SHIFTING GEARS: AN INTEGRATION OF SOLUTION-FOCUSED THERAPY AND EXPERIENTIAL THERAPY IN COUPLES COUNSELLING

BY

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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ABSTRACT

This practicum proposes a theoretical and practical integration of solution-focused therapy (SFT) and experiential therapy (ET) in the context of couples counselling. A comprehensive literature review of the aforementioned theoretical models is presented, followed by a rationale for the integration of these particular paradigms. Following the proposition of a theoretical integration, a demonstration of its practical application with seven couples, in a clinical setting, is provided. Three in-depth case analyses and four case synopses are presented as clinical illustrations of the proposed theoretical construct. The Dyadic Adjustment Scale (DAS), used as an indicator of relationship quality, was employed as a tool to measure clinical outcomes of the designed intervention. A qualitative client feedback form was utilized as an evaluative adjunct to the DAS, providing important feedback regarding the intervention, as perceived by clients. Both quantitative and qualitative data provide exceptional evidence of clinically significant improvements in client complaints. The integration of solution-focused therapy (SFT) and experiential therapy (ET) demonstrated outstanding effectiveness, as a respectful, client-centered therapeutic modality, with couples seeking to improve relationship satisfaction.

CHAPTER ONE

Introduction

The practice component of my graduate studies in social work provided me with the opportunity to integrate theory and practice as a social worker providing couples therapy. The practicum was completed at Manitoba Family Services and Housing, a community-based governmental organization, that provides voluntary and mandated family-focused services within Manitoba. Couples therapy was provided to couples seeking voluntary counselling services for a variety of issues resulting in dyadic conflict, stress, dissolution and overall relationship dissatisfaction. Supportive service to couples was carried out using an integrated approach that co-locates solution-focused therapy (SFT) and experiential therapy (ET).

Although there exist a myriad of therapeutic modalities for couples, my decision to undertake an integration of SFT and ET was based on several reasons. Both approaches are respectful and dignified ways of working with people, and in many ways reflect core social work values. It was my belief that ET would mitigate the weaknesses and limitations inherent in the SFT model. I conjectured that combining the strengths of the aforementioned paradigms, in a systematic integration, would evolve an increasingly effective client-centered, strengths-based, solution-oriented means by which couples could achieve preferred therapeutic ends. My intent was to propose and utilize these two approaches in a blended fashion, constituting a theoretical and technical eclecticism. Finally, my goal in illustrating a SFT-ET integration within a context of couples therapy served the purpose of meeting my proposed learning objectives, while simultaneously providing a respectful and effective intervention for meeting couples' needs.

This practicum reflects my belief in the fundamental value of the family unit. Healthy families are critical to the biopsychosocial development and growth of individuals and form the cornerstone of healthful communities. The strengths within the family contingent are very much governed by the condition of the marital and/or common-law dyad. Both theoretical and practice knowledge have demonstrated that often "unhealthy" or "dysfunctional" family manifestations are the result of a poor, conflicted, strained, or stressed couple system (Nichols & Schwartz, 1998). Conversely, "healthy" and "functional" family representations resonate from supportive and nurturing couple dyads. When the couple within a family is doing well, often the family is doing well.

Dyadic relationships are significant sources of comfort, sustenance and support to the individuals within the couple sub-system as well as to other family members. The biopsychosocial benefits of being in a satisfying relationship are multifarious. The individual's human need to belong, however, can sometimes conflict with a coexisting need to maintain autonomy and individual difference. There are many other complexities and dynamics that exist in relationships which may potentiate difficulties and create dyadic conflict, stress, and overall dissatisfaction.

Relationship deterioration and dissolution can lead to further problems which may result in separation or divorce. The negative implications of staying in an unsatisfying or "toxic" relationship may be just as detrimental, if not worse, than those that may ensue from divorce. The prevention of divorce is not my goal. As a matter of fact, divorce may be what some couples want and need. The aim of intervention within this endeavour was to provide couples, willing to enhance, improve, or repair their relationship, an effective therapeutic means by which to

increase relationship satisfaction.

Consistent with social work values, couples counselling is a proven effective modality for alleviating a multitude of dyadic problems, thereby increasing relationship satisfaction (Nichols & Schwartz, 1998). This mode of intervention is an important aspect of social work practice and constitutes a direct method of family intervention and is an indirect provision of community support. Therefore, my choice of and focus on couples therapy, falls well within the scope of the social work discipline.

Learning Objectives

The practice component of my MSW requisite contained two primary goals. The first was to propose and illustrate a theoretical integration of solution-focused therapy (SFT) and experiential therapy (ET) in the context of couples counselling. The second goal involved the ability to articulate and demonstrate the integrative framework with couples seeking therapy, with a variety of relationship issues, for the purpose of increasing marital or relationship satisfaction.

My practicum goals encompassed two significant objectives; to increase my theoretical knowledge and practice experience in the two areas of solution-focused and experiential couples therapy and; to demonstrate the proposed integration as an effective treatment modality for couples, thereby making valuable contribution to social work theory and practice knowledge.

In demonstrating therapeutic effectiveness, measurement and evaluation of clinical outcomes was essential. The combined methodology of quantitative and qualitative procedures were utilized to gather feedback from clients on the effectiveness of the proposed intervention.

This was done using a standardized questionnaire to measure marital adjustment and satisfaction before and after counselling. Further to this, an open-ended questionnaire was used to gauge, as perceived by clients, a description of the most helpful aspects of therapy. Further discussion and details regarding measurement and evaluation procedures will be provided in chapter 4.

The successful completion of my learning goals and objectives was contingent upon an ongoing literature review of descriptive, theoretical, and empirical information relevant to key areas within the scope of the practicum context. They were: (1) Benefits of marriage and the negative implications of marital conflict, distress, dissolution, and divorce (2) Solution-focused and experiential therapy (3) The Dyadic Adjustment Scale (DAS).

The learning gained from the literature review was supplemented with direct practice supervision from my academic advisor, my practicum committee, conjunctively with the necessary resources and support provided by Manitoba Family Services and Housing. These were all critical components necessary in the accomplishment of my learning goals and objectives.

In meeting established personal and professional aspirations I preserved, as my fundamental priority, the provision of a valuable and respectful supportive service for couples seeking therapy.

CHAPTER TWO

Literature Review

The Benefits of Marriage and the Negative Implications of Marital Conflict, Distress, Dissolution, and Divorce.

The challenges and struggles individuals experience in trying to make their relationship succeed may be worth the effort. Research indicates that married individuals, in general, are emotionally and physically healthier than their non-married counterparts (Coombs, 1991; Amato, 2000; Gottman & Notarius, 2000). Coombs (1991), in a review of more than 130 empirical studies, found that men and women generally live longer, are less stressed, and are happier than individuals who are not married. Scholarship regarding the profits of marriage (Wilson, 1967; Lynch, 1977; Berkman & Syme, 1979; Campbell, 1981; Veroff, Douvan, & Kukla, 1981; Brehm, 1995; Gottman & Notarius, 2000) coincide with Coombs' (1991) conclusions. As there exists a disparate gap between the emotional and physical variables of married and non-married couples, the discrepancy increases when the comparison is made between satisfied married couples and cohabiting couples, or dyadic relations who are experiencing, conflict, distress, dissolution, or divorce.

Literature investigating the relationship between marriage and well-being often overlook or fail to differentiate between cohabiting and married couples (Marcussen, 2001). Scholarship indicates that cohabiting couples experience similar benefits to psychological and physical well-being as married couples (Hyoun-Kyoung, 1999). However, existing research which compares married and cohabiting couples demonstrates that individuals in cohabiting relationships experience higher rates of relationship instability (Brown, 2000). Further, cohabiting couples

have reported lower relationship happiness (Skinner, Bahr, Crane, & Call, 2002), lower levels of intimacy and relationship satisfaction (Moore, McCabe, & Brink, 2001), and experience higher rates of depression (Brown, 2000) than their married counterparts.

A review of the literature by Gottman and Notarius (2000) clearly indicates that marital distress is related to suppressed immune function, cardiovascular stress, and an increase in stress-related hormones in both partners. According to Amato's (2000) review of research on the consequences of divorce for adults, "divorced individuals compared with married individuals, experience lower levels of psychological well-being, including lower happiness, more symptoms of psychological distress, and poorer self concepts. Compared with married individuals, divorced individuals also have more health problems and are at greater risk of mortality" (p. 1265). It is not only divorced couples that experience such negative implications. Often, marital conflict and distress may transpire in a marriage several years before a separation or divorce occurs (Amato, 2000).

Children are also negatively impacted by conflicted and distressed relationships. Gottman and Notarius (2000) report that "marital conflict, distress, and dissolution are linked to problematic childhood outcomes including depression, withdrawal, poor social competence, deterious health outcomes, lower academic achievement, and conduct-related incidents" (p. 936). Couples, as well as their children, in stressed and conflicted marriages that remain intact are also susceptible to psychological and physiological health risks (Amato, 2000; Gottman & Notarius, 2000).

Although divorce is not always equated with dysfunction, "it does appear that the decision to divorce is an attempt to extricate oneself from a trying, conflicted or unsatisfying

relationship" (Kaslow, 1981, p.662). It has been estimated that approximately one half of all marriages will end in divorce (Glick, 1984; Williams & Jurich, 1995; Amato, 2000). According to Amato (2000), the immense increase in today's divorce rate depicts a rise in marital dissatisfaction and instability. Using the rate of divorce as a general gauge regarding the state of marriages and cohabiting dyads, one can see the widespread difficulty individuals are having in creating and maintaining satisfying relationships (Williams & Jurich, 1995).

The benefits of marriage and the multifarious costs (physical, psychological, social) of marital stress and divorce denote a need for practitioners to intervene at the couple level. Marital therapy can be a valuable mode of intervention for supporting couples willing to improve their relationship and overall marital satisfaction.

Marital Therapy:An effective mode of intervention?

The literature regarding relationship "dysfunction" and marital dissatisfaction, conflict, and stress is overwhelmingly diverse. Within the complex comprehensive realm of marriage and relationship literature, there are as many different views and findings about the nature and origin of relationship dissolution and deterioration as there are relationships. However, it is not my interest, nor the endeavor of this practicum to discuss such matters, but rather support couples in meeting their goals for improving their relationship and increasing marital satisfaction. It is my contention that marital therapy is an effective means for couples to meet such an end.

Research evaluating the effectiveness of marital therapy is sparse (Gurman & Kniskern, 1981; Todd & Stanton, 1991; Nichols & Schwartz, 1998). Despite this fact, there is wide acceptance among marital theorists and therapists alike that marital therapy is effective in decreasing marital conflict and promoting relationship satisfaction in the short term (Gurman &

Kniskern, 1981; Todd & Stanton, 1983; Bray & Jourilles, 1995; Shaddish et al., 1995; Pinsof & Wynne, 1995; Nichols & Schwartz, 1998). However, a study by Jacobson and Addis (1993) which tested a variety of treatment approaches within a marital therapeutic context, reported a success rate of approximately 50%. Similarly, other analytic investigations using a broader sample of clinical studies "found that 41% of couples in marital therapy moved from distressed to non-distressed following treatment" (Bray & Jourilles, 1995, p. 464). Although such findings indicate betterment for couples, they also signify that available treatments for marital conflict and distress need ample improvement (Bray & Jourilles, 1995; Shaddish et al., 1995).

The verdict on the long-term effectiveness of marital therapy is still "in deliberation". Consensus among researchers regarding the effectiveness of marital therapy is only evident with respect to short-term success (Bray & Jourilles, 1995). Research on long-term effectiveness is almost non-existent, however, analysis of the meager few investigations available (Crowe, 1978; Snyder, Wills & Grady-Fletcher, 1991) by Bray and Jourilles (1995) reveal that such interventions are indeed forthcoming in their promotion of marital stability. Furthermore, both short-term and long-term therapies, when compared to control groups, conclusively demonstrate that treatment is more likely to help a relationship than not, and suggests that marital therapy decreases the likelihood that participating couples are going to separate or divorce (Nichols & Schwartz, 1998). Research, therefore, has demonstrated definitively that, marital therapy is an effective mode of intervention in decreasing conflict and inter-personal stress and elevating relationship satisfaction.

Theoretical Orientations:

Solution-Focused Therapy

Solution-focused therapy (SFT), also referred to as solution-focused brief therapy (SFBT) (De Jong & Berg, 1998) because of its emphasis on brief treatment length, is a post-modern, constructivist, strength-based, collaborative approach to psychotherapy (de Shazer & Berg, 1992; De Jong & Miller;1995; Hoyt & Berg, 1998). Although de Shazer and his colleagues at the Brief Family Therapy Center (BFTC) are credited with its inductive development, SFT has been influenced by and grown out of the work of Gregory Bateson, Milton Erickson, and the Mental Research Institute (MRI) (Nichols & Schwartz, 1998; De Jong & Berg, 1998).

Historical Influences

Gregory Bateson's (1972) theory of cybernetics provided valuable insights about families as self-correcting systems (Durrant, 1987; Nichols & Schwartz, 1998). His concept of cybernetics led to the theory of constructivism which is concerned with the subjective perceptions individuals have about reality and their behavior in the world (Durrant, 1987). Bateson's contributions to family theory include the essential focus on clients' frame of reference in order to make sense of their experience, and the idea that if families are to correct themselves they need to be given new information; news of a difference that makes a difference (Bateson, 1972; Durrant, 1987).

Spending little time theorizing or speculating on problems, Milton Erickson attempted to resolve clients complaints as quickly as possible, leading some to refer to him as the first solution-focused brief therapist (O'Hanlon & Weiner-Davis, 1989). In addition to this, he believed that client nor therapist could know exactly why a problem existed. The only certainty

was to know what would be happening when the problem is solved (de Shazer, 1988). Consequently, little information was necessary to solve the problem. Many of Erickson's assumptions have been carried over into the SFT model. He believed that individuals have the knowledge and skills to resolve their problems (O'Hanlon & Weiner-Davis, 1989) and that the therapist's role is to access these personal client resources in order to develop solutions. Erickson believed that even small changes could have profound effects on clients' lives.

Combining aspects of Erickson and Bateson's work, the MRI team took a strategic systems approach to working with families (de Shazer, 1990; Segal, 1991). Problems were viewed as interactional in nature; developing and persisting in the mishandling of life difficulties which lead people to do more of the same, thereby exacerbating the problem (Watzlawick, Weakland, & Fisch, 1974; Segal, 1991). In developing the first model of brief therapy, the MRI team focused on how the problem was maintained and, within ten sessions or less, applied strategic methods to interrupt the problem (Segal, 1991).

Having spent some time working with the MRI team de Shazer and his colleagues adopted a similar model of brief therapy. However, they discovered that many of their clients did not need to know a great deal about the problem in order to build solutions and resolve their complaints (de Shazer et al., 1986). It was their experience that clients could often describe exceptions, which are times when the problem was not occurring (de Shazer, 1985, 1988; Gingerich & de Shazer, 1991). The simplest way to solve problems was to focus on exceptions in order to increase their frequency, thereby decreasing the problem (Gingerich & de Shazer, 1991). Such profound discoveries led de Shazer and his colleagues to take a solution-focus rather than a problem focus, a shift which set the BFTC apart from the MRI approach (de Shazer,

1991; Stalker, Levine, & Cody, 1999). It was the influence and inspiration of Bateson, Erickson, and the MRI, and the newfound search for solutions, that led the BFTC to inductively develop the SFT approach.

Theoretical Foundations

The following assumptions underlying the SFT approach are strength based and open up possibilities for change. Because reality is created by language there is not "one" right way to view things (O'Hanlon & Weiner-Davis, 1989; Berg & de Shazer, 1993; de Shazer, 1994). Problems are viewed as unsuccessful attempts to solve the problem (de Shazer, 1986) and do not serve a purpose, nor are they seen as manifestations of an underlying pathology (O'Hnalon & Weiner-Davis, 1989; De Jong & Berg, 1998). No matter what the problem, there is always an exception to that problem. SFT views clients, motivated and willing to change, as having the strengths and the resources to resolve their complaints (de Shazer, 1984, 1985, 1988). There does not have to be a connection between the problem and the solution. It is believed that a small change is all that is necessary to begin resolving problems and that change in one part of the system will effect change in other parts of the system (de Shazer, 1988; O'Hanlon & Weiner-Davis, 1989). Further to this, no matter how long a problem has persisted, rapid change or resolution of the problem is possible (O'Hanlon & Weiner-Davis, 1989; Weiner-Davis, 1992; De Jong & Berg, 1998).

Clinical Approach and Techniques

Right from the first session and throughout, the role of the therapist is to co-construct a sense of competence with clients (Durrant & Kowalski, 1993; De Jong & Miller, 1995) by opening up possibilities for change and focusing on what clients want. A collaborative therapist-

client therapeutic stance is important as clients are considered experts on their own lives and experiences (De Jong & miller, 1995; De Jong & Berg, 1998). The therapist interviews purposefully (Lipchik & de Shazer, 1986; Lipchik, 1987; Hoyt & Berg, 1998) in order to draw out and amplify clients strengths successes and resources that can be used in building solutions (O'Hanlon & Weiner-Davis, 1989; De Jong & Berg, 1998). Since focusing on the problem is unhelpful, the therapist uses "solution talk" rather than "problem talk" to work towards possibilities (Berg & de Shazer, 1993; De Jong & Berg, 1998).

