal with it alone. He asserts that he deals with the cravings on an almost constant basis {14} and thereby asserting this is a big problem and thus he {~25} is not weak and a failure.

Text

109 Th: ((gestures towards self and nods yes)) Yeah: Yeah:
 110 I think that-that's:. right you'll have to do (Sam:
 111 yeah) that on a constant basis ((drops hands on lap))
 112 (hhh) and.. almost on a constant basis. (hhh) And you
 113 may ask yourselves, "Why do we have alcohol in the
 114 house when it (Sam: yeah) makes it ((holds and shakes
 115 pressed fingers in the air)) that much more difficult
 116 (Sam: hhh) ((Jill looks toward Sam)) =that little=bit
 117 more difficult for me?" ((briefly looks down at note
 118 pad))

Expansion

Th: Yes, based on my knowledge about alcohol addiction I think that you are correct {Convey}. You will have to deal with your alcohol cravings and thoughts on a constant, or rather on an almost constant basis {14}. Considering the frequency of your alcohol cravings {14} I want both of you to ask yourselves, "Why do we have alcohol in the house when the presence of alcohol seduces and tempts {13} you to drink Sam and adds more difficulty in abstaining from alcohol {~9}, especially adding more stress for me, Sam, in my struggle to maintain sobriety?"

Expanding the text. The therapist's gestures are used to accent the close proximity and seductiveness of the alcohol in the house and the difficulty this proximity can create for Sam in his sobriety. Another proposition arises; {Alcohol} Alcohol should not be in the clients' home.

Interaction

The therapist agrees with Sam's assertion {14} that he will have alcohol cravings on an almost constant basis and thereby acknowledging that he is {~25} not weak and a failure. She then indirectly requests information from both spouses about the reason for {10} having alcohol in the house. This request is based on the premise that {13} alcohol seduces Sam to drink, resulting in Sam having more

difficulty abstaining from alcohol {~9} and thereby she indirectly asserts that {Alcohol} alcohol should not be in their home. The therapist uses a mitigating form when making the indirect request, which is evident by her stating "And you may ask yourselves...", rather than using an imperative such as "Ask yourselves..." Simultaneously, the therapist is denying Sam's assertion {~9} that the presence of alcohol does not bother him or trigger alcohol cravings. She is also challenging his competence {?H-Head} in dealing with alcohol related concerns. That is, she is asserting that if Sam were competent {H-Head} in dealing with the alcohol, he would abide by the proposition {Alcohol} that alcohol should not be in their house.

By directing the question to both clients, the therapist is implying and redefining that both spouses are responsible for the presence of alcohol in their house and for creating more stress for Sam in his sobriety {Relational}. The therapist leaves the question open-ended by not looking at either client.

Text

119 Sam: (hhh) Yeah:. ((therapist looks first at Sam and
120 then at Jill and writes on a note pad)) I have thought
121 of. getting rid of it all like-our-my intention was the
122 holiday celebration party it would all be gone because
123 we had.. we:ll we didn't have the party we were.
124 planning on having because ((therapist looks up from
125 note pad toward a plastic alcohol bottle and then looks
126 at Sam)) of my injury and whatnot we only had a half
127 dozen people in (hhh) but I was hoping that it would
128 all be gone that night ((therapist puts head on chin
129 and looks at Sam)) so it wouldn't be there. Now.. we
130 have.. ((Sam gestures; therapist looks at bottle and

131 then at Sam)) family was over this weekend that sort of
 132 thing and.. ((back and forth gestures, drops hands on
 133 lap, shakes head)) we serve it to guests:. (Th: *yes*
 134 ((nods))) you know (Th: yeah) rather than ((shifts
 135 position and leans to left)) (hhh) (Th: yeah
 136 ((therapist looks at Jill))) you know.. I don't
 137 replenish our stock [

Expansion

Sam: Yes, I agree with your suggestion that {Alcohol} alcohol should not be in our home and I have at various times thought about getting rid of the alcohol in the house {18} in my own way {17}. For instance, our, no I should say my intention, because I am responsible for dealing with my alcohol dependence {17}, was that all the alcohol in our house {10} would be drunk by our guests at our holiday celebration party. Well this did not happen because we did not have the large party we had planned due to problems associated with my recent physical injury. We only had half a dozen people attend our party and they did not drink all the alcohol as I had hoped. I was hoping that all the alcohol would be consumed that night so that there would not be any alcohol left {19-S}. Another way that I planned to get rid of the alcohol in our house is by serving the alcohol to guests and family members who visit us like this weekend, for example {18}. Since I am trying to get rid of the alcohol in our home in my own way {17}, as is my responsibility, I would say that I am being both competent {2} in how I handle the alcohol and responsible {H-Head}. The reason alcohol is in our house is not because I replenish our alcohol stock, which would be a justifiable reason to criticize me for being irresponsible in my duties. But because the alcohol is still left over from the time when I was drinking I am being responsible and competent in my duties {H-Head}.

Expanding the text. The "getting rid of it" logically refers to getting rid of the alcohol which was the focus of the last utterance. The reference to an injury was expanded by referring to the first session in which Sam talked about a recent physical injury. The vague statement of "we serve it to guests rather than you know I don't replenish our stock" must be expanded and contextualized within Sam's

complete speech turn. The implication is that they have alcohol in the house because it is leftover from Sam's drinking days, not because he is buying alcohol while in sobriety.

Propositions not previously discussed were identified:

{18} Sam has plans to get rid of alcohol from the house.

{19} Client wants alcohol to be out of their house.

Interaction

Sam responds to the therapist's indirect request for information by initiating a narrative about {19-S} wanting to get rid of the alcohol by providing orientation on time, persons, place, and behavioral setting (See Appendix C). He gives information about {18} his plans to get rid of the alcohol and thereby asserting that these are his plans, not Jill's and as well, minimizing and dismissing Jill's input. He is the {17} one responsible for his alcohol dependence and dealing with any alcohol related concerns. Sam simultaneously asserts that {19-S} he does not want the alcohol in their house. He then gives evaluation of the narrative; he was not successful in getting rid of the alcohol. Sam then initiates another narrative about {18} his plans to get rid of the alcohol by providing orientation to time, persons, place, and behavioral setting. Sam then defensively supports the proposition {19-S} regarding his desire to get rid of the alcohol in their house by subsequently stating that he is not currently buying any

more alcohol and thereby asserting that he is competent {H-Head} in his role as head of household to deal with alcohol related concerns. The essence of the narrative was to assert his competence {H-Head} in dealing with alcohol and to indirectly assert that he has been abiding by the proposition {Alcohol} that alcohol should not be in their house by planning how to get rid of it.

Text

138 Jill: [again I always said
139 to you..... ((Sam sighs)) to get rid of it.
140 ((flicking away gesture)) and you always said that's my
141 problem.... [

Expansion:

Jill: Considering that the therapist is here to help me feel safe in voicing my opinion, I have some things that I want to say Sam about how you deal with your alcohol problem. Since you might get defensive I will take my time and choose my words carefully so as to not make {~15} you defensive. The therapist is confirming what I have always said to you, Sam, which is that you should get rid of the alcohol in our house {Alcohol;19-J}. But, your response to me wanting you to get rid of the alcohol has been to either deflect my concerns or to get defensive {15} and say, as you have always said, that your alcohol dependency is your problem {17} and that I should leave the alcohol alone {20} {?H-Head}.

Expanding the text. The long pauses may indicate uncertainty or thoughtfulness of words to use, especially considering that Sam's tendency is to get defensive. The problem that Jill is referring to is made explicit in session one. Both Jill and Sam discuss how Sam has decided that the alcohol dependency and alcohol related concerns are his to address and Jill does not interfere. Jill asserts in session one that she felt safer voicing her opinion because

the therapist was present.

Interaction

Jill interrupts Sam and indirectly asserts agreement with the therapist's assertion {Alcohol} that alcohol should not be in their house and that {17} Sam should get rid of the alcohol, especially considering that he is responsible for quitting drinking. Subsequently, Jill indirectly reprimands Sam for not {~2} competently and effectively getting rid of the alcohol. She asserts that she has always {19-J} wanted the alcohol to be gone from their house, but did not interfere because she {4} felt afraid of Sam's intimidation. She also asserts that she was competently carrying out her role {W-Support} of being a supportive wife who {20} does not interfere with Sam's decisions. Jill is beginning to question {?H-Head} whether Sam is competent in carrying out his duties in regards to the alcohol dependency. She has always respected {H-Head} his status and authority and not interfered even though she has wanted to be rid of the alcohol. In the therapy episode Jill is receiving the support for her original position {19-J} from the therapist.

Text

142 Sam: [Yeah. ((shakes head)) I've always
143 said

Interaction

Sam interrupts Jill and confirms that he has told her to leave the alcohol alone {17} and not interfere.

Text

144 Jill: leave it.

Expansion

(Part of previous expansion)

Text

145 Sam: Yeah. One way or other I mean. It-it because
 146 it's in the home I-I if I wanted to drink, it wouldn't
 147 matter if it was in the home or not.. I'd have a
 148 drink.

Expansion

Sam: Yes, you are correct Jill, I have always said that the alcohol is my personal battle which resides within me and thus, I have to control my alcohol battle. This means that I will decide how I will deal with the alcohol {17} in our house {10} {H-Head}. Jill, I am beginning to feel like you are criticizing me and saying that I am {25} weak and a failure for not getting rid of the alcohol. To let you know that I am not {~25} weak and a failure, I must tell you that neither the presence nor lack of alcohol in our house affects my decision to not drink {9}. I am in control {8} of the alcohol because its presence does not bother me {9}. If I really wanted to drink alcohol I would find a way to get a drink {11}. Ultimately the decision to drink or not drink is mine {17} and thus, I am in control of my battle with alcohol {8} and am competent {2} {H-Head}.

Expanding the text. In session three, Sam says

"Alcohol is my personal battle. Again I feel the problem is within myself. I have to control it. I alienate myself from her [Jill] in this respect and have done so basically after a couple of years." In session one, both Jill and Sam talk about how Sam has decided that he must single-handedly resolve his alcohol problem. The text is expanded to include the statements made in session one and three.

Interaction

Sam agrees with Jill that he has told her {17} to leave the alcohol related concerns to him. Sam then defends against the challenge {?H-Head} that he has not been competent in fulfilling requirements of his status and not been {~2} competent and effective in handling alcohol because he did not get rid of the alcohol. He asserts {9} that the presence of alcohol does not bother him and that his {11} decisions are final and if he wanted to drink he would. He is indirectly asserting that since {9} the presence of alcohol does not bother him, he is in fact {8} in control of his battle with alcohol and thus, {2} competent and effective in handling alcohol and competent in {H-Head} handling his status as being a responsible head of the household who can deal with his alcohol dependency.

Text

149 Jill: Yeah but.... accxxx [((unfolds and refolds
150 hands))

Expansion

Jill: I understand what you are saying Sam but I have also heard what the therapist said earlier in terms of the accessibility of alcohol making abstaining from alcohol more difficult for you {~9}.

Interaction

Jill agrees with Sam's assertion of proposition {11}, which is that if he really wanted to drink he would do so. She then uses mitigation, by making reference to the therapist's earlier comment, as she repeats her challenge to

Sam about {?9} the presence of alcohol negatively affecting him in his sobriety. Jill gives her interpretation that the {~9} accessibility of alcohol does bother Sam. She has internalized the therapist's reframe that alcohol seduces Sam and the close proximity of alcohol affects Sam's struggle to maintain sobriety. She uses this information to challenge Sam's competence {?H-Head} as head of household in {?2} effectively handling alcohol. By challenging Sam about the presence of alcohol affecting him, Jill is beginning to redefine that {Relational} the alcohol dependence is a relational experience. That is, both spouses are affected by the alcohol dependence and therefore it is not just Sam's problem. In questioning Sam about how he handles decisions related to the alcohol dependence, Jill is {~20} interfering and getting involved with the alcohol problem. Jill uses mitigation to avoid Sam getting defensive when she raises concerns regarding the alcohol dependency. Sam interrupts Jill and completes her sentence for her.

Text

151 Sam: [OH access it-it's you
152 know

Expansion

Sam: Oh, I am surprised because I thought you were {~W-Support} criticizing me or getting angry as you usual do when the alcohol is mentioned. I did not realize that you are referring to how I am affected by the accessibility of alcohol!

Expanding the text. The word "Oh", which is spoken louder than the surrounding text, indicates Sam's surprise

and is expanded. In the first and third session, both Sam and Jill talk about how Jill would express anger and criticism toward Sam when the alcohol issue was raised. In session three, he says he does not talk to Jill about the alcohol because "I assumed because of past experience that I'll get the same response from her which is 'No No No, No No - there is no discussion on the matter [regarding my alcohol dependence].'"

Interaction

Sam interrupts Jill and finishes the word she is attempting to utter. He deflects from {?9} the challenge to his earlier proposition, the challenge to both his competency {?2} in handling the alcohol as well as {?H-Head} his status as being responsible for his alcohol dependence by asserting his surprise at Jill's reference to the accessibility of alcohol. Sam is indirectly {?23} challenging whether Jill is really caring and attentive toward him and thereby challenging {?W-Support} whether she is competent in her supportive role. That is, if she were supportive and caring toward him then she would not criticize him about how he handles quitting drinking which results in him {25} feeling weak and a failure.

Text

153 Jill: its-its ((presses finger
154 together emphasizing closeness)) so much closer=I mean
155 we can get rid of it!

Expansion

Jill: I heard what the therapist said about the close proximity of alcohol affecting you and seducing you to drink {13}. I am concerned about how you are affected, Sam, when alcohol is so much closer to you by being in our home {?9}. I am aware of you getting defensive {15} and therefore, I will soften what I really want to say to you Sam. I want you to get rid of the alcohol in our house {Alcohol}! That is, I do not mind you getting rid of the alcohol in our house because I do not want it there {19-J}.

Interaction

Jill continues speaking even though Sam interrupts her. Jill expresses {23} her concern and care for Sam as she agrees with the therapist's assertion that {13} alcohol is a seducer tempting Sam and thereby {W-Support} supporting Sam. She uses mitigation to diffuse his {~15} defensiveness while she challenges {?9} that the presence of alcohol in their home bothers him. She agrees and accepts the therapist's proposition {Alcohol} that alcohol should not be in their home and is suggesting indirectly to Sam to agree with this proposition and to get rid of the alcohol. Jill also indirectly asserts that she too believes it is Sam's responsibility to get rid of the alcohol {17} and thus, she does not suggest getting rid of it herself. She asserts to Sam that they do not have to keep alcohol in the house for {19-J} her purposes. Jill uses mitigation to diffuse Sam's defensiveness when she asserts {19-J} not wanting the alcohol in the house. She says "we" which is a mitigating form used to mean Sam.

Text

156 Sam: OH easy enough! oh su:re[

Expansion

Sam: Oh, of course, getting rid of the alcohol in the house is an easy task for me because as I have said {9} the presence of alcohol is not the problem that I am concerned about. Since I can get rid of the alcohol in our house, this means that I am {8} in control of my battle with alcohol and thus, {~25} I am not weak and a failure.

Interaction

Sam agrees with Jill that the actual process of getting rid of alcohol from their house would be an easy task because {9} the presence of alcohol does not bother him and thereby asserting that {8} he is in control of his alcohol dependency and {~25} is not weak and a failure. Jill interrupts Sam to complete her preceding speech turn.

Text

157 Jill: [there is no problem with
158 tha:t

Expansion

Jill: Sam, I do not have a problem with you getting rid of the alcohol from our home {17} because I do not need or want to have alcohol in our house {19-J}. I actually do want you to get rid of the alcohol.

Interaction:

Jill continues with her preceding speech turn and does not acknowledge Sam's interruption. She asserts that she does not foresee a problem with getting rid of the alcohol which is a way of indirectly supporting Sam to accept the proposition of {Alcohol} getting rid of the alcohol. She

also indirectly asserts to Sam that she supports him in {17} getting rid of the alcohol and thereby asserting that she is {23} caring and attentive toward him and thus, {W-Support} competent as a supportive wife. Jill uses mitigation to circumvent his defensiveness while trying to get her point across. By using an impersonal pronoun such as, "there" suggests that she is using indirectness and mitigation when speaking to Sam about what she wants.

Text

159 Sam: give it to Jack..... ((laughs and tilts head to
160 the left))

Expansion

Sam: Since you, Jill and therapist, are both saying that the alcohol in our house is a problem {~9} and I should get rid of the alcohol {Alcohol}, then maybe to placate you both, and to not {~25} feel weak and a failure for not getting rid of the alcohol, I will jokingly suggest that I give the alcohol to our friend Jack who still drinks alcohol {18}.

Interaction

Sam continues with his earlier speech turn and deflects from the challenge to the proposition {?~9} that the presence of alcohol does bother him by using humour. He asserts a disputable event which is to give the alcohol to another alcohol dependent person. By making this assertion, Sam is indirectly implying that he is prepared to agree with the proposition {Alcohol} that alcohol should not be in the house and thereby, negating the indirect assertion that he is {25} weak and a failure for not getting rid of the alcohol. He introduces {18} a plan of how he could get rid

of the alcohol, but the teasing nature of his assertion suggests that Sam still believes {9} the presence of alcohol does not bother him. Sam recognizes that both Jill and the therapist are in agreement that {Alcohol} alcohol should not be in their home and that his way of getting rid of the alcohol has not worked. Hence, he uses humour to deflect from this contentious issue and thereby saving face.

Text

161 Jill: Well__ No ((looks toward therapist)) we would
162 create somebody else a problem ((laughter))

Expansion

Jill: Well no, Sam I do not agree with your idea of giving the alcohol to Jack {18} because you would just create a similar alcohol dependency problem as we are facing, for Jack and his family {H-Head}. I am also familiar with your tendency to use humour to change the topic of conversation when we approach this contentious issue of you getting rid of the alcohol from the house. You use humour to let me know you want me to stop interfering {20} and to let you deal with the alcohol in your own way {17}.

Interaction

Jill reluctantly, through mitigation, rejects Sam's {18} plan to give the alcohol to a friend who already has alcohol dependency problems. She again uses mitigation to challenge his competence {2} in effectively dealing with alcohol and to also challenge his competence {H-Head} as being responsible in his status as head of the household. Jill laughs and thereby suggesting her familiarity with Sam's tendency to use humour to deflect from the contentious issue of how he deals with alcohol, to stop her from {20}

interfering and to let him deal with the alcohol in his own way {17}.

Text

163 Th: So: ((laughs; back and forth gestures)) th-there is
 164 a possibility that you could get rid of it from the
 165 house

Expansion

Th: So, since this issue regarding getting rid of the alcohol is contentious, which I recognize by you, Sam, getting defensive and using humour as a deflection and you, Jill, using mitigation when speaking to Sam about the alcohol. I hear both of you saying that you want the same thing, that is, to get rid of the alcohol in the house {T-Common}. As well, Jill and Sam, you are both saying that you both could possibly get rid of the alcohol from your home if you chose to do so {21} {T-Common}.

Expanding the text. Although the therapist says "you", which is a single form, she is looking at both clients and thereby implying that they are both responsible for getting rid of the alcohol. She is also suggesting that both spouses agreed they could get rid of the alcohol if they chose to do so. The proposition identified is stated as; {21} Client is aware of choice in getting rid of alcohol in the house.

Interaction

The therapist gives an interpretation of the assertions made by both Jill and Sam thus far, which includes; getting rid of the alcohol from the house is a contentious issue between them, that they both agree they {19-S,J} want the alcohol out of the house, and there is the possibility of {21} getting rid of it and thereby, she asserts the {T-

Common} commonalities between them. Furthermore, their commonalities support the proposition {Alcohol} that alcohol should not be in their house. Through the clarification and paraphrasing of their previous assertions, the therapist uses mitigation to bring to both clients' awareness their possible {21} choice of getting rid of the alcohol. That is, she informs them that they have a choice in what they do about the alcohol in their house. The therapist joins the clients in their humour by laughing with them.

Text

166 Sam: Oh yeah!

Expansion

Sam: Oh yes, of course, I, {17} who am responsible for the alcohol concerns, could get rid of the alcohol in our house if I wanted to {21-S} because as I have already said the alcohol in our house is not a problem for me {9}. Consequently, I {8} am in control of my battle with alcohol and therefore, I am not {~25} weak and a failure.

Expanding the text. The "Oh" adds more emphatic stress to his absolute agreement to what the therapist has said.

Interaction

Sam agrees with the therapist's interpretation of {21-S} his choice to get rid of the alcohol if he chose to do so, and thereby asserting that {8} he is in control of the alcohol. Thus, he is {~2} neither incompetent and ineffective in how he deals with the alcohol nor {~25} weak and a failure. He again indirectly asserts {9} the problem for him is not the presence of alcohol in their house.

Text

167 Th: you could give it to Jack (Sam:Oh yeah, yeah) but
 168 then you might not want to give it to Jack

Expansion

Th: I recognize, Sam, that in order to not feel {25} weak and a failure and to save face, you used humour to deflect from this contentious issue {Convey}. You indirectly admitted to wanting to get rid of the alcohol in your house {19-S} by suggesting a plan {18} and thereby presenting that you are in control of how you choose to get rid of the alcohol {8}. Even though your idea of giving the alcohol to a friend would not work, you still presented that you have a choice {21} in getting rid of the alcohol {T-Highlight}.

Interaction

The therapist continues with her previous interpretation that {21-S} Sam has a choice to get rid of the alcohol by providing subsequent evidence of information Sam recently presented, such as giving the alcohol to a friend and thereby asserting {19-S} Sam's desire to also get rid of the alcohol. The therapist, at the same time, {T-Highlight} positively connotes Sam's deflection in order to help him save face and re-direct from him his experience of {~8} not having control over the alcohol and feeling {25} weak and a failure, to {8} him having control. She does this by presenting the {21-S} choice he made of how he might want to get rid of the alcohol.

Text

169 Sam: ((laughing; shakes his head)) No maybe not. He
 170 has enough of a problem with it already as it is any
 171 way.

Expansion

Sam: Your response to me, therapist, allowed me to save face and to feel that I {8} am in control of how I choose to get rid of the alcohol in the house, and therefore, I do not feel {~25} weak and a failure. I can now laugh at my suggestion without being defensive {~15} and can agree with you that maybe my choice of giving the alcohol in our house to Jack is not such a good idea {?18}.

Interaction

Sam expresses feeling {8} he has control over how to deal with the alcohol because of the {Highlight} therapist's positive connotation of his deflection. Hence, he {~25} does not feel weak and a failure or get {~15} defensive. Sam then agrees with the therapist's interpretation.

Text

172 Th: ((laughs; continual rotating hand gesture)) and
 173 um..... ((tilts head to the left)) I appreciate the
 174 humour. I wanted to say this to you last time; I
 175 appreciate the humour that you have the camaraderie you
 176 have going between you. ((Sam rubs his neck; Jill
 177 yawns)) (hhh) And: uh... on the one hand .. it makes
 178 it harder for you SAM.. that alcohol is in the house
 179 ((Jill looks toward Sam)) (hhh) BUT ON THE (Sam:
 180 *Yeah*) OTHER HAND you think we::ll if I wanted it, I
 181 would get it anyway ((singsong)) so (hhh)=part of you
 182 thinks (Sam: yeah) lets just keep it there. [*keep it
 183 there*

Expansion

Th: Since I am aware of the sensitivity of the subject matter so far, I would like to stop for a moment and comment on the strengths I notice in both of you. Highlighting strengths as well as difficulties in your relationship is part of my task as a therapist {T-Highlight}. Thus, I would like to say that I appreciate the humour and camaraderie that you both exhibit {T-Highlight}. Considering that getting rid of the alcohol in your house is a sensitive issue between the two of you, which is evident by you, Sam, using humour to deflect from this topic when Jill approached it, my concern is that this conflict about you, Sam,

getting rid of the alcohol from the house {Alcohol} will circumvent you from further exploring this topic because you may get defensive {15}. So, instead of focusing on this conflict which results in your defensiveness, I will highlight your strength in being able to diffuse tension through use of humour {T-Highlight}. Now that the tension seems to have decreased, which is evident by you yawning, Jill, and you rubbing your neck, Sam, I will focus on the conflict {Split} within you Sam. Focusing on your internal conflict will help to decrease your defensiveness {~15} as well as deter the possibility of an argument ensuing between you and Jill which will deflect from our issue at hand, which is for you to take responsibility for the choice of having alcohol in your house as well as your choice of drinking alcohol. The conflict {Split} I notice Sam, seems to exist within yourself in relation to having the alcohol in your house. On the one hand, the presence of alcohol in your home creates more difficulty in you abstaining from alcohol {~9} because you are compelled to wanting the alcohol. But then on the other hand, you rationalize {12} to yourself, "Well if I wanted to drink alcohol I would find some way of getting the alcohol so, ultimately having alcohol in our home is not going to affect whether or not I drink {9}. So, I continue rationalizing by saying to myself, 'Considering what this latter part of me said, I may as well keep the alcohol in our house.' I am convincing myself to keep the alcohol in our house." {12}

Expanding the text. The conflict is expanded to include what has been said so far in this episode. That is, that the presence of alcohol in the house makes abstaining from alcohol more difficult {~9} and that Sam uses rationalization to convince himself to leave the alcohol in the house. The conflict is emphasized by the therapist speaking louder when she says, "But on the other hand". The discourse marker "well" and the following singsong tone of voice is used to emphasize the way Sam rationalizes. The therapist's paralinguistic cues softens the confrontation of Sam's behavior.

Interaction

The therapist continues re-directing the conversation from the contentious issue of {Alcohol} getting rid of the alcohol by using immediacy to positively connote {T-Highlight} both the couple's strengths as well as Sam's use of humour to diffuse tension and thereby, she diffuses {~15} Sam's defensiveness which then allows them to address {17} Sam taking responsibility for his choice of keeping alcohol in the house. She then re-directs the conversation to Sam's earlier assertion of an A-Event. That is, an event known to Sam, but not necessarily known to either therapist or Jill and one in which Sam can expect to address without being contradicted. The therapist re-directs the conversation back to the original focus: {Alcohol} alcohol should not be in the house. She gives an interpretation of what Sam has said so far about what he experiences internally in regards to the alcohol being in the house by presenting it as a conflict {Split}. Consequently, she again indirectly challenges the proposition {?9} that the presence of alcohol does not bother Sam. She continues with her interpretation, using mitigation in the form of singsong voice, of how Sam's {12} rationalizing and justifying behavior results in him making a {21-S} choice to keep the alcohol in the house. The therapist introduces the conflict to also help Sam gain awareness of this conflict and how he creates this dilemma for himself. By repeating "keep it there" the therapist

heightens what Sam tends to say to himself and as well,
heightens the power of his rationalizing behavior.

Text

184 Sam: [WELL its the challenge. ((points toward bottle))
185 It-its there its like that sitting there. ((Jill
186 looks toward bottle while Sam points)) Like that
187 really catches my eye.. (Th: yeah ((scratches face;
188 Jill looks toward Sam))) and uh.. (hhh) you
189 know..((shrugs shoulders)) it-it's the same sort of
190 thing. It-it's benign ((points to bottle and looks
191 toward therapist)) as long as the top's on it. (Th: ah
192 huh) OK.. but when the top's off it and you're pouring
193 it then it's a threat. (hhh) and uh..... ((shakes
194 head)) so I feel as long as I can keep the top on it,
195 it's benign. ((points toward bottle)) I can see it..
196 vi-visually. (hhh) I can reach out and touch it. Yet
197 uh.... you know that's the challenge. There's the
198 challenge. There's the (hhh) the mountain you've got
199 to climb is right there. And that. I can't say
200 ((gestures)) it-re IT does reinforce me ((points to
201 self)) because I'm saying no to it. (hhh) So it. builds
202 inside me again. ((rolling hand gesture)) I mean I-I
203 as I-we went through this last time, ((gestures away
204 from self)) I quit h-half a dozen eight times through
205 the course of my life (hhh) and uh.... things that fuel
206 it like-a the first couple of times I quit (hhh)=I
207 could not have it in the house (hhh)=and ((rapid hand
208 gesture)) I could not walk into a bar.. pub or
209 anything.. and have a pop or have a mineral water or
210 something like that. I=just=simply=could=not=do=that=I
211 =would=not=allow=myself=to=get=into=a=situation (hhh)
212 =where I might fe-feel compromised. (hhh) And uh....
213 now I've gotten ((holds out open hands)) over that
214 step. So.. you know.. I-I-like-I you know it-it does I
215 mean=I wouldn't be talking about it if it didn't bother
216 me I guess in the house. But uh.. (hhh) it's [sort
217 of

Expansion

Sam: It is important for me to let you both know that I have made improvements in regards to my relationship with alcohol. That is, I can now be around alcohol without opening a bottle and drinking it which informs me that I am succeeding in my challenge and my battle against alcohol {8} and therefore, I am {~25} not weak and a failure. The reason I keep alcohol in our house {10} is because it is a challenge for me to keep the top on the bottle of alcohol {5} and to not {1} fail in

my goal by repeating my same on-off again pattern of drinking. A similarity exists with that large plastic bottle of alcohol sitting on that table and with having alcohol in our house. Seeing that plastic alcohol bottle in here is very unsettling for me. That plastic alcohol bottle is analogous to my experience of having alcohol in our house because that plastic bottle is as safe and comforting to me as is a real bottle of alcohol in our house, with the top on, sealing the bottle {9}. But when the top is off and I pour the alcohol, then the alcohol becomes a threat to me {~9} in terms of me starting to drink alcohol again. So, I feel as long as I can keep the top on the alcohol, alcohol is safe and comforting to me {5} and thus, the presence of alcohol is not what bothers me {9}. I can see alcohol and reach out and touch it. Yet, I know I should not touch the alcohol because when the top is off and I pour the alcohol, I will drink it. I am afraid that I will like it and continue drinking and you know that is the challenge. The challenge is to keep the top on the alcohol {5}. I do not feel in control of alcohol {~8} when the top is off. The close proximity of an actual bottle of alcohol to me symbolically represents the challenge, that is, my goal of maintaining my sobriety forever {1} which translates to me having to keep the top on the alcohol {5}. Keeping the top on alcohol is a hard struggle. I feel that trying to achieve this goal {5} and continually seeing alcohol in my presence does not help me to keep the top on {~9;~5}. I end up feeling like I am not in control and losing my battle with alcohol {~8}. Consequently, I feel weak and a failure {25}. Since I cannot tolerate feeling weak and a failure, I will not tell you that this is what I really feel. Instead, I will say that the presence of alcohol does help me to abstain from drinking alcohol {9}. But, as we discussed last session, I have failed to abstain from drinking 6 to 8 times through the course of my life. Considering that I failed and was never able to permanently abstain in the past, and that I am currently attempting to quit drinking again, I feel afraid {E1-S} I will fail again which would prove that I am incompetent and ineffective in dealing with alcohol {~2}. I can no longer tolerate feeling that I am weak and a failure {25} even when the desire to drink builds inside me and is fuelled by being in the presence of alcohol {~9}. Since I cannot accept myself as being weak and a failure {25}, I will say that it was only during my first two times of sobriety that I could not abstain from drinking alcohol when it was in my presence {~9}. During those first few times of quitting drinking, I could not have alcohol in our

house and I could not walk into a bar and drink a non-alcoholic beverage. I would not allow myself to be in a situation where I could not trust myself not to drink and to possibly compromise my resolve to not drink. But now I have accomplished that step in my sobriety. I can confront alcohol directly {5} and say No to drinking alcohol which then suggests that I am competent and effective in dealing with alcohol {2}. I want you both to know that my quitting drinking this time is different from those other two times. During those two times the presence of alcohol did not help me to abstain from drinking alcohol. Therapist and Jill, I have improved and now I can be around alcohol and not drink {9}. The presence of alcohol now does help me to abstain from drinking alcohol. Hence, I am showing myself and both of you, that I am not weak or a failure {~25}. But, as I speak so much about this topic {9}, I am beginning to have some doubt about what I am saying. I suppose I would not be talking so much about the presence of alcohol in the house if the presence of alcohol did not bother me {~9} {A-Behavior}. Also, by being in therapy about my problem with alcohol would naturally suggest that alcohol does bother me. I am able to admit that I may have a problem with the presence of alcohol because you, therapist, responded to me in such a way that allowed me to save face by reducing my defensiveness. I do not feel weak and a failure {~25} because I can tell you both that alcohol in the house bothers me {~9}.