Because the language that the therapist uses shapes reality within the therapeutic conversation (Berg & de Shazer, 1993), solution talk rather than problem talk is more helpful in building solutions. Problem talk is any discussion that is relative to the problem. SFT therapists believe that engaging in problem talk too long can discourage clients and therapist, leading to feelings of negativity and helplessness (Berg & de Shazer; De Jong & Berg, 1998; Friedman & Lipchik, 1999). Solution talk is language that is used outside of the problem, to purposely shape and direct attention to the building of solutions (O'Hanlon & Weiner-Davis, 1989; Berg & de Shazer, 1993; De Jong & Berg, 1998). Pre-suppositional language is one type of solution talk that is used to open up possibilities for change (O'Hanlon & Weiner-Davis, 1989; De Jong & Berg, 1998). It is the purposeful use of phrases such as "when things get better . . . when the problem is solved" as opposed to "if things get better....if the problem is solved", that presupposes goals will be reached, demonstrating the therapist's confidence that change will occur. "If the focus is on solutions and abilities rather than on problems and pathology, those images dominate" (O'Hanlon & Weiner-Davis, 1989).

Questions, another type of solution talk, are used as interventions because they shape

clients' focus and encourage a search for strengths and competencies (O'Hanlon & Weiner-Davis, 1989; Dejong & Miller, 1995). Several key questions are the miracle question, exception finding questions, coping questions, and scaling questions (De Jong & Miller, 1995). The miracle question, used to illuminate hypothetical solutions and form well defined goals, asks clients to imagine a problem free future that is detailed and vivid which can be worked towards (de Shazer, 1988, 1991). Although it can be presented in diferent ways, the miracle question requests clients to pretend, suppose, or imagine. The therapist may ask, "Suppose you went to sleep tonight and while you were sleeping a miracle happened. The miracle is, that the problem you came here with is solved. What will you notice tomorrow that will tell you that a miracle has happened? What will be different? What else will you know?" (De Shazer, 1988; De Jong & Berg, 1998). The miracle question allows clients to think of an unlimited number of possibilities, it shifts the focus from problem times to a more satisfying life. The details from the response to the miracle question provide a road map to a preferred future (Friedman & Lipchik, 1999).

Exception finding questions, used throughout the solution building process, draw out and amplify client strengths and personal resources that are present when the problem is not. In searching for exceptions, the therapist's role is to use the EARS (elicit, amplify, reinforce, start over) process to elicit, amplify and reinforce exceptions (De Jong & Berg, 1998). Exception finding questions assist the therapist in gathering details around exceptions. Details are the raw materials, the building blocks of solutions. The reinforcing of exceptions ensures that clients notice and value these strengths and successes that contributed to positive changes. Coping questions "highlight the often overlooked, but critical survival strategies that clients use even in the most apparently hopeless circumstances" (Berg & de Shazer, 1993, p.9). The details form the

beginning steps to cultivating strengths and personal resources necessary in developing solutions.

Scaling questions are used to make complex aspects of a clients life clear by having them place their observations, progress and predictions on a scale from 1-10 (De Jong & Miller, 1995; De Jong & Berg, 1998). Scaling questions are versatile and can be used at any time in the interview process, at any point in therapy, to scale the client's perceptions of almost anything including severity of a problem, pre-session change, between session change, self-confidence, self-esteem, motivation to find a solution, progress towards change, and evlauation of progress (De Jong & Miller, 1995; De Jong & Berg, 1998). The scale can also be helpful in finding out from clients what needs to happen to move one point up the scale. The client's detailed response to scaling questions allow the numbers to carry significant meaning based on the client's perception (Berg & de Shazer, 1993).

In the first session, following a brief description of the problem, clients are moved from problem talk to solution talk (De Jong & Berg, 1998). With the use of exception finding questions, strengths and resources are drawn out from the description of problem free times. Exceptions are elicited, amplified, and reinforced and used as integral aspects of solution-building (De Jong and Berg, 1998). Often the miracle question is used to move clients into a future orientation, when the problem will be solved, which initiates goal setting. For goals to be effective they must be well formed; important to the client, realistic, achievable, and defined in behaviorally measurable terms. When goals have been formed and exceptions gathered, clients are given compliments and validating feedback which affirms their successes, strengths, and personal resources. Clients are often given either observational or behavioral homework tasks between sessions which are designed to guide clients toward perceptions and behaviors that are

consistent with their goals (de Shazer, 1988, 1991; Hoyt & Berg, 1998).

Observation tasks require clients to pay attention, or observe behaviors in their life that may prove helpful in building solutions. They may also be asked to attend to specific details around noted exceptions so they will be able to "do more" of those things. Behavioral tasks require clients to behave in a way useful to the construction of a solution. Both types of tasks are designed to change the client's viewing and doing towards strengths, successes, and helpful solution-building resources.

The most notable assignment is the Formula First Session Task (FFST) (de Shazer, 1988; de Shazer et. Al., 1986; de Shazer & Molner, 1984; Gingerich & de Shazer, 1991; De Jong & Berg, 1998). It is usually prescribed when clients cannot find exceptions, or are having trouble defining goals. Generally, the FFST is presented in this manner; "Between now and the next time we meet, I would like you to observe what happens, between you and your partner, in your relationship that you would like to continue happening?" and "What is happening that tells you that this problem can be solved?". The Prediction Task (Selekman, 1993; De Jong & Berg, 1989), another observational type, requires clients to predict what type of days they are going to have in the following week. If they predict that they will fight on Tuesday, but they do not, they are asked to pay attention to what was different, and asked to think about how they were able to get that to happen. Details about what was different in the problem free times will provide resources for solution-building.

Several behavioral tasks popular among SFT therapists are *Pretend the Miracle Happened, Do Something Different, The Coin Toss*, and the *Surprise Task.* The first two are self-explanatory, requiring the clients to pretend the miracle or preferred future they described,

happened, or do something totally different. It follows that changing aspects of a situation will change behavior (de Shazer et. Al., 1986), thus potentially illuminating unnoticed strengths and resources. The Coin Toss and the Surprise Task have the same effect. The former requires the clients to flip a coin and describe that a "bad day" will be heads and a "good day" will be tails. If there is an inconsistency between the coin result and the actual day, clients are asked to account for those differences. The Surprise Task requires that one partner behave in the preferred future way while the other partner is required to try and guess what the other person is doing that makes things better. As clients begin to behave differently, they sometimes begin to experience themselves differently through making sense of the new behavior and others' reactions to it. The most straightforward behavioral task is "do more of what works" (de Shazer, 1988; de Shazer et. Al., 1986; De Jong & Bert, 1998).

Second and subsequent sessions build on and compliment the first session (De Jong & Berg, 1998) and continue the solution building process until goals are reached. Clients may return presenting with one of three scenarios - things are better, they are the same. or they are worse. De Jong and Berg (1998) outline specific directives to take with clients, that present in second and subsequent sessions, experiencing one of the aforementioned scenarios.

When clients return to therapy stating that things are better, the role of the therapist is to apply the EARS process. If goals are well-formed and exceptions are noticeable, the task "do more of what works" can be assigned. If clients, upon their return state that things are still the same, the role of the therapist is to ask, "how come things are not worse?" (De Jong & Berg, 1998). The details surrounding the answers to this question will highlight what has been happening (exceptions) and what clients have been doing to make those things happen

(resources). Clients may then be assigned an observation task in order to identify more exceptions. If clients state that things are worse, the therapist may ask, "how come things are not worse than they are now?" (De jong & Berg, 1998). The therapist should use coping questions (De Jong & Miller, 1995; De Jong & Berg, 1998) to find out what strengths and resources were used in order to cope. Once those resources that clients rely on within their own survival strategy are established, it is important that they are amplified and reinforced. Extremely discouraged clients may need to focus on the problem and talk about the past. This is done only to the extent that it reveals personal strengths and successes, and more importantly, who and what are important to the client (De Jong & Berg, 1998). SFT therapists attempt to shift from problem talk to solution talk as quickly as possible (De Jong & Berg, 1998).

Critique

SFT has been criticized for not considering larger gender, cultural, and political factors that may be contributing to clients' problems (Dolan-Del Veccio, 1998; Stalker, Levine, & Coady, 1999). SFTs collaborative stance has been challenged as being too directive (Wylie, 1990; Storm, 1991; Nylund & Corsiglia, 1994) and even strategic (Nichols & Schwartz, 1998). Formulaic and advanced agendas on the part of SFT therapists may leave little room for collaboration and authenticity (Soham, Rohbaugh, & Patterson, 1995) According to Taffel and Master (1990), brief treatment is only a band-aid solution, and similarly Stalker et al. (1999) argue that the brief treatment of SFT is not as effective with serious, longer-term problems.

Although SFT emphasizes a strengths-oriented, collaborative therapeutic alliance, (de Shazer, 1990; De Jong & Miller, 1995; Hoyt & Berg, 1998), according to Stalker et al. (1999), this has not translated into a focus on emotional support and the development of a warm,

empathic therapeutic relationship. Lipchik (1997) also criticizes the strict focus on brevity as a testament to the lack of attention to the therapeutic relationship. Nylund & Corsiglia (1994) state that SFT is "solution-forced", and can result in clients feeling rushed, or not attended to. SFT has also been criticized for focusing primarily on cognition and behavior at the exclusion of client's experience and emotions (Bischof, 1993; Kiser & Lipchik, 1993; Stalker et al.,1999; O'Hanlon, 1999).

Despite SFTs claims as a rapid and more effective approach to therapy than others, (1994), there is no empirical evidence that attests to such claims (Nichols & Schwartz, 1998; Stalker et al., 1999). In fact, according to Stalker et al. (1999), "there is limited evidence for its efficacy because no methodologically sound studies on SFBT have been conducted" (p. 471). Notwithstanding, a handful of studies that have been conducted to support the effectiveness of the model (De Jong & Hopwood, 1996; McKeel, 1996; De Jong & Berg, 1998), were informal initiatives which asked clients at termination and follow-up whether their treatment goals had been met. Nichols & Schwarts (1998), contend that such studies of outcome effectiveness are "as substantial as the ususal response to the waiter's question, 'How was everything?'" (p. 389).

Though research on SFT has not been formal nor forthcoming, Berg & De Jong (1996) argue that the scaling question, used with clients to rate their progress at the beginning, throughout, and at the end of treatment, "approximates the single-system design for measuring progress under social-constructionist and strengths-based principles" (p. 386). Nugent (1992) provides value to this claim by demonstrating that self-anchored scales in clinical application can have outstanding psychometric properties. Furthermore, Franklin, Corcoran, Nowicki, and Streeter (1997) have illustrated the utility of using self-anchored scales to measure outcomes in

solution-focused therapy.

Experiential Therapy

Historical Influences

The experiential branch of family therapy emerged out of the humanistic movement in the 1960's. Client-centered, gestalt, existential and psycho-dramatic philosophies and values underlie all experiential approaches to psychotherapy. These approaches have directly influenced the theory and techniques of experiential family therapy (Wetchler & Piercy, 1996; Watson, Greenberg & Lietaer, 1998; Nichols & Schwartz, 1998; Greenberg & Rice, 1997; Gladding 1998; Griffin & Greene 1999). Rogers' client-centered therapy emphasized an authentic relationship between therapist and client characterized by genuineness, empathy and unconditional positive regard. He believed that all humans were good and had a "growth tendency" towards actualization that could be accessed and released within a trusting therapeutic relationship (Greenberg & Rice, 1997; Watson et al., 1998). Rogers stressed that therapists enter the client's world in order to access and reflect back their clients' feelings in order to bring them into awareness (Watson et al., 1998).

Existential therapy is concerned with people realizing their full potential (Greenberg & Rice, 1997; Watson et al., 1998). Emphasis on working with the whole person and not losing their wholeness within a genuine or authentic therapeutic relationship is fundamental to this approach (Watson et al., 1998). The primary objective is to bring the client's inner intuitive and subjective knowledge into awareness. Gestalt therapy emphasizes "...that everything is relational and in flux; phenomenology, which emphasizes subjective experience and the creation of meaning; and dialogue, involving open engagement between the client and therapist for

therapeutic purposes" (Watson et al., 1998, p. 5). Gestalt therapy involves body awareness, direct experience, the importance of the encounter (experienced relationship), the use of experimentation, and awareness exercises (Greenberg & Rice, 1997; Watson et al., 1998).

All three humanistic approaches stress the importance of the individual uniqueness and value of humans, the I-thou relationship, the here and now, and the imperativeness of individual responsibility (Greenberg & Rice, 1997; Watson et al., 1998). The main objective of experiential therapy to working with couples and families, regardless of differences in methodology, practice or techniques, is working with client's awareness, both by focusing on subjective experience and by promoting a reflexivity and a sense of agency. Furthermore, the importance of the therapeutic relationship in facilitating change in clients, and the importance of examining inner subjective world views; feelings perceptions, goals and values, are cornerstones to experiential therapeutic approaches (Watson et al., 1998).

Theoretical Assumptions

Several major theoretical assumptions are evident in most experiential therapeutic approaches with couples (Wetchler & Piercy, 1996; Greenberg & Rice, 1997). These theoretical tenets are primacy of experience, the importance of affect, the person of the therapist, spontaneity and creativity, and present centeredness . Primacy of experience refers to the experientialist's idea that a person who only lives intellectually can not be in touch with his or her own life experience. This individual would not be able to truly know him or herself and have no authentic self to offer others in relationships (Wetchler & Piercy, 1996). The importance of experience leads experientialists to use a variety of procedures, to facilitate here and now encounters and

experiences.

The importance of affect can not be overstated. Couples who are not in touch with their present experiencing are thought to be emotionally dead (Wetchler & Piercy, 1996; Nichols & Schwartz, 1998; Gladding, 1999). Emotion and the experiencing of affect is growth producing (Greenberg & Safran, 1989; Johnson & Greenberg, 1994). Experiential therapists use many procedures to unblock honest emotional expression in couples as to open inner experience, bringing into awareness and integrating all aspects of the self in order to be more fully human (Satir & Baldwin, 1983; Wetchler & Piercy, 1996; Nichols & Schwartz, 1998). Experiential therapists assist partners within a couple to feel and experience themselves and each other in new ways. This heightens growth, understanding, acceptance thereby strengthening and enriching all the aspects of the dyad; "you", "me" and "we" (Satir, 1988) or the "I's" and the "We" (Whitaker, 1982; Connell et al., 1999). The person of the therapist denotes the therapist's active and personal participation in therapy sessions. Spontaneity and creativity are important because emotional experiencing is one of the primary goals. Most of the techniques used by the therapist are meant to foster and increase creative experiencing (Wetchler & Piercy, 1996).

Present-centeredness refers to the belief that, "immediate experiencing and person-to-person encounters can only take place in the present" (Wetchler & Piercy, 1996, p.82). Speaking about the future or focusing too much on the past undermines the here and now experience which is imperative to experiential encounters and the change process. One can see that, from the above discussion, there are key ingredients that constitute an experiential approach to working with couples.

Clinical Approaches

The amplitude of experiential theory and therapy blankets an extensive range of diverse and complex humanistic orientations and approaches. For the purposes of this composition, I will specify paradigms that are particularly relevant to my initiative. They are, Virginia Satir's approach to family and couples therapy, as well as Susan Johnson's emotionally-focused therapy (EFT) for couples.

Virginia Satir

The concepts of self-esteem and communication are central to Satir's view of pathology or dysfunction (Okun & Rappaport, 1980; Woods & Martin, 1984; Satir, 1988). According to Satir, these two concepts are directly tied to the patterns and rules within the family of origin. Satir pointed out that self-esteem affects the choice of spouse and the nature of the marital relationship (Satir, 1983; Woods & Martin, 1984). Self-worth and effective communication beget one another. Conversely then, low-self-worth and dysfunctional communication are correlative. Satir contends that couples resort to ineffective or dysfunctional communication when they can not reveal their true feelings or are afraid of rejection for being themselves (Satir, 1983, 1988).

In protecting themselves couples may resort to what Satir refers to as dysfunctional communication stances such as blamer, placater, computer and distractor. The blamer, often unwilling to take responsibility for self, presents the image of being strong and in control, as he accuses, blames and points out others' weaknesses. The placater attempts to keep others happy by never disagreeing and always obeying, at the expense of his own unmet needs. The computer appears calm, cool, and aloof and tends to rationalize situations or circumstances that may cause most people stress. The distractor does not respond to the relevant topic or situation at hand, but

rather strives to avoid, redirect, or deflect attention away from contextual stress. Although the outward behaviors and communication styles are different, the various stances exist in environments where individuals are not safe enough to express their true thoughts or feelings, and are the result of a poor sense of self and low self-esteem. Satir emphasizes the importance of high self-esteem, effective communication and acceptance of each spouse, all which are mutually influencing, within the marital dyad (Satir, 1983, 1988; Satir & Baldwin, 1983).

Satir (1988) refers to the marital couple as people makers. That is, their communications and self-esteem will be transferred to the children through the rules and boundaries that exist within the family. Therefore it is important for couples to accept one another so that communication can be effective, self-esteem high, and the acceptance of differences possible. Satir believes that for a marriage to be successful, couples have to make all three parts ("you", "me" and "us") work. If each person can continue to grow, the relationship can grow (Satir, 1988). Growth is stunted when self-worth in one or more parts is low. This leads to expression of poor self-worth, protection of what self-esteem is left, resulting in dysfunctional communication stances. Remember, it is when growth is stunted, or inner feelings are suppressed that symptoms and pathology emerge, leading to marital distress.