Expanding the text. The discourse marker "well" refers back to the topic that was discussed. It also "shows that what will follow is relevant to what preceded, but also marks a distinct shift of topic" (Labov and Fanshel, 1977, p. 182). Sam's utterance is based on the therapist's previous statement, but he makes a shift by adding another element, which is the challenge to keep the top on the alcohol. To understand what Sam means when he says he keeps alcohol in the house because this provides a challenge, it is necessary to refer to previous utterances as well as other therapy sessions.

Sam's hesitations and self-interruptions indicate his struggle with explaining what he means. He uses the object in the room to give an analogy of how he is affected by alcohol in the house. The euphemism "really catches my eye" is translated to mean that he feels very disturbed and unsettled as he sees the alcohol bottle in the room. Sam uses impersonal pronoun when he refers to himself such as "you're pouring it", instead of saying "I am pouring it", particularly when it is apparent he is referring to himself. The indirectness of using impersonal pronouns may suggest lack of taking responsibility for actions in relation to alcohol.

The stress placed on the words "threat" and "benign" indicates that the pouring alcohol is threatening to Sam and may result in him resuming drinking, whereas having a top on alcohol is harmless, non-threatening, safe, and comforting and not tempting him to drink. For instance, he says, "I can reach out and touch it" indicating its comfort and safety. The challenge is to reach out and touch the alcohol and at the same time keep the top on the bottle. The euphemism "mountain you've got to climb" is translated literally to goals that he has to achieve.

Interaction

Sam interrupts and informs both Jill and therapist of his improvements in relation to alcohol and thereby asserting that {8} he is in control of his battle with

alcohol and is {~25} not weak and a failure. He then gives another reinterpretation of why he keeps alcohol in their house, which is the {5} challenge to keep the top on the bottle of alcohol and thereby, defending the challenges to {2} his competence in dealing effectively with alcohol, to {?H-Head} his status as a competent head of the household, and to {?8} him not being in charge and in control of his battle with alcohol. The essence of the "challenge" is to save face and to show that {8} he is in charge and control of alcohol both to himself, Jill and the therapist. Sam then self-interrupts. In his representation of an A-event, which is known to A and possibly not known to B, he gives information about how an external symbol such as a plastic bottle of alcohol is symbolically representative of how he experiences the presence of alcohol. He continues giving information about what is and is not a threat to him maintaining his goal {1} of quitting drinking forever which also serves to support {9} that the presence of alcohol does not bother him. He then evaluates that the {5} challenge to keep the top on the alcohol is a struggle for him when in the presence of alcohol and thereby he indirectly refutes {~9} that the presence of alcohol does not bother him as well as simultaneously admitting {~8} not being in control of his battle with alcohol and therefore, {25} being weak and a failure. To gain {8} control and not be perceived as {~2} incompetent and ineffective and to not {~25} feel weak

and a failure, Sam again asserts {9} that the presence of alcohol does not bother him. He then initiates a narrative, providing orientation to time, place, persons, and behavior, to illustrate that at one time {~9} the presence of alcohol did bother him, but not anymore {9}. He then gives an evaluation of his current success of {9} the presence of alcohol no longer bothering him and thereby defending that {~2} he is not incompetent and ineffective in dealing with alcohol. Before either Jill or the therapist can respond, Sam contradicts his earlier position {9} as he becomes {A-Behavior} aware that his behavior of talking so much about the presence of alcohol in the house might signify that {~9} the presence of alcohol does bother him and thereby challenging {?9} this proposition. As well, he indirectly acknowledges that {T-Highlight;T-Track} the therapist's response allows him to save face and admit {~9} that the presence of alcohol does bother him.

Considering that both Jill and the therapist want him to get rid of the alcohol, Sam knows that he would not be able to keep insisting the alcohol does not bother him. Thus, to save face he must concur with them. At the point of admitting that he is bothered by the alcohol in the house he becomes much more hesitant and self-interrupting. As he begins to analyze and explain the reason for being bothered by the presence of alcohol the therapist interrupts.

As Sam discusses how he is and is not affected by the

presence of alcohol it becomes apparent to him that the metaphoric image of a plastic bottle of alcohol represents his relationship to alcohol. He talks about how the symbol is analogous to his experience of being in the presence of alcohol and thus, the symbol has been created.

Text

218 Th: [it's: part of
 219 ((rotating hand gestures)) it's part-partly a challenge
 220 partly its a tea::se: ((holds up clenched hand))
 221 [xxx

Expansion

Th: I do not perceive you as weak or a failure {~25} Sam. Based on what you have been just saying, the alcohol in your house functions partly as a challenge for you {5} to keep the top on the bottle as well as partly functions as a tease dangling in front of you, tempting you to drink it {13;~9}. Alcohol is seductive {13} in that it tempts you to become weak and to drink it. Since alcohol is difficult to resist due to its enticing nature, you are not weak {~25}. It is the alcohol enticing you to take the top off {13}.

Expanding the text. The therapist uses hand gestures to intensify how alcohol dangles in front of him, teasing and tempting him to drink.

Interaction

The therapist interrupts Sam and indirectly acknowledges that she does not perceive him as {~25} weak and a failure by reframing the function of alcohol as being {13} a seducer tempting him to become weak and take a drink. She also reinforces Sam's proposition {5} that the presence of alcohol is a challenge that helps him to keep the top on the alcohol as well as indirectly challenges {?9} that the

presence of alcohol does not function to tempt him to drink.

Both Sam and Jill interrupt.

Text

222 Sam: [Yeah:

Interaction

Reinforcement

Text

223 Jill: [We should get rid of it then. ((Sam
224 scratches neck)) I have often thought of getting rid of
225 it.... ((outward thumb gesture)) because it's always
226 ((holds hand up)) out of the way. It is up in the
227 cupboards [way out of the way....

Expansion

Jill: Sam considering that alcohol is seductive {13} in teasing and tempting you to drink it, you {17} should get rid of the alcohol in our house {Alcohol}, particularly now that you concede its presence is a problem {~9}. Furthermore, the therapist is in agreement with me that the alcohol should not be in the house {Alcohol} which allows me to feel safer in asserting to you what I think about the alcohol in the house. I have often thought of getting rid of the alcohol in our house myself {19-J}, but I was afraid of your defensive reaction {4}. You have always deflected from my concerns regarding this topic by either using humour or cautioning me that alcohol was your problem {17}. I wanted to get rid of the alcohol and often thought of dumping the alcohol that is stored high up in our cupboards, and not easily visible to you, Sam. But, I did not do this because I did not want to interfere {20} with your responsibility of getting rid of the alcohol {17} and thus render you weak and a failure {25} for not dealing with the alcohol on your own.

Interaction

Jill interrupts the therapist and responds to the therapist's interpretation of the alcohol being {13} seductive in tempting Sam to drink by encouraging Sam that

he {Alcohol} should get rid of the alcohol in their house. The pronoun "we" is a mitigation Jill uses to refer to Sam. Jill interprets that the therapist's comments are in accordance with her position, which is that {Alcohol} alcohol should not be in the house. Jill uses this latter interpretation as well as the therapist's assertion that {13} alcohol is seductive, to more avidly persuade Sam to get rid of the alcohol. Jill then initiates a narrative about often {19-J} wanting to get rid of the alcohol herself and gives information about why she has not got rid it. The proposition asserted in the narrative is {19-J} that she wanted to get rid of the alcohol, but was {4} afraid of Sam's defensiveness and intimidation tactics. He also would deflect from her concerns. Jill begins repeating herself and Sam interrupts.

Text

228 Sam: [yeah, don't.. see: it.

Expansion

Sam: Yes, I agree that the alcohol is out of view and I don't it.

Interaction

Sam interrupts Jill and reinforces what she said and attempts to finish her sentence.

Text

229 Jill: and you
230 probably wouldn't even know it was gone until I got rid
231 ((lowers hand)) of it but then I thought if I did
232 that..... ((back and forth gesturing)) [without saying
233 anything then I'm interfering with

Expansion

Jill: Sam, you do not see the alcohol now because it is stored high up in the cupboards. But, if I were to get rid of the alcohol from our house {19-J} that would be the time that you would probably notice that the alcohol was gone. But then I thought to myself that if I got rid of the alcohol in our house without telling Sam, then I would be interfering {~20} with his preferred way of handling his battle with alcohol {17} and indicating that I thought he was {~2} incompetent and ineffective in dealing with alcohol. He has always handled his alcohol dependency in his own way {17}. I have not ever interfered {20} when he starts and stops drinking because with Sam when he has made up his mind I cannot sway him anyway. He is like this with practically anything he does {11}. When his mind is made up he does what he wants {11}. I have been afraid to get rid of the alcohol because Sam, you would perceive me as interfering {~20} with your struggle to quit drinking alcohol and thus, admitting your failure {25} with regards to quitting drinking. If I were to perform your task of getting rid of the alcohol this would render you weak and a failure {25} which is not my intent. I know how important it is to you, Sam, to save face and to not feel weak and a failure {~25}. Thus, I attempt to refrain from making you defensive and subsequently feeling weak, worthless, and a failure. I feel intimidated by Sam because he can get very angry and threatening {4}. He has clearly stated to me that he wants to handle his alcohol dependency in his own way {17} and I have accepted this decision and not interfered {20;W-Support}.

Expanding the text. The emphasis on the word "that", which is explicated as Jill getting rid of the alcohol, and the subsequent long pause and rapid back and forth gesture indicate that secretly getting rid of the alcohol would not be an appropriate behavior on her part. Sam and her have agreed the alcohol problem is his to resolve. As stated earlier, this issue is discussed more fully in both session one and three.

The reference made to Jill not interfering with Sam's

decisions about his alcohol dependency is made explicit by using information from session one. Jill states, "Well Sam does all of this type of thing [quitting drinking] on his own and I never interfere with when he starts drinking and when he stops drinking because with Sam when he has made up his mind you can't sway him with anything and that is practically about anything. So when his mind is made up that is it... he has always thought he had to conquer it on his own" (Session one).

In session four, Jill talks about arguing with Sam as not being easy and feeling afraid of him leaving or exploding. She talks about the fights they had and how she could not voice her thoughts, Sam would not listen to her, and how Sam had thrown objects in her direction. Sam admits that he had thrown objects at least three times. This behavior exhibited by Sam is aggressive and has intimidated and scared Jill and has resulted in her withdrawing from Sam. Withdrawing, she said, is a protective way of handling situations with Sam.

Interaction

Jill continues with her narrative even though Sam interrupts. She gives information about why she did not get rid of the alcohol which is based on the proposition {20} that she does not interfere with {17} Sam's alcohol related decisions because he gets {15} defensive and {25} feels weak and a failure and thereby, she asserts being competent in

her {W-Support} role of supporting her husband's status {H-Head} by not rendering him {~25} weak and a failure. Jill explains that her reason for not getting rid of the alcohol herself is because she did not want to challenge Sam's authority {~?H-Head} and wanted to be respectful of Sam's desire to handle his own alcohol problem. She also asserts in this narrative that {11} Sam's decisions are final and without influence from her which is consistent with Sam's role {H-Head} of being the head of the household and having authority. She then asserts that {15} Sam's defensive behavior has {4} intimidated and scared her resulting in her {~20} not interfering. Sam continually interrupts Jill and helps finish her sentences which may be his way of asserting {H-Head} his authority. It is evident that Jill has perceived that the alcohol was a problem and, therefore, it would be inaccurate to say she denies and rationalizes that Sam can control the alcohol.

Text

234 Sam: [you're
235 interfering you're interfering with my[

Expansion

Sam: Jill, you are interfering {~20} with my way of handling my battle with alcohol and emphasizing my belief of myself as weak, worthless, and a failure {25}.

Interaction

Sam interrupts and thereby substantiates Jill's assessment that she would be {~20} interfering with his

alcohol battle and rendering him {25} weak, worthless and a failure if she got rid of the alcohol.

Text

236 Jill: [his way

Text

237 Sam: [yeah... of
238 handling the situation

Text

239 Jill: of handling the situation ((gesturing first to
240 self and then back and forth)) which has always been=he
241 has always handled it his own way. So that's why I
242 have always not touched it. It's because.....
243 ((holds hands open on lap)) he wants to do it his way.
244 So::::.... [xxx xxx

Expansion

Jill: The way that Sam handles his battle with alcohol has always been in his own way {17}. Subsequently, I never discuss my concerns {20} about Sam's alcohol dependency with him because he has insisted that he wants to quit drinking in his own way {17}. I cannot sway or influence Sam about the alcohol dependency decisions {11}, nor about other decisions he makes. I do not discuss my concerns with Sam because my experiences of how he deals with alcohol is generally negative and when I express this to Sam, his response to me is to feel challenged which then leads to him getting defensive {15} and mean with me. Consequently, I am mindful of how I phrase my thoughts to Sam with the intention of softening the effect of my words. I may speak in vague terms and/or repeat his exact words because I do not want to upset him or make him defensive, which is ultimately not in my own best interest {4}. Sam's approach to quitting drinking, which has been to quit drinking for a while and then to start up again, has not been an effective way of handling his battle with alcohol {~2}, but I tend not to say this because he will get angry with me. So, instead of him getting angry and intimidating me {15} I let him handle his alcohol battle in his way {20} even though his way apparently does not work {~2}. I do not feel safe saying anything else because what I have said so far has made it apparent that I do not think he is effective in handling his dependency {~2}.

Interaction

Jill continues giving information about the reason she has not {20} interfered with Sam quitting drinking which is due to Sam insisting he {17} quit drinking alone and in his own way. She indirectly asserts that {~2} Sam has not dealt with his alcohol battle very effectively and thus, {~8} he is not in control of his battle with alcohol. She, however, does not {20} interfere because {15} he gets defensive and mean which results in her {4} feeling afraid and intimidated. Jill asserts that to protect herself from his intimidation {21-J} she allows {17} Sam to make alcohol related decisions.

Text

245 Sam: [which ((therapist gestures))
 246 apparently has not always worked but ((laughs))]

Expansion

Sam: Jill, I am aware that you are saying that the way I have decided to handle my own battle with alcohol {17} has apparently not always been successful {~2} because I have stopped and started drinking many times and have not quit drinking permanently as I said I would. When you say this to me, I begin to feel weak, worthless and a failure {25}. To avoid feeling like a total failure {~25}, I want to tell you that I have had some success in abstaining from drinking alcohol {2} which means that my way is effective {2}.

Expanding the text. Sam has been closely following what Jill has been saying throughout this episode and often finishes her sentence and thus, it is logical to assume that he is still doing so when he begins to speak in this speech turn. That is, Sam is completing Jill's last word, "So..."

This then would imply that "which has not always worked" is made in reference to Jill's preceding statement that Sam has been incompetent in handling his alcohol dependency.

Interaction

Sam interrupts Jill and finishes her sentence when there is a long silence and her words are inaudible. He acknowledges Jill's challenges of his competency {?H-Head} as head of the household and him {?2} effectively handling his alcohol battle. As a result of the challenges, Sam asserts feeling {25} weak, worthless, and a failure. He then defends against Jill's challenges by asserting {2} that he has been effective and experienced some success in quitting drinking and thereby asserting {~25} that he is not weak, worthless, and a failure. The therapist gestures indicating she would like to speak.

Text

247 Jill: [Yeah but it has worked for
248 quite a while

Expansion

Jill: Yes, Sam, you have had some successes {2} in your repetitive on-off again pattern, but overall your failure to quit drinking permanently has been happening for quite a while {~2}.

Interaction

Jill interrupts Sam and reluctantly agrees with his assertion {2} that at times he has been effective and experienced some success in dealing with his alcohol dependency. She then asserts that overall Sam {~2} has not

been effective and competent in quitting drinking permanently and thereby she indirectly asserts that Sam is {~H-Head} not competent in his status and {~8} not in control of his battle with alcohol.

Text

249 Th: [So.. you've left it for him
250 to do?

Expansion

Th: So what you are saying Jill is that you do not interfere {20} because you have chosen {21-J} to leave Sam with the responsibility of deciding {17} what to do with the alcohol in your house.

Expanding the text. The therapist's utterance refers to Jill's preceding utterance in which Jill asserted the reason for not interfering with Sam's decisions. Consequently, the word "it" then refers to leaving the decision about the alcohol in the house to Sam.

In acknowledging Jill's choice and decision to not interfere, the therapist is elevating Jill's status in the relationship. That is, Jill is capable of making decisions. The proposition reads as; {24} Jill's status is elevated.

Interaction

The therapist interrupts Jill and finishes her sentence. She interprets Jill's preceding assertion of {20} not interfering with {17} Sam's alcohol related decisions, due to {15} wanting to avoid his defensiveness and intimidation, as making a {21-J} choice to leave Sam with the responsibility of getting rid of the alcohol in the

house and thereby asserting {A-Behavior} that Jill become aware of and take responsibility of her behavior {21-J}. Moreover, by asserting that Jill has a {21-J} choice to {20} not interfere with Sam's decisions, the therapist simultaneously {24} elevates Jill's status in the relationship. That is, Jill is, and has been, involved in the decision making process.

The therapist's assertion also serves to not negate Sam's desire to want to be responsible for his quitting drinking and to handle alcohol in his own way and thereby allowing him to save face and fend off {~25} feelings of being weak, worthless, and a failure. This desire is stated more fully by Sam on line 254 when he says he wanted to block Jill from making decisions.

Text

251 Sam: Yeah

Expansion

Sam: Yes, Jill is blocked out of my decision about what I do with the alcohol in our house because I deal with the alcohol in my own way {17}.

Interaction

Sam responds to the therapist's assertion that Jill left decisions to Sam by providing a reinterpretation. He asserts that he blocked Jill from his decision about the alcohol {17} as opposed to {21-J} Jill wilfully leaving him with the decision and thereby asserting {17} alcohol related decisions are his to make. He wants to take responsibility

for quitting drinking on his own and to fend off feelings of being {25} weak and a failure.

Text

252 Th: Alright__ [So ah ((points finger upward, stands up,
253 picks up bottle and sits down))

Expansion

Th: Alright, considering all that we have said so far in our session about alcohol I would like to change the focus to another realm.

Interaction

The therapist re-directs the conversation from the discussion about the alcohol in the house and whose responsibility for this decision is, by saying "alright" and then getting the plastic alcohol bottle. Since there has been much talking about and explaining in regards to the alcohol, the therapist decides to change the focus of the discourse to directly interacting with a symbolic representation of alcohol. Although the symbolic representation of the alcohol dependence has been referred to by Sam in his earlier assertion, the therapist now makes the symbol explicit.

Text

254 Sam: [I have always blocked her out of my
255 decision making with it. We went through that [last
256 time too.

Expansion

Sam: I have always blocked Jill out of my decision making process in terms of how I will handle my alcohol dependency {17}. In our last therapy session, Jill and I also talked about how I make decisions about quitting and starting drinking and that I tend to handle my

alcohol dependency concerns in my own way {17}. When I make a decision I firmly abide to my decision and nothing Jill says or does can sway me from my decision {11}.

Expanding the text. The conversation from session one is included in this expansion.

Interaction

Sam interrupts the therapist and continues reinterpreting the therapist's previous interpretation that Jill left Sam to make decisions about the alcohol in the house. He defends that he had been the one to block Jill from {20} interfering and thereby asserting {17} he makes the alcohol related decisions, not Jill, and that {11} his decisions are final. He simultaneously asserts his competence in {H-Head} having the authority in their household. The therapist gets the symbol and Sam continues speaking. As he begins initiating a narrative providing orientation to time, persons, and behavior, he is interrupted by the therapist.

Text

257 Th: [It's
258 very.. very significant that um..... you uh.. want a
259 challenge ((sets down bottle and gestures left to
260 right)) and.. uh that you've been in agreement that he
261 should be__ make these decisions. You've blocked her
262 out. She has decided that it is your responsibility so
263 together, collaboratively ((hands held together)),
264 you've agreed that he's to make these decisions.
265 ((folds hands))

Expansion

Th: I am wanting to introduce this symbol, but before I do so, I want to acknowledge significant points you have both raised. First, Sam, being challenged to keep

the top on the bottle of alcohol {5}, to keep alcohol away from your presence, and to get rid of the alcohol in your home {Alcohol} are very important to your alcohol recovery process. Second, both of you have either explicitly or implicitly agreed {Collaborate} that Sam should be responsible for quitting drinking and to make the decisions about how he deals with his alcohol dependency {17} such as, whether or not to keep alcohol in your house. The way you agreed to this decision was by you, Sam, blocking out Jill from your desire to quit drinking and helping you deal with your alcohol dependency and deciding that you must conquer and control your own alcohol dependency {17}. Jill has also decided {Collaborate} that it was your responsibility to quit drinking as well as the alcohol dependency concerns being your responsibility {17}. So together, collaboratively, you have both agreed {Collaborate} that Sam is to quit drinking and to make alcohol related decisions {17}. Consequently, Sam, it is not only your decision, Jill also wants you to quit drinking, and so, together, you have decided that the best plan is for Sam to be responsible for quitting drinking {17} {T-Common}.

Expanding the text. Information from the preceding text was used to expand the significance of challenges. Furthermore, information from session three which relates to Sam believing he must conquer the alcohol problems on his own is included in the expansion. The decision referred to follows logically from what has been the focus of the conversation, that is, leaving alcohol in the house. The therapist places stress on the word "together" to aid the couple in understanding that they both are involved in the decision making process. Another proposition, not previously stated, arises in this speech turn: {Collaborate} Clients collaborate on decision making process.

Interaction

The therapist sits down, interrupts Sam, and gives an

interpretation and summary of what has transpired so far in this therapy session which includes: Sam is {5} challenged to keep the top on the alcohol; Sam is not to have alcohol in his presence because {~9} it bothers him; {Alcohol} alcohol should not be in the house and; that both spouses have either explicitly or implicitly {Collaborate} collaborated in deciding that {17} Sam is responsible for quitting drinking and dealing with alcohol related concerns, including getting rid of the alcohol in their house. The therapist {T-Common} accents both spouse's commonalities, that is, both are saying and wanting the same thing in regards to the alcohol. As the therapist emphasizes the couple's desire for Sam to quit drinking she indirectly challenges Sam's individualistic beliefs that {?~17} he is not responsible for quitting drinking, {?~2} incompetent and a failure and {?~8} not in charge of his battle with alcohol if he includes Jill in his decision making process, and thereby she asserts {16} that Jill is, and should be, a part of Sam's recovery process. She simultaneously asserts the proposition {Relational} that alcohol dependency is a relational experience affecting both spouses. By placing emphasis on {21-J} Jill's choice to {20} decide not to interfere with the alcohol decisions, due to her {4} fear and intimidation, the therapist indirectly {24} elevates Jill's status and thereby challenges Sam's tendency to negate Jill in the decision making process. Sam's negation

of Jill's choice is connected with him feeling worthless if he is not in charge and feeling {~H-Head} incompetent in his authority as head of the household.

Through her verbal words and the emphatic stress on "together" the therapist introduces the systemic concept that in marital relationships both spouses agree either overtly or covertly to how decisions are made. Subsequently, she also introduces the notion that they both have a choice and responsibility for how they behave in relation to making decisions. That is, Sam is not solely responsible for the alcohol in the house because Jill has supported him in keeping it in the house by not interfering. She also reinforces the relational aspect of the alcohol problem and thus, it is not just Sam's problem.

Text

266 Sam: hmhm

Expansion

Sam: Yes what you have said is correct.

Interaction

Sam reinforces what the therapist said.

Text

267 Th: (hhh) Right now.. ((lifts and holds up bottle;
268 sets it down and folds hands)) um.. alcohol..... I
269 guess is in the room. Fear is in the room. Fear and
270 apprehension (hhh) and you mentioned ((rolling hand
271 gestures)) a number of things that you.. are feeling
272 scared about. (hhh) And um.... where ((looks at
273 bottle, taps it and then looks at Sam and Jill)) would
274 you put this right now in this room? ((holds up
275 bottle))

Expansion

Th: Having decided three key issues: (a) the alcohol problem lies with alcohol being a seducer {13}, not with Sam being weak and a failure {~25}; (b) Jill is, and should be, involved in Sam's recovery from alcohol {16} and; (c) you both {Collaborate} decided that getting rid of alcohol is the primary goal {1-S,J} of our therapeutic work, we can now begin to focus on exploring getting rid of alcohol. At this moment {Here}, as we discuss how alcohol is a part of your lives {Relational} and the associated feelings of fear and apprehension {E1-S;J}, alcohol is metaphorically present in this therapy room. The fear for you {E1-S}, Sam, is that you may fail and be ineffective in your goal to quit drinking alcohol forever {~2} and repeat your on-off again pattern of drinking. And you, Jill, expressed feeling fear {E1-J} when Sam drinks alcohol and about knowing that his drinking will worsen. Considering that alcohol dependency is present in your lives {Relational}, where would you put this symbolic representation of alcohol in relation to yourselves right now {Here} in this room?

Expanding the text. The reference to the alcohol, fear, and apprehension is expanded to include what was discussed in an earlier segment. The discourse marker, "right now" is used to focus the therapy from what had transpired earlier to what is happening in the here and now.

Interaction

The therapist re-directs the conversation from how the couple has related to alcohol concerns and decision making processes in the past to focusing on the {Here} present, here and now. She indirectly asserts three key issues addressed thus far in this couple's therapy which include: {13} alcohol is a seducer and thus, Sam {~25} is not weak and a failure; {16} Jill is, and should be, involved in Sam's alcohol recovery and; {1-S,J} the therapeutic goal is

to get rid of alcohol from their lives. The therapist asserts that the therapeutic subsystem has agreed to these three redefinitions which then permits exploring the couple's relationship with alcohol. She gives an interpretation of alcohol metaphorically being present in the therapy session and in the clients' lives. She then refers to the associated feelings of {E1-S,J} fear to the alcohol which were expressed earlier. She then introduces the symbolic representation of the alcohol dependence and requests that the clients metaphorically place the alcohol in relation to themselves. By engaging with the symbol of alcohol dependence, the therapist emphasizes her desire to change from "talking about" alcohol concerns to directly interacting with the symbol of alcohol which would allow direct experiencing to occur.

Text

276 Sam: Outside the door. ((low tone of voice))

Expansion

Sam: I want the alcohol placed outside the door, away from me, because I want alcohol out of my life forever {1}.

Interaction

Sam's responds directly to the therapist's request indicating his goal, which is that he wants {1} the alcohol out of his life forever.

Text

277 Th: You would like it outside the door?

Expansion

Th: Are you saying that you would like the alcohol outside the door?

Interaction

The therapist {T-Track} uses tracking as she repeats Sam's statement. She phrases his statement into a question which clarifies and heightens Sam's goal and desire {1}.

Text

278 Sam: (hhh) Yeah ((scratches head, smooths hair))

Expansion

Sam: Yes, I would like alcohol to be outside the door {22-S} because my goal is to be rid of alcohol forever {1}.

Interaction

Sam directly responds to the therapist's question by stating agreement.

Text

279 Th: Where would you... put this right now Jill?

Expansion

Th: Where would you place the symbolic representation of alcohol at this moment {Here} Jill?

Interaction

The therapist makes a direct request to Jill. The therapist says "right now" indicating reference to the here and now. When the therapist asks both spouses where the alcohol would be placed in relation to them she is indirectly asserting the proposition that {Relational} alcohol is a relational problem affecting both spouses, not

just the alcohol dependent person. Furthermore, in asking Jill to decide where she would place the alcohol, the therapist is {24} elevating Jill's status to a person who can make decisions about alcohol.

Text

280 Jill: Outside because he wants it outside the door.
281 ((Sam laughs)) Outside the door.

Expansion

Jill: I would place the alcohol outside the door because Sam says he wants the alcohol outside the door. He is responsible for quitting drinking and deciding how he will deal with his alcohol dependency {17}. I have decided not to interfere with whatever Sam wants to do with the alcohol {20} because he gets defensive {15} when he thinks I am telling him what to do. However, since Sam wants the alcohol outside the door and out of our lives, as I do {22-J}, then I will say that I too want the alcohol outside {22-J}.