Satir believed that the therapist needs to be flexible with families. Rather than fit people into theories she preferred to fit the theory into people (Okun & Rappaport, 1980; Woods & Martin, 1984). This was evident in her large repertoire of tools and techniques. Satir's techniques creative and spontaneous, were structured and used to maximize client awareness, in the here and now. Satir's interventions and techniques were all geared towards involving new ways for clients to look at and experience one's own, and others', behavior: "the implicit can be made explicit,

the unfamiliar can be made familiar, the verbally inexpressible can be expressed, and new awareness can be developed" (Satir & Baldwin, 1983, p. 241). Having clients live through an experience engages the total person, rather than just one part. Experiential techniques maximize the client's learning.

Intervention, in light of the causes of marital distress and dysfunction are targeted primarily in three areas; understanding family of origin issues as they affect self-esteem and communication; self -esteem and; communication patterns. Among many of Satir's techniques used for looking at family of origin issues were family maps and family chronology used primarily to look at one's place and role in their family. Family reconstruction, although used primarily in group settings, has been used in family sessions (Satir & Baldwin, 1983) to assist individuals in uncovering facts about the origins of distorted learning about self and other's in the family. This experiential journey allows individuals to experience themselves in new ways, by changing their perspective and their experience about themselves (Satir & Baldwin, 1983). Nerin (1986) states that some of the goals of family reconstruction can improve functioning of the individual which will increase functioning in relationships. Some of these goals are increased self-esteem, finishing unfinished business, greater congruence between what a person feels on the inside and how they communicate on the outside, filling in missing parts of themselves and achieving self -acceptance rather than depending on it from others (Nerin, 1986). These goals are directly congruent with the idea that as the self improves functioning, so does the relationship.

Communication in relationships can be improved from such simple techniques as clarifying nonverbal messages, bringing them into the couples awareness, or reframing incongruent communication in order to "level" it. More experiential exercises such as sculpting,

choreography or drama can be used (Satir, 1983; Satir & Baldwin, 1983). Satir has used such techniques when working with couples in identifying communication stances (Satir & Baldwin, 1982; Satir, 1988, 1996). Couples can be asked to sculpt, choreograph, or dramatize what they feel their stance is. The purpose of this exercise is so that partners may become aware of their interactional patterns and their meaning for self as well as to their partners. Furthermore, they may also discover incongruencies between what they feel on the inside and what they are expressing externally. Experiential exercises such as this may help couples articulate visually and experientially what is beyond their ability to articulate verbally.

Barbara Brothers (1996) uses many of Satir's ideas and techniques in improving communication between couples. Her goal is to increase couples awareness, both individually, and between each other, of internal feelings and needs so that the communication may be congruent and effective. One of Satir's main goals in improving communication is so that partners within a relationship can connect more fully and deeply (Satir, 1996). Communication according to Satir, is the bridge that builds and maintains intimate connections between partners.

Many of Satir's experiential techniques, which are too many to be covered in the scope of this paper, can be used separately, or in combinations with couples. Satir believed that experiential techniques and exercises are only limited by the therapists imagination (Satir & Baldwin, 1983).

Susan Johnson and Emotionally Focused Therapy (EFT)

Johnson (1996, 1999) relies on Bowlby's attachment theory to understand and define adult intimacy. It provides a map for relationships. According to adult attachment theory, a secure bond between partners results in trust and safety, where both partners are viewed by each

other as dependable. A secure attachment style is represented by an affirmative answer to the question, "Can I count on this person to be there for me, if I need him or her?" (Hazan & Shaver, 1994). The confirming positive response leads one to perceive others' as reliable and themselves as loveable and worthy of care. Couples with a secure bond are able to give clear emotional signals when their attachment needs arise and they tend to feel confident enough to assert themselves in the face of challenges, or differences, without the fear of being hurt, unloved or abandoned (Johnson, 1996, 1999; Wetchler & Piercy, 1996).

Johnson (1999)contends that insecure attachment styles, the result of poor attachment experiences in early life, lead to marital distress. Negative attachment styles define particular ways in which each partner views the self and other in intimate relationships (Johnson, 1999). For example, just as the affirmative response, to the aforementioned attachment question, 'Can I count on this person to be there for me, if I need him or her?', leads to a secure bond, alternative answers, or expectations shape specific attachment interactions and behaviors. Johnson (1996, 1999) identifies three types of attachment styles that lead to, and maintain, marital distress.

> If however, the answer to the above question is a tentative "maybe", and the attachment is thus defined as anxiously insecure, partners tend either to cling to attachment figures or aggressively demand reassurance, often fearing that they are somehow deficient and unlovable. If the answer to the above question is "no", partners tend to avoid closeness with others exhibiting an avoidant, fearful style, or they tend to deny their need for attachment and frame others as untrustworthy, displaying an avaoidant, dismissing attachment style" (Johnson, 1999, p. 16).

Poor attachments often result in partners hiding their primary emotions, such as fear or hurt, and instead exhibit "secondary reactive emotions", such as anger, frustration, aloofness (Johnson, 1996, 1999; Wetchler & Piercy, 1996). As Wetchler and Piercy (1996) put it, "This

leads to a negative interaction, such as pursue-distance or blame-withdraw, that serves as a defence against exhibiting the more vulnerable primary reaction. The enactment of these negative interaction patterns serve to heighten the fear that one's partner is not worthy of trust, which in turn maintains the pattern and further buries primary emotion" (p. 86).

The overall goal of therapy is to access each partner's primary emotions, enhance the emotional bond, which in turn will alter the interactional negative sequence (Wetchler & Piercy, 1996; Johnson, 1999). By accessing primary emotions, the therapist is able to reveal that a partner is hurt rather than mad, or scared rather than indifferent and is able to reframe the behavior as an attachment need. As partner's become aware of their own and their partner's attachment needs they will be able to express them differently, thus changing the overall interaction.

Emotional focused therapy goals are met through nine steps, that can be broken into three stages referred to as *cycle deescalation, changing interactional positions*, and *consolidation/integration.* Cycle deescalation involves creating an alliance with the couple; identifying the interactional cycle that maintains attachment insecurity and marital distress; accessing the unacknowledged emotion underlying interactional positions and reframing the problem in terms of the cycle and; accessing the underlying emotions and attachment needs. Changing interactional positions requires the promoting of identification with disavowed needs and aspects of self, and integrating these into relationship interactions; promoting acceptance of the partners' new construction of experience in the relationship and new interactional behavior and; facilitating the expression of specific needs and wants in the creation of emotional engagement. Consolidation/integration entails facilitating the emergence of new solutions to old

problematic relationship issues and consolidating new positions and cycles of attachment behavior (Johnson, 1996, 1999; Wetchler & Piercy, 1996). According to Greenberg and Johnson (1986), "Helping a husband to express his unexpressed tenderness towards his wife, or the wife to express her longings for competence and mastery allows them both to see each other in a new way and to feel more similar to each other" (p. 8).

The role of the therapist, according to Johnson (1999), is one of collaborator and choreographer. The emotionally focused therapist is a process consultant "helping partners reprocess their experience, particularly their experience of the relationship" (Johnson, 1999, p.7). The therapist is a collaborator who allows the couple to be the experts on their relationship. The therapist may sometimes lead or follow the clients depending on the needs of the therapeutic process (Johnson, 1996).

The three basic tasks involved in the successful implementation of EFT are the development of a positive therapeutic alliance with both partners; the accessing and reprocessing of emotional experience and; the restructuring of interactions (Johnson, 1996). Building a therapeutic alliance involves genuineness, empathy, and acceptance. Accessing and reprocessing emotional experience entails reflection and validation of the client's experience, heightening specific emotions to bring them into the "limelight", and empathic conjecture, used to clarify underlying emotions and experience that may be just outside the clients' awareness. Restructuring interactions also demands specific techniques such as tracking and reflecting the couples interactions, reframing interactions so that they may take on new meaning and be experienced differently, such as when a blaming husbands behavior is reframed in light of his vulnerability and attachment needs, and finally, the restructuring and shaping of interactions

based on the new experiences gained thus far by the couple.

Experiential approaches to couples therapy, although different in techniques or practice methods, have many similarities. Experiential couple or marital therapies can include gestalt techniques (Hale, 1978, Zinker, 1994), the use of psychodrama and metaphors as in Peggy Papp's (1982, 1990) staging of reciprocal metaphors in work with couples, Fow's (1998) partner-focused reversal with couples, or pragmatic/experiential couple therapy offered by Atkinson (1998). These approaches although having slightly different frameworks, various contributing theories and different practice methods and techniques, are all geared towards increasing individual awareness, experience and emotion of self and awareness of self in relation to their partner, resulting in changes in the relationship, due to the new experiencing of the couple.

Critique

ET has been criticized for focusing on the here and now, in the present, at the expense of gathering important historical data that may be relevant to the problem, as well as losing the opportunity to teach families how to work better in the future (Gladding, 1998). ETs focus on individual well-being and potential within the family system has been criticized for setting up the possible individual versus family dichotomy (Gladding, 1998; Nichols & Schwartz, 1998). Nichols & Schwartz (1998) have commented that the active role taken by the experiential therapist can lead practitioners to "telling clients what they should be, rather than simply helping them find out who they are" (p. 201).

Despite the important contributions made by ET, from a research perspective, it is perceived as exceptionally weak (Gladding, 1998). According to Nichols & Schwartz (1998),

there has yet to be empirical studies of outcome effectiveness conducted of experiential family therapy. Criticisms regarding the lack of empirically verifiable research are geared primarily at traditional approaches to ET such as the strategies of Carl Whitaker and Virginia Satir which were popular in the 60' and 70's. These two foremost ET therapists had very little interest in either theory or research results (Gladding, 1998; Nichols & Schwartz, 1998).

Notwithstanding the lack of research on the effectiveness of traditional ETs, Susan Johnson's EFT (1996) is one of the best, empirically validated, strategies for changing distressed relationships and improving marital satisfaction (Alexander, Holtzworth, Monroe, & Jameson, 1994; Dunn & Schwebel, 1995; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Research has clearly demonstrated how the process of change occurs (Johnson & Greenberg,1988) and has delineated the type of clients that would respond most favorably to this particular approach (Johnson & Talitman, 1996).

CHAPTER THREE

A Proposed Integration of Solution-Focused Therapy and Experiential Therapy

Integration in Therapy

According to research in the field of marital and family therapy (Smith, Glass, & Miller, 1980; Kazdin, 1994; Shaddish et al., 1995), one model or theoretical orientation has not proved itself superior in therapeutic effectiveness over any other orientation. In light of the fact that "human beings are complicated thinking feeling and acting creatures, who exist in a complex system of biological, psychological, and social influences" (Nichols & Schwartz, 1998, p. 423) and would require a comprehensive therapy to impact all of these domains, one can understand how a uni-modal approach can be limited in its narrow and somewhat myopic effort at change. According to Nichols & Schwartz (1998), this is probably the greatest argument for an integrated approach when working with human systems.

The utilization and incorporation of several models can expand the therapist's knowledge and understanding of human behavior (Lebow, 1984, 1987) and can facilitate therapeutic flexibility by capitalizing on the strengths of a variety of different models (Magnuson & Norem,1977). Being aware of a model's limitations and capitalizing on its strengths while integrating effective therapeutic components of other approaches may be most effective in meeting the complex and diverse needs of clients.

A Rationale for the Integration of Solution-Focused Therapy and Experiential Therapy

There is a vast amount of scholarship testifying to the importance of the therapeutic

relationship in therapy (Safran & Greenberg; 1991; Johnson & Williams-Keeler, 1998; Nichols & Schwartz, 1998; O'Hanlon, 1998; Staker et al., 1999). Research finds that the therapeutic relationship, one of safety, warmth and trust, is a key ingredient in effective couples therapy (Smith & Brown, 1994; Estrada & Holmes, 1999). According to Stalker et al. (1999), the therapeutic relationship goes beyond simply facilitating change; for some clients it actually provides the change. Before clients can change, it is imperative that they feel valued, validated and understood (Bohart & Grenberg, 1997; Lawrence, Eldridge, Christensen, & Jacobson, 1999; O'Hanlon, 1999).

Emotions are central to the lives of all people (Piercy & Lipchik, 1993) and according to research, are integral in interpreting, organizing, and appraising the world we live in, as well as motivating and communicating experiences through our behavior (Pierce, Nichols, & Dubrin, 1983; Greenberg & Safran, 1989, 1991; Greenberg, Rice, & Elliot, 1993). Emotion and cognition are complexly intertwined (Greenberg & Johnson, 1986; Safran & Greenberg, 1991). In order to affect change, both domains require intervention (Pierce et al., 1983; Greenberg et al., 1993; Garfield, 1995). Furthermore, Pierce et al. (1983), in an empirical evaluation of the effects of catharsis in expressive therapy, conclude that such an experiential process allows clients to become aware and "feelingful" of their emotions. Carver, Lanin, and Murray (1989) also found support for a model of therapeutic change, which emphasizes emotions and cognitive appraisal to be more effective than relying solely on a cognitive or behavioral approach.

I believe that the innumerable strengths which contribute to SFT effectiveness are hampered by the model's lack of emphasis on the therapeutic alliance, and the deficient consideration given to clients' emotions and experiencing. It is my contention that if these two

considerably significant areas of focus are incorporated into the SFT process, it would elevate therapeutic change. It is the therapeutic alliance and the significance of clients' emotions and experiencing that are given primary and profound importance within the ET orientation. It is for these reasons I propose that valuable ingredients of ET can be used to enhance the theory and practice of SFT, thereby producing an effective, client-centered, respectful approach in meeting the diverse and complex needs of clients. The integration of these two approaches would extend to the therapist a wide variety of knowledge pertaining to human behavior as well as a good repertoire of intervention strategies and techniques that can be targeted at cognitive, behavioral, and most importantly, the emotional level.

Due to major theoretical differences, in particular, emphasis on the problem (ET) versus non-emphasis on the problem (SFT), a complete integration of the two approaches may not be possible. However, important similarities provide an opening for initiating such an endeavor. The underlying assumptions about human beings, individual responsibility, the subjective nature of reality, the therapeutic stance and role of the therapist, and particular aspects regarding the nature of change, within both approaches, have significant commonalities.

SFT's belief that human beings are good and have the necessary resources to change (O'Hanlon & Weiner-Davis, 1989; De Jong & Miller 1995; De Jong & Berg 1996) is similar to ET's assumption that humans are innately good and have a growth tendency towards self-actualization (Greenberg & Rice, 1997; Watson, Greenberg & Lietaer, 1998). Both approaches reflect the importance of responsibility. SFT theorizes that clients know and want what is good for them (de Shazer, 1984, 1991; De Jong & Berg, 1996) and the humanistic approaches reinforce the notion of individual responsibility for the realization of one's potential

and one's own growth (Greenberg & Rice, 1997; Watson et al., 1998). Both approaches also hold the belief that individuals hold the personal resources to create change.

The concept of constructivism, that one's reality is subjective rather than objective or absolute, arose out of phenomenological doctrine (Durrant, 1987; Nichols & Schwartz, 1998). Both SFT and ET have been influenced by constructivism and phenomenology. SFT, a constructivist approach, (Berg & de Shazer, 1993; de Shazer, 1994; de Shazer & Berg, 1992) as well as most humanistic approaches, especially gestalt therapy, influenced immensely by phenomenology(Watson et al., 1998), share the notion that reality is socially constructed Therefore, the client is viewed as the expert on their own experiences. Following from this premise, SFT (Berg, Sperry & Carlson, 1999) and ET (Greenberg & Rice, 1997) are both considered client-centered and adopt a collaborative therapeutic stance with clients.

Regarding aspects of the change process, SFT therapists believe that change in one part of the system will create change in other parts (O'Hanlon & Weiner-Davis, 1989; de Shazer, 1985, 1988, 1990; De Jong & Berg, 1996). Relative to this, ET therapists purport that, although primary importance is given to individual actualization within relationships, system (relationship) improvement is thought to "follow automatically on the heels of individual growth" (Nichols & Schwartz, 1998, p. 181). It is also interesting to note that Kemplar (1981), a prominent experiential theorist and therapist, declared therapeutic "resistance" more a problem of the therapist than of the client. He did this years before de Shazer (1984) declared the death of "resistance"; an unhelpful therapeutic concept. SFT therapists share the assumption that clients are motivated and want to change.

The Integration: A Solution-Oriented Experiential Approach to Couples Counselling

This proposed integration, while maintaining a solution-orientation, will be less formulaic and minimalist, and will be more flexible than the "doctrinated" pure SFT, engendering malleability to include full client experiencing and emotions to the degree necessary to meet client needs. This approach will conserve a SFT framework which includes the four major solution-building steps as outlined by De Jong and Berg (1998); describing the problem; goal setting; exception finding; and feedback. However, based on clients' responses and needs, a decision will be made as to stay with a SFT approach, or deviate and add ET components and interventions.

When the therapist is attending to the couples' description of the problem it is necessary that he pay attention to the couples' learning preferences, communication styles, and where the clients are at emotionally. Clients may be more intellectually or cognitively oriented or rather, more emotional, experiential, or kinesthetic in their learning and communicating manners. Furthermore, clients may be presenting a variety of complex issues that may or may not be amenable to a solution-focused approach, but may be more receptive to a solution-oriented-experiential model. The aforementioned factors would assist the therapist in deciding what therapeutic orientation to rely on most and which intervention and activities to employ. The therapist should proceed with couples whose organizing, learning, and communicating styles are more cognitive, who can articulate their needs and desires verbally, in a solution-oriented manner, placing important emphasis on the therapeutic alliance, a prominent component of ET, within a SFT framework.