Interaction

Jill directly responds to the therapist's request. Jill mitigates her own desire {22-J} of wanting the alcohol outside the door by asserting that this is what Sam wants and thereby asserting {17} that Sam is responsible for handling alcohol related problems and that {20} she does not interfere due to his {15} defensiveness. She is {4} fearful and hence, careful to {20} not say or do anything that may result in Sam thinking she is trying to take charge which would result in {15} him getting defensive and intimidating. Thus, Jill asserts that she is in agreement with Sam about what to do with the alcohol to ensure she gets her desire met, which is to put the alcohol outside and to also not

have Sam act intimidating toward her. Jill asserts she decided to agree with what Sam wants in relation to the alcohol because she too wants the alcohol out of their lives. Jill repeats her assertion and thus accents her desire to have the alcohol outside the door.

Text

282 Th: So: you would put it outside the door. Would you
283 put it outside the door please? ((puts bottle on floor
284 and looks down))

Expansion

TH: So you are both in agreement {Collaborate} that you would like the alcohol outside the door {22-S,J}. Would you then please put the symbolic representation of alcohol outside the door?

Interaction

The therapist gives an interpretation based upon both spouses' preceding assertions that they would place the alcohol outside the door and thereby asserts {Collaborate} that they have collaborated in making this decision. She also Common} accents their commonality in wanting {22-S,J} alcohol out of their lives. She then makes a request for action (ie. to put alcohol outside the door). After making the request, the therapist looks downward so as to not influence who performs the task. The purpose of requesting the task is to heighten and intensify the experience of alcohol being out of their lives.

Text

285 Sam: *sure* ((picks up bottle and puts it outside the
286 door. Therapist smooths her hair and puts notepad on
287 table and leans forward)) ((Sam sits down and folds

288 arms over his chest))

Expansion

Sam: Sure, I will be the one to perform the task of putting the alcohol outside the door and away from Jill and I, because I am the one responsible for handling my alcohol dependency {17}. I have to be the one to perform the necessary tasks in relation to alcohol {17} {20} {H-Head}.

Interaction

Sam responds to the request for action by performing the requested action and thus, behaving in accordance with the proposition {17} that he will be the one responsible for dealing with alcohol related concerns. In performing the action, he thereby asserts his {H-Head} competence as head of household. Jill also gives support for both proposition {17} and {20} by not performing the task herself.

Text

289 Th: Now it's gone. At the moment....((back and forth
290 gesturing)) [you want it outside the door.

Expansion

Th: Now {Here} the alcohol is gone from this therapy room and from your lives. At this very moment {Here}, you both want the alcohol outside the door and away from your lives {22-S,J} {T-Common}.

Expanding the text. The discourse marker "now" indicates a shift in topic of conversation to the present, here and now, and away from their discussions about what the couple has done in the past with alcohol. The therapist is saying that symbolically the alcohol is gone from the therapy room and from their lives. She again emphasizes that she is referring to the here and now by saying, "at

this moment."

Interaction

The therapist re-directs the focus of the conversation to what is happening in the here and now. She gives an interpretation about what both spouse want {22-S,J} in the {Here} present moment and thereby accenting {T-Common} their commonalities. Sam interrupts after the long pause.

Text

291 Sam: [hm It's interesting

Expansion

Sam: After putting the alcohol outside the door I am aware that my internal bodily experience {A-Bodily} changed to feeling less apprehensive {E6-S}. This change in bodily response really surprises and shocks me.

Expanding the text. The "hm" suggests Sam's reflection on his new awareness of something happening internally which he describes more fully in his next speech turn. In reading ahead to line 303, Sam states that he experiences a bodily change of feeling less apprehension which surprises and interests him.

Interaction

Sam interrupts the therapist and begins to express his internal experience {A-Bodily} of performing the task.

Text

292 Sam: *Yeah*

Expansion

Sam: Yes, in response to your earlier interpretation, therapist, I do want the alcohol

gone from my life and from this room {22-S}.

Interaction

Sam's reinforcement is in response to the therapist's preceding statement that both spouses want to have alcohol out of the room.

Text

293 Th: And that's.... that's really important ((folds
294 hand)). Now that it is not here.... ((gestures toward
295 the door)) um.. I'm=I ((outward hand gesturing)) want
296 to ask you.. to uh.... to=let me know what's=that like
297 for you. ((looks from Jill to Sam and Jill looks at
298 Sam))

Expansion

Th: Wanting the alcohol outside the room and not in your lives {22-S,J} is really an important goal for you both {T-Common}. Considering that you both now have accomplished this task and the alcohol is not here in this room and not in your lives, I am wanting to venture into exploring your experience of performing this task. However, I am hesitating about introducing a more intense way of exploring your feelings in relation to the alcohol because I am cognizant that this is only our second therapy session, that I am also recently new to using this therapy model, and that typically both of you tend to be more comfortable in dealing with your problems in a cognitive domain. I am uncertain whether to introduce my next plan because I do not want to be intrusive {Non-intrusive}. Nevertheless, I will continue with following through with applying the intervention I had begun, and ask you both to tell me your experience of not having alcohol present {S-Express}.

Expanding the text. The discourse marker "now" suggests a change in topic of the conversation. The therapist wants to introduce the exploration of intense feelings that is particular to the ExST model. The therapist's hesitation, pauses, and self-interruptions reflect her uncertainty in implementing the intervention at

this point without intruding upon the clients' intense experiences. The hesitancy of the therapist may be due to her being new to this therapy model, wanting to be competent and effective in applying the model, this therapy case being one of her first ExST cases, and the clinical judgement that in a second session a therapist does not intrude upon clients by encouraging expression of intense experiences.

Interaction

The therapist continues asserting her preceding interpretation which is that {22-S,J} both spouses want the alcohol out of their lives and thereby accenting {T-Common} the commonalities between them. The therapist is not only speaking about the actual goal, to have alcohol outside the door, but also metaphorically being rid of alcohol forever. The therapist then hesitates and uses mitigation as she indirectly asserts not wanting {Non-intrusive} to be intrusive with this couple by having them express intense experiences and thereby regulating the intensity of their experiences. The therapist indirectly requests the couple to express what they experience and thereby requesting that they gain {Awareness} awareness and {S-Express} expression of their internal experience. This request is for an action to be performed (See Appendix C), not just a request for information, because the therapist is wanting them to develop awareness and to then experience this awareness in the here and now. By looking at both Jill and Sam, the

therapist indicates non-verbally that she wants a response from both spouses.

299 ((four seconds of silence))

Text

300 Sam: I feel less apprehensive to be frank with you uh
 301 .. that's interesting that is why I said OH THAT'S
 302 INTERESTING because I noticed it went down in me.
 303 (hhh) Uh when I first walked in and saw it..
 304 something triggered inside me and.. uh-uh you know it
 305 really.. caught my attention. Really caught my
 306 attention. And uh.. ((hand on face)) I thought it was
 307 a little unusual to have it in here (hhh) ((gestures
 308 away from self)) but=I=mean p-part of the therapy and
 309 everything else it is to see the reaction granted.
 310 (hhh) But uh.... apprehension levels have gone down.
 311 ((holds out open hands))

Expansion

Sam: To be honest with you, I feel less apprehensive {E6-S} since putting the alcohol outside the door and out of my presence {~9}. I am surprised at my reaction of feeling less apprehensive {E6-S} because I did not expect to be affected by having alcohol absent. That is why I said "Oh that's interesting" when I came back into the therapy room after putting alcohol outside. When I first walked into this room today and saw that large plastic alcohol bottle on the table I became aware of feeling very anxious {E5-S}. I questioned the appropriateness of having a plastic alcohol bottle in a therapy room when dealing with alcohol recovery. But then I suppose you, therapist, would say that part of the therapeutic process is to test how I would react to alcohol being present. I consider that to be challenging me, not supporting me {?Convey}, and possibly rendering me {~8} not in control and thus, weak and a failure {25} if I do not respond correctly. Although I felt very anxious {E5-S}, I am {8} still in control and still aware that my apprehension level has decreased {E6-S}.

Expanding the text. In saying, "to be frank with you", Sam indicates his directness and honesty in expressing his experience. Sam is surprised by the decrease in apprehension and indicates this by using a mitigating

phrase, "that's interesting" and then repeating it in a louder voice. The phrase, "something triggered inside me" is expanded to include his earlier assertion on line 187 when he talked about feeling anxious when he saw the bottle in the therapy room. The discourse marker "but" is used to shift the topic back to what he spoke about earlier, which is feeling less apprehension.

Interaction

Sam directly responds to the therapist's indirect request for action by expressing that he feels {E6-S} less apprehension as well as surprise because he did not expect to be affected by the absence of alcohol. That is, he did not perceive the problem to be the alcohol. Sam then initiates a narrative providing orientation to time, person, place, and behavioral setting. The narrative was about his experience of entering the therapy room in the beginning of the session and feeling {E5-S} anxious due to the bottle being present. He then interprets that the presence of the bottle is inappropriate in a therapy room and that it might be used to test whether or not he {?8} is in control of alcohol. The result of testing him in that way may possibly render {25} weak and a failure, depending on how he responded, and thereby he challenges {?Convey} the therapist's support and understanding. He concludes that he is {8} in control of alcohol. Sam then re-directs the conversation to his feeling of {E6-S} less apprehension.

Sam's internal process entails the following pattern: he begins this speech utterance by expressing how his body feels; he thinks about how interesting he finds the shift in his internal state; he explains his analysis of why he thought the bottle should not be present in the therapy room and; then he shifts back to expressing his feeling of less apprehension. This internal process described, suggests that when the feelings become intense for Sam, he shifts to a cognitive realm which is a safer and less vulnerable way of being for him. When he feels safe again he shifts back to experiencing intense feelings. This process was explicated and discussed in session one by the therapist.

Sam's process of going in and out of feelings is also consistent with the therapist's desire to not intrude upon the clients when intense experiences arise. Thus, the therapist and client co-create how they interact with one another to regulate the intensity of experiences. When the experiences or emotions become intense for Sam, both he and the therapist shift the intensity to him gaining control of his experience and thereby decrease his feeling of being weak, worthless, and a failure. For instance, when Sam begins to express feelings of fear he begins to feel not in control which leads to feelings of being weak, worthless and a failure. To prevent these feelings from emerging he then must gain control of his experience.

Text

312 Th: So ((gesturing)) what's it like Sam to have
 313 apprehension levels gone down a bit? *What's that
 314 like?*

Expansion

Th: As I said earlier, I am wanting to be careful to not intrude upon you, Sam, when you experience intense emotions {Non-intrusive}. So given that you have said your apprehension level has decreased {E6-S}, which I recognize is a surprise to you, what is your experience like of having your apprehension level decrease a bit Sam? {Awareness} What is this experience like for you? {Experience}

Expanding the text. The therapist uses a mitigating phrase, "a bit" in reference to Sam saying he experienced "less" apprehension. Using mitigating forms is consistent with the therapist's desire to not intrude upon clients when intense experiences emerge.

Interaction

The therapist asserts her desire {Non-intrusive} to not be intrusive and thus, regulates the intensity of experiences. She then acknowledges Sam's feeling of {E6-S} less apprehension and directly requests that Sam {Awareness} develop awareness of his internal state in the here and now. Simultaneously, she indirectly requests an action; that Sam focus on his experience of feeling less apprehension. By doing so, the therapist asserts that through {Experience} heightening and intensifying Sam's experience of less apprehension new awareness of his internal process as well as change may be created.

The therapist asks a question designed to keep Sam

focused on feeling less apprehension as well as deepen his experience of this feeling. She softly repeats the question to heighten his awareness and experience of his less apprehensive state. Repeating the request in a soft voice also provides more empathy which may possibly allow Sam to more fully experience the feeling.

Text

315 Sam: um.. I relax a little bit more.. you know (Th:
316 *yeah* ((nods))) um..... I'm not as tentative I-I
317 ((gestures)) already I feel like it=something has
318 changed.

Expansion

Sam: When I feel less apprehensive {E6-S}, I feel a little bit more relaxed {E4-S}. I no longer feel as tentative {~E5-S}, unsure, or cautious as I did when I first entered the therapy room today. However, I am uncertain what has changed, except I do know that I now feel more relaxed and less cautious {Novelty}.

Interaction

Sam responds directly to the therapist's request about what he experiences internally (Sam's representation of an A-event). He hesitates, stammers and pauses as he expresses feeling {E4-S} more relaxed when he experiences (E6-S} less apprehension. The therapist provides reinforcement for him to continue expressing his emotions. Sam then expresses feeling {~E5-S} less tentative {Here} at this moment and thereby, indirectly asserting the contrast in feelings from when he first entered the therapy room. He gives an evaluation of these current feelings as indication of the change he experiences {Novelty}.

Text

319 Th: ((gesturing outward and then up and down)) So feel
 320 a little more relaxed.. (Sam: yeah, yeah) ah not quite
 321 as tentative.. and.. a=little easier (Sam: hmhm
 322 ((nods))) in yourself. (Sam: yup) OK. ((lowers head
 323 and gestures to her body)) Where do you feel that in
 324 your-your body?

Expansion

Th: To ensure safety {Safety} in therapy, pacing is important. I do not want to work too fast with you, Sam, because I am aware that experiencing intense feelings is uncomfortable for you and that you may feel out of control which we know leads to you feeling weak, worthless and a failure {25}. I will then slow us down a little and help you to not feel weak and a failure {~25}. So, Sam, what I have heard you say is that you feel a little more relaxed {E4-S}, not quite as tentative, unsure, or cautious {~E5-S}, and a little easier {E4-S} within yourself now that alcohol is not within your presence {~9}. Ok, now that we both know what feelings you experience {A-Feeling} and you are still feeling in control and not feeling weak and a failure {~25}, will you focus internally and become aware of where you actually feel the relaxed, less tentative, and easier feeling in your body? {A-Feeling; Bodily}

Interaction

The therapist, through gesturing, pausing and matching Sam's style of speech, indirectly expresses concern about the possibility of {~8} Sam feeling out of control if his emotions become too intense, resulting in him feeling {25} weak and a failure, and thereby she asserts the need for {Safety} pacing the work. The therapist then repeats Sam's preceding expression of feelings {E-S} (Sam reinforces each feeling by nodding or saying yes) and thereby the therapist {Experience} heightens and deepens the contrast between feeling tense and relaxed. The pauses in her speech help to

heighten the feelings for Sam and aid him in {A-Feelings} developing awareness of his feelings when alcohol is not present. The therapist matches Sam's speech style and thereby she is {T-Track} noting and highlighting Sam's experiences which aids in establishing acceptance and safety in the therapeutic relationship as well as regulates the intensity of his experience. The therapist also indirectly denies {~9} the proposition that alcohol does not bother Sam. To aid Sam in gaining awareness of his {A-Bodily} bodily sensations associated with feeling {E4-S} relaxed and {~E5-S} less tentative when alcohol is not present, the therapist indirectly requests that Sam perform the action of focusing internally to where he experiences these feelings. This process also results in the therapist gradually increasing the intensity of and deepening his experience. The therapist is attempting to integrate bodily, cognitive, and emotional responses.

Text

325 Sam: Right across here ((back and forth gestures across
326 shoulders))

Expansion

Sam: I feel the relaxed {E4-S}, less tentative, unsure, cautious {~E5-S}, and easier {E4-S} feeling across my chest and shoulders {A-Feeling;Bodily}.

Interaction

Sam responds directly to the therapist's request and expresses {A-Feeling; Bodily} awareness of feeling the relaxation {E4-S} in his shoulder and chest area and thereby

{Experience} deepening the contrast between {E1-S} apprehension and tension and {E4-S} relaxation.

Text

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

Expansion

Th: Sam, you are saying you feel the relaxed {E4-S}, less tentative {~E5-S}, and easier {E4-S} feeling across your chest and shoulder {A-Feeling; Bodily} {T-Track}.

Interaction

The therapist responds by {T-Track} reflecting, noting and highlighting, through use of verbal words and gestures, Sam's experience. The intent is to gradually intensify and deepen this feeling of relaxation in his body when alcohol is not present, and thereby bringing this information {A-Feeling, Bodily; Experience} into his awareness.

Text

329 Sam: Yeah right across there

Expansion

Sam: Yes, you are correct, I feel the relaxed {E4-S}, less tentative {~E5-S}, and easier feeling {E4-S} right across my chest and shoulders {A-Feeling, Bodily}.

Interaction

Sam agrees with the therapist's empathic statement. He repeats where he feels the relaxation in his body, indicating he has {A-Feeling, Bodily} developed awareness of and experiences both feelings and bodily sensations, and thereby he further {Experience} deepens the contrasting

experience as well as intensifies his experience.

Text

330 Th: you feel easier (hhh)and ah.. ((looks downward and
331 continues gesturing across shoulders)) right across
332 there ah.. what is it like ((moves head forward))
333 inside there *right across there*?

Expansion

Th: Sam, you are experiencing feeling easier {E4-S}
right across your chest and shoulders. What do you
experience inside your chest and shoulder area as you
feel this easier feeling? {A-Feeling, Bodily}

Interaction

The therapist repeats Sam's expression of feeling {E4-S} easier in his chest and shoulder area and thereby {Experience} deepening the contrast between feeling tense and relaxed, easier, and calm. She continues to {T-Track} track his experience by matching his style of speech as she gradually aids in intensifying and deepening his experience. She also indirectly suggests that he develop and experience this {A-Feeling, Bodily} awareness. To continue heightening and intensifying his {A-Feeling, Bodily} contrasting experience, the therapist then indirectly requests that Sam focus internally and thereby develop {A-Feeling; Bodily} awareness of what he experiences in his body when he has this {E4-S} easier feeling.

Now that he knows what feelings he has, where he has the feelings, the therapist is helping Sam to become aware of what the feeling is like by requesting that he expand on what the easier feeling is like in that particular area of

his body. The intent of this intervention is to intensify and deepen the relaxed feeling in the chest and shoulder area and to have the client experience this feeling on a deeper level.

Text

334 Sam: It feels calm right now. (Th: *ah*) And that's
 335 where it seems to have welled up into. ((continues
 336 with shoulder gesture)) Th-The apprehension was right
 337 through there ((drops hands on lap)).

Expansion

Sam: I feel calm {E4-S} inside my shoulder area at this moment {A-Feeling; Bodily}. However, as I continue focusing on this calm feeling in my shoulders, I am aware that in this calm area is where I previously felt my apprehension {E1-S}. That is, my feeling of apprehension {E1-S} was located right in my chest and shoulder area {A-Feeling; Bodily}.

Expanding the text. When Sam refers to "that's where it seems to have welled up into" he is no longer referring to the calmness, but is talking about the apprehension welling up in his shoulder and chest area. This is based on his following sentence in which he says "the apprehension was right through there". He shifts from his present feeling of calmness to his previous apprehensive state.

Interaction

Sam directly responds to the therapist's request and expresses feeling {E4-S} calm, indicating {A-Feeling; Bodily} awareness of both feelings and bodily sensations when alcohol is not present. He then gestures and stammers as he expresses that in this calm area of his body he previously felt {E1} apprehension and thereby {Experience}

he intensifies, deepens and heightens the contrast of apprehension and calmness. Sam is noticing the contrast between feeling apprehension and calmness and thus, developing an experience of difference {Novelty}.

Text

338 Th: *Yeah:* ((nods; gestures to shoulder)) So__

Expansion

Th: Yes, I understand {Convey} Sam that you experienced apprehension {E1-S} in your shoulder and chest area when alcohol was present {~9}. Now that the alcohol is gone you have a calm feeling {E4-S} {A-Feeling}.

Interaction

The therapist, through using gestures and soft spoken speech, agrees empathically with Sam {Convey}. She {T-Track} notes and highlights his experience which aids in establishing acceptance and safety in therapy. The therapist is about to continue speaking when Sam interrupts.

Text

339 Sam: ((gestures to shoulders)) But then I have been
340 injured through here too

Expansion

Sam: Even though I experienced a change in myself, I do not know if the apprehension {E1-S}, tentativeness, anxiety, and uncertainty {E5-S} that welled up in my shoulders is directly linked to the alcohol being present. I have also been physically injured in my shoulders so maybe those apprehensive, tense, and anxious feelings {E1-S; {E5-S} are attributed to the injury, not the alcohol being present {?~9}.

Interaction

Sam continues completing his preceding sentence and asserts that the {E1-S; E5-S} feelings of apprehension may

be linked to a physical injury and thereby indirectly challenging that {?~9} the presence of alcohol bothers him resulting in him feeling apprehension and tension in his shoulders.

By focusing on the physical injury as creating his feelings of apprehension and tension, Sam is lessening the intensity of the impact of alcohol on his life. He is attempting to place the feelings of apprehension, tension, and anxiety onto an injury rather than onto the alcohol.

Text

341 Th: Right

Expansion

Th: I recognize that you are feeling doubtful about the link between alcohol and apprehension. I also know that you have an injury in your shoulder area which you think could contribute to you feeling apprehension {Convey}.

Interaction

The therapist indirectly acknowledges that Sam feels doubtful and that he has an injury and thereby asserting {Convey} that she understands his dilemma and his desire to regulate the intensity of his experience.

Text

342 Sam: So you=know ((drops hands on lap))

Expansion

Sam: So, considering that I also have an injury in my shoulder area, I have some doubt about linking my feeling of apprehension {E1-S} to the alcohol being present {?~9}. Consequently, I am not sure whether I can accept that the problem of my tension and apprehension in my shoulders lies with the alcohol. I

think the problem is connected with the injury.

Interaction

Sam continues talking about his doubt and challenge to {?9} the presence of alcohol not bothering him. He uses the discourse marker "you know" to enlist support from both Jill and the therapist in regards to what he spoke of earlier. That is, Sam refers back to his previous assertion of {9} the presence of alcohol not bothering him and thereby he continues to lessen the intensity and impact of alcohol in his life. However, he soon withdraws from the verbal interaction by stopping his speech turn and dropping his hands on his lap.

Text

343 Th: ((continues with shoulder gestures)) So: Right now
 344 your experience is that the apprehension uh.. a few
 345 minutes ago=a few seconds ago changed to..
 346 calmness.

Expansion

Th: I understand your dilemma Sam {Convey}. But, what I want to say is that at this moment {Here} your experience is that the apprehension {E1-S} that you felt a few minutes in your shoulder area, or more accurately a few seconds ago, changed to calmness {E4-S} after alcohol was placed outside the door {~9} {T-Track}. In other words, the change you experienced in your shoulders occurred when you put alcohol outside. If the apprehension and tension in your shoulders was linked to your injury, then these feelings would not have changed to calmness when you put alcohol outside. Therefore, I would say that your feeling of apprehension {E1-S} in your shoulder area is directly linked to alcohol being in the room {~9}, not the injury.

Interaction

The therapist {Convey} conveys understanding of Sam's

dilemma and then re-directs the conversation to {Here} the present and {T-Track} highlights what just happened with Sam {Here} in the therapy session. She asserts that his feelings of {E1-S} apprehension changed to {E4-S} calmness after alcohol was not present and thereby, she asserts that {~9} the presence of alcohol does bother Sam, and that the problem is the alcohol, not the physical injury. By presenting the sequence of events that occurred, the therapist asserts the logical conclusion and accents that Sam did in fact experience a change in his body when alcohol was not present.

By "talking about" and analyzing whether or not the apprehension was linked to the alcohol suggests that Sam is becoming more cognitively oriented and removing himself from directly experiencing what is happening within himself. Consequently, the therapist re-focuses Sam onto his experience of first feeling apprehension and then calmness as she summarizes what had occurred and thereby she gradually intensifies and deepens his experience with alcohol. She indirectly asserts that she does not want him to "talk about" his experience and focus on past experiences, but wants him to directly experience the difference between apprehension and calmness when alcohol is not present.

Text

347 Sam: hmhm.((nods)) Settled down. sure

Expansion

Sam: Yes, therapist, when you describe what happened to me as you just did, I must agree that my feeling of apprehension {E1-S} in my chest and shoulder area changed when I put the alcohol outside the door {~9}. Since I am not quite ready to fully accept the contrast between feeling apprehensive when alcohol is present and calm when alcohol is absent, I will mitigate the change that occurred by saying that the feeling of apprehension {E1-S} changed to me feeling less apprehension {E6-S}, not all the way to feeling calm {~E4-S}. The leap from feeling apprehension to calm is too great for me to accept at this moment. But, I am certainly willing to concede to my re-definition of feeling less apprehension {E6-S} when alcohol is not present {~9}.

Interaction

Sam agrees with the therapist's evaluation of his experience in the session and thereby acknowledges that an internal change occurred within his body from feeling {E1-S} apprehension to feeling {E6-S} less apprehension which was directly linked to him putting the alcohol outside the room. Thus, he indirectly asserts that the {~9} presence of alcohol bothers him. Sam then asserts a correction to the therapist's evaluation. He negates the feelings shifted from {E1-S} feeling apprehension to {~E4-S} feeling calm. Instead, the shift was from {E1-S} feeling apprehension to feeling {E6-S} less apprehension and thereby, Sam indirectly asserts, through use of mitigation, that he is not yet willing to accept the intensity of feelings and experiences associated with the alcohol. That is, he is not ready to let go of the idea that alcohol is not the problem and therefore, he lessens the impact of alcohol on his life by

lessening the contrast between apprehension and calmness. Sam's correction is also supported by referring back to his preceding utterances on line 334. At that time, he made reference to feeling calm in relation to his "easier feeling" which is not the same as his apprehension changing to calmness.

Text

348 Th: *Yeah:* ((nods, continues shoulder gesture)) OK.
 349 settled down a bit. (hhh)=so that calmness that sort
 350 of settling down a bit. (hhh) Do you have any sense
 351 of-of feeling the sensa-sation of that? What's that
 352 like? ((holds hand on chest))

Expansion

Th: Ok, I understand and accept your correction that your experience was more of the apprehension level lessening {E6-S} when you put the alcohol outside the door, rather than an experience of calmness {~E4-S}, as I suggested {Convey}. Again, Sam, I am aware of this experience being intense for you which is evident by your use of mitigation. Therefore, I am wanting to be respectful of your experience and not intrude upon these intense experiences {Non-intrusive} and, yet, I am wanting to go ahead with the intervention I have introduced and ask you to experience your emotions a bit more. However, I will attempt to be careful and not intrude as we move along with you experiencing yourself in relation to the alcohol not being present. So, Sam, you experience calmness, or as you pointed out, you feel less apprehension {E6-S} {T-Track}. Since you have doubt about your apprehensive feeling being related to alcohol being present, I want to focus on the difference you felt when the alcohol was not present. Do you have any awareness of feeling the physical sensation associated with feeling {E6-S} less apprehension in your chest {Awareness}? What is the physical sensation of feeling {E6-S} less apprehension like in your chest area? {A-Bodily}

Expanding the text. The discourse marker "Ok"

signifies that the therapist has understood and accepted Sam's correction. She repeats his statement that his

experience is one of "settling down a bit". However, she quantifies this feeling by adding a modifying form, "a bit". This is consistent with Sam's earlier statement of feeling "less apprehension" which also mitigates the feeling. The therapist corrects herself when she says "calmness" rather than "settled down", but adds a mitigating phrase "sort of settling down." Her hand gesture to her chest area indicates she wants Sam to focus on his physical sensation.

Interaction

The therapist acknowledges and agrees with Sam's correction. She acknowledges that Sam does not experience the change as {~E4-S} calmness, but as {E6-S} feeling less apprehension. She interrupts and corrects herself when she again repeats her definition of his experience of "calmness" and then adds his correction of "less apprehension". After affirming his feelings, the therapist indirectly acknowledges the intensity of this experience for Sam, which is evident by him using mitigation. She then indirectly asserts {Non-intrusive} not wanting to intrude on his intense emotions and experiences and thereby regulates the intensity and contrast of his feelings. The therapist then re-directs the conversation back to his {E6-S} feeling of less apprehension, by {T-Track} noting and highlighting his experience, and thereby re-focusing on his doubt that his feeling of apprehension in his shoulders is linked to the presence of alcohol {~9}. She then requests that Sam

experience the {E6-S} feeling of less apprehension and to describe the sensations that are associated with this feeling and thereby she indirectly asserts that {Awareness} Sam develop awareness of his physical sensations. She first asks a yes-no interrogative, requesting whether he has awareness of physical sensations associated with {E6-S} feeling less apprehension. Before Sam can respond, she indirectly requests that he {A-Bodily} develop awareness of and experience bodily sensations in his chest area. The purpose of the request is heighten and intensify his {Experience} experience of feeling {E6-S} less apprehensive when alcohol is not present which may result in gaining awareness and change as well as lessen his doubt about the link between tension and alcohol.

The therapist is accompanying Sam in his process of "going in and out of emotions". That is, to briefly experience the intensity of his emotions/experiences and then to talk about, analyze or explain what is happening. The process is then repeated.

Text

353 Sam: You mean physically? (Th: yes ((nods))) yes

Expansion

Sam: Are you asking me whether I am aware of the physical sensation of the apprehension lessening {E6-S} in my chest? Yes, I do have an awareness of feeling the physical sensation of the apprehension {E6-S} lessening in my chest {A-Bodily}. But, I am hesitating about focusing on my physical sensation because I am still having difficulty accepting the change I experienced in my body as being linked to alcohol not

being present.

Interaction

Sam requests information using the rules of embedded requests which, in this case, is a rhetorical request for information, and thereby indirectly refusing the request so as to lessen the intensity of his experience of alcohol. He is experiencing difficulty accepting the impact alcohol has in his life. The therapist nods yes to his request and Sam responds in the affirmative to her first question. That is, he asserts having an awareness of feeling the physical sensation when he feels {E6-S} less apprehension in his chest {A-Bodily}, but does not comply with expressing his awareness due to not yet being ready to accept that the change he experienced is linked to alcohol. He has held onto the belief that he is in control of alcohol and that the presence of alcohol does not adversely affect him.