No matter which direction is selected, within this approach, the therapeutic alliance is

paramount. As much time should be taken to allow clients to tell their stories as they relate to the problem. It is the role of the therapist to develop a safe, trusting, genuine, and collaborative relationship and to ensure that clients feel heard and that their experiences are validated. Unlike the SFT approach where brevity is a factor, all the time necessary to build and maintain a good therapeutic alliance should be taken.

Couples who present with more emotive or kinesthetic learning styles may benefit from a solution-oriented approach that emphasizes process rather than content. A framework similar to one which is presented by Bischof (1993) may be suitable for most clients, as well as for clients intellectually or mentally less capable, allowing them to enact or express non-verbally what is difficult to express verbally.

Bischof (1993) proposes that ET exercises and activities can be adapted to the SFT approach. For instance, couples could be asked to enact the miracle question (de Shazer, 1988) rather than describe how things will be when the problem is solved. The therapist could ask,"show me how you would be standing...acting..sitting..engaging..interacting when you wake up and the problem is solved". Exception questions (Berg & de Shazer, 1993; De Jong & Miller, 1995): What do things look like when you do not experience the problem?; coping questions (De Jong & Berg, 1998): "How distant have you too been before therapy? Wow, how could you two manage to be that close when things seemed so bad?"; and scaling questions (Berg & de Shazer,1993; De Jong & Miller, 1995), used to describe client goals or progress: "Given this distance is a scale of how far you need to come before your problem with your spouse is solved, where would you position yourself?", can all be utilized and physically enacted in a similar manner. A variety of ET techniques such as family sculpting (Duhl, Kantor, & Duhl, 1978; Satir

& Baldwin, 1983) and family choreography or metaphorical staging (Papp, 1976, 1982) could be used to physically move partners around in different positions to symbolize and express their responses to the above SFT intervention questions.

In other instances a therapist may have to go beyond simply blending ET exercises within a SFT frame as offered by Bischof (1993). Because couples present with a variety of complex problems, have unique experiences, and organize emotions and experiences differently, the therapist may have to rely on a comprehensive knowledge of ET theory while navigating within a solution-oriented experiential approach. Couples may get stuck together or individually, at various points in the therapeutic process, whether it be while describing the problem, forming goals, searching for exceptions, or completing homework tasks. Rather than continue with the SFT process, it would be up to the therapist to halt the search for exceptions and access whether past experiences, poor communication, intense negative emotions, or lack of understanding and empathy between the partners was contributing to the impasse.

Once the therapist, in collaboration with the couple, can pinpoint the area, he should use his knowledge and experience of ET combined with his awareness of clients' learning, organizing, communicating style, and the strength of the therapeutic alliance to intervene appropriately. Depending upon the assessment, a number of experiential interventions may be used to resolve issues that may be blocking forward motion towards the couples' goals of a preferred future. For instance, a couple may be having difficulty communicating due to low self-esteem or fear of rejection by the other partner if he/she communicates his/her true thoughts and feelings. Communication may be incongruent, leading to all types of problems including the inability to work effectively on common therapeutic goals. If this is the case, the therapist may

choose one of the many techniques used by Satir (1983, 1988) to level communication and to generate increased clarity and emotional honesty. Interpreting and bringing into awareness incongruent, non-verbal messages and body language that perpetuate mixed messages may be employed. It may be helpful to partners, within a safe therapeutic environment, to share inner feelings with each other to increase empathy, acceptance, and trust, thereby contributing to increased honesty and intimacy.

Some couples have difficulty identifying or imagining a future without the problem (Kiser, Piercy, & Lipchik, 1993), or have trouble finding exceptions to the problem due to intensely negative or automatic emotions that are blocking possibilities. Partners may be moved too quickly into solution talk, without feeling validated, or releasing pent up emotions. Each partner may be re-experiencing a resurgence of emotions due to past hurts, or one or both partners may need to work through an unresolved family of origin conflict that is causing distress.

If the therapist has moved too quickly to solution talk, he may want to back up and allow the client to express or process negative emotions before proceeding. If the assessment hints at unresolved past hurts, the therapist may want to utilize Chasin and Roth's (1999) approach which requires the partner experiencing difficulties moving towards goals to imagine the preferred future and symbolically, with their partner, work through a past hurt which is blocking forward movement. The cooperating partner is to rewrite and enact the script based on how the other partner wished the past experience had gone. Once the obstacle has been lessened, or resolved, the couple can continue working towards their preferred future.

When issues of family of origin are causing family distress or are hampering the solution-

building process, the therapist may rely on a variety of experiential techniques, depending on the specific nature of the issue (s). Family maps and family chronologies (Satir, 1983, 1988; Satir & Baldwin, 1983) may be helpful in enlightening spouses as to how family of origin roles and rules may be affecting their sense of self, and others in relationships. Symbolic re-parenting (Whitaker, 1982; Napier, 1987a, 1987b, 1999) may be necessary in helping clients work through unresolved family of origin conflicts that are causing marital disruption. This is important on many levels. Doing this work in the presence of each partner increases not only awareness of self, but awareness and understanding of the other, resulting in a greater tolerance for differences and understanding of the relationship (Napier, 1999).

The therapist may ascertain that negative interactive patterns such as pursuer-distancer or blamer-placater (Johnson, 1999) between spouses are mitigating against the solution-building process due to poor or insecure attachments. If this is the case, it may be necessary to access each partners' primary emotions and bring them into awareness in order to reveal their individual attachment needs (Wetchler & Piercy, 1996; Johnson, 1999). As partners become aware of each own's and others' attachment needs, a greater understanding is created. Partners may be better able to express their needs more congruently and interpret their spouses behaviors more accurately, thus limiting negative cycles of interaction (Johnson, 1996, 1999).

The number of scenarios that can be presented are limitless as are the number of ways a solution-oriented experiential model can be utilized. The solution-oriented aspect refers to a flexible and liberal adherence to solution building stages (De Jong & Berg, 1998) while maintaining a genuine client-centered approach that is responsive to meeting the complex cognitive, behavioral, and emotional needs of clients. The solution-oriented experiential therapist

must contain a comprehensive knowledge and understanding of solution-focused and experiential theory, intervention strategies, and techniques. In addition, it is an integral requisite for the therapist to be creative and spontaneous in order to "shift gears" and rely on aspects of the model that best meet clients' needs. Finally, as well as facilitating a "here and now" encounter, the therapist must be able to co-construct with clients, goals that are future-oriented and also maintain the ability to symbolically visit the past as needed.

CHAPTER FOUR

Practicum Details

The general objective of this practicum was to provide couples, seeking counselling for the purposes of improving relationship satisfaction, a respectful and effective means by which to reach such an end. The following chapter will outline the various practicum details including setting, administrative procedures, supervision arrangements, clients, evaluation tools and methods of measurement.

Setting

The learning goals and objectives contained within the practicum were carried out and fulfilled at Manitoba Family Services and Housing in a rural community within Manitoba. This was done over a period of 20 weeks, from March 5 to July 23, 2001. Manitoba Family Services and Housing is a community based governmental agency that provides a number of mandated and voluntary family focused services within the community. One of the primary reasons for choosing this agency was based on a shared philosophy between myself, the mission of the practicum, and the organization.

Family Services and Housing view the family unit as a critical rubric to healthy communities. Furthermore, families are viewed as the best resources for the members within the family contingent, especially children. These philosophical underpinnings are represented in the vast array of services that are offered to families through Family Services and Housing. All programs, whether voluntary or mandated are geared towards the protection of children, and the support, enhancement, or preservation of the family unit. Many of the programs include, Foster

Care, Adoption, Day Care, Child Protection, Vocation and Rehabilitation, Family Concilliation, Permanency Planning for children in care, Community Support, and Parent- Teen Mediation.

A secondary, however significant, reason for my decision to complete the practicum component of my M.S.W. at Family Services and Housing was due to an identified need, or gap in services for couples within this particular community. Following a brief evaluation of the social services offered in the community, it was apparent that there was a gap in services for couples seeking support for relationship issues. A thorough discussion with various agencies within the community further revealed that the best place to provide a temporary service to fulfill the identified need would be Family Services and Housing. The director and management of Family Services and Housing were receptive to the idea of supporting my learning goals and objectives by providing a practiccum environment, and in doing so would be offering a much needed supportive program for couples seeking counselling within the community.

Family Services and Housing are well equipped to provide services to families. I was given all the support I needed and had access to required resources to meet my practicum objectives. The location of the agency was easily accesible by couples seeking service. The entrance way to the counselling rooms was very private and discrete ensuring anonymity and confidentiality. There were several well furnished counselling rooms which were very comfortable and conducive to therapeutic interviewing and clinical exercises. The interview rooms were equipped with inconspicuous video and audio recording devices and contained a one-way mirror observation room for supervision if and when it was required.

I was presented with a building security pass and keys to the necessary office doors. This ensured that I could meet the diverse needs of clients and their life schedules by maintaining

flexibility and availability even outside the regular hours of the agency. I was given access to an office and desk in which to work on case preparation and notes. I was provided with a locked cabinet in which to keep case files and recorded videotapes from clients' sessions. Video tape viewing, at the agency, was possible with access to private office space and the use of a television and VCR.

Because the need for couples counselling seemed to be in such demand, the referral base was going to be provided by the various programs within the agency itself. In particular, the Family Concilliation Program and the Specialized Counselling Program (parent-teen meditaion) were identified as providing services to families where there is often an identified need for couple intervention. These two programs were provided with information regarding the practicum particulars and were encouraged to refer couples, seeking services, on to me.

However, following several weeks referrals were not forthcoming. An internal memo was then circulated to the rest of the programs within the agency indicating the service that was being offered for the completion of the practicum. The programs were given specific criteria on the couples that would be appropriate for the practicum initiative. These couples were to be voluntarily self-referred, or referred by another agency, department, or service, at the clients' request for support for the purpose of increasing relationship or marital satisfaction. Couples were to be living together, married, or common-law. It was clear that cases that have children who are in protective custody, who are going through a custody dispute, or who have been ordered by the courts would not be appropriate for this practicum. Couples would not be appropriate if they were "coerced", ordered, or pursuing counselling for some other reason than improving the relationship.

Suprisingly, no referrals for couples counselling were made through any of the programs at Family Services and Housing. Because this was the case it was necessary to provide advertising within the community in order to obtain couples for the practicum. Advertising was maintained through several mediums - the community television channel, the radio station, and the local newspaper. Information regarding this practicum and the offering of couples counselling within the community was distributed to almost every agency that provided some form of support to individuals and families. All couples seen throughout the duration of the practicum were self-referred.

Administrative Procedures

The intake process involved in this project was quite simple. Couples seeking service contacted me directly and an appointment was set to discuss the appropriateness of their case and provide information regarding the details of the practicum. Once it was agreed upon that the couple would engage in couples counselling the necessary information was given and forms were filled out. I informed them that I was a graduate student completing the practice component of my M.S.W. degree, and that I would be video taping our sessions together which would be viewed by my direct supervisor and academic advisor for the purposes of feedback and evaluation; a critical piece to my learning process.

Participation in the practicum was contingent upon the couples' consent to participate. Consent forms (Appendix A) were required in order videotape sessions and administer necessary questionnaires that were used as methods of measurement and evaluation. The couple was administered the Dyadic Adjustment Scale (DAS) (Appendix B), a standardized questionnaire, at

the beginning of therapy (pre-test) and at termination (post-test). The questionnaire took, on average, approximately ten to fifteen minutes to complete. Further to this, the couples' were provided an open-ended feedback questionnaire (Appendix C), in the final session, to gauge their perceptions of the therapeutic process. The couples were offered to complete it in pencil-paper or interview form. All couples chose to complete the questionnaire in a dialogic manner requiring, on average, 10 to 20 minutes.

All of the sessions were held on the site of Family Services and Housing. Each session was videotaped for the purposes of self-evaluation, feedback, and supervision. All videotapes and case files were locked in a protected and confidential filing cabinet. The utmost respect for confidentiality was maintained.

Supervision Arrangements

My practicum committee was made up of Maria Cheung, practicum chair and academic advisor, Heather Funk, direct supervisor at the agency, and Barry Trute, second committee member from the faculty. Heather provided weekly ongoing supervision. We convened regularly to review videotaped sessions for the purposes of feedback and supervision, an integral aspect of my learning. Maria and I were in contact via e-mail, telephone, and in-person on a bi-weekly basis. We reviewed videotapes together and discussed cases for the purposes of evaluating the skills employed in therapy and to monitor the proposed theoretical integration into practice. Barry and I were in contact several times, via e-mail and telephone, throughout the duration of the practicum He was helpful in answering my questions regarding practicum details and providing case consultation when needed. The supervision provided by my committee was

invaluable and critical to the fulfillment of my learning goals and the successful completion of the practicum.

Clients

Thirteen couples contacted me for couples counselling. However, six of those couples were experiencing serious addiction and violence issues, which are contra-indicated for marital therapy. It is my belief that such issues are not necessarily relationship problems, and individual work may be required before relationship difficulties can be effectively dealt with.

Throughout the practicum I provided counselling to seven couples in total. All seven couples were self-referred as they had seen the advertisement in the paper, the community channel, or heard it on the local radio station. All couples, although looking to improve relationship satisfaction, presented with a variety of relationship problems ranging from infidelity, volatile and destructive arguing, communication complaints, trust issues, relationship insecurity, lack of intimacy, and relationship issues arising from struggles with chronic pain. Names and identifying information have been changed or altered to ensure that client confidentiality is maintained. Individuals within each dyad have been given pseudonyms. The couples themselves, however, will be referred to as couples "A", "B", "C" , "D", "E", "F", and "G".

Due to the collaborative client-centered nature of the theoretical paradigm employed, the purpose, direction, and length of therapy was determined by the particular needs and goals of the clients. Five of the seven couples ("A", "B", "C", "D" and "E") were seen from beginning to end, that is, they were engaged from the beginning phase throughout the intervention to

termination. Therapy was completed when the couples identified that therapeutic goals were met to their satisfaction. Two of the seven couples ("F" and "G") did not receive completed service. Couple "F" planned to leave the community until well after the projected practicum deadline. However, to ensure that they received the support they required, we contracted to resume our work together upon their return. The DAS and the feedback questionnaire were completed as a mid-term report to be included in the practicum report. Couple "G" were experiencing serious individual afflictions that were undermining efforts to work on the relationship. Although we contracted to finish our work together and plan for referral for individual interventions, the couple failed to return to counselling. Further details regarding presenting problems, case distinctions and specific intervention particulars will be provided later within the formal in-depth case analyses and synopses in chapter five.

A profile of the seven couples seen throughout the practicum is provided in Table 4-1. As stated, all couples were self-referred. They were all Caucasian, heterosexual couples, however, they varied in their socioeconomic status. Couples "A", "D", and "F" were "middle age" couples that were married, represented nuclear families with two or more children, and had all been wed for fifteen years or more. Couple "A" had been married 27 years, couple "D", 15 years, and couple "F", 20 years. Couple "G" has been married for six years and have two children. Although couple "G's" family represents a nuclear structure, the marriage is the second for both partners. Couples "B", "C", and "E" were all living common-law and depict a blended family structure, where at least one child in the home exists from a previous relationship. Couple "B" were expecting their first child together, and had only been together for one year. Couple "C" has been living together for six years, and two of their three children are biological offspring.

Table 4-1

PROFILE OF SEVEN COUPLES

Couples	Age of Male	Age of Female	Marital Status	Length of Union	Type of Family	Ethnicity	Number of Children	Number of Sessions
A	47	46	Married	27 years	Nuclear	Caucasian	4	15
B	26	22	Com.-law	1 year	Blended	Caucasian	1	15
C	29	26	Com.-law	6 years	Blended	Caucasian	3	12
D	42	32	Married	15 years	Nuclear	Caucasian	4	11
E	36	39	Com.-law	14 years	Blended	Caucasian	2	9
F	42	41	Married	20 years	Nuclear	Caucasian	2	12
G	36	34	Married	6 years	Blended	Caucasian	2	7

Couple "E" has been living together for 14 years, and one of their two children was born within their union.

The length of therapy and the number of sessions varied and was dependent upon a multitude of factors. These details will be discussed in the following section regarding the intervention and further elaborated on in the case analyses presentation. Therapy was provided to all seven couples over a period of 20 weeks. Couples were seen once a week on average. Although couples were seen conjointly, there were occasions in which partners' were seen on an individual basis for one or more sessions. Couples were seen for a total of 81 counselling sessions which each lasted approximately 1.5 to 2 hours. Depending on couples' needs and energy levels, there were sessions that lasted roughly 3 hours. The longest number of sessions required was 15 sessions, while the shortest was 7. Generally clients were counselled for an average of 11 sessions.