Text

354 Th: ((continues holding hand to chest))
 355 physically=what's it like physically?

Expansion

Th: I recognize that you may find it difficult to express what you experience physically because you still have some doubt about your change in feelings being linked to the alcohol {Convey}. Although you are hesitating, I am still inviting you to continue focusing internally to your physical sensations and become aware of what you experience physically {A-Bodily} when you feel less apprehension {E6-S}. I will ask you again. What do you experience physically {A-Bodily} in your chest and shoulder area when you feel the apprehension lessening {E6-S}? {Experience}

Interaction

The therapist indirectly acknowledges Sam's hesitation and doubt and thus, {Convey} conveys her understanding. The therapist then reinstates her request more explicitly, which is that he is to focus internally and {A-Bodily} develop awareness of and express the physical sensations he experiences in relation to feeling less apprehension and the alcohol not being present and thereby she {Experience} intensifies, deepens and heightens this experience. She also uses hand gestures indicating she wants him to focus on the physical sensation in his chest. Essentially, the therapist wants Sam to gain {A-Bodily} awareness of how he physically experiences {E6-S} apprehension lessening in his chest area when alcohol is outside the door so that he may achieve {Novelty} alternate ways of being in relation to alcohol not being present.

The goal of ExST is to help clients become aware of not only emotional, cognitive or behavioral states but also physical states. The therapist has moved Sam from experiencing his emotions, cognitions and now experiencing his physical state when alcohol is not present. Rather than have him experience what it is like when alcohol is present, she has decided to focus on his experiences when alcohol is not present. Since he is probably more able to identify what he feels in relation to alcohol being present, she is helping him to experience and become aware of other aspects

of himself when he is not in the presence of alcohol. She is not focusing on the problem "alcohol", but letting him know there is an alternate experience.

Text:

356 Sam: Ah.. ((shakes head)) the muscles have relaxed th-
 357 the ((gestures to shoulders)) you know.. right up in
 358 here ((drops hands on lap)) y-you know definitely
 359 relaxed subsided some [xxx

Expansion:

Sam: Alright, I will focus on what I experience physically in my chest and shoulders. As I focus on my physical state, I am aware that my muscles in my chest and shoulder area have relaxed {A-Bodily}. My muscles in this area have definitely relaxed and the tension has subsided to some degree {A-Bodily}.

Expanding the text. The intensity of this experience for Sam is evident by his hesitation, pauses, and shaking of his head. He uses hand gestures to indicate that he is referring to his shoulder and chest muscles.

Interaction

Sam directly responds to the therapist's request by complying and focusing internally. He then expresses feelings of {E4-S} relaxation in his chest and shoulders and thereby indicating that he has developed {A-Bodily} awareness of and experienced the bodily sensation of feeling {E6-S} less apprehension. He then more definitely asserts feeling that his muscles are {E4-S} relaxed and {A-Bodily} that he has gained this awareness. Sam then uses mitigation to assert that the tension in his muscles subsided to some degree and thereby indirectly lessening the contrast in

sensations and concurrently lessening the impact of alcohol on his life. By conceding that the change in his internal state is from tension to less tension, this suggests less impact than if it were to shift from tension to relaxation. Conceding to this latter shift would be too drastic of a change and would also heighten the contrast between feeling relaxed and tense and hence, Sam mitigates the impact.

Text:

360 Th: [So the muscles.. ((continues
361 with shoulder gestures)) you have a-an awareness that
362 the muscles have relaxed

Expansion

Th: So, Sam, you notice and have developed an awareness {A-Bodily} that your muscles in your chest and shoulder area have relaxed {E4-S} when the alcohol is outside the door {Novelty} which suggests that the presence of alcohol does bother you {~9}.

Interaction

The therapist interrupts Sam when his words are inaudible. She empathically responds to Sam's feeling {E4-S} of relaxation by {T-Track} noting and highlighting his experience and thereby indirectly interpreting that his {A-Bodily} physical awareness, which is that his chest and shoulder muscles relaxed when he put the alcohol outside the door, has resulted in him {Novelty} gaining awareness of an alternate way of being. That is, he feels relaxed when alcohol is not present. The therapist reflects what he said to aid in gradually intensifying his experience as well as deepening the contrast between tension and relaxation. She

also indirectly denies his assertion that the {~9} presence of alcohol does not bother him.

Text

363 Sam: hmhm ((nods)) hmhm

Expansion

Sam: Yes, I agree with you that I have developed the awareness {A-Bodily} that my chest and shoulder areas are relaxed {E4-S} when alcohol is not present {Novelty; ~9}.

Interaction

Sam agrees with the therapist's interpretation that he has developed a physical {A-Bodily} awareness of experiencing relaxation when alcohol is gone and thereby denying the proposition that {~9} the presence of alcohol does not bother him.

Text

364 Th: Ok.. OK.. ((continues with shoulder gestures)) And
365 if those muscles had a voice.. what would they say
366 right now?

Expansion

Th: OK now that we have identified that you have developed an awareness {A-Bodily} of feeling relaxed {E4-S} in your chest and shoulder area when alcohol is outside the door {~9}, I want to explore this sensation further. But, again, I am hesitating because I am aware of intensifying your feelings too much Sam, especially considering that this is only our second session and that you have a desire to be in control. I do not want to be intrusive when your experiences are intense {Non-intrusive}. My hesitation is also about wanting to effectively introduce this intervention and being aware that you may experience awkwardness in doing as suggested. However, I will proceed with following the process of implementing this intervention and hence, ask you to focus on your muscles. If we were to imagine your relaxed chest and shoulder muscles had a voice and could speak, what would your relaxed chest

and shoulder muscles say right at this moment? {A-Cognition}

Interaction

The therapist reinforces and {T-Track} highlights the {A-Feeling; Bodily} awareness that Sam has developed thus far, and thereby indirectly asserts denial of the proposition {~9} the presence of alcohol does not bother Sam. Before venturing into new territory the therapist expresses the reason for her hesitation which includes: not wanting to {Non-intrusive} intrude upon clients when intense experiences emerge, especially in a second therapy session, and; wanting to implement the intervention competently and effectively and thereby, the therapist accents {Safety} the importance of pacing the therapeutic work by matching the needs of the client as well as regulates the intensity of the therapeutic process. She then indirectly requests Sam to perform an action requiring him to focus internally and develop awareness of and experience {A-Cognitions} cognitions associated with his recent {A-Feeling; Bodily} awareness of feelings and physical sensations and thereby, she {Experience} deepens and heightens his experience of alcohol not being present. This intervention is introduced after the therapist establishes with Sam that the presence of alcohol makes him feel tense and that the absence of alcohol makes him feel calm, or less tense. To heighten and deepen this contrasting experience in the here and now the therapist asks his muscles to speak.

Text

367 Sam: Gee I don't know..... Thanks. ((laughs; opens
 368 hands and drops on lap)) I don't know

Expansion

Sam: I am surprised by your request and feel awkward doing as you requested because I typically do not imagine my muscles having a voice. However, since you have generally demonstrated your support of me in therapy, allowed me to save face when necessary, and considering that you are the therapist and must have some reason for suggesting this action, I will comply with your request. My first thought is that I do not know what my relaxed chest and shoulder muscles would say {~A-Cognition}. As I think about this question some more, I am aware that my relaxed chest and shoulder muscles might feel grateful and say "Thanks Sam for allowing me to relax." {A-Cognition} But, then I don't know about this request because it feels weird to me.

Expanding the text. The word "gee" is "used as an introductory expletive or to express surprise or enthusiasm" (Webster's ninth new collegiate dictionary, 1983, p. 509).

Sam's subsequent phrase, "I don't know" and pause also indicates his surprise at the therapist's question.

Interaction

Sam begins by briefly putting off the request. Although he apparently feels awkward about the therapist's request, which is evident by his hesitation and laughter, he responds. Sam's direct response to the request indicates that he perceives the request to be valid and thereby he indirectly asserts that the therapist has been competent {T-Track} in both noting and highlighting his experiences and subsequently, establishing acceptance and safety in the therapy. Sam initially denies {~A-Cognitions} having

awareness of cognitions related to the relaxed muscles. Shortly thereafter, he expresses {A-Cognition} his awareness and thereby {Experience} deepening and heightening the contrast between alcohol being present and absent and asserting that the presence of alcohol makes his muscles tense {~9}.

Text

369 Th: ((rapid hand rolling gestures)) So they might
 370 say=they=might=say ((Sam leans to the right, puts head
 371 in hand)) *Gee I don't know* ((Sam laughs; "yeah"; and
 372 then crosses his legs)) or-or.. sure__ sure__ or they
 373 might say thanks=or they might say pro-likely ((nods
 374 head)) they would say both.

Expansion

Th: So you imagine your relaxed chest and shoulder muscles might say at first, "Gee I don't know what to say" {A-Cognition; T-Track}. I recognize that due to your laughter you may be feeling awkward with my request to have your muscles speak {Convey}. I want to assure you that the response you just gave is appropriate and your muscles might say that {Convey}. Or your relaxed chest and shoulder muscles might feel grateful and say, "Thanks Sam for allowing me to relax" {T-Track}. Or, more likely, your relaxed chest and shoulder muscles would say both, "Gee I don't know what to say" and "Thanks Sam for allowing me to relax." {A-Cognition; T-Track}

Interaction

The therapist acknowledges Sam's expression of his cognitions by {T-Track} noting and highlighting his experience. She then interprets his {A-Cognitions} cognitions as being related to his relaxed muscles. As it becomes noticeable that Sam is feeling uncomfortable, by him shifting body position and laughing, the therapist begins speaking rapidly as she reassures him that his response is

appropriate and acceptable and thereby conveying {Convey} that she understands and supports Sam and simultaneously regulating the intensity of his experience. Furthermore, as she highlights the cognitions associated with Sam's muscles, the therapist simultaneously confirms that {~9} the presence of alcohol does bother Sam, because it makes him feel tense, and also {Experience} deepens the contrast in experiences when alcohol is present and absent.

Text

375 Sam: Yeah. Quite possible. ((mumbling))

Expansion

Sam: Although, I usually do not imagine my muscles speaking, I agree that my relaxed chest and shoulder muscles would probably respond in both ways you and I suggested {A-Cognition}. This then would then probably suggest that the presence of alcohol makes my muscles tense {~9}.

Interaction

Sam expresses agreement with the therapist's interpretation of his experience and thereby asserts, through use of mitigation, that he is in the process of accepting that {~9} the presence of alcohol makes his muscles tense and hence, he gradually intensifies his experience. The use of mitigation is consistent with Sam's tendency to lessen the impact of alcohol and the contrasting feelings.

Text

376 Th: Yeah. ((gestures to her shoulders and chest)) Ok
 377 so I appreciate your willingness to-to just explore
 378 that a bit=so that's important that you notice

379 ((gestures behind her)) when alcohol went outside the
 380 door.. ((Jill looks at therapist and fidgets with
 381 fingers. Therapist gestures to chest and shoulder area
 382 and looks at Sam)) that you. felt calm, less
 383 apprehension, and.. uh that's an easier, more relaxed
 384 feeling.

Expansion

Th: Yes, based on your experience in here Sam, your muscles become tense when alcohol is present and relaxed when alcohol is absent. Sam, I recognize that your experience in here may be getting too intense for you, resulting in you possibly feeling not in control and thus, feeling weak and a failure {25}. Since I do not want you to feel {~25} weak and a failure and do not want to intrude upon you when intense emotions emerge {Non-intrusive}, I will focus on diffusing the intensity of your experience by highlighting your strengths {T-Highlight}. I admire your willingness, Sam, to allow yourself to explore your feelings, thoughts, and sensations in your body {Awareness} for a little while after you put alcohol outside the door {T-Highlight}. It is important in your alcohol recovery process to notice the impact of alcohol on you when alcohol is both present and absent {Awareness}. You noticed in here that when alcohol is not present in your life that you experience within your chest and shoulder area a feeling of calmness {E4-S} and less apprehension {E6-S}. This calmness and less apprehension is an easier {E4-S}, more relaxed {E4-S} feeling {Novelty}.

Expanding the text. The pro-form "to just explore that" refers to Sam's recent exploration of his internal experience of alcohol outside the door. This is determined by the therapist's following reference to Sam feeling calm, less apprehension, and easier in his chest and shoulder area as alcohol was outside the door. The therapist again gestures to her chest and shoulder to signal what area she is referring. She uses a mitigating phrase "a bit", indicating that Sam explored his internal state to a small degree which is consistent with regulating the intensity of

experiences.

Interaction

The therapist affirms that Sam's muscles are tense when alcohol is present and calm when alcohol is absent and thereby indirectly asserting that {~9} the presence of alcohol bothers Sam. She then acknowledges the intensity of emotions that Sam experienced in therapy and indirectly expresses that this intensity may result in {~8} him feeling not in control and thus, {25} feeling weak and a failure. She also indirectly interprets that the intensity of Sam's experience may be too high and thereby asserts the proposition {Non-intrusive} that she, as a therapist, will not intrude upon intense experiences that emerge. She then {T-Highlights} highlights his strength in taking the risk to experience his emotions, thoughts, and bodily sensations in the therapy session and thereby she regulates the intensity of his experience. She then asserts the importance of Sam being {Awareness} aware of his internal experience of {E4-S} calmness and {E6-S} less apprehension when alcohol is not present and thereby indirectly asserting that {~9} the presence of alcohol does bother him and, therefore, {Alcohol} alcohol should not be in their house. Talking about his experience serves to again regulate the intensity of his experience. The therapist also simultaneously summarizes Sam's experience {A-Feeling} of feeling calm when alcohol was outside the door and thereby asserting {Novelty}

an alternate way of being without alcohol was experienced.

Text

385 Sam: But see now that is really interesting to me..
 386 because ((gestures)) that happened and I just got
 387 finished saying that it doesn't bother me being in the
 388 house and seeing it and that ((points to table for 8
 389 seconds)) was a plastic bottle. (Th: *yes*) (hhh) I
 390 think the size of it is one thing that really....caught
 391 me. as well. ((drops hands on lap)) The visual size of
 392 it (Th: *yeah* ((nods))) because the impact of alcohol
 393 in my life (hhh) for a bottle of this size ((hand
 394 indicates size)) is about as big as that in the impact
 395 [you know so:

Expansion

Sam: Yes, I do realize that I felt {E4-S} calm, {E6-S} less apprehensive, and an {E4-S} easier feeling when alcohol was outside the door {~9}. But, what puzzles me is the contradiction within myself {Split} between being affected and not affected by alcohol and the contrasting feelings of tension and calmness in regards to alcohol either being present or absent. I know that I experienced feeling {E4-S} calmness and {E6-S} less apprehension when alcohol was outside, yet, I had just finished saying to you both that the presence of alcohol in our house did not bother me {9}. Obviously, I was not really aware of the effect the presence of alcohol had on me because it only took a plastic alcohol bottle, not even a real alcohol bottle, to impact me so strongly. I am feeling so puzzled by my response in here to alcohol that I want to try to understand what happened to me by analyzing {7-S}. I think part of my strong response was due to the large size of the plastic bottle. It represented the large impact that alcohol has on me in my life. The impact of drinking an actual bottle of alcohol, which is approximately 6" tall, is actually as large as that big plastic bottle. I recognize that sometimes I minimize {12} or am not aware of how big an impact alcohol has on me {Novelty}.

Expanding the text. The discourse marker "now"

represents a change in the time frame of the conversation. Sam wants to focus on his present state of experiencing a contradiction within himself.

Interaction

Sam agrees with the therapist's interpretation. He then re-directs the conversation to {Split} the conflict, within himself; between the {~9} alcohol bothering him or {9} not bothering him and the contrasting feelings of {E4-S} calmness and {E1-S} apprehension and tension in regards to the alcohol. He gives an evaluation of his earlier assertion, {9} that the presence of alcohol does not bother him, based on his recent awareness and experience, and asserts {Split} the contradiction and thereby denies the proposition {~9}. He expresses feeling puzzled about the {Split} contradiction. He then begins analyzing {7-S} his recent experience in therapy and gives an interpretation of {Novelty} the change he experienced, which is that the impact of alcohol on his life is larger than he thought and thereby {Experience} deepening the contrast of his experience and the impact of alcohol. A bottle of alcohol is in reality only 6", but the impact on his life is much larger, like the symbol, for example.

Text

396 Th:
 397 [Sure.. ((several head nods)) sure.. I appreciate
 398 ((gestures to her head)) your willingness to analyze
 399 (hhh) and.. uh what I'm-I'm noticing is that uh.... you
 400 were willing. AND YOU MAY NEED TO TAKE a bit of time
 401 off: ((gestures to and from self)) right now and you
 402 can do that inside yourself (Sam: sure ((rubs his
 403 neck))) or (hhh) ah I ((sharp hand gestures)) remember
 404 last week that. you wanted to=you're here to talk about
 405 your feelings (open hand gesture)) and yet (hhh) uh..
 406 it seems important that you take some time off for
 407 yourself. And.. so we're sort of ((long back and forth

408 gestures)) go in and out of feelings (Sam: hmhm
 409 ((nods))) (hhh) and ah you ((gestures toward Sam)) can
 410 be in charge of that process. (hhh) So: ((looks toward
 411 Jill and continues with gesturing to her chest and
 412 shoulder)) Jill what is it like for you?.. that uh..
 413 Sam is saying uh after alcohol went out the door (hhh)
 414 that he's saying that.. uh for him the experience was a
 415 relaxing, easy, letting go a bit.. and ah ah...
 416 [

Expansion

Th: I am noticing Sam that you are beginning to analyze {7-S} how the symbol of alcohol impacted you. However, I want to ensure that you do not feel criticized by me and therefore do not get defensive {15} when I talk about your tendency to analyze. Consequently, I will highlight the strength I observe in you, which is your willingness to analyze {7-S} and understand what is happening to you {T-Highlight}. I remember last week, we identified your tendency to go in and out of feelings when the intensity of these feeling get to be too much for you {Safety}. One of the ways we discovered that you create safety for yourself is to analyze. And you may need to now take some time for yourself {Safety} and experience the effects of putting the alcohol outside the door. This may mean analyzing {7-S} quietly to yourself. I also remember last week you said that you are here, in therapy, to talk about your feelings and, yet, it was also important for you to create a sense of safety by going in and out of your feelings {Safety}. Doing so, is an acceptable and appropriate way to be in therapy Sam. Although you said you wanted to talk about your feelings, I recognize that for you it seems important to take time off from experiencing your feelings {Safety} by analyzing {7-S}. What we have been doing here today, is going in and out of feelings. Sam, you can be in charge of your own process of going in and out of feelings. I want to now focus on your experience, Jill, and ask you about your experience? {Awareness} That is, what happens to you {Awareness} when Sam says that after alcohol was put outside the door he feels relaxed, easy, and letting go a bit of his ...?

Expanding the text. This speech utterance is expanded to include information presented in session one, at which time the therapist and couple discuss Sam moving in and out of intense feelings and his desire to be attentive during

the therapeutic process. In the first session, the therapist acknowledged Sam's pattern of experiencing feelings and then stopping feelings by analyzing. She also talked about the importance of developing a sense of safety within himself which may mean that Sam experiences feelings for a while and then analyzes.

Interaction

The therapist interrupts Sam and acknowledges his preceding interpretation of the symbol as well as his tendency {7-S} to analyze. To prevent the possibility of Sam becoming {15} defensive, the therapist {T-Highlight} highlights his strength in being willing to understand and {7-S} analyze himself. She then refers to the previous session and interprets that Sam's tendency to analyze is his way of {Safety} attaining a sense of safety when emotions or experiences are intense and thereby she reduces the intensity of his recent experience. By explaining the function of his behavior, the therapist helps bring into Sam's awareness his pattern of going in and out of feelings and that analyzing serves to protect him from intense emotions and experiences and thereby, {Convey} normalizing his internal process. The therapist supports Sam being in his process by giving him the responsibility to decide when he will feel emotions and/or analyze his experience. She also reminds him of the importance of creating a sense of inner {Safety} safety. The therapist then re-directs the

conversation to Jill. She indirectly requests that Jill focus on her internal experience and thereby, asserting {Awareness} that Jill develop awareness of her inner process as well as simultaneously asserting {Relational} that both spouses are affected by alcohol dependence.

An externalization intervention, in ExST, requires that both spouses experience their relationship to the alcohol dependence which also supports the concept {Relational} that alcohol is a relational experience affecting both spouses. The therapist then gives information and explains that she wants Jill to focus on her experiences when Sam expressed feeling more relaxed, etc., when alcohol was put out the door.

Text

417 Jill: [less
418 apprehension ((leans back slightly))

Expansion

Jill: Since I listen closely to what Sam says, I will tell you that I heard Sam say he felt less apprehension {E6-S} when alcohol is outside the door.

Interaction

Jill interrupts the therapist and finishes her sentence. Jill helps the therapist remember what Sam said and thereby, indirectly asserting that {23} she is caring and attentive toward Sam as well as fulfilling her role {W-Support} of being supportive and attending to her husband's needs.

Both in the first and subsequent therapy sessions, Jill

often refers to it being important for her to listen and learn about Sam's experiences and problems associated with alcohol. This is consistent with her earlier assertion that she wants to know what Sam thinks and says so as to not say things that may result in him becoming defensive, mean, and intimidating her, and thereby protecting herself.

Text

419 Th: LESS APPrehension (Jill: *yeah*) ((Sam smooths his
420 hair)) calming him

Expansion

Th: Putting alcohol outside the door resulted in Sam feeling less apprehension {E6-S} and also calming {E4-S} him which indicates that the presence of alcohol does bother him {~9}.

Interaction

The therapist continues with her preceding speech turn (i.e. request) and repeats Jill's words. Jill reinforces the therapist. The therapist adds that Sam felt calm when alcohol was outside the door and thereby indirectly asserting that {~9} the presence of alcohol does bother Sam.

Text

421 Jill: ((fidgets with her fingers)) I have always
422 wondered why..... we.. keep alcohol in the house
423 when... he's not drinking. ((flicking away gesture
424 and therapist moves her chair)) I mean.. ok.. ((tilts
425 head to the right)) I-I still ((holds hands open on
426 lap)) will have the occasional glass of wine
427 ((therapist nods)) but very rarely ((looks at Sam and
428 Sam moves hand to face)) unless somebody else is
429 around.

Expansion

Jill: What happened in here today with Sam confirms what I had always thought, which is that having alcohol

in the house bothers Sam when he is not drinking {~9}. Having always thought this, it has not made sense to me why he would want alcohol in the house when he was not drinking {17}. There would be no point having alcohol present unless he thought it was for my benefit. I admit that I still have the occasional glass of wine, but this occurs very rarely and only when we have guests in our home. However, my occasional drinking is not a good reason to keep alcohol present when Sam is not drinking. Considering that I only drink occasionally, I do not have a need or desire for the alcohol to be in our house {19-J}. I am worried that you might be experiencing me as challenging your {?2} competence Sam and thus, getting defensive {15}. Hence, I will ask you whether what I have said so far is acceptable to you.

Expanding the text. The word "we" is a mitigating form used to address Sam. Jill perceives it to be Sam's responsibility to get rid of the alcohol, not both of them.

Interaction

Jill initiates a narrative in response to the therapist's request with the point being that what occurred in the therapy with Sam confirms her belief that {Alcohol} alcohol should not be in the house. She asserts, through use of mitigation, that she has always wondered why Sam keeps alcohol in the house when he does not drink and thereby indirectly asserting that {17} Sam is responsible for quitting drinking and how he deals with alcohol. Jill then gives current information about herself as she indirectly asserts that {19-J} she does not want or need the alcohol in their house. Jill then looks toward Sam and indirectly asserts her {4} fear that he will feel challenged and get {15} defensive by what she has said, and thereby Jill indirectly requests affirmation from Sam that what she

has said will not result in him getting {15} defensive.

Text

430 Sam: hmhm

Expansion

Sam: Yes, Jill what you are saying is acceptable and I do not feel defensive {~15}.

Interaction

Sam proves reinforcement to Jill's request for affirmation.

Text

431 Jill: In fact__ ((leans back; opens hands)) Never.. ...
 432 I never drink on my own ((Sam clears throat)) or.....
 433 um..... things like that so:....um..... but I've
 434 stopped wondering about that as well becaus:e
 435 ((therapist leans toward Jill)) Sam has always
 436 reinforced ((rolling hand gestures)) that it doesn't
 437 matter. ((Sam shifts position)) Leave it there. And
 438 we never have a lot.. ((holds open hands on lap)) I
 439 mean:: ((Th: yeah)) we have got a [

Expansion

Jill: Since you agree Sam, I can continue expanding on my previous comment without you getting defensive {~15}. I never drink alone. Considering that I only drink when we have guests, which occurs occasionally, there is no reason for either you or I to have alcohol in our house, Sam {19-J}. Hence, alcohol should not be in our house {Alcohol}. I am feeling hesitant as I venture into talking about the contentious issue of alcohol in our house because Sam may feel challenged by me and thus, get defensive {15}. But, therapist, you asked me about my experience, so I will continue and mitigate when I deem it necessary. I have also given up wondering why Sam has alcohol in our house when he is not drinking because he always reinforced that having alcohol in our house does not bother him {9}. He has always said to leave the alcohol in our house {17}. I did not interfere with his decision {20} to leave alcohol in the house because he would become defensive and mean {15} and this scared and intimidated me {4}. I had always wanted Sam to get rid of the alcohol because I thought that having alcohol in the

house was an ineffective way of dealing with quitting drinking {?2}. I am aware that I may be challenging your competence in how you deal with alcohol {?2} again Sam, which may result in you getting defensive {15}. So, I will be careful to not criticize you, Sam, by changing the subject and talking about the quantity of alcohol in the house. I just want both of you to know that I do not think Sam is completely incompetent or ineffective in dealing with the alcohol {2} which is evident by him not keeping much alcohol in our house. He only has one bottle in the house now.

Expanding the text. Jill begins by stating factually that she never drinks alone and then lets the sentence trail off by pausing at length and saying "things like that so" which serves as a form of mitigation. She hesitates and pauses again before resuming with her speech turn. The next sentence which begins with "but" refers back to Jill's preceding statement in which she said she has always wondered why Sam keeps alcohol in the house. That is, she always wonders and, yet, she has also stopped wondering. Before completing this statement, Jill begins to pause and self-interrupt indicating she may be worried about Sam becoming defensive.

Interaction

After receiving affirmation from Sam that he is {~15} not defensive, Jill continues giving information about herself not drinking much. She repeats her assertion {19-J} that she does not want alcohol in their house and thereby, indirectly asserting that {17} Sam is responsible for keeping alcohol in the house, not her, and that he should get rid of it because {Alcohol} alcohol should not be in

their house. Jill then hesitates and indirectly expresses concern that {?2} Sam may feel his competence challenged as she talks about {17} his way of dealing with alcohol, resulting in him possibly getting {15} defensive, and thereby she reduces the intensity of her assertion. Jill continues giving information about why she stopped wondering why Sam keeps alcohol in the house when he is not drinking, and thereby asserting that {17} Sam is responsible for quitting drinking and handling alcohol related concerns and that {20} she did not interfere due to feeling {4} fearful of his {15} defensiveness and meanness. Jill also indirectly asserts a challenge to Sam about {?2} not being competent and effective in dealing with alcohol. After she indirectly challenges his {?H-Head} authority as head of household, Jill re-directs the conversation to preventing Sam {~15} from getting defensive. Jill gives information about the small quantity of alcohol in the house and thereby indirectly asserting that due to Sam not keeping much alcohol in the house he is demonstrating {2} some competence in dealing with alcohol. This last utterance is used to diffuse {~15} Sam's defensiveness and to demonstrate her support for him and thereby indirectly asserting {23} she is caring and attentive toward Sam. Sam interrupts Jill and she responds affirmatively to his comment and withdraws from verbal interaction, allowing him to speak. The emphasis on diffusing Sam's defensiveness also serves to reduce the

intensity of Jill's internal experience.

Text

440 Sam: [we usually drink it
441 xxx

Text

442 Jill: a bottle of.. Well
443 yeah ((looks at Sam)) y-you...

Text

444 Sam: We'll bring a bottle home and it will be gone in
445 that night basically

Expansion

Sam: When Jill and I buy alcohol we tend to buy one bottle of alcohol at a time and drink it all within that night. In other words, I agree with Jill that there usually is not much alcohol in our house {12-S}.

Interaction

Sam interrupts Jill and attempts to finish her sentence. He interprets Jill's preceding utterance as indicating that she is supporting his {12-S} tendency to minimize the problem of having alcohol in their house and thereby asserts his agreement {2} that he is competent in dealing with alcohol. However, his response is not directly related to what Jill is saying. Jill is talking about the alcohol in the house since he quit drinking, while he is referring to past incidents when they have drunk together.

Text

446 Jill: Yeah. ((rubs face and neck)) But I mean also when
447 you are not drinking there's never a lot there. There
448 is a like a little bit (Th: So ((therapist leans
449 forward with hand extended))) of Brandy (Th: So-So)
450 for.. baking (Th: So what's) my cakes and things like
451 that (hhh)

Expansion

Jill: Sam, I agree that during your drinking periods when we would bring a bottle of alcohol home we would drink the entire bottle of alcohol within that night. But, what I meant in my last comment is that when you have stopped drinking you never have a lot of alcohol in the house. This means to me that you are {2} showing some competence and effectiveness in dealing with your alcohol problem. Therapist, I use the little bit of Brandy that is in our house for baking my cakes and other items, which is an acceptable way of helping Sam get rid of the alcohol.

Expanding the text. Jill's affirmative response is in relation to Sam's preceding remark. The discourse course marker "but" is used to indicate on the contrary. Jill's use of mitigation entails using impersonal and indirect pronouns. The phrase, "like a little bit of Brandy" is another form of mitigation used by Jill.

Interaction

Jill agrees with Sam's assertion about them not having much alcohol in the house when he was drinking. She then re-directs the conversation to her preceding assertion which refers to the times when Sam was not drinking. Jill then re-asserts that she considers Sam {2} to be competent and effective, to some extent, in dealing with the alcohol. Jill then gives information to the therapist about what she does with this small quantity of alcohol. She indirectly asserts her method is an acceptable way to help Sam get rid of the alcohol in the house. Jill's use of mitigation in this speech turn is used to prevent Sam from {~25} feeling weak and a failure, due to her {?2} challenge of his

competence, and thus {~15} not becoming defensive and mean toward her.

Text

452 Th: Yeah: ((gestures to and from mouth)) So you are
 453 filling me in with some of the details and.. uh
 454 ((rotating hand gesturing)) letting me know that uh....
 455 ((fingers move as if in dialogue)) it's easy to get
 456 into a discussion about how much you had or what you
 457 did with it how quickly it went. (Jill: hmhm
 458 ((fidgeting with fingers))) And kind of easy ((moves
 459 hand across forehead)) to get into our heads and you
 460 might notice ((gestures to chest and shoulder)) Sam
 461 what's happening to these muscles right now and um..
 462 ((gestures up and down her torso)) what's it-what's it
 463 like internally for you Jill?.... now that ((gesturing
 464 to her body))

Expansion

Th: Yes, I understand that the alcohol in the house is a contentious issue that results in you, Sam, {15} becoming defensive when you think Jill may be challenging {?2} your competence in dealing with the alcohol, and Jill, you have your own opinion about the alcohol in the house and are careful to try to diffuse {15} Sam's defensiveness because he can become mean, which you {4} fear {Convey}. So, to avoid the challenges, defensiveness, intimidation, and feelings of weakness and fear, both of you engage in deflection by discussing how much alcohol you had in your house when Sam drank and when he is sober, what you did with the alcohol in your house, and how quickly you got rid of the alcohol by either drinking the alcohol or using it for baking purposes. Your use of deflection, in response to my earlier question, informs me that when the subject material is intense or contentious, both your tendency is to diffuse the issue by becoming more cognitively oriented and to analyze or explain {7-S,J} rather than experience the intensity. Taking into account what I said, I would like you, Sam, to notice what is happening in your chest and shoulder muscles at this moment {A-Bodily} as you analyze {7-S} and are not experiencing your feelings {~A-Feeling}. I am also aware of not wanting to intrude upon you, Jill, {Non-intrusive} and causing you to feel afraid and intimidated {4}. I know that Sam can get defensive {15} and mean when he thinks you are challenging him about his {?2} competence in how he deals with his alcohol dependence. However, I will venture forth and

ask you about your experience, but will also be respectful and attempt to not be intrusive {Non-intrusive}. So, Jill, what do you experience internally at this moment? {Awareness}

Interaction

The therapist acknowledges that alcohol in the house is a contentious issue that results in {15} Sam feeling defensive if he thinks Jill is challenging {?2} his competence in how he deals with alcohol and, yet, Jill has her own opinion about the alcohol in the house which she does not directly assert due to {4} feeling afraid and intimidated by Sam's {15} defensiveness. The therapist interprets that the couple deflects from this contentious issue by becoming more cognitively oriented and {7-S;J} analyzing and giving information which then serves to regulate the intensity of their experiences. She also {T-Common} accents their commonality in using analyzing behavior. By explicating their pattern of analyzing, the therapist brings to the clients' awareness their pattern of talking about their behavior and being more cognitively oriented when that particular contentious issue is raised. Once they become aware of their pattern they then have a choice about how they respond and to also take responsibility for their choice. The therapist then redirects the conversation to {Here} the here and now by indirectly requesting that Sam focus and become aware of his {A-Bodily} internal bodily sensation as he {7-S} analyzes. The therapist then indirectly acknowledges Jill's {4} fear

of Sam's {15} defensiveness and intimidation and thereby indirectly asserts {Non-intrusive} not wanting to intrude upon Jill feeling {4} fear and intimidated. She then re-directs the conversation and indirectly requests that Jill focus internally and become {Awareness} aware of her internal experience {Here} at this moment and thereby asserting that {Awareness} clients are to develop awareness of their inner process.

Text

465 Jill: Right now?

Expansion

Jill: Are you asking to describe what my internal experience is at this specific moment {Here} or to describe my internal experience when Sam shared his feelings of being less apprehensive, more relaxed, calm and feeling easier after he put alcohol outside the door?

Interaction

As Jill requests more information she uses the rules of embedded requests. Jill is perceived as asserting a need for more information before being able to respond to the therapist's request.

Text

466 Th: Yeah: Now that um.. ((gestures to shoulder)) Sam
 467 shared with you that with=me=too=with=us that he felt
 468 more relaxed.... and um.... ((gestures to Jill and Sam
 469 turns head toward pictures on the wall)) I noticed how
 470 patiently you listened to him.... and uh I'm=just
 471 wondering what it is like for you inside? ((gestures
 472 to her body))

Expansion

Th: Yes, I am asking you to describe what you

experience internally at this moment {Here; Awareness} since Sam shared with us that he felt less apprehensive {E6-S}, easier, and calm {E4-S} in his chest and shoulder area after alcohol was outside the door {~9}. Again, I am aware that we may be venturing into a sensitive area which may result in intense emotions emerging. Hence, I do not want to intrude upon your feelings of fear and intimidation {4} {Non-intrusive} that result when Sam gets defensive {15} because he thinks you are challenging {?2} his competence in dealing with the alcohol. So, instead, I will diffuse the intensity of your feelings by highlighting your strength Jill {Highlight}. I noticed how patiently you listened to Sam when he was talking about his experience with alcohol which indicates your attentiveness and support for him {23}. I wonder what you experienced internally, inside your body, as you listened patiently to Sam share his internal experiences when alcohol was outside the door? {Awareness}

Expanding the text. The discourse marker "now that" represents a change in the direction of the conversation. The therapist wants Jill to describe her internal experience since Sam shared his feelings of being more relaxed, less apprehensive, calm, and feeling easier. The therapist indicates, by gesturing to her chest and shoulder area, that she is referring to the feelings in Sam's chest after the alcohol was outside the door. The therapist then self-interrupts and her words are spoken rapidly as she corrects her statement about Sam sharing feelings with both of them.

Interaction

The therapist responds directly to Jill's request for information and responds affirmatively to focusing on {Here} the present moment. She then gives more information explaining her request in more detail. The therapist then hesitates and pauses as she indirectly expresses concern

about intruding upon Jill possibly feeling intense emotions of {4} fear and intimidation, which are associated with Sam getting {15} defensive when he perceives Jill's experience to be challenging {?2} his competence and effectiveness in dealing with alcohol, and thereby asserting her desire to {Non-intrusive} not intrude. Subsequently, the therapist lessens the intensity of Jill's experience by {Highlight} highlighting Jill's strength {23} of patiently listening and attending to Sam and thereby she indirectly asserts that Jill is competent in her role as {W-Support} the supportive wife by not challenging Sam when he spoke. Highlighting Jill's strength {23} also serves to {24} elevate Jill's status in the marital relationship. That is, Jill is a respectful, attentive and caring person who is not intent on hurting Sam. This elevation in status also serves to highlight for Sam that Jill is caring and does not want to negate his competence. The therapist then re-directs and repeats her earlier request, suggesting {Awareness} that Jill develop awareness and experience her internal process.

Text

473 Jill: We:ll. ((therapist looks at her watch and leans
 474 forward)) I feel ((flicks back head and hair))
 475 uh..... like I-I'm taking note ((rapid hand
 476 gesturing)) of everything that he's saying ((fidgets
 477 with fingers)) because (Th: *yeah* ((nods 7 times))) it
 478 is important to me ((points to herself)).
 479 Like=really=important=to me to know.. how he feels....
 480 exactly.. so I feel..... uh that I've learned
 481 ((gestures toward therapist)) something from that. (Th:
 482 *yeah*)I ((gestures to self)) don't feel any different
 483 per se [as far as physically...

Expansion

Jill: Well, I am feeling concerned about expressing how I feel because I am afraid {4} that Sam will think I am challenging him which will result in him behaving defensive and mean {15} toward me. To prevent this from happening, I will be careful about what I say. As I listened to Sam share his feelings of relaxation, etc., after the alcohol was outside the door, I am aware of carefully attending to all Sam said about his experience with alcohol {A-Cognition} because everything Sam says and how he feels exactly is very important to me {23}. If I know what he feels and thinks about the alcohol, then I can be careful to not say or do things that may offend, criticize or challenge him and thus, this would prevent him from thinking I am challenging him about his competence {~?2}. Hence, he would not feel weak and a failure {~25} and get defensive and mean with me {~15}. Knowing what Sam experiences helps me to protect myself from his defensiveness and meanness {15}. Considering that Sam's exact feelings and experiences are very important to me, I have learned today that he feels less apprehension, calm, more relaxed and easier inside his chest and shoulder area when alcohol is not present and he feels tense when alcohol is present {A-Cognition}. I, however, in response to your request of my physical state, therapist, do not feel physically different per se when Sam shared his feelings in relation to alcohol being outside the door {~A-Bodily}.

Expanding the text. The discourse marker, "well"

"refers backward to some topic that is already shared knowledge among participants. When 'well' is the first element in a discourse or a topic, this reference is necessarily to an unstated topic of joint concern" (Labov & Fanshel, 1977, p. 156). In this utterance, Jill is referring back to the preceding information disclosed about feeling afraid and intimidated when Sam gets defensive and mean when he thinks she is challenging him. Jill describes herself as "taking note" which is defined as "to observe or treat with special care" (Webster's ninth new collegiate

dictionary, 1983, p. 1203), what Sam says because his experiences are important to her. She places stress on the words "exactly" and "me" and points to herself which suggests that his experiences are very important to her. In session three, Sam talked about not sharing his feelings about the alcohol cravings and other related alcohol concerns because he had determined that alcohol was his problem to conquer. Furthermore, Jill stated, in the first session and in the earlier segment of this session, that she had learned more about how Sam feels in relation to alcohol in session one because he had not ever given her this information. The reason for knowing what Sam experiences and what she learned regarding Sam's feelings is made explicit.

Interaction

Jill responds indirectly to the therapist's request. She initially expresses {4} feeling fear and intimidation about expressing her experience because Sam may {2} think she is challenging his competence in dealing with alcohol and then get {15} defensive and mean and thereby, she asserts that she will respond carefully to the therapist's request in order to protect herself. This assertion serves to also reduce the intensity of Jill's experience. Jill then asserts she intently listened to Sam speak {23} because she wants to learn about his experiences with alcohol which will in turn help her learn how to respond to him and

thereby protect herself from {15} his defensiveness. Jill then re-directs the conversation to herself and asserts that she does not {~A-Bodily} feel physically different.

Text

484 Th: [ah how do you feel inside? ((therapist gestures
485 to her own body))

Expansion

Th: So if you are not aware {~A-Bodily} of feeling physically different, how do you feel inside your body? {A-Feeling}

Interaction

The therapist interrupts Jill. Considering that Jill says she is not aware {~A-Bodily} of her physical sensations, the therapist then requests how Jill feels {A-Feeling} and thereby asserts that Jill {Awareness} develop awareness of her feelings. The therapist implements interventions/requests to aid Jill in becoming aware of her internal physical and emotional state in the here and now and to gradually intensify her experience.

Text

486 Jill: um..... I feel.. ((Sam sniffles and
487 turns toward Jill and therapist)) um.... normal,
488 Really. I'm=just.. ((rapid rolling gestures)) taking
489 it in (Th: ok (hhh)) CALM I guess. ((holds hands
490 open)) I feel calm [

Expansion

Jill: I am aware of feeling the way I normally feel {A-Feeling}. I am primarily aware of listening and taking into my mind what Sam says about his feelings and experiences in the therapy session {A-Behavior} so that I can learn how to be around him without him thinking I am challenging him {~?2}. As I continue focusing internally, I begin to be aware of feeling calm {E4-J}.

Yes, I definitely feel calm {E4-J}.

Interaction

Jill directly responds to the therapist's request, expressing that she is aware {A-Feeling} of feeling her normal feeling. She then asserts what she is aware {A-Behavior} of doing, which is to listen to and understand Sam. This assertion is consistent with both Jill's earlier assertion that {23} she is caring and attentive toward Sam and that she wants information to protect herself from his {15} defensiveness and meanness. Jill regulates the intensity of her experience by deflecting and focusing on Sam. The therapist provides reinforcement. Jill then hesitantly expresses awareness {A-Feeling} of {E4-J} feeling calm and then asserts this feeling more definitely and thus, Jill develops {A-Feeling} awareness of and experiences this feeling.

The long pauses and hesitations suggest Jill is attempting to identify and describe her feelings which is possibly due to not often identifying her feelings. This interpretation by the analyst is verified in session four, at which time Jill asserts that expressing feelings is unfamiliar to her. The therapist interrupts as Jill pauses momentarily.

Text

491 Th: [Yeah ((gestures outward)) so
 492 you feel some calm too and.. sort=of, sort of your
 493 normal feeling (Jill: yeah) and when you feel calm
 494 [..

Expansion

Th: I understand that you also feel calm {E4-J}, as does Sam {E4-S}, plus you have your normal feeling. When you feel calm...

Expanding the text. By saying, "too" the therapist is referring back to Sam, who also felt calm. The therapist was about to further explore the calm feeling when Jill interrupted.

Interaction

The therapist acknowledges that Jill feels {E4-J} calm, as did Sam {E4-S} when alcohol is not present, and feels her normal state and thereby accents {T-Common} common experiences between the couple. The therapist simultaneously heightens and deepens Jill's calm feeling and is about to continue when interrupted.

Text

495 Jill: [I ((wiggles fingers)) shouldn't say I feel calm
496 I'm picking at my fingers I'm not ((laughing and looks
497 at Sam)) really as calm as I think I am

Expansion

Jill: As I continue becoming aware of my internal state, I am aware of picking at my fingers and, therefore, I should not say that I feel calm {~E4-J}. Picking {A-Behavior} at my fingers indicates to me that I am not really as calm {~E4-J} as I think I am {Split}. Recognizing this contradiction within myself results in me feeling anxious and awkward and, so to deflect from this feeling, I laugh.

Expanding the text. Jill wiggles her fingers accenting that picking at her fingers implies she does not feel calm. Her laughter suggests that she feels anxious and awkward and thus, uses humour as a deflection.

Interaction

Jill interrupts the therapist and contradicts her previous assertion of feeling {~E4-J} calm as she develops awareness {A-Behavior} of her behavior and the {Split} contradiction, which is between what she thinks she feels and with what she is actually doing to her body. Jill then gives an interpretation of her behavior as not feeling {~E4-J} calm. She uses laughter as a deflection when she gains this awareness about herself and thereby lessens the impact of this contrasting feeling. Essentially, Jill is developing awareness of both her internal and external state.

Text

498 Th: ((laughs, gestures to her head and Sam shifts
499 position)) part of you that uh takes another
500 perspective (Jill: yeah) that says "hey just wait a
501 minute ((wriggles fingers)) notice what I am doing with
502 my fingers" ((joking tone of voice)) [

Expansion

Th: Jill, I recognize that this experience of becoming aware of the contradiction within yourself {Split} results in you feeling anxious, which is evident by you using humour to deflect. And again, I do not want to intrude upon you when you experience this intense emotion {Non-intrusive}. So, instead, I will be cautious and join you in your laughter as I note and highlight {T-Track} your recent experience. I notice that you have become aware of your feelings of calmness {E4-J} and, yet, another part of you has a different perspective {Split} besides feeling calm {~E4-J}. This other part of you does not feel calm and the way you know this, Jill, is by your fingers wriggling {A-Behavior}. It is almost as if this non-calm part lets you know it is present by saying to you, "Hey just wait a minute, I am not feeling calm {~E4-J} which is apparent if you notice what I am doing with my fingers" {A-Behavior}.

Interaction

The therapist acknowledges that Jill may be feeling anxious due to her using humour to deflect, and thus, the therapist indirectly asserts caution about {Non-intrusive} not wanting to intrude upon Jill when she experiences intense emotions. The therapist then {T-Track} notes and highlights, through use of humour and matching Jill's style of speech, the {Split} contradiction within Jill, which includes a calm part and an emerging non-calm part, and thereby regulates the intensity by gradually {Experience} heightening and deepening Jill's contrasting feelings. The therapist then, by using humour, which is evident by her laughter and her singsong voice, gives a voice to Jill's non-calm part. She gives an interpretation of this finger picking as informing Jill when she is not calm and thereby asserts that Jill is {A-Behavior} aware of what her behavior means. That is, Jill's body informs her about what she feels and thus, Jill should notice her fingers to help her develop awareness of her internal state.

Text

503 Jill: [I notice what I
 504 did last week. I picked at my skin ?here?
 505 ((inflection; points to hand and looks at Sam)).. and I
 506 was all red.. ((Sam laughs and therapist nods head)) so
 507 I mean...

Expansion

Jill: Last week, I noticed that during our therapy session I had picked at my skin right here on my hand, Sam, which resulted in reddening of my hand {A-Behavior}. Considering that I am picking at my skin

during the therapy sessions this indicates to me that I am obviously not as calm {~E4-J} as I think I am {A-Feeling} when we discuss our experiences with alcohol. So, what I suppose this means is that I do have some fear about expressing my experiences about alcohol with you, Sam, but I do not want to tell you I feel fearful {E1-J} at this moment because you may interpret this as me challenging you, which is not what I am doing {~?2}.

Interaction

Jill interrupts the therapist to initiate a narrative providing orientation to time (last week), place (therapy room), person (herself), and behavior (picking at herself). She then gives an evaluation of the narrative which is that she is not really calm in the therapy sessions, which are focused on discussing the alcohol dependency. Jill then indirectly asserts that the reddening of her skin metaphorically represents her {E1-J} feelings of fear and apprehension about discussing the alcohol dependency because of Sam's {15} defensiveness and intimidation, and thereby {Experience} heightening and deepening the contrasting feelings of fear and apprehension.

Text

508 Th: So there is some ((rolling hand gestures)) fear and
509 apprehension

Expansion

Th: So, Jill you have noticed {A-Behavior} that your picking at your skin means that you feel some fear and apprehension {E1-J} while in the therapy sessions when we discuss the alcohol dependency. You feel fear and apprehension {E1-J} because what you say may result in Sam feeling challenged {?2} and thus, getting defensive {15} and becoming mean and intimidating with you, which you fear {4}.

Interaction

The therapist completes Jill's preceding sentence and gives an interpretation of Jill's finger picking behavior as her feeling {E1-J} fear and apprehension about Sam feeling {?2} challenged by her if she discusses her feelings and concerns about the alcohol and thereby, she {Experience} heightens and deepens Jill's contrasting feelings of fear and apprehension.

Text

510 Jill: Yeah. ((nods 3 times)) there is, there is

Expansion

Jill: Yes, therapist, you are correct, I do feel fear and apprehension {E1-J} about discussing my feelings and thoughts in regards to the alcohol.

Interaction

Jill strongly agrees with the therapist's interpretation and advanced empathy that she feels {E1-J} fear and apprehension, which is evident by her repeated assertion and head nod, yes, and thereby {Experience} she heightens these contrasting feelings.

Text

511 Th: Ok (hhh)

Expansion

Th: Ok now we are in agreement that you, Jill, feel some fear and apprehension {E1-J} while we discuss the alcohol dependency.

Interaction

The therapist reinforces Jill's feeling of {E1-J} fear

and apprehension and continues to {Experience} heighten and deepen Jill's contrasting feelings.

Text

512 Jill: Yeah so=I'm.... ((sharp downward gestures)) but
 513 as far as what Sam said I've taken it in.. ((gestures
 514 to self)) (Th: *Yeah* ((nods))) and uh... .. I feel
 515 good about.... what he said because it-I've learned
 516 from it. (Th: *yes*) ((looks at Sam)) I think when we
 517 go home we'll..... if that is what you want we can just
 518 get rid of IT.

Expansion

Jill: Yes, I am feeling fear and apprehension {E1-J} which I want to lessen for myself. I am also beginning to feel concerned about discussing my fear because what I have to say may result in Sam interpreting it as a challenge {?2} to his competence and I want to avoid him getting defensive {~15}. So, to diffuse any defensiveness, I will focus on what Sam said which will be a safe topic to talk about and it will also lessen my feelings of fear. If I repeat what Sam says then I can be assured that I will not be challenging him {~?2}. As far as what Sam said earlier, I have internalized this information which feels good to me because now I have learned how he feels and what he thinks in relation to alcohol. This information will help me to now not to say things that result in him feeling challenged {~?2} and becoming defensive {15} and then intimidating me. Sam, considering what you said about feeling calm, relaxed, less apprehension, and easier when alcohol is not in your presence, I think when we go home today, and if you agree {17}, that you should get rid of the alcohol in our house {Alcohol}. Even though we have both agreed to not wanting the alcohol in the house, I still respect that you want to make the decision about how you handle alcohol, so I will let you decide to get rid of it {17;20}.

Interaction

Jill agrees that she feels {E1-J} fear and apprehension. She then interrupts herself and re-directs the conversation from discussing her fear because she wants to lessen the impact of these contrasting feelings both

within herself and in relation to Sam. She indirectly asserts feeling concerned that Sam may interpret what she says as {?2} challenging his competence in dealing with alcohol which results in him getting {15} defensive and then intimidating her. She then diffuses Sam's possible defensiveness by re-directing the conversation to things she learned from Sam. She indirectly asserts that learning what he thinks and feels in relation to alcohol will aid her {~?2} in not challenging him and thus, not {~4} feeling fearful and intimidated by him. She expresses feeling good about learning how Sam is affected by the alcohol and thereby, asserting that she is competent in her role {W-Support} of wife, which is to understand and help her husband. The therapist provides reinforcement. Jill then indirectly asserts to Sam that he get rid of the alcohol in the house and thus, asserts that {Alcohol} alcohol should not be in their house. She uses a mitigating form to assert that this action would only be performed if Sam wants and she is therefore not challenging either his authority as {~?H-Head} head of household nor {~?17} his responsibility in making alcohol related decisions. Jill simultaneously asserts that her role as {W-Support} wife is to be supportive and not {20} interfere with her husband's decision. Jill is offering her support to Sam to get rid of the alcohol based on how he is negatively affected by the alcohol. By shifting the focus onto Sam, she reduces the

intensity of her fear.

Text

519 Sam: (hhh) Yeah see I'm thinking that it doesn't bother
520 me (Jill: yeah) but it must

Expansion

Sam: Yes, I will get rid of the alcohol in our house {19-S; Alcohol}. I realize that I have all along been thinking {A-Cognition} that the presence of alcohol in our house does not bother me {9}. But, considering how I responded by feeling less apprehension {E1-S}, calm, relaxed, and easier {E4-S} when I put alcohol outside the door in this session, this experience has proven to me that I obviously must be bothered by the presence of alcohol in our house {~9; Novelty}. I accept that the presence of alcohol bothers me {~9;Novelty}.

Expanding the text. The discourse marker "see" means "to grasp something mentally" (Webster's ninth new collegiate dictionary, 1983, p. 1062). Sam grasped the realization that he actually was affected when alcohol was present. He then places contrastive stress on the word, "must" which again indicates that the presence of alcohol does bother him, as opposed to not bothering him as he originally claimed.

Interaction

Sam agrees to Jill's request to get rid of the alcohol and thereby indirectly asserts {Alcohol} alcohol should not be in the house. He then re-directs the conversation back to the contradiction of his earlier assertion {9}, that the presence of alcohol does not bother him, and to the contrast in feelings he experienced. He gives an evaluation of this assertion {9}, which is based on him experiencing {Novelty}

a definite change within himself when the alcohol was outside the door, and thereby he denies that {~9} the presence of alcohol does not bother him. Sam redefines for himself, and is more accepting, that he is bothered by the presence of alcohol.

Text

521 Jill: but it must do

Expansion

Jill: I know that you thought that the presence of alcohol did not bother you {9}. But I agree with you that based upon your experience in here today with feeling less apprehension {E6-S} and calm {E4-S} when alcohol was not present, that you must be bothered by the presence of alcohol {~9; Novelty}.

Interaction

Jill agrees with Sam's {~9} interpretation and redefinition by repeating his last phrase. Thus, they have both come to the {Collaborate} same realization and agreement that the presence of alcohol does adversely bother Sam.

Text

522 Th: So: (hhh) ((gestures with hand; Sam looks toward
523 pictures on the wall)) you're willing to be honest and
524 to know that.... there's more to the situation than
525 we're normally aware of. There is much more and you
526 are willing to be open to new information. (Jill:
527 hmhm) ((Sam turns back toward Jill and therapist))
528 (hhh) And what some of the feelings that I imagined
529 you had toward Sam was ah (hhh) a lot of caring (Jill:
530 *Oh yeah*). You are feeling attentive towards him,
531 ((rests head on chin)) listening, ah being concerned.
532 It sounds like you are very caring and concerned about
533 him. (hhh) And also you had a feeling of sort of OH
534 YEAH feeling of sort of inner familiar state, fairly
535 calm. ((fidgeting with her fingers)) But somewhere
536 ((singsong voice)) there's a little bit of agitation.

537 (Jill: hmhm) It was kind of in your fingers. You're
 538 kind of picking at-at yourself a bit. It reminded you
 539 of what happened last week. (Jill: hmhm) OK. I
 540 appreciate knowing those details. So-uh ((Jill
 541 scratches face and fidgets with fingers)) there's some-
 542 something in the fingers that lets you know that uh..
 543 hey all is not so calm

Expansion

Th: Considering that I noticed you, Jill, deflecting from the intense feelings of fear and apprehension, this informs me that maybe the deepening of these feelings is not appropriate for this session. So, instead, I will also aid in reducing your intense feelings (Non-intrusive). I will then take a moment and highlight the strengths {T-Highlight} and commonalities {T-Common} that I observe in both of you. I notice that you are both willing to be honest and acknowledge to yourselves and each other the changes and discoveries that you respectively experienced in here today even when intense emotions were experienced {T-Highlight; T-Common; S-Share}. As well, you both are willing to accept that there are aspects of our awareness that are hidden from us resulting in there being more to situations than we, as conscious human beings, are normally aware. There are many perspectives to a situation and both of you are expressing a willingness to be open to new information that may be presented {T-Common}. In getting back to your experience in here today, Jill, I want to say that I imagined that as Sam experienced the effect of alcohol on him, you were not challenging him {~?2}, but rather, you felt a lot of caring toward him {23;24}. You appeared to be attentive towards him, listening to what he said and feeling concerned about him {23}. Based on what you have said in here and how you responded while Sam spoke, you seem to be very caring and concerned about Sam {23}. Furthermore, you also experienced feelings of an inner familiar state, feeling fairly calm {E4-J}, but then somewhere in your body you experienced a little bit of agitation. This agitation was experienced in your fingers which is evident by you picking at yourself {Novelty}. This picking at your fingers today reminded you about how you picked at your skin last week and that you feel fear and apprehension {E1-J}. I appreciate being told about awareness that you gain about yourselves {Awareness} because that is part of the therapeutic process. So there is something in what you do with your fingers that informs you that you are not feeling as calm as you may think you are {Novelty; A-Behavior}.

Interaction

The therapist indirectly acknowledges that Jill's deflection from her intense feelings of fear and apprehension was used to lessen the intensity of these contrasting feelings and thereby asserts {Non-intrusive} she will not intrude upon Jill's intense feelings. To aid in regulating the intensity of Jill's experience, the therapist then gives an interpretation and summary of what had transpired. She {T-Highlight} highlights both spouse's strengths and {T-Common} commonalities, which include them both being willing to develop awareness of and experience their internal process and demonstrating a willingness to explore contradictions within themselves that had been out of their conscious awareness. She acknowledges their openness to new experiences and to new awareness. The therapist then re-directs the conversation back to Jill's experience and gives a summary. In her summary, the therapist gives an evaluation of how she perceived Jill's behavior toward Sam. She asserts that Jill was {23} attentive and caring toward Sam which suggests that Jill is competent in fulfilling her role {W-Support} of being an attentive, supportive, and understanding wife who does not {~?2} challenge her husband's competence in dealing with the alcohol and thereby, {24} elevating Jill's status as a competent and caring person who is, and should be, involved in Sam's alcohol recovery. Jill provides reinforcement.

The therapist continues with her summary as she acknowledges Jill's experience of feeling {E4-J} calm and agitated and how Jill developed the {A-Feeling; Behavior} awareness of her feelings and behavior and thereby, through use of mitigation, she regulates the intensity of Jill's experience. The therapist then asserts that she appreciates knowing about the clients' awareness and thus, indirectly asserts that {Awareness} clients should become aware of their internal state. She then repeats her earlier assertion that Jill's finger picking is a signal that Jill is not calm and thus, asserting that {Novelty} Jill has come to a new awareness of herself not being calm. She also simultaneously {Experience} heightens and deepens Jill's contrasting feelings. Jill throughout this speech turn gives reinforcement.

Text

544 Jill: Yeah. *yeah*

Expansion

Jill: Yes I agree that my finger picking {A-Behavior} informs me that I am not as calm {~E4-J} as I may think I am {Novelty}.

Interaction

Jill agrees with the therapist's interpretation that she is not calm and thereby {Experience} this experience is heightened and deepened.

Text

545 Th: Ok. ((nods twice)) (hhh) So:-um..... ((moves chair
546 forward, smooths hair))what-what's happening for me: is

547 that uh..... I'm feeling ah calm myself..... a:nd I'd
 548 like to invite you.. if you're willing to turn your
 549 chairs to face each other. Would you be willing to do
 550 that? Let's just find out.

Expansion

Th: Since the three of us are involved in this therapeutic relationship it is important for us all to debrief our experiences. Since we have concluded with debriefing both of your experiences of this intervention, I want to take a moment and express what I experience. I feel calm {E4-Th}. Now that this intervention is concluded I would like to focus on another intervention.

Interaction

The therapist ends the debriefing of the clients' experience of the externalization intervention and then expresses her own feelings of calmness. The therapist then re-directs the conversation to another intervention.

Summary of Therapy Episode

Relational novelty is the enactment of alternate ways of being in therapy that allows substantive relational themes and patterns to change (Friesen et al., 1989). Relational novelty may occur on three levels including; the intrapersonal, interpersonal and at the level of the presenting problem (Friesen et al., 1989). The therapy episode under investigation revealed that the clients and therapist co-created the three levels of relational novelty using the symbolic externalization intervention of ExST. For example, the intrapsychic relational novelty experienced included; Sam felt relaxed when alcohol was not present and Jill felt agitation, fear and apprehension, which was

different from the calmness she thought she felt. On the interpersonal level, Jill's status in the relationship was elevated. She began to have an equal voice and Sam began to include Jill in his alcohol recovery. With respect to the presenting problem, the relational novelty created involved Sam symbolically removing the alcohol from his life and Jill having a voice in its removal.