The Intervention

Because the solution-oriented experiential (SOE) approach respects clients as the experts on their own lives and their problems, its client-centred, constructivst methods are extremely responsive to couples' needs. Consequently, at times, although the approach may appear quite systematic within the therapeutic process, at other points it may seem somewhat amorphous. The purpose, direction, specific interventions, and length of therapy were determined by the particular needs and goals of the clients. Both SFT and ET paradigms were employed in a variety of blended and integrated ways throughout the therapeutic process, capitalizing on relevant properties of either approach, at any given time, that best fit with client needs and clinical

objectives. Most technical guidelines for direct clinical intervention, regardless of theoretical orientation, follow a general framework of consecutive practice phases; assessment, planning and contracting, intervention, and evaluation and termination (Sheafor, Horejsi, & Horejsi, 1994). Often the stages of problem solving, which include description of the problem, problem assessment, intervention planning, intervention and evaluation and follow-up are used to guide direct practice interventions (McMahon, 1990). Such technical practice guidelines do not fit with the solution-oriented experiential (SOE) paradigm being proposed, and therefore, are not identifiable within the conceptual discussion of the model. This is so for several important reasons, some of which contribute to the distinction between SOE and other theoretical and therapeutic approaches.

Firstly, within the SOE approach, assessment, rather than being an initial phase, is a process that is ongoing, from beginning to end. Depending on the clients and the presenting issue (s), it may not be necessary to know a great deal about the clients' life, or their complaint. However, this is not true for all clients or issues, and a more complete assessment was required. Secondly, goal setting is initiated immediately in the first session, rather than following a thorough assessment, or detailed picture of the problem. In addition, the intervention stage, within this paradigm, is likewise unidentifiable as it is the whole approach from the beginning, through to the end that is, in its entirety, the intervention. This is so because right from the beginning and throughout the therapeutic process clients are encouraged to shift their viewing away from problems towards strengths, exceptions, and personal resources that are necessary in moving them forward to their preferred future.

Furthermore, the SOE approach, in a number of clinical situations, can call for active

experiential exercises that are undertaken, by clients, within sessions that shifts not only the viewing, but also the experiencing of clients', further contributing to necessary therapeutic change. Finally, the SOE approach although technically and systematically eclectic, does not adhere to delineated phases or stages that can be applied from one case to another. Client problems and identified needs required a flexible approach that varied from case to case. This is remarkably evident in the presentation of the individual case anlyses and synopses of the seven couples that were seen throughout the practicum. As the therapeutic procedure of SOE therapy does not fit a specific practice format, nor does it abide by specific technical or procedural guidelines, the model will be presented in terms of three stages of practice intervention. They are the beginning phase, the middle phase, and the ending or termination phase. Although delineation of the three phases was developed as a retrospective summary to guide the reader, I believe that the three stages were helpful as tentative practice guidelines.

As stated, this approach, in clinical practice, may appear just as diverse as the clients that it is being applied to. Consistent with the ideas of renowned experientialists, Carl Whitaker and Virginia Satir, it was important to fit theories to people rather than trying to fit people into theories (Nichols & Schwartz, 1998). Because of the constructivist, client-centered nature of this approach, throughout all three phases, therapy was guided and primarily directed by clients' needs, and by their receptiveness to therapist feedback, concerns, and suggestions.

The Beginning Phase

Couples were informed, at this phase, about the therapeutic format, structure, and process and were encouraged to ask questions, or air any concerns before we began. Couples filled out necessary consent forms and were administered the DAS. They were also encouraged to ask

questions and make comments at any time throughout the therapeutic process. .

The beginning phase of therapy was primarily geared towards building rapport with clients, gaining an understanding of their presenting difficulties, establishing goals for therapy and immediately moving couples toward those goals by shifting their focus from problem to problem-free times that already existed in their lives. This phase of therapy was complete when couples were able to establish clear, well-formed goals that were important to both partners. Finding exceptions to the problem was also a requisite of moving onto the next phase of therapy.

Once goals were established, exceptions elicited, amplified and reinforced, couples were provided with feedback and compliments that affirmed their efforts, personal resources and strengths that led to the exceptions. They were then assigned either an observational or behavioural task that encouraged them to actively search or create more preferred ways of experiencing the relationship and each other. The first phase was then built upon in following and subsequent sessions, in which clients and I co-created solutions that moved them towards therapeutic goals.

The Middle Phase

The middle phase is the longest and the most active phase of therapy. It was in this phase that the co-creation of solutions continued by building on and complimenting the work done in the beginning phase. When clients' could continue identifying exceptions, strengths and personal resources, these were reinforced, affirmed and complimented. Steps were taken to build on these accomplishments in order to approximate the couples' goals.

However, the mere unveiling of exceptions was not always sufficient to move clients on towards solution building. For a variety of reasons, clients became "stuck', or reached an

impasse in working towards their preferred future. More often than not it was the result of some type of emotional issue that required an experiential application in order to move on. In such cases, solution building was slowed considerably, or put on hold completely. At these points, it was necessary to undertake a more thorough assessment of the presenting block in order to effectively apply an appropriate ET intervention.

When clients have agreed that they have dealt with, or resolved, emotional issues that were blocking forward motion, solution-building is resumed. This process continues until goals are met.

The End Phase (Termination)

Termination was often considered right from early on in the beginning phase. As an important aspect of goal setting, clients' were asked to define in behaviourally, specific, concrete terms, what would be happening when their problem(s) is solved. Further to this, clients were asked what number, on a scale of 1-10 would they be at which would indicate therapy was no longer required. Their answers to such questions provided the means by which to consistently gauge how close we were to projected goals and the end phase.

In short, it was up to clients to determine whether therapy was required any longer. I agree with de Shazer (1991), in his contention that, "If therapists accept the client's complaint as the reason for starting therapy, therapists should, by the same logic, accept the client's statement of satisfactory improvement as the reason for terminating therapy" (p. 57).

Once the decision that termination was indeed appropriate and agreed upon the end phase consisted of several key activities geared towards building on positive changes and focussing on necessary strategies for sustaining such changes. A comprehensive review of

clients' goals for therapy was undertaken. Clients' were then complimented, reinforced, and affirmed on their efforts to bring about desired changes. Clients were also encouraged to acknowledge their partner's efforts and share their thoughts and feelings on the meaning and significance of these changes. Following this, clients were engaged in a discussion regarding the use of newfound knowledge and experiences in handling similar relationship difficulties in the future. Furthermore, clients were asked to consider and plan for possible setbacks.

Finally, the client feedback questionnaire became an integral aspect of termination, as it gave clients' the opportunity to express their thoughts and feeling regarding the therapeutic process. The administration of the DAS for the purposes of evaluating clinical outcome was the final activity that clients engaged in. Following some laughs and small talk, the case was closed.

Evaluation

A crucial practicum objective was to demonstrate the solution-oriented experiential approach as a respectful and effective modality for couples therapy. In order to accomplish this goal, it was imperative to evaluate clinical outcomes. It is critical that evaluation measures of client change identify the therapeutic intervention as a key variable contributing to such change. In accomplishing this matter it was my intent to measure clinical outcomes using a pre-experimental design of pre-test and post-test in conjunction with a client feedback questionnaire.

The measurement package consisted of both quantitative and qualitative methodology. Overall marriage quality was measured using a quantitative standardized questionnaire known as the Dyadic Adjustment Scale (DAS) (Spanier, 1976). A qualitative open-ended questionnaire was used to elicit a descriptive narrative, from clients, as to what they found most helpful

regarding perceived changes within the therapeutic experience.

The Dyadic Adjustment Scale (DAS)

The DAS (Spanier, 1976)(Appendix B) measures the quality of marriage and similar dyads, specifically marital adjustment and satisfaction. It is a 32 item, likert-type scale, designed to assess the quality of the relationship as perceived by the couple. Factor analysis indicates that the instrument measures four aspects of the relationship; dyadic consensus (Dcon), dyadic satisfaction (DS), affectional expression (AE), and dyadic cohesion (Dcoh). Dyadic consensus refers to the agreement between partners' on issues of importance to the relationship Dyadic satisfaction pertains to satisfaction with, and commitment, to the relationship. Affectional expression concerns matters of satisfaction with expressions of sex and affection. Dyadic cohesion refers to mutually shared activities.

I selected this scale as a global measurement of marital adjustment and satisfaction for many reasons. The DAS has exceptional psychometric properties which indicate that it is reliable in measuring what it purports to measure. It has excellent internal consistency with a Cronbach's alpha of .96. The sub-scales have fair to excellent internal consistency; Dcon =.90, DS = .94, AE = .73, and Dcoh = .81. The DAS has been utilized in hundreds of empirical and clinical studies, which further verifies the instrument's reliability.

The DAS has excellent face and content validity. Criterion validity was established by discriminating between married and divorce couples. The DAS has a theoretical range of 151 with a cut-off score of 101; lower scores indicating less marital adjustment and satisfaction (relationally distressed) and higher scores reflecting greater relationship adjustment and

satisfaction (relationally non-distressed). The mean total scale scores provided for the DAS for marital and divorced couples are 114.8 and 70.7 respectively. Concurrent validity is evident in its high correlation with the Locke-Wallace Marital Adjustment Test (MAT) (1959). This comparison further leads to excellent construct validity which was also confirmed with the factor analysis (Spanier, 1976).

The DAS is easily accessible, affordable, and simple to administer and score. It takes about 10 to 15 minutes for clients to complete. It has been demonstrated that its stability is not influenced by clients' age, educational attainment, number of children, relationship duration, or the length of the test-retest interval (Carey, Spector, Lantinga, & Krauss, 1993).

Other standardized measures for assessing marital satisfaction were considered, but for various reasons, were not suitable for this endeavour. Two assessment tools, in particular, that were seriously considered are the Marital Satisfaction Inventory (MSI) (Snyder, 1979) and the Kansas Marital Satisfaction Scale (KMSS) (Schumm, Milliken, Poresky, Bollman, & Jirich, 1983). The MSI, while maintaining exceptional psychometric properties, would have been considered if it were not for its length. With 280 items, the MSI would have taken too much time to administer. Moreover, if I was using a measurement scale as an assessment tool, the MSI may have been the questionnaire of choice. Furthermore, the sub-scales, great indicators of specified problem areas, are not of great importance for this particular initiative.

What was attractive about the KMMS, was the quickness of its administration. The KMSS uses three items to assess marital satisfaction. Subsequently however, the psychometric properties of the KMSS, were not as reassuring as those of the DAS or MSI. The revised DAS (Busby, Christiensen, Crane, and Larson, 1995) and the short forms of the DAS (Hunsley,

Pinsent, Lefebvre, James-Tanner, & Vito, 1995) were also promising in that they are shorter to administer, yet maintain comparable psychometric integrity to the original DAS. However, they were not considered because they are relatively new and lack sufficient empirical evidence.

Among the criticism regarding the DAS is the assertion that the four sub-scales could not be verified upon empirical efforts to do so (Sharpley and Cross, 1982; Sabourin, Lussier, LaPlante, & Wright, 1990; Crane, Busby, and Larson, 1991), and it is cautioned that it only be used for measuring adjustment and satisfaction. However, there are two sides to this debate and in an empirical evaluation of the DAS, Heyman and Weiss (1992) contend that the DAS sub-scales do indeed measure what Spanier (1976) claims.

For the purpose of this practicum, I was interested in the DAS only as a global measurement of relationship adjustment and satisfaction. The DAS was not used as an assessment tool. The SOE paradigm, being constructivist and client centered places much respect and trust in clients' ability to accurately articulate their needs. The sub-scales were just barely considered as peripheral thermometers, considered only in light of the client narratives, gathered from the feedback questionnaire. Using the DAS in this way renders the aforementioned limitations and criticisms of the device less serious. However, due to the significant congruence between the DAS sub-scales and client feedback, sub-scale scores are discussed in the presentation of outcome.

Client Feedback Questionnaire

A qualitative open-ended feedback questionnaire (Appendix C) was developed in order to appraise the most helpful aspect of therapy as perceived by the couple. Qualitative methodologies are useful in capturing lived experiences from those who have lived it and created

meaning from it (Padgett, 1998). Consistent with a postmodern, constructivist approach which respects clients' as experts on their own lives, the questionnaire was developed to capture a descriptive narrative regarding the SOE approach, from the clients' perspective. Details from client feedback was compared and combined with the quantitative measure in order to gain a more comprehensive view of specific variables that contributed to clinical outcomes.

It should be noted that evaluation and feedback were elicited from clients in an on-going, informal manner, throughout the entire therapeutic process. Clients were consistently asked for feedback as to their thoughts and feelings regarding therapeutic structure, process, specific tasks, etc. Throughout and at the end of every session, clients were asked, "Do you feel we're moving in the right direction? Is there anything you think we're missing, or has been overlooked? Does that make sense to you?". These and similar questions ensured that I was in tune with clients. Ongoing feedback and check-ins further reinforced the collaborative nature of the SOE paradigm, entrusting clients as co-partners in the therapeutic process.

Finally, an informal manner of evaluation was undertaken with the consistent employment of scaling questions, an integral clinical tool within the solution-oriented paradigm. Scales were developed out of couples' language and meanings and were used to measure client perception of progress towards identified goals. According to Bloom, Fischer, and Orme (1999), client rating scales have exceptional reliability and validity and are comparable to measures with outstanding psychometric properties (Nugent, 1992). Therefore, client scaling provided an accurate measure in gauging therapeutic progress.

Administration of Measurement Package

The DAS was administered, as a pre-test, at the first meeting with couples. As stated, it was not used as an assessment tool, therefore, was not an integral component in the direction of therapy. Couples were, again, administered the DAS, as a post-test measurement, at the end of the last session of therapy.

The client feedback questionnaire was administered at the end of the final meeting. Couples were given a choice to answer the feedback questionnaire in paper-pencil format, outside of the presence of the therapist, or in the manner of an oral dialogue. All of the couples chose the latter format. Most agreed that it was easier to complete in such a manner, and stated that it was a good way to "close" our work together.

CHAPTER FIVE

Case Illustrations

The following chapter will present an illustration of my work, as a clinical social worker using a solution-oriented experiential approach to counselling, with seven couples. An in-depth case analyses of couples' "A", "B", and "C" will provide a full examination and explanation of the therapeutic operation, including content, process and specific technical interventions. Following the case analyses, synopses of the remaining four cases ("D", "E", "F", "G"), which will give the reader a snapshot view of the overall therapeutic process, will be presented.

Case analyses and synopses will be demonstrated from a conceptual perspective, guided by, and reflecting, relevant theoretical, descriptive, and empirical knowledge. Although the following case annotations have been undertaken from my particular perspective, content and process recordings were made from videotaped sessions, which were included so as to give the clients' perspective a voice within the case illustration.

Consistent with both constructivist and experiential approaches, the first order of business, within the first session of all seven cases, was to inform the couples that they were the experts on their lives, and that I was a relationship consultant, or guide. Together, in a collaborative partnership, we were going to work at getting them to where they wanted to go; their desired future. This was done to demystify client-therapist hierarchy, and was a beginning step to building rapport and establishing a strong therapeutic alliance.

Couple A: Bill and Nora

Presenting Problem and Case Summary

Bill and Nora presented to therapy remarkably distressed and were considerably

withdrawn from each other. Nora stated that separation was a consideration, unless things changed. She was tired of, "doing all of the work in the relationship", was feeling unappreciated, devalued, and resented Bill's inattentiveness and apparent lack of commitment to the relationship. Bill felt that his efforts to contribute to the relationship were going unnoticed. He too was feeling devalued and unappreciated.

During the process of co-creating a preferred future with Bill and Nora, our collaborative explorations revealed key past relationship and family of origin issues that were contributing to relationship difficulties. Many of their past experiences, and family of origin beliefs and rules led Bill and Nora to adopt certain roles in their relationship. Nora was very emotionally expressive and extremely active in the relationship. She took on the responsibility of care taking their union as the caregiver and nurturer, even at the expense of her own needs. Bill, however, was more passive in the relationship. Although he spent time with the family and reciprocated affections with Nora, Bill was not very emotionally expressive.

Several years ago, a work-related accident left Bill permanently disabled and in chronic pain. Over the last couple of years, due to the challenges posed by the implications of the accident, the relationship has really deteriorated. Bill's "natural tendency" to withdraw into himself was compounded with the onset of continuous pain that, at times, was debilitating, depleting his physical, emotional, and mental energy. Bill's struggle with his sense of self and identity had taken a major toll on his self-esteem. Keeping his troubles to himself led to further withdrawal, increasing the distance between himself and Nora. Nora's continuous attempts to comfort and support him were unsuccessful. Nora began to withdraw.

As a result of their unconnectedness and lack of intimacy, communication was extremely poor, leading to inaccurate perceptions, assumptions and misinterpretations of what each was thinking and feeling. Nora's withdrawal, interpreted by Bill as giving up on the relationship, was actually Nora's way of preserving what little self-worth she had left. Nora's interpretation that Bill was rejecting her, that he did not love her anymore, in fact had more to do with Bill's personal struggles than it did with Nora.

Nora and Bill's withdraw/withdraw position, a common stance among couples experiencing relationship difficulties (Satir, 1988; Johnson, 1999), was constricting positive interactions and precluding emotional engagement. Bill and Nora were going to have to risk vulnerability, express their true feelings, expectations and perceptions in order to initiate emotional engagement and increase empathy regarding their personal struggles. A better understanding of each other's struggles and needs within an intimate engagement was required to increase feelings of self-worth and improve communication.