A micro-analytical investigation revealed eight themes that contributed to the co-creation of relational novelty. These themes were not discrete, rather they recurred throughout the episode and were inter-connected with one another. Although the eight themes generally followed a sequential progression, from beginning to end of the episode, in attaining relational novelty, there was a recursive looping back and forth of the themes as new information was introduced into the therapeutic system. How the clients and therapist responded and influenced one another in the course of therapy is revealed through the following themes. The discussion below will examine each of the eight major themes found in this case study: (a) creating and maintaining a collaborative atmosphere, (b) challenging propositions and competence, (c) reframing alcohol as a seducer, (d) moving from an individual to a relational understanding of the role of alcohol in the relationship, (e) re-defining and accenting the couple's commonalities, (f) diffusing tension and defensiveness, (g)

regulating the intensity of experiences and, (h) deepening contrasting experiences.

Theme I: Creating and Maintaining a Collaborative Atmosphere

A collaborative atmosphere is one in which an I-Thou relationship exists which includes mutual trust, respect, cooperation and a sense of togetherness between the clients and therapist while on the therapeutic journey. A collaborative atmosphere results in establishing a safe therapeutic context which allows for implementing the symbolic externalization intervention and attaining relational novelty (Friesen et al., 1989). An example will be used to illustrate how the therapist aided in creating a collaborative atmosphere. This will then be followed by a discussion of the interactive process between the therapist and clients and how they influence one another.

Example of creating a collaborative atmosphere. The therapist aided in establishing a collaborative atmosphere in three ways. First, the therapist set the framework and structure of how the therapy would proceed by asserting that clients were to become aware of and express their experiences which include; emotions, cognitions, behaviors and physical sensations. The therapist established the context of the therapy by implicitly asserting therapeutic propositions and adhering to the principles of the ExST model, such as establishing a therapeutic mandate, a systemic focus, and a here and now focus. Second, through

explicating the clients' goals, the therapist attempted to attain mutually agreeable therapeutic purposes. Third, the therapist highlighted both spouses' difficulties and strengths and conveyed understanding of and normalized their experiences throughout the course of therapy.

The interactive process of creating and maintaining a collaborative atmosphere between the therapist and clients incorporates the concept of structural coupling. Structural coupling, as defined by Maturana (cited in Friesen et al., 1989), refers to the ongoing relationship building between a person's personality structure and the environment. Both the structure and environment influence one another resulting in a mutual interlocking and common state between the two systems. Maturana (cited in Friesen et al., 1989) identified this interlocked conduct as the consensual domain in which people can learn about self, the environment and establish meaning of their behavior.

Example of developing structural coupling. The focus for the therapist at the outset of the therapy episode was to establish the context for therapy. The therapist re-directed the topic of the conversation to encouraging the couple to continue expressing and sharing their feelings in the therapeutic setting and with one another (lines 1-15). She then summarized what had happened in the therapeutic context to date, particularly, in relation to the clients feeling fear and apprehension about the alcohol problem.

Sam responded to the therapist's emphasis on his feelings of fear by interrupting and indirectly asserting that this focus on his fear resulted in him feeling not in control of his battle with alcohol and subsequently, he felt weak, worthless and a failure. To rid himself of these intense emotions, re-gain control of his experience and save face, he deflected from the intense emotions by giving information about the reason he stayed in therapy (lines 16-17). Sam indirectly asserted that, for himself, the intensity of experiences were to be regulated which the therapist then agreed with.

Sam's perception of himself as weak and a failure influenced the process of the therapy as well as how he interacted with the therapist. The therapist became aware of Sam's anxious and fearful personality structure. She subsequently realized that she must accommodate him or else he may leave therapy. This point is further illustrated in the ensuing interaction between Sam and the therapist.

Sam expressed feelings of fear about his challenge to keep the top on the bottle of alcohol (line 19). The therapist acknowledged his fear and re-directed to Sam's goal to handle his fear and his perception of how dullness affected him (lines 20-23). She highlighted the strength of his analyzing behavior as helping him gain control of his experience and re-assured him that while in therapy he would be challenged to not experience the dullness that led him to

drink. The therapist's empathic responses helped Sam save face, which then allowed him to express his own feelings of being weak, worthless and a failure for not competently and effectively quitting drinking. As these feelings intensified within Sam, he then reduced these intense feelings by expressing his desire to be in control of his battle with alcohol and by analyzing his experiences (lines 24-26; 30-33). The therapist responded by explicating his goal of confronting and handling his fear which aided in further reducing the intensity of his experience (lines 34-38) and thereby implicitly collaborating with Sam to regulate the intensity of his experiences. Sam agreed with this goal and provided evidence about his past successes with alcohol so as to not only reduce his feelings of being weak and a failure, but also change those same perceptions in Jill and the therapist (lines 39-78). He described the intensity of his alcohol cravings and thereby accented the enormity of his problem which then justified him seeking help by attending therapy.

Essentially, what occurred is that Sam expressed feeling weak and a failure for not being in control of his battle with alcohol. As a result, he fluctuated between perceiving alcohol as a problem and not perceiving it as a problem and as well he fluctuated between asserting both his competence and incompetence and feeling weak and a failure and feeling strong and successful. The therapist, Sam and

Jill collaborated about how they would interact with one another in the therapeutic relationship. The consensual domain was created, as well as the particular direction and course of therapy, as they modified their interactions with one another.

As demonstrated, establishing a collaborative therapeutic relationship does not centre upon the therapist imposing a rigid treatment program toward adhering to the therapeutic propositions and principles. Unless the couple's words, actions and personality structures are also included in the construction of the therapeutic discourse, the therapist would be unable to accomplish her goals. Each member of the therapeutic system provides information about his or her own agenda and personality structure of which the interactions are created as well as each influences the others in creating the interactions. The therapist adjusted and modified her discourse to accommodate the interactions that were embedded within the context.

The theme of creating a collaborative atmosphere was integral to all three levels of relational novelty in the therapy episode and was consistent with the premises of ExST. It was evident from the interactions between clients and the therapist that relational novelty only occurs in a safe context. In order for clients to create relationally novel experiences through intensifying either intrapsychic aspects of self, relationship with others, or with the

presenting problem, they must experience a sense of safety in the therapeutic relationship.

Theme II: Challenging Propositions and Competence

Challenging has been defined by Egan (1986) as a way to help clients develop alternate perspectives and frames of reference to clarify problem situations. Challenging can take the form of challenging discrepancies and distortions that keep clients mired in their problem situations. The intent is to invite clients to challenge the discrepancies and distortions that keep them entrenched in restrictive and rigid ways of being in the world (Egan, 1986). Challenges can induce various responses within clients. It may result in either a defense or an admission (Labov & Fanshel, 1977). In this episode, Sam responded defensively which is consistent with the view presented by Egan (1986), who said that challenge can induce dissonance (Festinger cited in Egan, 1986) (discomfort and disequilibrium) resulting in the client attempting to rid self of this discomfort. According to dissonance theory, the way in which Sam dealt with his dissonance, in regards to the challenges to him, was to "persuade challengers to change their views" (Egan, 1986, p. 205). The client dealt with the challengers by reasoning with and encouraging them to change their perception and accept his point of view.

Example of challenging clients' propositions and competence. Sam asserted that the presence of alcohol did

not bother him to illustrate his improvement in his control over alcohol (lines 39-77). That is, he could now be in the presence of alcohol and not drink. The therapist's response was to heighten the proximity of alcohol indicating the difficulty created in abstaining (lines 78-79) and to begin the process of indirectly challenging Sam's assertion that the presence of alcohol did not bother him. Considering that Sam's proposition was supported by his status of being a competent and responsible head of household, who was solely responsible for alcohol related decisions and whose decisions were final and did not involve his spouse, then the therapist was heard as challenging both Sam's competence in his status as head of household and him being in control of his battle with alcohol. When he was perceived, either by himself or others, not to be in control of his battle with alcohol, Sam felt weak and a failure. Hence, he defended himself against these challenges and his subsequent feelings by providing evidence of his successes and competence in relation to dealing with alcohol (lines 88-108). The therapist's response was to normalize his constant alcohol cravings and thereby asserting that he was not weak and a failure (lines 109-112). She then suggested that alcohol should not be in the house and thereby again challenged Sam about his views (lines 113-118). Sam defended against the challenges by giving information about his plans to get rid of the alcohol (lines 119-137). Jill,

as a result of the therapist challenging how Sam dealt with alcohol which also was consistent with her own beliefs, felt safer and supported in expressing similar challenges to Sam (lines 138-141). Jill asserted that she did not interfere with alcohol related decisions because Sam would act defensively and intimidating toward her (lines 138-141). Sam responded by defending his competence and effectiveness (lines 145-148). As the challenging and defending of challenges ensued between the couple, Jill continued to persuade Sam to accept that the alcohol should not be in the house and that he get rid of it (lines 153-155).

Both the therapist and Jill had formed an alliance with respect to adhering to the propositions that alcohol should not be in the house and that Sam was bothered by the presence of alcohol. In order to deflect from their challenges and to save face, Sam used humour to concur with their suggestion to get rid of alcohol (lines 159-160).

What occurred in the interaction of challenging and defending propositions and competence was that Sam concurred that he also believed that the alcohol should not be in the house. Furthermore, both the therapist and Jill confronted and challenged Sam's denial and belief that he had control over alcohol. He could no longer remain entrenched in his belief that others support him in believing the presence of alcohol did not bother him.

Challenging clients' propositions and competence helped

co-create relational novelty in both intrapsychic and interpersonal domains and with the presenting problem. By challenging Sam about his asserted proposition, that the presence of alcohol did not bother him, the therapist introduced new information to the couple's subsystem. This information helped to facilitate the process of Jill voicing her opinion and challenges to Sam and thus, she began acquiring an equal voice with respect to alcohol. On the intrapsychic level, the challenging of Sam's proposition served to confront his denial of the affect of alcohol. The challenge to how Sam was affected by alcohol became the focus of the therapeutic work in the episode and contributed to him eventually resolving that the presence of alcohol did bother him.

Theme III: Reframing Alcohol as a Seducer

Reframing is defined by Watzlawick, Weakland, and Fisch (1974) as

to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby change it's entire meaning (p. 95)

Reframing may have a direct impact on people's construction of reality by contributing to changes in cognitive, behavioral and emotional responses to the situation. Through reframing, new perspectives may be introduced, lessening the possibility of perceiving the situation in the same way. Reframing is based on the

concept that people use cognitive activity to aid in creating their reality. Subsequently, people's reality is often constructed through use of language. When people are stuck in rigid and restrictive realities, therapists may use reframing to aid in developing a more flexible reality. In this particular episode of the therapy, the therapist's reframe of alcohol as a seducer allowed both Sam and Jill to no longer perceive Sam as being weak and a failure.

Reframes and re-definitions may facilitate changing clients' perceptions about their actions and motivations resulting in developing a new frame of possible actions and enhancing their sense of self-control and self-esteem (L'Abate, Ganahl & Hansen, 1986). Once the old frame is blocked, permitting the new frame to be explored and highlighted, the clients may now perceive the problem as manageable and under their control. Reframes provide positive and acceptable qualities in a non-judgemental way with explanations of behavior which are not a result of inherent individual deficits (L'Abate et al., 1986).

Example of reframing alcohol as a seducer. When Sam fluctuated between feeling weak and a failure and feeling strong and successful in his battle with alcohol, the therapist heightened the proximity of alcohol (lines 78-79). The therapist asserted that the alcohol was very powerful; tempting and seducing Sam to drink and thus, he was not weak and a failure (lines 81-87). The problem was framed as the

alcohol, not Sam.

Sam, however, disagreed that alcohol compelled him to drink because he interpreted being tempted as indicating weakness. He subsequently defended against perceived challenges to his competence and alcohol not bothering him (lines 88-108). After Sam illustrated his competence the therapist agreed. She then continued with the reframe of alcohol as a seducer while she simultaneously suggested that the alcohol should not be in the home (lines 109-118). Sam again responded to the perceived challenges rather than the reframe of alcohol.

Jill re-introduced the reframe of alcohol as a seducer to diffuse Sam's emerging defensiveness as well as challenge him about the presence of alcohol not bothering him (lines 153-155). Sam responded directly to the possibility of getting rid of the alcohol rather than the reframe because he still perceived his competence to be challenged. Consequently, the focus of the therapy shifted from the reframe to challenging and defending propositions. Once the tension was diffused and Sam could save face again, the therapist re-asserted the reframe of alcohol as a seducer (lines 218-221). The problem, she asserted, was the alcohol enticing him to drink. Sam agreed with the therapist's reframe (line 222). Jill interrupted and concurred with the reframe and used it to persuade Sam to accept that alcohol should not be in the house and to get rid of it (lines 223-

227). As Jill changed the topic to herself and spoke about how she wanted to get rid of the alcohol, Sam looked away and briefly dis-engaged from the conversation. The conversation then shifted to discussing Jill's role and involvement with alcohol. Now that it was understood that alcohol was the problem, not Sam, the couple could then deal with other relationship concerns such as, Jill's involvement in Sam's alcohol recovery.

The theme of reframing alcohol as a seducer fits with all three levels of relational novelty. The reframe not only challenged and shifted Sam's restrictive self-perception, but also shifted Jill to not perceive Sam as weak and a failure in relation to alcohol. Sam's entrenched view of himself was expanded, as was the problem. Now that everyone agreed that alcohol was the perceived problem, not Sam, the problem definition was expanded which resulted in establishing, together, a workable problem and task of therapy such as, getting rid of alcohol.

Although Jill immediately accepted the reframe of alcohol, Sam did not because of challenges to his competence and status. It was only after the couple engaged in challenging and defending behavior and the therapist aided in diffusing the defensiveness and tension between the couple that Sam was willing to accept the reframe. Thus, it was important for the therapist to re-assert the reframe twice and address other interfering concerns before the

reframe was accepted by Sam.

Theme IV: Moving From an Individual to a Relational Understanding of the Role of Alcohol in the Relationship

The symptom of alcohol dependence is viewed by ExST as evidence of relational difficulties. The development, continuation and treatment of alcohol dependence is affected by various relational systems such as intrapsychic and interactional systems of family members (Friesen et al., 1989). Both the alcoholic and nonalcoholic family members are psychologically and behaviorally impacted by alcoholism (Steinglass et al., 1987). Thus, therapy will require examining how both spouses are affected by the symptomatic behavior of alcohol dependence. The systemic perspective suggests that people engage in a dynamic interactional process in which they are both affected by and affecting a continually developing environment. Neither causes the other to behave in a particular way, but both mutually influence and are influenced by one another.

Example of the couple shifting to a relational understanding of alcohol. The therapist's emphasis on working systemically resulted in her often either implicitly or explicitly introducing and accenting the relational experiences between the couple. For example, the therapist introduced the concept of alcohol being a relational experience involving both spouses when she asked them why they had alcohol in the house considering that it made it

more difficult for Sam to abstain (lines 109-118). In making the request to both spouses, the therapist was implicitly asserting and re-defining that both were responsible for the alcohol in their home and that alcohol was a relational experience affecting both spouses. Sam was opposed to this concept because he believed himself to be solely responsible for dealing with alcohol and involving Jill in this decision making process would result in him feeling incompetent, weak and a failure. Thus, his response was to assert the plans he had to get rid of the alcohol and thereby clearly asserting that since alcohol was his responsibility, not Jill's, he would plan how to get rid of it (lines 119-137). Consequently, due to his unwillingness to relinquish any control of alcohol to Jill he minimized and dismissed Jill's input.

Jill, however, got involved with alcohol-related concerns as she expressed agreement with the therapist that alcohol should not be in the house and that Sam should get rid of it (lines 138-141). Although Sam continued interrupting Jill and deflecting from the issue, Jill persisted with her involvement (lines 223-227). She asserted wanting to get rid of the alcohol herself but did not because this would undermine Sam which could result in him getting defensive and intimidating (lines 230-233). The therapist then re-defined that Jill had chosen to let Sam make alcohol related decisions and thereby she elevated

Jill's status in the marital relationship, as one who is capable of making decisions. In her re-definition, the therapist did not negate Sam's desire to be responsible for the alcohol (lines 249-250). Sam disagreed with the therapist's re-definition. He re-interpreted that he blocked Jill from interfering and therefore Jill did not wilfully decide to let him make the decisions (lines 251; 254-256). The therapist continued to accent the couple's collaboration in deciding that Sam was to quit drinking and be responsible for dealing with the alcohol (lines 257-265). Hence, the therapist indirectly challenged Sam's individualistic beliefs that he was not in control of alcohol and was incompetent, weak and a failure if he did not quit drinking alone and in his own way, and did not include Jill. She asserted that alcohol was a relational experience affecting both spouses and that Sam did not have to be alone in his alcohol recovery. Sam agreed and the therapist then re-asserted that Jill was, and should be, involved in his recovery process.

The therapist again accented the relational aspect of alcohol when she asked the couple where they would each put the symbolic representation of alcohol (lines 272-275) and when she intensified both their experiences of alcohol being absent. The implicit message in this request was that both Jill and Sam were affected by alcohol. Furthermore, in asking Jill where she would place the alcohol served to

elevate Jill's status and competence in making decisions about alcohol. Both spouses responded to the therapist's request without minimizing or challenging one another.

Essentially, the above interactions resulted in a gradual shift toward a systemic understanding of the role of alcohol which led to co-creating interpersonal relational novelty. Sam began permitting Jill's involvement in his alcohol recovery process and simultaneously Jill's status in the marital relationship was elevated to include her in his recovery process. The therapist held to her systemic perspective throughout the episode which was evident by her continually accenting and including Jill in Sam's alcohol recovery process and aiding Sam in not minimizing Jill's input.

Theme V: Re-defining and Accenting the Couple's Commonalities

Identifying and then re-defining couples' commonalities helps couples to recognize their initial goals and intentions, especially when they may be entangled in recursive challenges and arguments and no longer see the larger picture. The couple may have limited cognitive categories to describe their experience which results in categorizing their experiences in concepts that are either black or white, bipolar, and over-inclusive (L'Abate et al., 1986). The context of their relationship may be expanded by introducing new information that provides alternate goals

that allows them to work together and identify their similarities rather than work in opposition.

In this particular therapy case, the couple was engaged in win-lose interaction patterns while failing to see their common goals. The therapist's re-definition of the couple's commonalities changed their interaction patterns which then aided them in making changes with respect to the presenting problem such as, symbolically getting rid of alcohol.

Example of re-defining couple commonalities. The re-definition of the couple's commonalities occurred throughout this episode and was related specifically to Sam's responsibility to quit drinking and deal with the alcohol. When the couple engaged in challenging and defending against propositions and competencies, they both indirectly asserted agreement about Sam's responsibility. Jill argued she did not have a need or desire for alcohol to be in the house while Sam argued he could get rid of the alcohol if he chose to do so. In asserting his plans for getting rid of alcohol (lines 119-137; 159-160), Sam indirectly asserted his agreement that alcohol should not be in the home. The therapist accented both spouses' agreement about their choice and possibility of getting rid of the alcohol (lines 167-168). Once the couple's commonality had been introduced, the therapist then re-directed Sam to take responsibility for his choice in having the alcohol in the house and drinking. The re-definition of their interactions

as having a common underlying theme helped shift the couple from their challenging and defending interaction pattern.

The couple's understanding and acceptance of their common goal, that Sam was responsible for quitting drinking and getting rid of alcohol, then led to the therapist introducing the symbolic representation of alcohol (lines 272-275). Sam asserted wanting the alcohol outside (line 276), as did Jill (lines 280-281), and thereby they indirectly expressed their common desire to have alcohol out of their lives. The therapist accented this agreement and collaboration (lines 282-284). Sam then performed the requested action of putting alcohol outside with Jill's silent support, which was consistent with their collaborative decision that this was his responsibility.

Explicating both spouse's agreement and them working toward common goals helped to reduce the defensiveness and challenging interaction patterns that ensued between the couple. They were then able to explore, together, their respective experience of alcohol being out of their lives.

The acknowledgement and acceptance that Jill had similar goals as Sam served to co-create interpersonal relational novelty. The result was that Jill's status in the relationship was elevated to her being included in Sam's alcohol recovery.

Theme VI: Diffusing Tension and Defensiveness

Diffusing tension and defensiveness is similar to the

interactive dimension of mitigation (Labov & Fanshel, 1977) in which the person mitigates or modifies expressions that may be offensive or produce conflict. Throughout the episode all three members of the therapeutic subsystem engaged in diffusing tension and/or defensiveness. Each had their own style of diffusing. For example, Sam diffused his defensiveness, avoided contentious issues and saved face by using deflection, particularly humour. Jill, on the other hand, used mitigation to diffuse Sam's defensiveness so as to protect herself. She tended to use words, style of speech and changed the topic to herself to diffuse tension. The therapist diffused tension between the couple and Sam's defensiveness by positively connoting the deflecting behavior, providing reinforcement and highlighting strengths. Many of the challenges and defenses, discussed earlier, were asserted through use of such mitigating devices as indirectness.

Example of diffusing tension and defensiveness. When the therapist suggested that alcohol compelled Sam to grab it (lines 81-87), Sam deflected from his subsequent feeling of being weak and a failure as he asserted his competence and success with alcohol (lines 88-108). The therapist provided reinforcement about the enormity of his alcohol cravings and thereby supported Sam in his desire to be competent and successful (lines 109-118). She then asked the couple about having alcohol in the house which resulted

in her challenging Sam's views and competence. Subsequently, Sam became defensive (lines 119-137). As Jill interrupted Sam and asserted her agreement with the therapist that alcohol should not be in the house, she simultaneously diffused his defensiveness by using lengthy pauses and carefully choosing her words (lines 138-141). Continuing to use mitigation, Jill asserted why she did not get rid of alcohol herself and also indirectly challenged Sam's competence. Sam again defended against the challenges to himself and then deflected from himself as he challenged Jill's supportiveness (lines 151-152). Jill attempted to diffuse his defensiveness as she referred to the therapist's reframe that alcohol is a seducer and thereby, asserted that she did not perceive him as weak and a failure (lines 153-155). To encourage Sam to get rid of the alcohol and not become defensive, Jill mitigated her request by saying they both could get rid of the alcohol. Sam deflected from Jill's request by responding to the ease of getting rid of alcohol and thereby simultaneously asserting his competence (line 156). He then proceeded to deflect from both the therapist and Jill's challenge and suggestion to get rid of the alcohol by using humour (lines 159-160). He used humour to deflect from the contentious issue of alcohol in the house and to save face. The therapist acknowledged both the contentious issue and tension between the couple and hence, to diffuse the tension she highlighted their strengths and

positively connoted Sam's deflection (lines 172-183). The therapist's response allowed Sam to save face and not feel defensive and thus, move toward exploring the issue of him getting rid of the alcohol.

This example illustrates that tension and defensiveness in the therapeutic subsystem had to be diffused before the couple could attain their goal of getting rid of alcohol. Diffusing tension and defensiveness was used throughout this episode and served to help the clients express their thoughts and feelings to one another which contributed to the initial promotion of couple equality as well as symbolically getting rid of alcohol.

Theme VII: Regulating the Intensity of Experiences

Regulating intensity of emotions and experiences is a way to develop a sense of safety in the therapeutic relationship as well as help clients to gradually explore, intensify, and accept their experiences which may then lead to attaining relational novelty. Throughout this episode the intensity of experiences was regulated and co-constructed by all three members of the therapeutic system.

Example of regulating the intensity of clients' experiences. The therapist and clients co-constructed regulating the intensity of clients' experiences after the therapist introduced an ExST intervention designed to intensify the couple's experience of having alcohol out of their lives (lines 293-298). When introducing the

intervention, the therapist, through hesitation and use of mitigation, indirectly asserted not wanting to intrude upon the clients' intense experiences, especially considering that this was only their second therapy session, the couple tended to be more at ease functioning in a cognitive domain and that she, herself, was new to the therapy model. The therapist then proceeded to ask both clients to become aware of and express their respective experiences of the absence of alcohol. Sam began describing his experience and when his feelings intensified he shifted to a cognitive domain. Functioning in a cognitive domain was a safe and more familiar way of being for Sam and it simultaneously aided in regulating the intensity of his emotions. After Sam lessened the intensity of his emotions, through analyzing, he shifted back to experiencing his emotions.

Sam's tendency to go in and out of intense experiences was also consistent with the therapist's desire to not intrude upon the clients when intense experiences emerged. When Sam's experiences became intense, both he and the therapist shifted the intensity so that he could gain a sense of control of his experience.

The therapist gradually intensified Sam's experience as she asked him to describe and experience more fully his emotions, physical sensations and cognitions associated with having alcohol outside. As Sam responded to each request, and the therapist tracked his experience, both therapist and

Sam continued to gradually intensify his experience (lines 327-328; 330-333). The therapist, through use of gestures, pauses and matching Sam's pattern of speech, indirectly asserted the importance of pacing the therapeutic work to prevent Sam from feeling weak and a failure (lines 319-324).

Sam, at times, reduced the intensity of his experience as he "talked about" the apprehension he experienced earlier in the session (lines 334-337) and focused on an injury (lines 339-340). The therapist tracked what had occurred when alcohol was put outside and re-directed Sam back to his here and now experience and thereby gradually intensified his experience with alcohol (lines 343-346). Sam concurred with the therapist's evaluation and then asserted a correction to his feeling which served to again lessen and regulate the intense impact of alcohol (line 347).

The therapist acknowledged Sam's use of mitigation to lessen the intensity of his experience when alcohol was either present or absent. Subsequently, the therapist aided Sam in regulating the intensity of his experience by highlighting his strengths and talking about the importance of his awareness of calmness when alcohol was not present (lines 376-384). Sam, however, continued to intensify his experience with alcohol as he re-focused on his inner conflict regarding the presence of alcohol (lines 385-395). The therapist reduced the intensity of Sam's experience by first interpreting that Sam's analyzing behavior was his way

of gaining control and creating safety within himself and then asking Jill about her experience (lines 396-416).

Jill's response was to diffuse Sam's defensiveness which simultaneously served to lessen the intensity of her own experience with alcohol (lines 421-429; 431-439). As the couple engaged in explaining and analyzing their experiences with alcohol, the therapist acknowledged the analyzing as their method of reducing intense experiences (lines 452-264). The therapist continued to lessen Jill's experience with alcohol as she highlighted Jill's strengths (lines 466-472). Jill again initially diffused Sam's defensiveness (lines 473-483) and then fluctuated between expressing her intrapsychic experience and focusing on what Sam had said. Jill asserted awareness of another feeling and then used laughter to deflect and lessen the intensity of this experience (lines 495-497). The therapist collaborated in lessening the intense impact of Jill's behavior by using laughter and a sing-song voice and matching her style of speech as she tracked Jill's experience (lines 498-502). Shortly after both the therapist and Jill intensified Jill's feelings of fear and apprehension, Jill lessened the intensity of these feelings by re-directing the conversation to what she learned in the session and shifting the focus onto Sam getting rid of alcohol (lines 512-518). The therapist again implicitly collaborated with Jill in regulating the intensity of her

feelings as she highlighted the couples's strengths, accented their commonalities and used mitigation as she summarized Jill's experience (lines 522-544).

In summary, regulating the intensity of experiences helped both clients gradually explore, intensify and accept their internal experiences in relation to alcohol being present and absent which contributed to attaining intrapsychic and interpersonal relational novelty. For instance, the shifting back and forth between analyzing and direct experiencing resulted in Sam gradually intensifying his experience to the point of realizing he felt relaxed in the absence of alcohol and tense and apprehensive in its presence. Regulating the intensity of experiences also enabled Jill to gradually become aware of and intensify her feelings of agitation, fear and apprehension. Furthermore, in regulating the intensity of experiences both clients gradually experienced their respective relationship to alcohol and each other at the physical, emotional, behavioral and cognitive level and thus, gained a broader understanding of the impact of alcohol.

Theme VIII: Deepening Contrasting Experiences

Clients intensify and deepen polarities and contrasting experience by methods such as symbolic externalization and repetition. Through the intensification of experiences, alternate ways of being in the world may emerge. The intensification process involves a holistic approach which

includes cognitions, emotions, bodily responses, behaviors and perceptions. Deepening contrasting internal experiences contributed to both Sam and Jill attaining relational novelty on an intrapsychic level. By gradually deepening the contrast of feeling tension and relaxation, Sam was able to experience and accept that he felt relaxed when alcohol was not present. Jill also experienced agitation, fear and apprehension through the deepening of her experience.

Example of deepening contrasting experiences. Sam introduced a contrasting experience after first asserting the presence of alcohol did not bother him (lines 88-108) and then concurring with the therapist and Jill that it probably bothered him (lines 214-217) which marked the beginning of him fluctuating between these two contrasting experiences. If he admitted to the alcohol bothering him then he perceived himself as weak and a failure and if he admitted to the alcohol not bothering him he perceived himself as strong and successful. This polarity was intensified after the therapist introduced the concept of direct experiencing.

After engaging with the symbol, Sam expressed feeling less apprehension and surprise because he did not expect to be affected by the absence of alcohol (lines 300-311). The therapist focused Sam on his less apprehensive feeling which then resulted in him identifying the contrast in feelings when alcohol was absent or present. The therapist

heightened and deepened the contrast between him feeling apprehension and tension and relaxation as she asked where in his body he physically experienced the relaxation and what it felt like. As Sam expressed awareness of what he experienced internally when the alcohol was not present, both he and the therapist heightened and deepened his experience through use of repetition and highlighting of responses.

When Sam became aware of feeling calm he then focused on the apprehension he experienced earlier and thereby heightened and deepened the contrast between feeling calm and apprehensive. Subsequently, he asserted that the apprehensive feeling may be linked to his physical injury, not the alcohol, and thus, he challenged whether he experienced tension and apprehension when in the presence of alcohol. Focusing on the physical injury, as creating feelings of apprehension and tension, served to lessen the impact of alcohol on his life. The therapist re-directed to the present and highlighted what had transpired, which was that the feelings of apprehension changed to calmness after alcohol was put outside which then logically suggested that it was the alcohol that resulted in the change (lines 343-346). Sam agreed, but then again lessened the impact of alcohol by mitigating the contrast between feelings of apprehension and calmness (line 347). Although Sam mitigated the effect of his experience, the therapist

continued to re-direct him to continue experiencing the decrease in apprehension and the associated cognitions when alcohol was absent in order to heighten and deepen this contrasting feeling and to deepen the link between alcohol and tension.

Once the therapist explored emotions, physical sensations and cognitions associated with the experience of placing alcohol outside, the therapist summarized the experience. That is, Sam had experienced another way of being without alcohol, which was to be relaxed. Sam then re-directed the conversation back to the conflict within himself. He denied his earlier proposition that the presence of alcohol did not bother him based upon his recent therapeutic experience and then asserted his realization that alcohol had a larger impact on his life than he had thought (lines 385-395). The therapist interrupted and lessened the intensity of Sam's experience and then heightened Jill's experience of the absence of alcohol (lines 396-416). Shortly thereafter, Sam expressed more definitely his realization that the presence of alcohol must bother him (lines 519-520).

Jill's experience of symbolically externalizing the alcohol was also heightened and deepened by both the therapist and Jill. The therapist continued to re-direct the conversation back to Jill's intrapsychic experience (lines 462-464; 466-472). Jill eventually expressed that

she did not feel physically different, but felt calm (lines 489-490). The therapist heightened and deepened the calm feeling through reflection. Jill interrupted and expressed awareness of another contrasting feeling which was evident by her finger picking behavior (lines 495-497). Jill used laughter to deflect from the intensity and impact of this contrasting experience. The therapist acknowledged the use of deflection by using humour herself as she heightened and deepened Jill's contrasting experience (lines 498-502). Jill deepened this non-calm feeling as she expressed experiencing this feeling during the previous therapy session (lines 503-507). The therapist then interpreted Jill's finger picking behavior as an expression of fear and apprehension, to which Jill strongly agreed, and thereby they both engaged in deepening the contrasting feelings. When Jill re-directed the conversation (lines 512-518), the therapist recognized this shift as Jill's deflection from the intensity and impact of these contrasting feelings and thus, the therapist summarized what had occurred rather than continue heightening and deepening Jill's experience (lines 522-544).

In summary, all eight themes influenced one another throughout the therapy episode in creating the three levels of relational novelty. What emerged in the therapy episode was that a collaborative atmosphere was first established which also entailed regulating the intensity of the

therapeutic process. The ensuing challenging and defending of propositions and competence resulted in exploring the problem of alcohol dependence so as to expand, shift and change the perception of the problem. After reframing alcohol as a seducer, moving from an individual to a relational understanding of the role of alcohol in the couple's relationship, accenting and re-defining the couple's commonalities and diffusing tension and defensiveness, the therapist and clients were then able to work together to explore the clients' respective relationship to alcohol and explore the goal of getting rid of alcohol. Intensifying and deepening the clients' experiences of getting rid of alcohol could now occur due to mutual understanding and agreement about the problem, the therapeutic goals, couple collaboration, promotion of couple equity and the direction of the therapy.

CHAPTER V

DISCUSSION

This investigation has examined a segment of a therapeutic interview using comprehensive discourse analysis (Labov & Fanshel, 1977). By documenting proximal outcomes of the therapeutic process, a greater understanding of the change process was realized. A review of family therapy process research literature identified the importance of utilizing methodologies that assist in understanding the change process in family therapy. In this investigation, comprehensive discourse analysis which examines the co-construction of people's social realities was identified as a suitable methodology to serve our purposes. An episode of a therapy case was analyzed using this methodology to examine how the therapist and clients co-create relational novelty using symbolic externalization intervention with a successful ExST case involving marital treatment of alcohol dependency. The principles of therapy utilized in the actual therapy episode and the therapist and couple's interactions and themes identified that contributed toward co-creating relational novelty were examined. This chapter focuses on the research question and rationale for conducting this study and include the theoretical refinement and the establishment of the clinical utility of the constructs of symbolic externalizing and relational novelty. The chapter also presents the major findings of this case

study, the implications of it for research and practice, the limitations of this approach and directions for future research.

Major Findings Revealed in the Case Study

The case study has explored and analyzed the therapeutic process of change, particularly the construct of relational novelty co-created by the therapist and clients using the symbolic externalization intervention of ExST in addressing alcohol dependency. The theory and clinical practice of ExST and its accompanying symbolic externalization intervention has been previously described in the manual (Friesen et al., 1989). The fit between the ExST theory of change and what actually occurred in therapy is of central importance to the model. This therapy episode involving the co-creation of relational novelty provided further descriptions and understandings of this theoretical model.

The concepts that underlie the themes revealed in the study and which are essential to an understanding of how relational novelty was co-created in the therapy episode include; social constructivism and contextualization. The eight themes identified in the study and reported in this chapter contribute to our understanding of the externalization intervention, the therapeutic process, and the construct of relation novelty. The themes found in this case study include: (a) creating and maintaining a

collaborative atmosphere, (b) challenging propositions and competence, (c) reframing alcohol as a seducer, (d) moving from an individual to a relational understanding of the role of alcohol in the relationship, (e) re-defining and accenting the couple's commonalities, (f) diffusing tension and defensiveness, (g) regulating the intensity of experiences and, (h) deepening contrasting experiences.

Social Constructivism

This investigation supports the constructivists' belief that the co-creation of people's social realities, such as therapeutic realities, is mediated through language. People are language-generating and concurrently are meaning makers and achieve understanding through the use of language as they interact with others (Anderson & Goolishian, 1988). It is through engaging in such communicative action as meaning-generating discourse in particular social milieus that meaning and understanding specific to that milieu is attained. In a therapy context, communicative action specific to the therapeutic system is employed to generate language and meaning around a problem. The therapeutic system is organized around a presenting problem and the therapist and client(s) are engaged in evolving language and meaning specific to the problem, specific to the organization of the problem and specific to the dis-solution of the problem (Anderson & Goolishian, 1988). Therapy occurs through a process of ongoing conversation, that is, a

therapeutic conversation of mutual exploration through dialogue in which new meanings continually evolve toward resolving the problem. The therapist and client(s) co-construct a reality, or meaning-generating system during the therapeutic discourse. In the process of co-creating this reality they each contribute their own ideas, values and biases. By perceiving therapy as occurring in a social milieu in which change can be socially co-constructed by therapist and client(s), we can study the therapeutic discourse to understand how relational novelty was socially co-created through the activity of symbolic externalization.

The themes identified in the case study demonstrate that the process of therapy involved both the clients and therapist participating, sharing and developing meaning (Goolishian & Anderson, 1990) with respect to the presenting problem and the therapeutic process. Each of the themes was co-constructed through conversation between the therapist and clients. For example, the theme of creating and maintaining a collaborative atmosphere in therapy involved both the therapist and clients determining the nature of the therapeutic process. The therapist learned that she must accommodate the clients by regulating the intensity of their experiences. The clients learned, based upon the therapist's assertions of therapeutic propositions, what the framework of the therapy would be and what was expected of them. That is, they were expected to develop awareness of

and express their experiences in therapy. The therapeutic subsystem also participated in creating meaning of the presenting problem of alcohol dependence when the husband asserted the proposition that he was not bothered by the presence of alcohol. This assertion, and his subsequent discrepant description of how he was affected by alcohol led to the theme of challenging the husband's proposition and competence in dealing with alcohol via the theme of reframing alcohol as a seducer. After suggesting the alcohol was the problem, based upon the husband's description of the problem, the therapist challenged him with the proposition that he was bothered by the presence of alcohol. The introduction of this new information into the therapeutic subsystem by the therapist resulted in the wife also challenging the husband's perspective. The husband eventually concurred that he was bothered by the presence of alcohol. An example of co-creating meaning regarding the issue of who was involved with the presenting problem and how such involvement occurred is illustrated in the theme of re-defining and accenting the couple's commonalities. As both spouses described their respective beliefs and expectations about who was responsible for dealing with the alcohol in the house, the therapist noted and highlighted that they shared a common goal regarding the husband's responsibility to deal with the problem. Once the therapist explicated the couple's implicit collaboration in making the

decision about the alcohol in the house, the couple broadened their understanding of the wife's involvement in alcohol related decisions. In the above examples, each member of the therapeutic subsystem participated in developing meaning. The co-construction of realities is an important shift from the perspective that the therapist changes the clients by implementing specific interventions.

The above findings of the case study support the view that by exploring the logic of the descriptions of a problem system, other descriptions and meanings will emerge that result in the problem no longer being labelled as a problem (Anderson & Goolishian, 1988). Through expanding and saying the "unsaid", a new reality is created.

The constructivist view is that problems are constructed realities in language, which are fluid and changing. Family members' multiple and conflicting interpretations of the problem suggest the fluidity of the problem definition (Anderson & Goolishian, 1988). The problems presented in therapy are often constrictive and fixed in meaning. Through therapeutic conversations, the fixed meanings and behaviors are expanded and changed allowing for more flexibility and alternate ways of being for the client (Anderson & Goolishian, 1988).

The case study revealed that the clients and therapist organized themselves around the problem of alcohol dependency. The clients' meaning and understanding of the

problem was restricted which circumvented changes occurring in either intrapsychic or interpersonal levels. For example, the husband perceived that he was weak and a failure for not being in control of his battle with alcohol. Moreover, this perception was reinforced if he involved his spouse in his alcohol recovery. Subsequently, he decided that he had to quit drinking in his own way without the assistance of others. The wife perceived the husband to be ineffective in how he handled alcohol related concerns, but she did not interfere due to fear of his defensiveness and intimidating behavior.

The task of the therapist was to aid in expanding the restrictive meanings and understandings of the problem (Anderson & Goolishian, 1988). In order for the expansion of meaning to occur, a collaborative problem definition had to be developed. This was accomplished in the case study through the therapist making space for and understanding of the multiple perspectives of the problem. Through inquiry and using the clients' description of the problem, the therapist discerned and expanded the meaning of the clients' restrictive problem definition. The therapist reframed the problem as alcohol seducing and tempting the husband to drink. Once the reframe was accepted by the therapeutic subsystem, the husband was no longer identified as having a characterological deficit because the problem was the alcohol, not his weakness and failure. Reframing the

alcohol as a seducer enabled the husband to reconstruct his initial meaning of his alcohol cravings, giving him a new understanding and expansion of the restrictive relational patterns with self, others, and the presenting problem. The interpersonal context of the problem definition was further expanded and shifted as the therapist introduced both themes of moving from an individual to a relational understanding of the role of alcohol and redefining and accenting the couple's commonalities. The two latter themes contributed to the elevation of the wife's status in the marital relationship which resulted in the initial promotion of her acquiring an equal say with regard to the alcohol. The two themes just described, helped to expand the husband's individualistic beliefs that he had to go through his alcohol recovery on his own and minimize and dismiss his spouse's input. Subsequently, the couple could work together on the problem. This expanded meaning led to the couple addressing how they were impacted by both the presence and absence of alcohol. The above-mentioned examples illustrate that "meaning and understanding in dialogue and conversation are always an interpretive activity and always in flux... All meaning, understanding, and interpretation is inherently negotiable and tentative" (Anderson & Goolishian, 1988, p. 381). There is a continual shaping of worlds through dialogue and conversation. Thus, "change is the evolution of new meaning through dialogue"

(Goolishian & Anderson, 1990, p. 108).

As the therapeutic system engages in generating language and meaning in relationship to the problem and its organization, we need to first understand the meaning attributed to the problem. That is, the problem of alcohol dependence must be contextualized.

Contextualization: The Therapeutic Episode, Alcohol Dependency and Constructs of Relational Novelty and Symbolic Externalization

Throughout the analysis of the therapy episode, a recurring realization emerged indicating that this analysis would lack coherence without contextualizing the episode under study within the larger therapeutic framework. Therapeutic events and interventions are not fragmented activities that occur in isolation from the rest of the therapeutic process (Orlinsky & Howard, 1986). It is therefore essential to investigate and understand how these events and interventions inter-connect with the ExST theoretical and therapeutic process. The particular constructs and specific change moments being studied must reflect the therapy process under consideration (Newman, 1991). Moreover, the meaning of both the process of the therapy and the particular therapeutic intervention utilized must be identified to aid in illustrating the theoretically significant change that occurred. De-contextualizing therapy episodes and therapeutic interventions would fail to

contribute significant knowledge of the change process. Unless the therapy episode is contextualized, an adequate understanding of how change occurs in therapy would not be attained. The theoretical importance of contextualizing the relational matrix of alcohol dependence and how it affects clients' intrapsychic and interpersonal world in the change process needs to be addressed. It is our purpose in this investigation to illustrate how ExST theory and process explains the observed co-creation of relational novelty. The following discussion describes how the ExST model attempts to contextualize the alcohol dependency, the construct of relational novelty, and the symbolic externalization intervention and how this process leads to change.

Contextualizing the Symptom of Alcohol Dependence

The interactional model of alcohol dependence proposed by ExST is based on multiple levels of system analysis (Friesen et al., 1989). The interactive process may include the physiological, intrapsychic, interpersonal, and socio-cultural functioning of people. Davis et al. (1974) suggest that the adaptive consequences of alcohol dependence, which may operate at an intrapsychic level, interpersonal level, or at a level of maintaining homeostasis, reinforce the abuse of alcohol. The implication for clinicians is to determine the adaptive function of the alcohol dependence with regard to the above-mentioned three levels. Clients

are then aided in acquiring the adaptive behaviors while sober and to learn alternate coping behaviors.

The analysis of the case study demonstrated the importance of conducting an ecological assessment of the alcohol dependence problem in phase one as described by the ExST model. This assessment, which examines the physiological, intrapsychic, interpersonal, social and cultural functioning related to the alcohol dependence, helped to determine the meaning the clients generated about the alcohol dependence problem as well as where the relational rigidity and restrictiveness of the problem lay.

The gathering of information about the symptom development is important because symptoms are viewed as messengers summoning attention and analogically conveying that there are problems in the relationship (Friesen et al., 1989). Behavior is then considered to be arbitrary and its meaning is understood contextually. The contextual meaning of the alcohol dependence in each therapy case has many functional aspects that must be explored.

The case study investigated revealed that there were at least six functions of alcohol which influenced the issues/themes addressed in therapy. Primarily, as identified in session one of the study, alcohol provided the husband with a means to gain acceptance from his peers and helped him find a place where he belonged. Secondly, the alcohol provided him with a means to escape and distract from his

pain and sadness, particularly in relation to the many losses he suffered. Thirdly, alcohol functioned to liven up the couple's marital relationship because during drinking periods there was arguing and generally much more interaction. Fourthly, alcohol served to maintain a level of intimacy which they could accommodate. With alcohol, both spouses kept their pain to themselves. Their interpersonal conduct revolved around the alcohol and thus the alcohol served to keep distance between them. Fifthly, the alcohol dependence functioned to provide a socially acceptable reason that summoned therapeutic aid. Lastly, the alcohol served as a way to provide a context through which both spouses could directly express their fears and pains to one another and to establish a more satisfactory level of intimacy in their marital relationship. In summary, the symptomatic behavior of alcohol dependency developed and continued as a medium which was used to deal with the intrapsychic and interpersonal relationships to which it was connected. The alcohol dependency symbolically represented disturbances in the relational matrix. The relational difficulty lay with the alcohol dependency being rigidly entrenched in the clients' ecology of how they expressed and communicated problematic issues. Flexible ways of communicating and addressing the relational problems were not available within the clients' repertoire and thus an important part of therapy was to expand alternative

possibilities through experiencing concrete relational novelty. Considering the various relational and system levels of involvement in the therapy case and their influences on each other, the transformation or dis-solving of the problem included exploring the intrapsychic psychological systems of each spouse, interpersonal functioning between the spouses, peer group culture, and the therapeutic system.

The findings of the study demonstrated that once the alcohol dependency had been contextualized within the therapy case, this then led to transforming the various systems and relational levels affecting the alcohol dependency. Each of the eight identified themes were connected to one or more of the systems and relational levels attended to in the therapy episode. For example, both the intrapsychic and interpersonal systems were transformed when alcohol was reframed as a seducer. The perceptions and meaning attributed to the alcohol shifted for both the husband and wife so that they then perceived the alcohol, not the husband, as the problem. The theme of diffusing tension and defensiveness illustrates how the therapeutic system was involved with and helped influence the transformation of the problem. Both the therapist and clients determined that in order for clients to experience an alternate way of being in relation to alcohol the tension and defensiveness in the therapy session had to first be

diffused. For example, prior to the husband concurring with the therapist and his spouse that the alcohol should not be in the house, he deflected from the tension by using humour. The therapist acknowledged the tension between the couple and hence she positively connoted the couple's strengths as well as connoted the strength of the husband's use of deflection. Diffusing the tension between the couple resulted in the conversation being re-directed to the problem of alcohol in the house. Furthermore, the theme of regulating the intensity of clients' experiences also contributed to influencing the transformation of the problem. This co-constructed theme helped pace and match the therapeutic process of dealing with the alcohol dependency according to the clients' comfort level.

Contextualizing Constructs of Relational Novelty and Symbolic Externalizing

The ExST therapist strives to offer opportunities to experience relational novelty and to directly influence unsatisfactory relationships with self and others rather than continue the process of engaging in repetitive and invariant behavioral sequences (Friesen et al., 1989). Perturbing patterns and sequences with self, others, and the presenting problem is phase two of the ExST model. During this phase of therapy, specific interactional sequences are attended to and given symbolic significance. The therapist employs various interventions to disrupt, challenge and

change entrenched and dissatisfying sequences of interaction. The clients' sense of constriction through an immediate experience is expanded and new potential emerges. It is important that the interventions are implemented in accordance with the clients' readiness and/or modified depending on the clients' changing needs.

The themes identified in the case study revealed that various meaning shift interventions (Friesen et al., 1989) were used to perturb restrictive intrapsychic and interpersonal systems. The themes pertaining to meaning shift interventions included; reframing alcohol as a seducer, challenging clients' restrictive propositions, moving from an individual to a relational understanding of the role of alcohol and re-defining and accenting the couple's commonalities.

The crucial components that helped shift the focus from the couple's challenges and defenses to getting rid of the alcohol was the acceptance of the above alternate re-definitions or themes. That is, once the couple accepted the re-definition of the alcohol problem and their interaction patterns, they could then view one another as being on the same side and hence, explore together how to get rid of the alcohol from their lives.

It was after the above-mentioned themes were co-created and accepted by the therapeutic subsystem that the symbolic externalization intervention was implemented. Engaging with

a symbolic representation of the alcohol in the here and now was introduced as another way of addressing the couple's relationship with the alcohol. The principle of direct experiencing was introduced as the therapist asked the clients where they would metaphorically place alcohol. The theme of deepening contrasting experiences was a method used to intensify the clients' experience of alcohol.

Contributions to Understanding Symbolic Externalization

There are three methods of externalizing. These methods include externalizing through use of language, through objects and images, and through experiential enactment. Jung (1964) stated that "because there are innumerable things beyond the range of human understanding, we constantly use symbolic terms to represent concepts that we cannot define or fully comprehend" (p. 4). There are two types of symbols. Words are discursive symbols and objects are representational symbols.

The externalizing method used by White and Epston (1990) is discursive experiencing. In this approach, externalizing is mediated through use of language to determine the influence of the problem and the client's influence in the "life" of the problem. White and Epston (1990) suggest that externalizing the presenting problem "enables persons to separate from the dominant stories that have been shaping their lives and relationships" (pp. 40-41). Questions asked by the therapist allow for the

emergence of unique outcomes and alternate stories in relation to self and others that have been previously neglected or unknown.

An alternative to a discursive approach to therapy is to use objects. Objects have the potential to move the therapy from a discursive level to a representational level. Representational symbols touch deeply the client's sense of personal meaning and significance (Friesen, 1991). Andolfi et al. (1989) suggest

The metaphoric object offers many levels for changing connections. The clear visual and tactile presence of the object accentuates the contrast between its literal, concrete meaning and its symbolic implications, creating confusion as to which level is relevant to the message received (p. 78).

By using objects, the therapeutic process is energized and adds an element of play (Andolfi et al., 1989). The theory underlying symbolic externalizing in ExST is that when clients separate and gain distance from the problem through engaging with a symbolic representation of it, they are allowed to examine other aspects of their relationship (Friesen et al., 1989). This process may result in a shift in the client's identity leading to alternate ways of being.

The findings of the case study support the notion that representational symbols aid in developing creative novelty. The theme of deepening contrasting experiences revealed that by gradually intensifying and deepening the husband's experience of alcohol symbolically placed outside the door resulted in him experiencing and realizing that he was

affected by the presence of alcohol. That is, he was relaxed in the absence of alcohol and tense and apprehensive in its presence. Furthermore, the gradual deepening of the wife's contrasting experience of calmness and fear and apprehension resulted in her experiencing a previously unacknowledged aspect of herself. That is, she experienced that she was not as calm as she had thought.

Intensifying and deepening the clients' experiences in relation to the symbolic representation of alcohol facilitated a deep and profound knowing which was not attained during their dialogue about the problem of alcohol and its effect. This finding supports the ExST theory that through the process of symbolic externalization a holistic integration of the client's world occurred including cognition, behavior, affect and perception. It was evident from the clients' conversation that when clients discussed the alcohol problem and their relationship to it, they engaged in a restrictive, challenging and defending behavior pattern. It was only after they symbolically externalized and intensified their respective experiences that relational novelty occurred.

Implication for Theory and Practice

The description of the theory underlying symbolic externalizing is broad and through this analysis more specific details of the construct were captured. The essential component of symbolic externalization is to create

a symbolic representation of the problem and then distance and separate from it so that the problem is no longer perceived as an inherent and fixed quality residing within the person. Hence, it seems that externalizing deals primarily with representing and distancing from stories or meanings associated with the problem. The themes that emerged from the case study, however, indicate that there is much more involved in externalizing than representing and distancing from the problem. Prior to introducing the symbolic representation of the alcohol both the therapist and clients began to shift from the old story or meaning about the alcohol dependency to a new story while simultaneously moderating the therapeutic atmosphere. As the clients' experience with the symbol was intensified there was a separation and clarification of the two stories or meanings that were developing.

Three themes, resulting from the old story or meaning of the alcohol dependency, became the ground for novelty and focused on kindling a new therapeutic story for the clients. First, the theme of reframing alcohol as a seducer focused directly on changing the old story from the husband's weakness and failure for not controlling alcohol, to alcohol being the problem that enticed him to drink. Second, the theme of moving from an individual to a relational understanding of the role of alcohol in the couple's relationship did not just deal with representing the old

story, but was also designed to create novelty and difference in their relationship. That is, there was a shift to include the wife in the husband's alcohol recovery and to begin the promotion of equity in their decision making process. Third, the theme of challenging propositions and competence focused on shifting the husband's existing belief that he was not affected by the presence of alcohol. Again, the emphasis was on looking for alternate perspectives in relation to how alcohol was previously perceived. Although these three themes deal with representing the old story, they all contribute to making major movements toward difference, novelty and change.

Movement toward developing the basis for the new story or meaning was evident through the theme of re-defining and accenting the couple's commonalities. The new story emphasized the couple working together toward common goals which simultaneously served to elevate the wife's status in the marital relationship so that she could be involved in the alcohol recovery. The new story was about exploring, together, their goal of getting rid of alcohol and their respective experiences of alcohol being out of their lives. The basis for the new story focused primarily on the interpersonal functioning between the spouses.

Other themes identified in the study were not concerned with either the old story of the alcohol dependency or the new story that was emerging, but were concerned with

developing a certain atmosphere or character of the therapy for the externalization to be effective. These themes dealt primarily with accompanying and accommodating the clients' internal process in order to moderate the therapy. The themes of regulating the intensity of experiences and diffusing tension and defensiveness were found to moderate the therapeutic process. Moderating the therapy included pacing the therapeutic process to help clients gradually explore, intensify and accept their experiences. The third theme, dealing with the therapeutic climate, was creating and maintaining a collaborative atmosphere which served to establish the ground or base of the therapy. In order for the symbolic externalization intervention to accomplish its task of creating relational novelty, the therapeutic alliance had to develop a sense of safety and collaboration.

The final phase of the therapeutic story in the therapy episode was to separate and clarify the two kinds of stories that were developing in relation to the alcohol dependency. This separation and clarification occurred via the theme of deepening contrasting experiences. Heightening the contrast between the clients' previously existing experiences and new experiences resulted in the clients becoming aware of, experiencing and accepting the new story or meaning about the alcohol dependency problem.

In summary, using the symbolic externalization intervention entailed a movement from the old story or

meaning about the alcohol dependency to developing a new story. To reinforce the new story, both stories were separated and clarified and then heightened. An integral element for the intervention to be effective required that the therapeutic alliance moderated the therapy by establishing a certain atmosphere.

As a result of these above findings, the theoretical construct of symbolic externalizing was made more specific which then contributed to enhancing clinical utility. The specific aspects documented in this study provide clinicians with knowledge about necessary components to effectively introduce and implement the symbolic externalization intervention. In particular, the findings revealed the complexity of using symbolic externalization and that it is not sufficient for clinicians to just introduce the intervention and then intensify and deepen the experience. Clinicians must first acquire information about the old story of the presenting problem and then create movement toward difference, novelty and change. This movement toward the new story will be most effective if the atmosphere of the therapy is continually moderated and both the old and new story are separated, clarified and heightened.

Attending to the Therapeutic Process

The findings of the case study support the view that the quality of the relationship between client and therapist influences much of what occurs in therapy (Rogers, 1957).

An effective type of therapeutic relationship varies with different client-therapist systems, but it is generally considered that focused attention and mutual respect are invariably important components. These components were manifested in this study's theme of creating and maintaining a collaborative atmosphere. It is also important that therapists remain flexible in their role so they may facilitate the variety of experiences required in the course of therapy.

In their review of process-outcome studies, Orlinsky and Howard (1986) found that "effectively therapeutic" components of psychotherapy included: (a) the therapeutic bond between therapist and client which entailed reciprocal role-investment, empathic resonance, and mutual affirmation; (b) therapeutic interventions implemented skilfully and with suitable clients; (c) the therapeutic subsystem focused on the client's feelings; (d) preparing the client for the ensuing therapeutic process and therapist-client collaboration with regards to the therapeutic contract; and (e) at times having more than less therapy. These researchers suggest that the reason for their findings of inconsistent associations between client outcome and therapeutic interventions is because therapeutic interventions do not directly influence therapeutic realization. Instead, therapeutic interventions "require an 'open' state of self relatedness for this influence to

become effective" (Orlinsky & Howard, 1986, p. 369). The findings of their research suggest that a strong therapeutic bond increases the client's willingness to participate in therapeutic interventions. It was proposed that several factors influence the development of the therapeutic bond. First, the accumulation of meaningful interventions that are experienced as helpful by the client may enhance the therapist's credibility as well enhance the client's investment in the therapeutic bond. Second, implementing a collaborative client-therapist therapeutic contract enhances the development of a good therapeutic bond.

The findings of the case study are consistent with Orlinsky and Howard's (1986) suggestion that other factors relating to the therapeutic alliance influence the effectiveness of the intervention. The co-construction of the themes by the therapist and clients in and of itself enhanced the quality of the therapeutic bond. Additionally, the accumulation of such co-constructed and accepted themes and interventions as, reframing alcohol as a seducer, challenging propositions and re-defining commonalities may have enhanced both the therapist's credibility and the clients' investment in the therapeutic relationship.

The case study supports Goolishian and Anderson's (1990) notion "that it is the slow and careful development of a co-created reality in a narrative that provides the context and the space for change" (p. 104). The therapist

provides the space for and facilitates the dialogical conversation. This is done through inquiry that opens up and mobilizes rather than closes down and immobilizes clients (Anderson & Goolishian, 1988). The careful development of a co-created reality in the therapy episode required that the therapist and clients engaged in first forming a collaborative therapeutic atmosphere. The context and space for change was further opened by diffusing tension and defensiveness, regulating the intensity of experiences, and a gradual deepening of contrasting experiences.

Implication for Theory and Practice

Prior to the intensification of the clients' experiences, which led to attaining relational novelty, the therapeutic subsystem attended to the seven themes that preceded the eighth theme of deepening contrasting experiences. Although relational novelty was accomplished after experiencing the relationships to self and others in the absence of alcohol, these preceding seven themes that emerged from the analysis of the therapeutic episode had to be resolved and accepted. These seven themes, which will be discussed in the following section, have implications for theory and practice with regards to both the therapeutic relationship and process.

1. Creating and maintaining a collaborative atmosphere.

This study confirmed, through the theme of creating and maintaining a collaborative atmosphere, the ExST's theory of

therapist and client collaboration. The therapeutic relationship created an atmosphere of mutuality and respect for others and their ideas in the therapy. The mutuality and respect was demonstrated by the therapist and clients co-constructing the eight identified themes. Based upon Orlinsky and Howard's (1986) findings, establishing a collaborative therapeutic mandate further enhanced the therapeutic bond. Considering that the collaborative relationship between therapist and client is essential to both symbolic externalizing and relational novelty, then it would seem that this theme is a condition for therapy rather than a mechanism of change in itself. The collaborative atmosphere moves the therapy toward a process in which all members of the therapeutic system can be open to change and the meaning and integrity of members is not challenged (Anderson & Goolishian, 1988).

The clinical utility of this finding is that the quality of this safe and trusting collaborative atmosphere is crucial when externalizing and intensifying experiences, especially considering that clients may take personal risk in experiencing previously unacknowledged and possible threatening aspects of the experience both within self and with their spouse and therapist. It was evident in the investigated therapy episode that both clients experienced previously unacknowledged aspects of themselves during the externalizing intervention. Creating a collaborative

atmosphere is integral to the beginning phase of ExST and involves the therapist validating each spouse's experience of the marital relationship. As this validation process enhances the creation and maintenance of collaboration, it also validates clients' responses and encourages them to further explore their relationships. In marital ExST the therapist must join with both spouses in their inner and outer realities even though there may be differing views. As the therapist joins with and validates each spouse's experience, without alienating the other person, it requires not ascribing blame to the other. An example of how the therapist in the case study joined the clients in their respective experiences without minimizing or dismissing the other, was when she introduced (via the theme of re-defining the couple's commonalities) their implicit collaboration about what to do with the alcohol in the house. The therapist simultaneously elevated the wife's status in the marital relationship to one who had the ability to make alcohol related decisions and did not negate the husband's desire to be in charge of his battle with alcohol.