Beginning Phase

The beginning phase consisted of two sessions in which SFT and ET orientations were applied at different times, consistent with clinical objectives. As stated in chapter 4, the purpose of the beginning phase was to establish a strong therapeutic rapport within a safe and trusting environment, and to institute well-formed goals for therapy. When these two primary objectives were satisfied, and Bill, Nora, and I began working towards their identified goals, the beginning phase was complete.

SESSIONS 1 & 2

Consistent with an experiential frame, the beginning of therapy was essentially geared

towards joining, establishing a safe and secure environment, and providing Bill and Nora with the validation and support that they required. Given their significant level of distress and mutual feelings of low self-worth it was critical that Bill and Nora feel cared for. It was my contention that initiating a strict SFT approach in the beginning would undermine Bill and Nora's significant need for empathic alignment and understanding. Feeling cared for was necessary for them to function effectively, within the relationship (Satir et al.,1991), both within and outside the therapeutic domain.

The necessary time was taken to validate and normalize Bill and Nora's experience, to help them feel valued, understood and accepted. Bill and Nora responded favourably to my empathic and validating responses which seemed helpful and affirming. Therefore, contrary to SFT's commitment to moving away from talking about the problem as soon as possible (De Jong & Berg, 1998), in order to initiate solution-building, we did not move towards solution-talk until Bill and Nora felt heard and understood. Moving too quickly might have jeopardized the relationship, especially if they felt rushed, unable to share their story. Therefore, it seemed favourable to stay with Bill and Nora, at their pace, in the here and now.

Once I believed that Bill and Nora felt understood and validated, I shifted from an experiential focus on the problem to a SFT approach in order to create a future-orientation (de Shazer, 1991; DeJong & Berg, 1998; Friedman & Lipchik, 1999). By asking, "What needs to happen as a result of you coming here to see me?", I encouraged Bill and Nora to shift from focusing on the problem to envisioning a problem-free future, a critical step in solution-building (De Jong & Berg, 1998; Hoyt & Berg, 1999). Bill and Nora's extreme distress limited their ability to envisage a future free of the problem. This prompted my use of the miracle question

(De Jong & Miller, 1995), a SFT technique which I employed to encourage Bill and Nora to vividly imagine a problem-free future, thereby transporting them, even momentarily, out of their problem saturated context. Introducing the miracle question, I asked Bill and Nora,

> "Suppose that when you go to bed tonight,...while you're sleeping, a miracle happens. Now, what that miracle is, is that everything that you came here with, all of your problems, are solved...However, because you were sleeping, you are not aware that anything has happened. What will be happening the next morning that will indicate or tell you that a miracle has occurred? What will be people be doing or saying that will indicate, 'hey things are better!'".

Bill and Nora's response to the miracle question was quite positive. A sense of hope and optimism seemed to be instilled as they vividly described imagary of a future free of the problem. Adhering to the SFT approach specific therapeutic gaols were extracted from the description of the miracle picture. Consistent with SFTs outline for well-formed goals (De Jong & Berg, 1998), Bill and Nora's objectives were important to them, seemed achievable, were concrete, described in behaviourally measurable terms. And they were described as the presence of something (what will be happening) rather than the problems absence. Furthermore, multiple descriptors, or therapeutic targets, which are important elements in solution-building were identified within the therapeutic goals. According to de Shazer (1988, 1991), multiple targets help assure both therapist and clients' that goals have been met.

Both Nora and Bill agreed that communication needed to improve. They both desired to be more intimately close as friends and as lovers. Additionally for Nora, if the miracle happened, she and Bill would be talking more openly and honestly about their thoughts and feelings. They would also be speaking regularly about their day and their interests. According to Nora, Bill would be paying more attention to her by holding the door for her, getting her a drink, sitting with her while she watched T.V., and he would be taking more of an interest in some of the

activities she enjoyed. Nora stated that they would be going for coffee, spending time with the family, and generally they would be more affectionate with each other. An important goal for Nora was that, when the problem is solved, she would have a better idea of how to support Bill on his "bad pain days", and have a better idea of what his needs are. Bill agreed with, and recapitulated most of Nora's goals for himself. Bill added that he would be more relaxed, less stressed, and happier, which meant that he would be having less frustrated and angry outbursts towards Nora and his family.

Compatible with a SFT approach, I employed a scaling question (De Jong & Miller, 1995), on an nominal scale from 1 to 10, to establish a format of tracking and evaluating Bill and Nora's progress towards identified goals. With 1 being the worst the problem could be and 10 being the identified miracle picture, Nora conveyed that she was at a 2, and Bill shared that he was at a 4. They both agreed that they would be at an 8 on the scale and that therapy would no longer be required if they could consistently maintain changes at that identified level.

Following the development of therapeutic goals, I maintained a solution-focus and engaged Bill and Nora in a search for exceptions; times in their lives, when the problem wasn't such a problem by asking, "...are there things, or pieces of the miracle, no matter how small, that are happening presently, or recently, in your relationship?". Although several exceptions were forthcoming, Bill and Nora's level of distress and disconnection outweighed and overshadowed the new found optimism and hope that was being established. Due to the lack of exceptions, which are key ingredients in solution-building (De Jong & Berg, 1998), I adhered to the guidelines for assigning a homework task (de Shazer, 1988, 1991; De Jong & Berg, 1998) and prescribed an observation assignment; "Between now and the next time we meet, I would like

you to pay attention to those thing that are happening in the relationship that you appreciate, you would like to keep, and that you would like to have happen more often. Pay attention to what it is that you and/or you partner is doing that may be contributing to these things". The purpose of this specific task was to stimulate a shift in Bill and Nora's perspective from focusing on the problem to looking for exceptions that elicited, amplified and built upon as solution-building materials.

Middle Phase

The middle phase consisted of a combination of both conjoint and individual sessions with Bill and Nora. Initially this phase continued a SFT orientation, however, earlier in the process, experiential properties were incorporated into the SFT framework in a blended fashion. This was done to create an intimate connection in order to heighten experiencing and reinforce mutual changes that were perceived as positive. Towards the middle of the phase, it became apparent that serious emotions were blocking the couple's forward motion towards their preferred future. Subsequently, client needs and clinical goals necessitated a move from conjoint to individual sessions, and a full shift to an experiential methodology was undertaken. Finally, an integration of the two approaches was reestablished in an effort to continue a collaborative effort and move towards Bill and Nora's established goals.

SESSIONS 3 to 6

Bill and Nora responded positively to the SFT frame, and stated that the shift in focus from the problem and what was not happening to the good things that were already occurring made an affirmative difference to them both. Bill and Nora were feeling increasingly hopeful and optimistic as they began to discover exceptions to the problem and witnessed little pieces of their miracle happening. Consistent with a SFT orientation I applied the EARS (Elicit, Amplify,

Reinforce, Start over) process (De Jong & Berg, 1998) in order to elicit, amplify and reinforce exceptions, which revealed personal strengths and resources that were used as building blocks for solutions. An integral aspect of these sessions included compliments and feedback that affirmed and validated their efforts. It was evident that the positive shift to solution-building was creating preferred changes within Bill and Nora's relationship. Although Nora had a tendency to focus on the negative, encouragements to shift her concentration to the good things, made a big difference for her. A shift in perspective opened up new possibilities as Nora, permitting a glimpse of the current affirming qualities that existed in the relationship.

As Bill and Nora were feeling increasingly optimistic and hopeful, and were enjoying each other more, they began to speak more directly to each other, rather than through me. This shift resulted in Bill and Nora connecting more intimately. I took advantage of this opportunity to capitalize on the intimate engagement and directed the discussion of exceptions to a more experiential level. This called for an combination of SFT and ET, as the solution-focused EARS process alone, does not promote emotional engagement or the heightening of experience. Such an integration would expand the discussion beyond perceptions and behaviours, to include feelings and emotions.

Several methods taken from emotionally focused therapy (EFT), as described by Johnson (1996), were helpful in meeting the clinical objective of cultivating and expanding Bill and Nora's emotional experience, as they related to exceptions. Particular techniques implemented included evocative responding, heightening, tracking and reflecting interactions (non-verbal behavior), and reflecting underlying emotions. Although these specific procedures have been adopted from EFT, Satir (1983, 1988; Satir & Baldwin, 1983), Atkinsen (1999), and Whitaker

(Connell, Mitten, & Bumberry, 1994), among other experientialists employ similar methods to access and bring emotion into awareness.

Therapist: What else happened this week that was better? *(Exception finding question)*

Nora: I noticed that Bill was trying to pay more attention to my needs.

Therapist: Wow, how did you manage that? *(Exception finding question)*

Bill: I just did it...It's important that things continue to get better...I don't want to lose Nora...

Therapist: Can you look at her and tell her that again? *(Heightening)*

Therapist: Nora, you haven't taken your eyes off of Bill since he's started talking to you...It's almost like you're lost in his eyes. (Tracking and reflecting non-verbal interactions) ...What's it like for you to hear him say that? *(Evocative responding)*

Nora: It feels good...It makes me feel loved...when he says that I know in my heart that he still loves me.

Therapist: It's times like this that you feel valued? *(Reflecting primary emotions)*

Nora: Yes.

An integration of SFT and ET in such a manner maintained the solution-building process, however, the search for exceptions became increasingly intimate, where Bill and Nora were able to connect more fully, completely, which increased the meaning and significance of the collaboration.

SFT scaling questions remained a regular component of these sessions 3 to 6. Bill and Nora remarked in each meeting, that they were making progress towards their goals. Scaling revealed that Nora had moved up the scale to a 4, and Bill was at a 5. Following the scaling, I asked, "What needs to happen, to move up one point, or even half a point, to continue moving up the scale?". This question elicited small steps, or mini objectives, that Nora and Bill would

employ, within their relationship, in order to build on positive changes that were already occurring. For instance, Bill stated that he could ask Nora how her day went, three times during the week in an attempt to communicate and show her more attention. Nora stated that she could ask Bill what he was thinking instead of guessing, or making assumptions. The abovementioned identified tasks set the stage for behavioral homework assignments.

Midway through a search for exceptions in session 5, Bill shared that he felt many of his efforts were going unnoticed and unacknowledged. This triggered an extreme verbal and emotional outburst from Nora. Nora was angry, frustrated, and became emotionally distraught as she began listing all of the things that she had done for Bill, throughout their marriage, that she was not credited with. She verbally attacked Bill, accused him of not understanding her contributions to the relationship and charged him with being insensitive and selfish. Bill countered Nora's attack, accusing her of not understanding the difficulty of his efforts, as he was contending with his pain, which was making even simple things difficult. It was obvious that Bill and Nora were still carrying a lot of hurt, disappointment, and anger. Despite their substantial gains towards their goals, Bill and Nora were still feeling misunderstood, unappreciated and unvalued.

Bill and Nora were stuck. The reciprocal attack challenged the positive, safe environment and caused them both to disengage as they began to withdraw. My attempts to reinitiate solution-talk and focus on exceptions were unsuccessful. It was very clear that there were deeper emotional issues that were blocking forward motion towards Nora and Bill's preferred future. Given this fact, it was at this point, I decided shift from SFT and employed a total experiential approach to deal, more fully, with the presenting emotional issues that were limiting Bill and

Nora's progress and restricting their emotional interactions.

Drawing upon Satir's (1988, Satir et al., 1991) notion that withdrawal in a relationship is often a coping behavior used to preserve self-esteem, I normalized and validated Bill and Nora's positions of mutual withdrawal. I also shared with Bill and Nora Satir's (1988) concept of the self-esteem pot, similar to Robinson's (1997) self-esteem bank, which contends that when self-esteem or self-worth is low, it becomes difficult for one to give in a relationship. Nora responded immediately, "That's it! I'm totally empty! I want to give, but I can't". I took the metaphor further to include that the pot can only be filled with the three A's - *Acceptance, Acknowledgement, and Appreciation.* Bill and Nora both agreed that they seemed stuck, and again were unable to give to each other. Because of this position, I thought, it may be helpful to give them each individual time to express themselves openly. I had a hunch that, due to the explosiveness of Nora's anger, there were more underlying needs and emotions that required addressing directly. My judgement was that it might not be helpful for Bill to sit through that process at this point. Furthermore, due to Bill's withdrawal in response to Nora's attacks, I decided that individual sessions with Bill would provide him some time to express his thoughts and feelings in a safe environment.

Seeing them individually would give me an opportunity to further strengthen my relationship with each of them. Although I shifted gears and was utilizing an experiential approach within the sessions, I assigned a a solution-oriented observation task for in between meetings. I asked Bill and Nora to look for those things in the relationship that were happening that have resulted, or were resulting in "self-esteem deposits".

SESSIONS 7 to 10

Individual sessions with Nora took on a more comprehensive experiential exploration of important intra- and inter-personal issues such as, self-esteem, family of origin rules, roles and learning, that shaped her feelings, perceptions, and expectation about herself and her self in relationship to Bill. Meetings with Nora revealed that most of her life, in relationships, she has taken on the role of placater (Satir, 1988), in which, at the expense of her own needs and true feelings, she has kept those people closest to her happy. Nora has always had a fear of rejection and was taught to care for and please others', in order to be loved. This has contributed, over the years, to her low feelings of self-worth. Nora's unexpressed feelings had contributed to incongruent communication between herself and Bill. According to Satir et al. (1991) incongruent communication occurs when there is an inconsistency and disparity between inner feelings and outward expressions. Feeling that Bill had suffered enough with the accident and his chronic pain, her over-attentiveness to Bill's needs combined with the fear of his rejection, exacerbated her loss of touch with her own needs. Bill's withdrawal was being perceived as rejection which further damaged her sense of self, as a caregiver, which she gained much value and identity from.

Consistent with the ET focus on the individual within the relationship, Nora developed personal therapeutic sub-goals. One of Nora's personal objectives was to cultivate and bring into awareness her feelings and needs, so that she could own and articulate them. This was crucial on many levels. First, being able to articulate your own feelings is a first step towards nurturing self-esteem and honouring your self (Satir, 1983). This was an affirming and empowering process for Nora. Second, individuals who feel better about themselves, can function more effectively in

relationships (Satir, 1988; Connell, Mitten, & Bumberry, 1994). Third, it was important for Nora to understand her own needs and feelings, in order to express herself more clearly to Bill, thereby levelling the congruence of communication. In between sessions, with Nora, we maintained a SFT orientation by having her remain focused on the good things that were still happening within the relationship, and to continue doing what she knew was working. Nora reported that this positive frame encouraged her to see the valuable gains that were continuing to unfold within the relationship.

Bill's individual sessions maintained an experiential context similar to Nora's individual meetings. In a collaborative effort, Bill and I explored his own personal struggles as they related to his self, and self in relation to Nora. Bill revealed that he did want to have a closer relationship with Nora, but the pain was interfering by draining his physical, mental and emotional capacities. He wanted her support, but was having difficulty asking, especially when communication had been so poor and they have been so distant and disconnected. Bill also did not want to appear "needy" or selfish at a time when he thought that he should be supporting Nora more. Bill's family of origin learning and personal convictions precluded his asking for help and perpetuated his withdrawal. Bill's sessions also revealed that he had been struggling with his identity, his sense of self, and his self-esteem, since his debilitating accident. These were other things that he has kept from Nora in an attempt to deal with them in his own way. Bill admitted that his frustrations with the pain, and his personal struggle, were contributing to his angry outbursts towards Nora and the kids. Bill was not willing, at this stage in therapy, to deal with his issues of self, self-esteem, or the accident, but preferred to focus on his relationship with Nora. He did state that he was gaining a better understanding of how the the pain, and his personal struggles,

were impacting his relationship with Nora. Bill agreed that maybe he was closer to taking a risk and was willing to share some of our discussions, from individual session with Nora.

Although individual sessions with both Bill and Nora conserved an experiential mandate that explored needs, wants, perceptions and expectations, there were periods in which a SFT search for exceptions was employed within the experiential paradigm. Nora and I focused on exceptions related to her personal goals; times when she was able to express her needs and nurture her self. This search revealed personal strengths and resources that contributed to past successes. One of Nora's tasks became, "do more of those things that you know contribute to your self expression and contribute to congruent communication". With Bill, we focused on his exceptions; the times that he was able to communicate, clearly, to Nora, his need for support and comfort. Several key exceptions were revealed in which Bill was going to draw from in order to continue such efforts with Nora. Bill and Nora, although focusing on themselves, in sessions, were continuing the solution-building process outside of therapy, by making efforts and taking small steps towards their preferred future.

SESSION S 11 and 12

Given Bill and Nora's desire to be closer and understand each other better, I capitalized on their increased openness to be vulnerable and take risks in sharing unexpressed thoughts and feelings. It was for these reasons that I facilitated and orchestrated an intimate encounter wherein congruent communication of needs, wants, feelings, perceptions and expectations were shared between Bill and Nora. The main clinical objective of the engagement was to provide an experiential context, within the here and now, to access and elicit unexpressed thoughts and feelings as they relate to each Bill, Nora, and the relationship. Communication was clear,

congruent, and increased empathic attunement, understanding, and created an intimate connection between Bill and Nora. Several ET techniques used to clarify and level communication (Satir et al., 1991) and evoke and heighten feelings and emotion (Johnson, 1996) were employed.

The following transcript, which is only a minute portion of the entire process, epitomizes the intimate encounter exercise;

Bill : I get confused sometimes ... I don't know where I'm going or who I am, some days, since the accident.

Therapist :Do you get scared? (*Heightening, Evocative Questioning)*

Bill: Yes.

Therapist: What are you afraid of? (*Evocative questioning, Clarifying Feeling)*

Bill: That I wouldn't be able to provide for my family or for you.

Therapist: How has that effected the relationship?

Bill: It takes my attention away from you ... and then I get scared and frustrated ... and when the pain interferes, I just can't handle it and I go into my house of pain.

The "house of pain" was a metaphor Bill and Nora used when Bill withdrew into himself. As stated, in chapter 3, clients' language symbolizes the meaning and significance of their world view and experience. Both the SFT and ET approaches stress the importance of utilizing client language to access and amplify meaning.

Therapist: What's it feel like for you when Bill goes into his house? (*Evocative Questioning, Heightening)*

Nora: Left out, ignored... rejected. I feel rejected, like your saying I don't want to be with you. It feels awful.

Therapist: Is that what's happening? Bill, are you saying you don't want be with Nora? (*Clarifying- Levelling Communication)*

Bill: No.

Therapist: What's happening? (*Clarifying)*

Bill: I get confused, scared, frustrated, and that's the way I've learned to deal with things. But I'm not rejecting you.

Nora: Would talking to me help? What should I do?

Therapist: Sounds like you want to be in the house with him.(*Evocative Responding)*

Nora: Yes, I do.

Therapist: Is there a way that Nora can be there with you... for you... or do you need to be by yourself ?

Bill: She can come in.

Nora: Are you being honest?

Bill: Yes.

Bill: No, I really want to have this conversation, but it's just so hard to think straight sometimes (sobbing)with the pain...and the medication.

Nora: I am sorry you feel like this. I can't know what it's like ... (stroking his hands) ... I love you.

Therapist: Is it times like this that you want to return into your house? (*Clarifying - Levelling Communication)*

Bill: Yes.

Nora: Why?

Bill: Because I can't even carry on a normal conversation (crying) ... I can't give you what you need.

Therapist: Would you Like Nora in the house with you, to be with you?(*Clarifying*)

Bill: Yes... I would.

Nora: Maybe we should put one of those hotel signs on the door, that say 'come in' or 'do not disturb'. That way I'll know when I can come in and be with you in your house, or whether I should just leave you alone.

Therapist: I think that's a good idea.

Bill and Nora successfully risked sharing hurts and fears allowing room for affirmation and validation of each own's needs. They began to achieve a better, fuller understanding of what each was dealing with. Major shifts occurred in their perceptions, expectations and feelings. These major shifts resulted in changes in their interactions, within and outside of therapy.

Bill and Nora respected each others' need to withdraw, a little, from the relationship, at times, in order to take care of their own needs, but were prepared to communicate thoughts and feelings regarding their expectations and desires so as not to give mixed messages. Nora respected Bill's need to be in his "house of pain" once in a while. They made a commitment to come up with signals and signs to communicate when Nora could be in the "house" to comfort Bill. They also agreed that Nora, if unable to be with Bill, would do something for herself, and take care of her needs. Bill respected and supported Nora's new focus on self-care. A major shift occurred in their perception that neither were being rejected or devalued. Open and honest communication was contributing to a greater understanding of each others' individual and relationship needs. Further to this, the discovery of exceptions combined with mutual understanding and the creation of new behaviors, permitted them to see that it was possible to create a more satisfying relationship.

The pain was a significant factor that complicated their lives. Unless Bill and Nora could cope and deal with the pain effectively, it would continue to challenge their relationship. It was at this point that I reintroduced a SFT orientation, thus, we embarked upon a search for exceptions regarding their successful coping with the pain and its implication in the past. Capitalizing on Bill and Nora's connectedness I employed a constructivist technique known as externalization

(Friedman & Lipchik, 1999). Pain and its complications were defined as a force "outside of the relationship" that, periodically, attempted to come in between Bill and Nora. This frame encouraged Bill and Nora to continue working togther, as a team, in order to stand up to the pain. A search for exceptions was initiated when I asked, "Tell me about the times that you guys have stood up to the pain, and it's negative effects? What's happening at those times? What's different?".

Bill and Nora went on to list numerous exceptions in which they were able to stand up to the pain. Employing the abovementioned EARS process, I elicited, amplified, and reinforced the personal strengths and resources that contributed to their successes. Commending and complimenting them on their efforts I attempted to sustain their emotional engagement by having them compliment and affirm each others' efforts and the significant meanings those efforts had for them. Once again, this incorporation of experiential components within the solution-building framework reinforced Bill an Nora's already strong engagement as they continued to move towards their preferred future. Following the scaling of progress towards goals Bill and Nora identified small contributions they each could make, during the following week, that would enhance their success at standing up to the pain. This became their behavioral homework task.

The changes that began to occur in Bill and Nora's relationship were astounding. They reported that not only were they standing up to the pain, but they were starting to live the miracle picture that they described early in therapy. This was a cue to stay on the a SFT path in order to elicit, amplify and reinforce all of the strengths and personal resources that were contributing to the plethora of changes. Bill and Nora felt extremely optimistic and hopeful as they elaborated on the details of their efforts, increasing the raw materials for maintaining such changes. Although

primarily relying on a SFT frame, I continued to engage Nora and Bill, on several occasions, in deeper emotional engagements in which they reciprocally validated and affirmed each others' contributions to the relationship,.

In scaling progress towards their preferred future, Bill and Nora both reported that they were at an 8 on the scale. This was the value given, in the beginning of therapy, that would indicate counselling would no longer be needed. This fact, combined with their verbal feedback regarding the approximation of their therapeutic goals, led to a natural decision to plan for termination. Observation tasks, "do more of what you're already doing", were assigned to both Bill and Nora.

End Phase

Termination consisted of the final two sessions. As discussed, Bill and Nora were approximating their goals they had set from the beginning of therapy, thereby creating a clear understanding that a transition to work towards closing was required. The final phase of therapy constituted the maintenance of an integration of ET components within a SFT framework. It was important to conserve the intimate connection that had been fostered between Nora and Bill. I believed that continuing the promotion of emotional engagements, while cultivating and exploring feelings, regarding the significance of the changes, would enhance and consolidate such relationship modifications.

SESSIONS 14 & 15

Scaling progress revealed that Bill and Nora had exceeded the original scale value of 8 that they had set for termination. They both reported that they were at a 9.5 on the scale. A full review of their miracle picture and the goals set for therapy was undertaken, as I simultaneously

applied the EARS process. As I commended, complimented and affirmed their efforts contributing to the positive changes in the relationship, Bill and Nora were engaged in an intimate encounter wherein they shared appreciations and affirmations as they took turns sharing their thoughts and feelings regarding each others' efforts that made a positive difference.

Consistent with the SFT paradigm, a great deal of time was spent in the final sessions reviewing the details around discovered exceptions that were gained throughout therapy. This review substantiated a type of resource inventory of the details both Bill and Nora needed to be aware of in order to maintain and increase the positive changes that were already occurring. Following this, we planned for possible setbacks. Bill and Nora were exceptionally confident that they could maintain these beneficial changes. I shared their confidence and in a final affirmation added that, I knew from the beginning that they had the strengths and the personal resources to create their preferred future.

Evaluation of Outcomes

The primary evaluation methods for measuring outcome were the DAS and the feedback questionnaire. However, the scaling questions that were employed at the beginning, and throughout the intervention, were effective in providing ongoing evaluation of progress toward therapeutic goals. Defining goals in concrete, behaviorally measurable terms was also helpful in evaluating clinical outcome. Bill and Nora reported, consistent with clinical observations, that they had reached all of their goals defined in the beginning of therapy; they were living their miracle picture. Bill and Nora described that they both had a better understanding of their own and their partner's needs. Both were feeling valued and appreciated and remarked that they were communicating openly and honestly about thoughts and feelings. Bill and Nora were spending

much more quality time together, engaging in activities that they both enjoyed.

Dyadic Adjustment Scale (DAS)

Bill and Nora's DAS scores are represented in Table 5-1 and Figure 5.1. The scores demonstrate an increase in marital adjustment and satisfaction. Nora's change depicts an exceptionally significant change from extremely distressed to a non-distressed position. Despite the verbal report of significant and positive changes, in almost every aspect of their relationship, according to the DAS scores, their existed a considerable margin between Nora and Bill's score increases. One possible reason for this discrepancy in scores may have to do with Bill's personal struggle with his identity and self-esteem. Bill did note that he is just beginning to understand that he may not have dealt with his personal losses and the subsequent negative intra-personal implications arising from the accident and struggle with chronic pain. Another possibility may have to

do with the fact that Bill was less distressed than Nora upon entry into therapy. Furthermore, Nora was the one who initiated counselling. Being more important to Nora, she may have had more to gain from the therapeutic intervention. Unlike Bill, Nora made great gains in the areas of her personal issues, in particular, her self-esteem. In this respect, the experiential belief that level of self-worth directly affects one's functioning in relationships may shed additional light on the differences between Bill and Nora's DAS score increases.

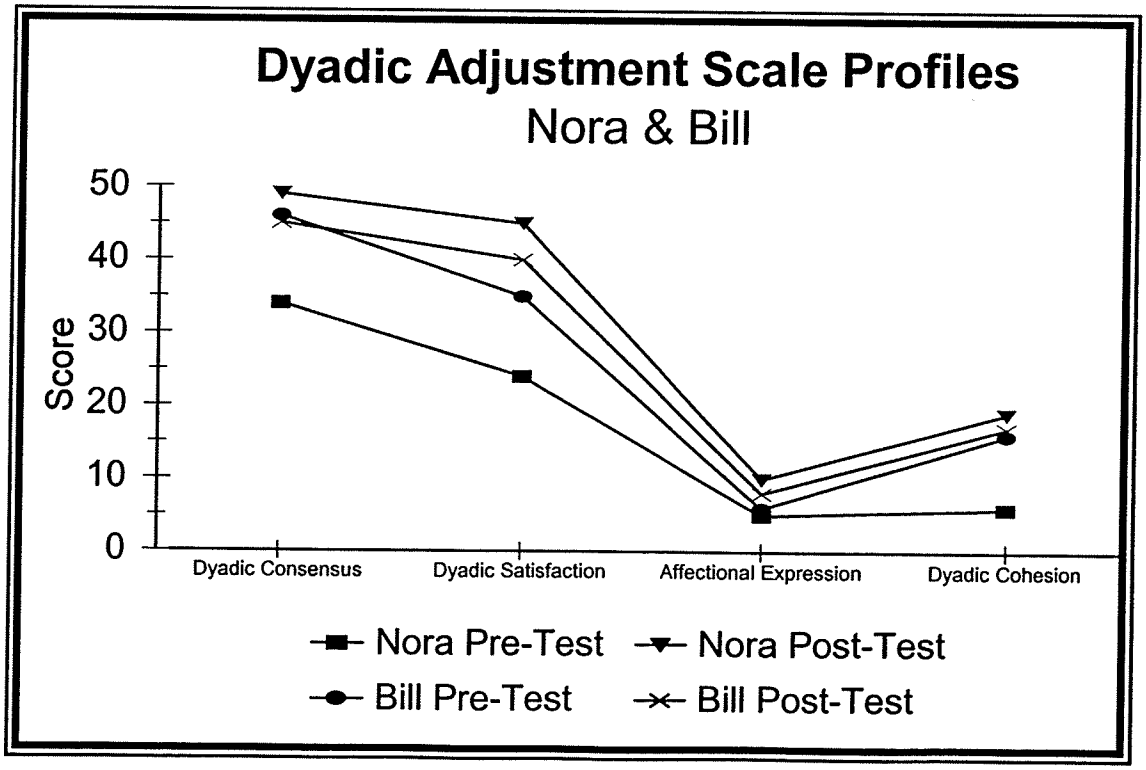
Although the DAS was used only as global measurement of marital adjustment and satisfaction, the sub-scales seem to represent a consistency with reported relationship changes. Nora made considerable gains on all sub-scales, which is congruous with her narrative regarding a myriad of changes in almost every aspect of the relationship. Nora's primary complaints and

TABLE 5 - 1

	COUPLE "A"					
	Bill		Nora		Norm Scores for:	
DAS Sub-scales	Pretest	Post-test	Pretest	Post-test	married couples	divorced couples
Dyadic Consensus	46	45	34	49	52	35
Dyadic Satisfaction	35	40	24	45	41	22
Affectional Expression	6	8	5	10	9	5
Dyadic Cohesion	16	17	6	19	13	8
Total: Marital Adjustment & Satisfaction	**103**	**110**	**69**	**123**	114/115 (114.8)	70/71 (70.7)

* Total DAS *scores less than 101 represent distressed relationship functioning. Scores greater than 101 represent non-distressed relationship functioning*

Figure 5.1



objectives, that were met through the therapeutic process, were concerned with the amount of attention and affection she received from Bill, the amount of time spent doing activities together, and generally, her satisfaction with the general state of the relationship. The DAS was sensitive to, and representative of, the increases in the aforementioned areas.. There were considerable increases in the sub-scales relevant to such reports. In particular, the greatest gains occurred in the areas of affectional expression, dyadic cohesion and dyadic consensus.

Bill's sub-scale scores represented significant changes in two areas; dyadic satisfaction and; affectional expression. The changes in scores along these sub-scales are compatible with clinical observations and Bill's reports of therapeutic gains in the areas of his primary concerns; lack of affection, appreciation, and acknowledgement that he was receiving from Nora. Likewise, he did not feel like his needs for support and understanding were being met. Bill reported that these areas were no longer problematic for him upon completion of therapy. I was surprised, however, at the marginal change in Bill's dyadic consensus and dyadic cohesion scores. Both Bill and Nora reported a considerable increase in time spent together talking and engaging in joint interests together. Further to this, I assumed that the DAS, in particular the dyadic consensus, would pick up on the major increase in Nora nd Bill's ability to understand and support each other as they jointly problem-solved and collaborated on relationship issues.

Client Feedback

Bill and Nora's responses to the feedback questionnaire provided clear impressions as to what were the most helpful aspects of therapy. Both indicated that therapy was exactly what they needed . They agreed that setting specific goals and meeting them, was one of the most helpful aspects to therapy. Their responses reflected the value inherent in the search for exceptions, and

the small concrete steps needed to move towards goals that are representative of the SFT approach:

Nora: *We had specific goals and you helped us reach all of them...I liked that you told us, and brought our attention every time you noticed something good happening.*

Bill: *I agree with Nora...we set goals...we took the necessary steps to reach them.*

Nora also seemed to find the integration of SFT and ET helpful during the search for exceptions:

Nora: *It helped when you slowed us down, after we said something that we knew was making a difference for the other person...and you asked that other person how that made them feel. I got a better understanding of how he was feeling...I knew what we needed to do...It helped me a lot that I knew what he was thinking and feeling.*

Bill and Nora's comments often reflected my clinical observations about our collaborative rapport, and reinforced and reflected what is at the heart of the experiential paradigm; a therapeutic relationship which is characterized by genuiness, empathy, and unconditional positive regard:

Bill: *We've seen a couple of counsellors...some of them don't give a shit, but not you. You care a lot and you work hard...you should be careful that you don't burn yourself out, caring too much.*

Nora: *It felt good that you got to know us, and that you cared about us..we can really feel good...that you cared about us...I felt important when I was here, like you really cared about us*

Finally, Nora's conclusive comments regarding the most helpful aspects of therapy reflected another integral component of experiential therapy. That is, the focus on self, as well as self in relation to others (Satir, 1983, 1988; Connell, Mitten, & Bumberry, 1994).

Nora: *I also liked the fact that you not only focused on us as a couple, but also on each of us as individuals...it's true, if I'm not good, we're not good. And the same with him...if things aren't right with him, there not right with us. You helped me reconnect with what my needs were. I think we're both better for that.*

Both quantitative and qualitative methods of evaluation demonstrated significant

improvements in Bill and Nora's relationship. Taking into consideration clinical observations and impressions, client responses and feedback, and the results gathered from evaluation data, I am convinced that this particular therapeutic intervention was effective, successful, and provided a respectful and valuable resource for Bill and Nora.

Couple B: Jack and Diane

Presenting Problem and Case Summary

Jack and Diane presented to therapy exceptionally distressed and uncertain about the future of their relationship. According to Diane, couples counselling was presented to Jack as a final ultimatum; a "last ditch" effort to "make the relationship better". They described how arguments, almost a regular part of their daily interactions, were verbally vicious and emotionally destructive. According to Jack and Diane, issues were not dealt with or discussed, and following intense arguments they would endure days, sometimes a week or two, of mutual withdrawal, non-communication and avoidance.

Throughout the collaborative process of co-creating a preferred reality with Jack and Diane, several key relationship needs, issues and patterns became apparent. On-going assessment revealed that Jack's past relationships resulted in an avoidant attachment style (Hazan & Shaver, 1994; Johnson, 1996). We also co-discovered that Jack's low feelings of self-worth and fear of being hurt led to difficulties with expressing vulnerability and developing trust in relationships. This perpetuated Jack's withdrawal. When Diane's pursuits and demands for affection created anxiety for Jack, he attacked Diane in an attempt to create distance and maintain safety. Unable to express his true feelings, which were somewhat out of his awareness, Jack's communication was

incongruent. His verbal expression did not match his true feelings, which often led to misperceptions and miscommunications sustaining Jack and Diane's misunderstandings of each other.