The other component linked to the theme of creating a collaborative atmosphere, as found in this case study, was consistent with Maturana's (cited in Friesen et al., 1989) theory of structural coupling and developing a consensual domain in the therapeutic relationship. There was a common joining of aspects of the personality structures of each

participant and the therapeutic environment which resulted in agreement of the therapeutic goals and perceived relevance of the tasks associated with the therapy process. This study found that forming the consensual domain required the therapist to accommodate the clients' particular personality structure in the therapy process and the clients to accommodate the therapist's therapeutic principles via the process or theme of regulating the intensity of experiences. Creating and maintaining a collaborative atmosphere requires that clinicians incorporate and integrate clients' particular personality structure into the therapy which will ultimately determine the idiosyncratic course and process of therapy for each client. The therapist and clients co-construct the therapeutic context.

2. Regulating the intensity of experiences. The theme of regulating the intensity of experiences is linked to creating and maintaining a collaborative atmosphere. The therapist must remain attuned to each client's readiness for change and then match the intensity of the therapeutic process to that of the client's internal and contextual world (Friesen et al., 1989). As was found in the case study, this may require shifting back and forth from heightening a particular emotion, physical sensation, behavior or cognition through repetition to analyzing the experience. In tracking the clients' experiences and matching their pattern of speech, the therapist in the case

study paced the process of therapy. The use of mitigation, analyzing of experiences and highlighting strengths are examples of how the therapist lessened the intensity of experiences. The clients in the case study regulated the intensity of their experiences by using mitigation and by analyzing their behavior and experiences. It was the gradual progression toward and the eventual intensification of experiences that contributed to co-creating relational novelty. Observing and becoming aware of the ways in which clients and therapists lessen the intensity of experiences will aid clinicians in assessing clients' readiness for change and the need for regulating intense experiences.

3. Diffusing tension and defensiveness. A corollary to the regulation of intense experiences is the theme of diffusing tension and defensiveness. To avoid creating offense and to lessen the impact of overt expressions, assertions, suggestions and challenges, both the therapist and clients in this study mitigated and modified expressions that may result in conflict. Diffusing tension and defensiveness contributed to building and maintaining the therapeutic relationship and was a means of achieving the goals of therapy. For instance, when the therapist diffused the tension between the couple as they engaged in an invariant pattern of challenging and defending behavior, this enabled the focus of the therapy to be re-directed to the goal of getting rid of alcohol. The process of

mitigating responses and assertions was the way members of the therapeutic subsystem tried to understand each other and the presenting problem. The clients and therapist related to their understanding of the problem idiosyncratically and with differing levels of value investment. They also had an opportunity to discourse and change at their own pace and in their own way (Anderson & Goolishian, 1988). By use of cooperative rather than uncooperative language, linguistic mobility was enhanced and the interview moved toward "collaborative conversation rather than toward confrontation, competition, polarization, and immobility" (Anderson & Goolishian, 1988, p. 382). This led to the therapeutic conversation remaining open to allow for evolving of new meaning and understanding of the problem.

In regards to clinical utility of the theme of diffusing tension and defensiveness, clinicians must learn, understand and converse in the clients' language because the words, language and meaning used by clients in therapeutic discourse is the metaphor for their experiences (Anderson & Goolishian, 1988). Diffusing tension and defensiveness, through various means, was the therapeutic subsystem's method of generating meaning about the problem.

4. Challenging propositions and competence. The theme of challenging propositions and competence is related to the idea that clients may understand their problem relationships in ways that typically impedes the possibility of

resolution, resulting in repetitive interaction patterns. Thus, in order for the possibility of resolution to occur, it is important to change the perception of the problem relationship and of self. Challenging propositions and competence in relation to the clients' perception of self, others, and the effect of alcohol perturbs interactional sequences on various relational levels. For example, in this study challenging the alcohol dependent client's perception that he was not adversely affected by the presence of alcohol provided new information which contributed to co-creating relational novelty in both intrapsychic and interpersonal domains. That is, the husband's perception of how he experienced alcohol was expanded. The challenge introduced information to the therapeutic subsystem that led the wife to begin having a say with respect to the alcohol.

In regards to the utility of challenging propositions, the therapist must inquire about discrepancies and distortions that keep clients mired in their problem situation. As suggested by Anderson and Goolishian (1988), the therapist inquires in such a way that does not judge whether the client's view is right or wrong. This process may then lead to a mutual inquiry about entrenched ideas, resulting in expanding and creating new meaning.

5. Reframing alcohol as a seducer. Another method of expanding and creating new meaning found in this study was

to reframe the perception of the problem. Rather than continue with a constrictive perception of self in relation to alcohol, information may be introduced that effectively shifts the meaning of the relationship with alcohol and the nature of the problem itself (Friesen et al., 1989). The intent is to alter the clients' perception of their relationship with alcohol so that the behavior connected to the alcohol and the meaning attached to this behavior are re-examined and understood differently.

This study found that the reframe of alcohol as a seducer was re-introduced several times before it was accepted by the alcohol dependent client. His previous self-perception of being weak, worthless and a failure in relation to his battle with alcohol was not easily altered. Thus, clinicians may need to introduce the reframe more than once in order for it to be accepted by all members of the therapeutic subsystem.

6 & 7. Moving to a relational understanding of alcohol and re-defining the couple's commonalities. These two themes are specifically connected with addressing the interpersonal functioning between the spouses in relation to the symptomatic behavior of alcohol dependency and are integral to the systemic principle of ExST. The systemic perspective holds that individuals engage in a dynamic interactional process in which they both mutually influence and are influenced by one another.

Providing a context for systemic transformation requires clinicians to either implicitly or explicitly introduce and accent the relational experiences between the spouses. This may include introducing the concept of collaboration about issues related to the alcohol dependency. For instance, in this therapy episode both spouses implicitly collaborated that the husband was to deal with the alcohol in the house. Furthermore, when the spouses did not recognize their common goals and desires re-defining and accenting their commonalities helped them to work cooperatively rather than in opposition.

Contributions to Understanding Relational Novelty

The theory underlying the construct of relational novelty is that relational patterns within intrapsychic, interpersonal and environmental domains are enacted and perturbed so that alternate ways of being may occur (Friesen et al., 1989). The purpose is to directly affect the rigid and restrictive sequences of relational patterns and expand alternatives. Friesen et al. (1991) suggest:

Novelty emerges spontaneously, as old recursive patterns of relationships are modified, revised or replaced through processes of recognition, acceptance, negotiation, apology, forgiveness and grieving (p. 17).

The findings of the case study support ExST's view that relational novelty is co-created by therapist and client within the various domains suggested. Through the co-construction of the identified themes in the case study, new meaning emerged that transformed the clients' experience in

regards to the connections in their relational matrix. As the problem relationship changed, there was a shift in the relational systems that contained the problem interactions. The following discussion examines how each relational level was affected in the therapy episode investigated.

Presenting Problem

Clients have a particular relationship with the problems they present in therapy. In ExST, this relationship is brought into the clients' awareness through intensifying their experience of relating to a concrete symbol, such as a bottle of alcohol. The relational nature of the problem is explored for the purpose of developing a collaborative problem definition. The presenting problem in ExST is reframed "in terms of the interaction or the relationship of the client to the problem" (Friesen et al., 1989, p. 81). In the present study, the therapist framed the problem of alcohol dependence as the relationship and interaction between the client and alcohol. More specifically, the concrete symbol of alcohol was framed as something that enticed the husband to drink, created fear and apprehension for both spouses and as preventing intimacy in their marital relationship. The couple was then invited to concretely explore their relationship with alcohol by engaging with it. Fully experiencing their respective relationship to alcohol at the physiological, emotional, behavioral and cognitive levels, via the theme of deepening

contrasting experiences, permitted the couple to gain a broader understanding of the alcohol problem and each other.

Before a new and relationally novel experience occurred within the context of the presenting problem, intrapsychic and interpersonal aspects were first addressed. The theme of challenging the husband's proposition of how he was affected by alcohol was instrumental in focusing the therapeutic process toward addressing the effect of alcohol. The challenge resulted in him eventually concurring that he was adversely affected by alcohol. Furthermore, the husband's self-perception of himself as weak, worthless and a failure in relation to alcohol was reframed and accepted before he engaged with the symbolic representation of alcohol. At the interpersonal level, the couple resolved aspects of their relationship that prevented the wife's involvement in the husband's alcohol recovery process via the themes of moving from an individual to a relational understanding of alcohol and re-defining the couple's commonalities. The relational novelty that occurred in the episode with respect to the presenting problem was that the husband symbolically got rid of the alcohol and the wife had a voice in its removal.

Intrapsychic Domain

The rigid and recursive patterns of relationship also occur at the intrapsychic level as manifested by defeating self-talk in relation to the presenting problem and in

interpersonal interactions (Friesen et al., 1991).

Relationally novel experiences occur when clients, for example, experience both the characteristic of kindness within self and the previously disowned cruel and unkind aspects of self. Clients may also experience relational novelty by engaging in a dialogue with previously unacknowledged or disowned aspects of self.

In the present study, relationally novel experiences occurred via the theme of deepening contrasting experiences. The husband experienced previously unacknowledged aspects of himself which included feeling tense in the presence of alcohol and relaxed in its absence. His previous tendency was to not acknowledge how he was affected by alcohol because his relational experience with alcohol was that he was weak and a failure for not controlling it. Bringing the unacknowledged aspects of himself into awareness through gradually deepening his contrasting experience of tension and relaxation was relationally novel in and of itself. Relational novelty was also experienced by the wife when her contrasting feelings of calmness and fear and apprehension were gradually deepened. She experienced a previously unacknowledged aspect of herself, which included her fear and apprehension.

The theme of regulating the intensity of clients' experiences contributed to attaining a new and novel inner experience of their relationship with alcohol. By pacing

the therapeutic process, the clients gradually intensified their inner experience of alcohol.

Interpersonal Domain

Interpersonal interactions between individuals, family members and therapists may be affected by intrapsychic aspects of self and the presenting problem. Relational novelty may occur in the interpersonal domain when the couple's constrictive interaction patterns are perturbed and intensified resulting in the transformation of more flexible sequences of behavior and interaction (Friesen et al., 1989).

The experiencing and sharing of intrapsychic aspects of self in the therapy episode was a novel experience for the couple who had not previously revealed information to each other about how they were affected by alcohol. Their previous interactions with respect to dealing with alcohol had entailed angry, intimidating, defensive and fearful responses. The interaction in the therapy episode after the alcohol was placed outside represented a shift in the couple's typical interaction pattern and revealed that the intrapsychic level was linked to the interpersonal level. They were able to include one another in their experience of alcohol and how the alcohol affected them. Subsequently, a relationally novel experience occurred at the interpersonal level when both spouses were involved in the removal of alcohol. For the husband to include his spouse in its

removal was the initial promotion of the couple's equity. The wife's status in the marital relationship was elevated to her having a say about the alcohol.

The themes of moving from an individual to a relational understanding of the role of alcohol and re-defining and accenting the couple's commonalities aided in facilitating the couple's understanding that they were both influenced and affected by alcohol. Their common goals and desires indicated that they both wanted the alcohol out of their lives and that its removal was the husband's responsibility. Thus, these two themes were specifically connected with co-creating relational novelty at the interpersonal level.

In summary, the findings of the case study support that the construct of relational novelty may occur at the three relational levels of functioning as described above. There were specific themes that contributed to each relational level, but generally they were inter-connected with one another throughout the therapy episode. One theme influenced the attainment of another. As is consistent with the theory of ExST, the findings of the study support that the collaborative nature of the therapeutic relationship is essential for the co-creation of relational novelty. In addition, the theme of diffusing tension and defensiveness is also a component of the therapeutic relationship.

Contributions to Marital and Family Therapy Process Research

This study supports the assertion made by family

therapy process researchers that understanding the mechanisms that facilitate therapeutic change is a complex process which has been inadequately attended to in research. The complexity of this change process was acknowledged by utilizing a methodology which was as complex and in depth. Methods that were reductionistic in nature were deemed not appropriate for the purpose of this research. The methodological approach chosen was considered to be effective due to its comprehensive nature and ability to contextualize the therapeutic change moments. Comprehensive discourse analysis, developed by Labov and Fanshel (1977), is a methodology that was capable of accommodating the following recommendations of marital and family therapy process research: examining the interactions of both therapist and client (Gurman et al., 1986; Pinsof, 1991); including verbal, non-verbal and paralinguistic cues (Gurman et al., 1986; Pinsof, 1991); providing clinically relevant information (Gurman, 1988; Newman, 1991; Wynne, 1988); developing a clear theoretical approach of the change process (Gurman, 1988; Newman, 1991; Wynne, 1988); and incorporating systemic concepts (Gurman et al., 1986; Pinsof 1988, 1991). The methodology enabled the reciprocity and the mutual influencing between clients and therapist to emerge. This information helped to facilitate a systemic understanding of how clients and therapists co-construct the problem definition and the dis-solution of the problem.

Limitations of the Case Study

Yin (1989) accented three major criticisms of case study research. The first criticism has been the lack of rigor of case study research, as compared to experimental and survey research designs, resulting in the possibility of researcher and analyst's biases influencing the direction of the findings and conclusions. The case study method employed in the present investigation endeavoured to reduce the bias by providing the empirical data in its entirety. The empirical data included the actual transcript of the therapy episode and evidence from other segments of the therapy to support the text expansions. The research method employed, promoted the explication of underlying assumptions and theory of the therapeutic model utilized in order that analysts are attentive to their own biases. Researcher bias is not only applicable to case study research, it can also affect survey and experimental research strategies.

The second criticism of single or multiple case study research designs is the limitation to generalize beyond the case study. Yin (1989) asserts that "case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes" (p. 21). Subsequently, the researcher's goal is to expand and generalize theories and not to provide statistical frequencies. The purpose of this case study was not to generalize to a population, but to aid in refining and modifying the theory underlying the

ExST symbolic externalization intervention. Given that the focus in this study is on proximal outcome of one therapy episode of a therapy case in which the intervention was implemented, generalizing facts and experiences to another therapy case would not be appropriate. What may be possibly generalizable, but would require additional case study research to substantiate, are the identified themes and their significance in externalizing alcohol dependency. This case study was descriptive, aimed at an in-depth understanding of the phenomena of co-creating relational novelty in therapy using symbolic externalizing in order to extend further research directions and examine associated change mechanisms arising from this investigation.

The third criticism centres on the laborious task of undertaking case study research resulting in large, unreadable documents (Yin, 1989). Yin asserts that this criticism "incorrectly confuses the case-study strategy with a specific method of data collection, such as ethnography or participant-observation" (p.21). The sophisticated and comprehensive nature of the methodology utilized assured that the data would be functional, understandable and "readable". The presentation of the data included first providing the actual text, the text expansion, the interaction and finally the episode summary. It is true, that this was a very detailed and time-consuming task to which the researcher committed many hours.

In case study research, there is concern about internal validity and making inferences (Yin, 1989). Inferences occur when the direct observation of an event is not possible. In the present study, the expansion of the text involved referring back to other segments of the therapy case which can result in making inferences. In order to account for inferences, the researcher provided information from other texts to substantiate the text expansion.

Direction for Future Research

This research begins the process of utilizing empirical analysis to understand how the change process in marital and family therapy is co-created by therapists and clients. More specifically, it begins the process of describing how therapists and clients co-create relational novelty using symbolic externalization intervention in the treatment of alcohol dependence. However, further research is necessary to expand upon the findings presented in this study.

One of the main recommendations for future research is that the theoretical refinement and clinical utility identified in this study be used to further analyze the constructs of symbolic externalizing and relational novelty. Now that the constructs have been more specifically defined other researchers could use this information to build upon the present findings. It is through the continued expansion of these constructs that family therapy process researchers and clinicians will be able to identify more clearly the

mechanisms of therapeutic change. Further research could, for instance, be conducted to substantiate the way in which the eight themes contributed to movement toward developing and accepting a new story or meaning of the alcohol dependence as well as moderated the therapy.

Conducting multiple case studies utilizing the same methodological procedures and research design as in the present study would aid in furthering the present findings as well as enhancing the generalizability of the findings. More of the same studies would expand our understanding of how the themes or other identified themes facilitate the co-creation of relational novelty.

Another recommendation for enhancing the validity of the findings would be to have other researchers analyze the present data. This type of investigation would expand the results and provide a fuller understanding of the therapeutic change process, particularly relational novelty.

Additional research, utilizing this methodology, may also be conducted in related areas. It could be used to examine how other presenting problems, besides alcohol dependency are symbolically externalized. Other theoretical and therapeutic orientations could be examined to determine specific components that contributed to the effectiveness of the therapeutic change process. The generic and/or common elements and mechanisms of change in effective marital and family therapies could then be further researched (Gurman,

1988). The methodology utilized also lends itself to analyzing the other six transactional classes of ExST to determine how they accomplish what they purport.

The importance of the concept of contextualization, as identified in this study, suggests that it is important to not compartmentalize interventions and de-contextualize therapeutic change moments. Considering the lack of research about this concept, it would be fruitful to study this further. This would entail studying the therapeutic process as well as attending to the therapeutic alliance.

A final suggestion for future research when addressing such presenting problem as alcohol dependency from a systemic perspective is to examine the role of women. Rather than immediately assume that women collude with and deny the alcohol dependence of their spouse due to their silence, it is important to explore the reasons for their silence. There may be other factors contributing to their behavior such as, a fear of violence.

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APPENDIX A

Transcript Notation

- (.) A dot is used for each 1/2 second of pause.
- = There is not a discernable pause between the end of an utterance and the beginning of the next.
- :
- Indicates extension of the preceding vowel sound.
- Under Contrastive stress or added emphasis is indicated by underlining characters.
- CAPITAL Capitalized words indicate that the words were spoken louder than the surrounding utterances.
- (.hhh) Exhalation of breath.
- (hhh) Inhalation of breath.
- uh, um, Hesitation forms.
- xxx Signifies that words are not discernable, or there is doubt of accuracy.
- [Indicates that the talk is overlapped.
- (()) Kinesic or nonverbal cues are placed inside double parentheses e.g. ((laughter)).
- ? Signifies a rising inflection.
- ! Signifies an animated tone.
- . Signifies a stopping fall in tone.
- * * Words between * * are quieter than the surrounding utterances.
- _ Indicates an abrupt termination of speech.
- Indicates sounds that are less than a word e.g. stammering repetition (n-not).

APPENDIX B

Propositions**General Propositions**

Therapeutic propositions:

{S-Share}	Spouses should share feelings and needs with one another.
{S-Express}	In therapy clients should express their feelings.
{Awareness}	Clients should develop awareness of their internal process in regards to emotions, cognitions, bodily sensations, and behavior.
{A-Feeling}	Therapeutic process involves becoming aware of feelings and experiencing them in the here and now.
{A-Bodily}	Therapeutic process involves becoming aware of bodily sensations and experiencing them in the here and now.
{A-Behavior}	Therapeutic process involves becoming aware of behaviors and experiencing them in the here and now.
{A-Cognition}	Therapeutic process involves becoming aware of cognitions and experiencing them in the here and now.
{Convey}	Therapist conveys understanding of and normalizes clients' feelings and experiences.
{T-Common}	Therapist accents couple commonalities.
{T-Highlight}	Therapist highlights clients' strengths as well as difficulties.
{Non-intrusive}	Therapist does not intrude upon clients when intense experiences emerge.
{T-Track}	Therapist notes and highlights clients' experiences.
{Mandate}	A therapeutic mandate must be established in ExST.
{Split}	A conflict/contradiction is brought to the clients' awareness.
{Here}	ExST focuses on the here and now experiences.
{Safety}	Pacing the therapeutic work is important.
{Experience}	Heightening and intensifying experiences is important to aid in gaining awareness of internal process and to create change.
{Novelty}	Direct experiencing in therapy deepens and expands alternate ways of being, ie. relational novelty.
{E-S} {E-J}	Sam (Jill) feels an emotion.
{E1-S} {E1-J}	Sam (Jill) feels fear or apprehension.
{E2-S} {E2-J}	Sam feels anger. Jill feels anger.
{E4-S} {E4-J}	Sam (Jill) feels relaxed, calm, and easier.

{E5-S} Sam feels tentative, anxious, unsure.
 {E6-S} Sam feels less apprehension.

Other general propositions:

{Collaborate} Clients collaborate on decision making process.
 {Relational} Alcohol dependence is a relational experience.
 {Alcohol} Alcohol should not be in the clients' home.
 {H-Head} Husband is a competent head of the household.
 {W-Support} Wife is a competent support to husband.

Local Propositions

{1} Sam's goal is to quit drinking alcohol forever.
 {2} Sam is competent and effective in dealing with alcohol.
 {3} Sam is motivated, willing and committed to make changes.
 {4} Jill feels afraid and intimidated by Sam's aggressive behavior.
 {5} Sam is challenged to keep the top on the bottle of alcohol.
 {6} Sam's goal is to confront and handle his fear that he will revert back to his repetitive drinking pattern.
 {7-J}{7-S} Client tends to analyze and explain behavior.
 {8} Sam is in charge and in control of his battle with alcohol.
 {9} Presence of alcohol does not bother Sam and make it more difficult to abstain from alcohol.
 {10} Alcohol is in the clients' home.
 {11} Sam's decisions are final and absolute.
 {12} Client rationalizes, minimizes, and justifies behavior.
 {13} Alcohol is seductive in tempting Sam to drink.
 {14} Sam craves alcohol almost on a constant basis.
 {15} Sam gets defensive when alcohol concerns are raised.
 {16} Jill is, and should be, a part of Sam's alcohol recovery process.
 {17} Sam is responsible for quitting drinking and dealing with alcohol related concerns on his own.
 {18} Sam has plans to get rid of alcohol from the house.
 {19} Client wants alcohol to be out of their house.
 {20} Jill does not interfere with alcohol related concerns.
 {21} Client is aware of choice in getting rid of alcohol in the house.
 {22} Clients do not want alcohol in their lives.

{23} Jill is caring and attentive toward Sam.
{24} Jill's status is elevated.
{25} Sam feels weak, worthless, and a failure.

Special Symbols

~9 Proposition {9} is denied.

~~9 It is not true that Sam is not bothered by the
 presence of alcohol.

?9 Proposition {9} is questioned and challenged.

APPENDIX C

Discourse Rules

The interaction which forms "what is done" in a conversation is layered with many speech acts. Labov and Fanshel (1977) found that the coherence of discourse was based on the connections of speech acts via sequencing rules of production and interpretation. Labov and Fanshel (1977) identified four groups of speech acts or "verbal interactions" which are delineated below. The rules "bridge the gap between what is said and the most immediate interpretation of the actions performed by these words, for example, by the following utterances and actions" (Labov & Fanshel, 1977, p. 71).

Meta-linguistic

Meta-linguistic actions deal with the regulation of speech itself and they describe the behavior of the speaker other than taking a speech turn.

1. Initiate is when the speaker completely begins a new speech event such as a narrative.

2. Interrupt another speaker is also a form of initiating.

3. Re-direct is when the speaker changes the conversation into another direction.

4. Respond is often done after a speaker makes an utterance.

5. Continue is when the speaker speaks for any length

of time. The speaker may for instance continue a narrative.

6. Repeat is when the speaker re-states a speech act.

7. Reinforce is when the other person encourages the speaker to continue speaking by saying "Mhm" or "uh-huh".

8. End: the speaker ends a discussion or narrative.

9. Signal Completion of a speech event is performed in various ways by speakers such as, using gestures.

10. Withdraw from verbal interaction is also performed idiosyncratically.

Representations

Other speech actions are "representations of some state of affairs" (Labov & Fanshel, 1977, p. 62). One set may pertain to the speaker's biography and these would be classified A-events, which are known to A and possibly not known to B. Typically A has privileged knowledge about these particular events and can expect to deal with them as an expert and not worry about being contradicted.

1. Give information: speaker A may report or give information about particular events pertaining to self.

2. Express: speaker A may express feelings or thoughts about these events.

3. Refer: speaker A may introduce particular information that both the clients and therapist know from an earlier session.

4. Reinforce: speaker B may reinforce what was said.

5. Acknowledge: speaker B may acknowledge what speaker

A said.

Another set of representations deals with disputable events (D-events) which are events that both speaker and listener know that the proposition is not necessarily true. This results in the speaker acting as if someone may disagree.

1. Assert: speaker A may present disputable information by asserting it.

2. Give an evaluation: "after presenting a series of events representing something that actually happened, speaker [A] gives an evaluation of the significance of these events in emotional or socially evaluated terms" (Labov & Fanshel, 1977, p. 63).

3. Give an interpretation: an interpretation is given by speaker A when the event is symbolic of another implicit meaning.

4. Give an orientation: speaker A may give a set of normative guidelines which are intended to orient the listener to a specific set of behavior.

5. Agree with: speaker B may agree with the assertion of speaker A.

6. Deny: or speaker B may deny the assertion.

7. Support: speaker B may also support the assertion.

8. Give reinterpretation: speaker B may give interpretation after A has given an interpretation.

Before or after B speaks A may do one of the following:

9. Contradict: speaker A makes a statement contradicting his or her position.

10. Support: speaker A supports his or her earlier statement with subsequent evidence or argument.

Requests

1. Rule of requests: If speaker A addresses to listener B a request specifying an action at a particular time, and B believes that A believes that; (a) the action needs to be performed and as well there is a need for the request because B would not do the action without the request, (b) B has the ability to perform the action, (c) B has an obligation or is willing to perform the action, and (d) A has the right to tell B to perform the action then, the request made by A is heard as valid.

These four preconditions (needs, abilities, obligation or desires, and rights) for a valid request are not usually stated explicitly when a direct imperative request is made.

2. Rule for indirect requests: Mitigating devices may be used in interactions between individuals. If speaker A makes a request for information or an assertion to B about (a) the existential status of an action to be conducted by B such as "Have you washed the car yet?", (b) the consequences of conducting the activity such as "This car would look better if you washed it.", (c) the time referent that the action might be conducted by B such as, "When do you plan to wash the car?", and (d) any of the four preconditions for a

valid request for the action (e.g. need for action and request, ability, willingness, and obligation), then an indirect request has been made.

Requests are made through the interactive dimensions of mitigation and aggravation. Mitigation refers to the individual's desire to modify an expression that may offend another person. When references to needs and abilities are made these are considered mitigating forms, whereas references to rights and obligations are aggravating forms. Requests for information are considered more mitigating than assertions.

3. Putting off requests: If speaker A made a valid request for action of B and B conveys to A (a) a positive assertion or request for information about the existential status of the action (e.g. Isn't the car washed already?), (b) a request for information or negative assertion about the time referent (e.g. It is not the time I usually wash the car.), and (c) a request for information or negative assertion about any one of the four preconditions, then B is perceived as refusing the request.

To refuse a request by reference to obligations and rights is considered aggravating while refusing based on needs and abilities is more mitigating. A refusal which includes an account for the refusal is considered to reasonably polite and not leading to a break in social relations.

4. Relayed requests: If speaker A requests that B make a request of C, and B states that C will probably not comply with this request, B is perceived as putting off A's request.

5. Requests for information: If speaker A conveys to B a request for information or an interrogative centering on the information, and B believes that A believes that (a) A has the information, (b) B does not have the information, then A is considered to have made a valid request for information.

6. Rules of embedded requests: If A requests action from B, and B's response is to request information, B is perceived as asserting a need for more information before being able to respond to A's request.

7. Reinstating requests: If B responds to A's request for action by requesting information, and A gives this information, then A is perceived as repeating the original request for action.

Challenges

Challenges are requests that have been perceived as criticisms. "A challenge is a speech act that asserts or implies a state of affairs that, if true, would weaken a person's claim to be competent in filling the role associated with a valued status" (Labov & Fanshel, 1977, p. 97). The authors conclude that if a challenge is successful the individual may lose his or her claim to hold the status

in question. The response to challenges or questions are either a defense or admission.

1. Rule of delayed requests: If speaker A requests that B conduct an action related to his or her role and which is based on valid needs, abilities, obligations, and rights, then A is perceived as challenging B's competence in his or her role.

2. Rule of repeated requests: If A requests an action of B in his or her role, and A repeats the request before B responds, then A is perceived as emphatically challenging B's performance in his or her role.

3. Rule of overdue obligations: If A states that B has not performed his or her role obligations, then A is perceived as challenging B' competence in his or her role.

4. Rule for challenging propositions: The challenge may not be to the individual's role but to the proposition uttered. If A states a proposition that is supported by his or her status, and B questions this proposition, then B is perceived as challenging A's competence in his or her status.

Coherence

1. Rule of implicit responses: If A requests something of B, and B responds with a statement without expanding to include A's statement, then B is perceived as stating there is a proposition known to both A and B.

2. Rule of confirmation: If A makes a statement about

events known to B but not to A, then this is perceived as a request for confirmation.

3. Rules of disputable assertions: If A asserts events that are known to be disputable, this is perceived as a request for B to evaluate the assertion.

4. Rule for socratic questions: If A asks B a yes-no interrogative about events that are known to be disputable, this is perceived as a request for information about B's position on this event, which forms the basis for more discussion.

Narratives

In therapeutic discourse, narratives are used to represent past experiences by stating a temporal sequence of the events. Narrative events are usually relayed in more than one sentence. The narrative is often introduced by stating the proposition that the narrative is meant to illustrate. The proposition is often affective in nature and is directed by the event itself. Narratives may also operate as a response, refusal, and challenge. Narratives typically begin with a reference to time, place, persons, behavior particular to the situation. The rule of narrative orientation signifies the initiating of a narrative: If A refers to a past time or event which cannot be interpreted as a distinct speech act in itself, then B will perceive that a narrative will ensue. The listener must be able to interpret the point of the narrative correctly if he

or she is to understand the coherence of the discourse. Narratives can operate as responses to requests for information which coincides with the rule of narrative response. That is, if A requests information of B, and B initiates a narrative, the B is perceived as giving the information requested via the essence of the narrative. The listener can agree or disagree with the proposition.