Diane interpreted Jack's withdrawal and his attacks as a personal rejection, a lack of interest and caring for her. She felt unappreciated and devalued. Jack's negative and disrespectful tactics in reestablishing distance, further ruptured Diane's self-esteem. In an attempt to preserve her self-worth Diane would attack Jack in defence. Diane's efforts to preserve self-esteem in a volatile and destructive context led further to her incongruent communication as it was not safe to openly express vulnerabilities and feelings with Jack. I estimated that Diane's attempts to protect herself further reinforced Jack's ideas that people cannot be trusted, and that if you allow them too close they will hurt you. This self-fulfilling prophecy, further maintained his avoidant attachment style.

In order for Jack and Diane to shift from negative reactions and defensiveness to positions of reflection and understanding, they were going to have to change the destructive nature of their interactions. A safer relationship context is conducive to trust and understanding. Jack and Diane needed to communicate more openly and honestly their primary emotions. This would level communication and lead to preferred empathic attunement, thereby creating a new way of experiencing each other and their relationship. This would create greater space for increased approachability and closeness.

Beginning Phase

The beginning phase consisted of the first two sessions in which a SFT approach was employed. Following a positive start, attempts were made to integrate ET. However, the overall

client response to this shift was not positively receptive and therefore SFT remained the primary orientation though out this phase. The beginning phase was completed once therapeutic goals were well established and efforts to move toward such ends were initiated.

SESSIONS 1 & 2

My primary goal in the first session was to join with Jack and Diane and allow them the necessary time to share their story. Diane was extremely distressed and cried though out her discussion of the problem. My attempts to validate and normalize her experience by responding empathetically had an affirming affect with Diane. However, in sharing his perspective, Jack became accusatory and blaming. His sudden attack ignited Diane's anger and resentment resulting in an outburst of reciprocated accusation, blame, belittling and name-calling. This provided me with a glimpse into the extent of this couples' severely embattled positions. Several attempts to continue a discussion of the problem led to further explosiveness and arguments. Intensely reactionary, Jack and Diane were unable to hear or reflect upon each other's perspective.

Jack and Diane vehemently defended their own position and perceptions as they verbally attacked and hurt each other. The reactive-defensive mode Jack and Diane were in led me to steer away from an emotional engagement early on. The environment was not yet safe for either of them to engage empathically with each other. Continued discussion around the problem was unhelpful, increasing blame and mutual negativity.

It was for these reasons that I shifted to solution-talk (DeJong & Berg, 1998) within a SFT orientation as a means of engendering hope and optimism. In moving focus away from the problem to create a more positive future orientation I asked, "what is it that you would like to

have happen as a result of coming here to see me?" Jack and Diane were unable to think of a positive future without the problem. Presuppositional questions (O'Hanlon & Weiner-Davis, 1989; DeJong & Berg, 1998) and solution-talk, including the miracle question were not helpful in producing a positive connotation. Jack sat disengaged, appearing aloof, while Diane cried and withdrew.

I spent a great deal of time validating their distress and inability to risk closeness in an unsafe context. I made efforts to validate and normalize their mutual feelings of hurt and their reactive defensiveness. Jack denied that he was hurt and stated he was angry and frustrated with Diane's nagging and constant pursuits for affection and comfort. I acknowledged Jack's perspective. I took his response as a sign that he was unable to risk appearing vulnerable by agreeing with my feedback. Jack was not ready or willing to engage in an emotionally expressive engagement.

Attempts to gain a complete picture of the problem were followed by explosive outbursts and continuous mutual attacks of reactions and defensiveness. The clinical environment was becoming extremely negative and volatile. I made one last attempt to utilize a SFT orientation to initiate solution building. In a desperate, yet strategic attempt to elicit strengths and exceptions I asked "Wow, what makes you think this relationship is even worth saving?" Surprised to hear this from me, Jack and Diane became intensely serious. Diane recalled the first four months of their relationship when they would talk, laugh, and enjoy each other's company, at a time when name-calling and personal attacks were non-existent. Jack's attitude of indifference changed to a positive interest as he joined in the discussion and reflections of better times.

Jack and Diane's positive responsiveness led me to a second attempt to initiate solution-

building by reintroducing the miracle question. This question created a sense of hope and optimism as Jack and Diane vividly described a problem free future. Goals for therapy were drawn from the discussion of their miracle picture. Consistent with SFT guidelines for well formed goals (De Jong & Berg, 1998), Jack and Diane's therapeutic objectives were specific, detailed and described in concrete, behaviourally measurable terms.

Diane's goals outlined that when therapy was successful they would be talking to each other respectfully and caringly about thoughts and feelings. Diane wanted the name-calling and the personal attacks to stop. She also wanted Jack to be more affectionate and not as emotionally closed off. Initially, Jack's goals included that Diane would respect his need for space and that she would be less nagging and controlling. To Diane's surprise Jack added that they would be communicating more openly about their thoughts and feelings. Both Jack and Diane agreed that they would be talking "nicely" to each other when the fights were no longer occurring. They concurred that the destructive fights would be stopped, resulting in a renewed sense of trust and comfort in the relationship.

Following the miracle question (deShazer, 1991; DeJong & Berg, 1998), and formation of goals, we embarked on a search for exceptions; times when the problem was not a problem. Jack and Diane, although feeling more positive and hopeful, had difficulty identifying exception times. They agreed that for the past several months they have been focussing only on the negatives in the relationship. Diane remarked, "things have been so bad for so long" and Jack replied, "It can't get any worse". Given the lack of identifiable exceptions, following the SFT guidelines for homework assignments, I prescribed an observation task (de Shazer et al., 1986; DeJong & Berg, 1998). This was done to shift their focus from negatives to positive things that did exist in their

relationship. I suggested, " Between now and the next time we meet, I would like you to look for those things that are happening in the relationship that you appreciate and that you would like to have happen more". I asked them to note "what was happening at those times? What are each of you doing when things are better?".

For the purposes of tracking and evaluating progress towards their preferred future, maintaining a SFT stance, I employed the scaling question (De Jong & Miller, 1995; De Jong & Berg, 1998). With 1 being the worst things could be and 10 being their miracle picture, Diane stated that she was at a 2 on the scale. Jack provided the same value. They agreed that therapy would have been successful and no longer needed if they could reach a 6.5 on the scale.

Middle Phase

The middle phase contained a combination of conjoint and individual sessions for a total of 10 meetings. Jack was seen individually for 3 meetings while Diane attended two sessions individually. We met together, conjointly for 5 sessions. Innumerable shifts in theoretical orientation, including a variety of integrations were necessary throughout this phase. Client responsiveness to intervention approaches and clinical objectives determined whether SFT or ET were employed separately, or used in a integrated fashion.

SESSION 3

This session was significant as both Jack nd Diane reported positive relationship changes. A SFT stance was maintained as they both responded exceptionally well to the affirmative and optimistic focus.

Considering Jack and Diane's tendency to slide into negativism, I began the sessions with a SFT focus on the positive by asking, "So, what is better?" This question has a tendency to

presuppose change and shift perspective towards exceptions, perceptions and behaviors conducive to solution-building. Jack and Diane responded favourably to this focus and described a week full of exceptions and positive events. Jack and Diane described a full week without a fight. Several nights during the week they layed in bed cuddling each other and talked about their days. It was the best week they could recall for a long time. I employed the EARS (DeJong & Berg, 1998) in an effort to elicit, amplify and reinforce the numerous exceptions that had occurred. I complimented and commended Jack and Diane on their efforts to bring about such change. Diane was able to identify her contributions to change. She shared her attempts to give Jack more space. She tried not to "nag", and stayed focused on the positive things that were occurring in their relationship. She also noticed that Jack made efforts in being more relaxed, open to her affectional expression, attentive and did not belittle or name-call. Despite Diane's recollection of his efforts, Jack maintained his aloofness, replying that he had done nothing different. I sensed Jack's reluctance to take responsibility, even for the positive changes. I interpreted this as meaning his taking responsibility for the positive would thereby make him responsible for when things were not going well. Something he was not yet prepared to do.

Following a bombardment of reinforcements and compliments on their efforts to move to their preferred future, I posed the scaling question (DeJong & Miller, 1995) to measure their perceived progress. Both Jack and Diane reported being at a 5 on the scale, due to aforementioned relationship changes. Because Jack was unable to note his contribution to change, I assigned him an observation task to pay attention to those things he is doing that seem to make a positive difference in the relationship. For Diane, who was well aware of her personal contribution to the affirmative relationship changes, I assigned the behavioral task of "do more of

what you know is working".

SESSION 4

Jack attended the fourth session individually, as Diane could not make child care arrangements. He presented an extremely tough and indifferent exterior, had very few positive things to say about the relationship, and was unwilling to engage in a solution-oriented discussion of positives. Sensing Jack's reluctance to engage, my goal for the session was to monitor the therapeutic alliance (Johnson, 1986) and take the necessary time to establish a trusting rapport with Jack. This required a shift to an experiential frame in which to fully respect, affirm and validate his experiences. Jack eventually responded well to this approach and by the end of the meeting was feeling more positive about himself and his role in the relationship. He was more willing to actively participate in bringing about positive change.

Initially, however, Jack spent a great deal of time trying to convince me of his "bad" nature. He shared, in detail, past violent thoughts and violent acts of a "hardened man" who had done jail time. He bragged about how ex-girlfriends, friends and past psychiatrists have labelled him a "psycho". My response to Jack was non-judgmental and validating, but also contained an agenda for cultivating a deeper meaning. I stated, "Wow, you must have a really good reason for thinking and doing those things". Consistent with my experiential, humanistic philosophy, I made attempts to express my feelings about Jack's worth and value as a human being by conveying an understanding and acceptance of his experience. Further to this, I felt that Jack's negative description of himself was unhelpful and I wanted to illuminate the positive aspects of his self. Concurring with Satir's belief that unhelpful perceptions maintain unhelpful positions (Satir et al., 1991), I was concerned that Jack's overemphasis on his "tough" self would continue to

constrain and limit intimate interaction with Diane.

Therapist: I am sorry, but I don't think you're a psycho, Jack. You probably had a very good reason to think, feel and behave in those ways. The psychos I've met don't enter couples counselling, don't have close relationships with their mothers and sisters, and they definitely do not cuddle in the spoon position at night with their partner.

In an attempt to encourage Jack to take responsibility for his behavior in the relationship, I commented on the myriad of incongruencies between his verbal expressions and his behavior. This is consistent with Satir's (1983, 1988) technique of levelling.

Therapist: I find it interesting that you say you can take or leave this relationship, yet you make efforts to attend counselling . . . You say that you don't need affection yet you cuddle, very intimately, with Diane . . . Last week you said you did nothing different, yet Diane listed several positive changes in your behavior, that have made a big difference for her.

Jack opened up and admitted that he was committed to the relationship. A collaborative discussion of his efforts and exceptions created a positive opportunity for Jack to take responsibility for his efforts. His responsiveness led me to re-initiate the solution-building process. I applied the EARS process and reinforced and commended Jack on his efforts. In employing the scaling question, Jack identified that he could make several small efforts to move up one point on the scale. I then assigned him the specific behavior task, "try those things out and tell me if they make a difference".

SESSIONS 5 - 7

The next several sessions maintained a SFT frame while incorporating experiential properties. Jack and Diane continued to make progress towards their goals and were beginning to live their preferred future. However, the therapeutic process and the positive relationship changes were seriously jeopardized as Jack and Diane encountered a significant and destructive impasse which required individual sessions.

Capitalizing on the positive nature of the solution-building process, I incorporated experiential components within the solution-oriented frame. In affirming and reinforcing their efforts, I engaged Jack and Diane in a face to face encounter and asked them to share with each other, the meaningful differences the other's behavior was making for them. Diane shared deeply, on an emotional level, while Jack maintained a positive, however, emotionally disconnected contribution. Jack and Diane were becoming more intimately connected both within and outside of therapy.

These sessions maintained the scaling process in order to track and evaluate progress towards their goals. As Jack and Diane were able to identify concrete behavior and exceptions that contributed to positive changes, consistent with the SFT orientation, behavioral tasks were assigned. In between sessions Jack and Diane were encouraged to "do more of what is working".

Despite forward motion towards their preferred future, an explosive argument erupted in session seven, resulting in Diane's storming out. She was hurt, angry and confused. Despite her efforts, Jack admitted to starting several fights "for no real reason". The "old aloof Jack", indifferent and emotionally detached, also re-appeared in therapy. Diane and Jack were extremely negative, and quickly reverted to reactive and defensive positions of blaming, name-calling and belittling each other. At this point, I suggested several individual sessions to engage in a more complete assessment of the present circumstances that were blocking forward motion towards their desired future. Further to this, individual sessions would remove the "reactive potential" that led to disruptive and destructive interactions and provide room for both Jack and Diane to fully reflect upon and share their experiences. Finally, individual sessions would allow for greater development of a strong therapeutic alliance with each partner.

SESSIONS 8-11

Jack's individual sessions were focused on a collaborative effort to understand his distancing and attacking behavior in relation to Diane. This necessitated a divergence from a SFT frame and the adoption of an experiential approach. An ET shift was necessary in exploring Jack's past relationships and deeper feelings that were maintaining his negative interactions with Diane and limiting their intimate engagement. Because Jack had a tendency to be emotionally unexpressive, it was crucial that I progress slowly while constantly monitoring the therapeutic alliance.

Johnson's (1996) emotionally focused therapeutic lens was helpful in framing Jack's behavior within an attachment context. Jack experienced three significant past relationships in which he was left feeling abandoned and betrayed. He made a vow to not trust others or he would be hurt again. Our collaborative exploration revealed that Jack's distancing behavior was the result of an insecure attachment which left Jack feeling anxious in close relationships. This information was critical, and provided an opening for a reframing of his behavior in a new context. Jack entertained the possibility that he was distancing himself so as not to be hurt again. He also realized that starting fights and hurting Diane were efforts at creating distance if he felt he was getting too close.

Consistent with many experiential approaches (Johnson, 1996, 1999 ; Atkinsin, 1999), I decided that an exploration of Jack's primary emotions underlying his secondary and reactive emotion of anger, may provide insight into his current relationship difficulties. Jack was open and receptive to such a dialogue. Acknowledging feelings not yet acknowledged, Jack began to shift from talking about anger to reveal feelings of hurt, betrayal, confusion and loneliness. He began

to realize that an increase in closeness in his relationship with Diane would require some risk-taking on his part. This meant that Jack, rather than distance himself, needed to maintain closeness. Further to this, it was going to be necessary for him to risk vulnerability by expressing his true feelings to Diane rather than hide behind his "tough guy" defences that were constricting their interactions and limiting their closeness.

Although sessions with Jack maintained an ET approach, several occasions required a SFT search for exceptions. For instance, between sessions, Jack and Diane explored the times that he was able to maintain closeness, despite his fear of being hurt and searched for times he was able to risk expressing emotions or deeper feelings with Diane, or others. Following the application of the EARS process, Jack was encouraged to continue to utilize the personal strengths and resources which led to those exceptions, between sessions. Therefore, following the SFT orientation, Jack was assigned behavioral tasks to do those things that lead to successes and which move him and Diane to their preferred future. Jack risked vulnerability in our sessions, however, he stated that he was yet unwilling to share many of his discoveries about himself with Diane. Although not yet comfortable to openly express himself with his partner, he was agreeable to me sharing my thoughts from our individual sessions with Diane, in our individual sessions together.

My approach to Diane's individual sessions were less experientially exploratory than Jack's. I maintained a SFT search for exceptions and details regarding success in order to build on and continue the solution-building process. My rationale for this stance arose out of Diane's apparent commitment to "do anything to make it work". Unlike Jack, it did not seem that there were deeper issues that were perpetuating negative behavior, thereby blocking forward motion

towards goals. Further to this, Diane echoed a solution-oriented sentiment, "If we can have four really awesome weeks, we can have more". She too believed that, within those four weeks the ingredients for building solutions existed.

Building on her hopeful and optimistic perspective, I maintained the SFT search for exceptions, followed by the EARS process. Scaling was used to evaluate and track Diane's perceived progress towards goals. Diane identified specific behavioral tasks that would ensure continual motion towards the preferred future. Diane reported that she would continue giving Jack the needed space and would begin using "I" statements rather than personally attacking Jack when she was upset. She believed that this would decrease the likelihood of Jack becoming defensive and attacking back. Diane was changing all ways of interacting and replacing this with more helpful ways to interact and communicate.

Diane reported that, at home, her change in behavior seemed to be creating a safer place for Jack to open up. He began to share feelings with Diane and was beginning to communicate congruently, that is, outwardly expressing what he was feeling on the inside. Jack informed Diane that he did not mean many of the cruel things he had said to her and that these were an attempt to get her back when he felt badly or hurt by her. This made a big difference for Diane, as she began to understand that Jack was protecting himself because he was also hurting. In addition, Jack shared with Diane some of his insecurities and expressed his deep seeded fear of being alone.

It seemed that the change in the environment from a battlefield to a safer place, had contributed to Jack taking risks and exposing true feelings. Diane and Jack were becoming increasingly emotionally and physically intimate. Jack was continuing to show more affection, was more approachable and was treating Diane with increased respect and understanding. Diane

was feeling valued and appreciated.

SESSIONS 12 & 13

Upon returning to conjoint sessions, Jack and Diane were experiencing major shifts in their perceptions, expectations, and feeling regarding the relationship. They reported that things continued to get better, "Jack was a changed person", and they were almost living their miracle picture described early in therapy. Given Jack's newfound openness to the expression of feelings and discussion of emotions, I decided to incorporate experiential properties within the SFT solution-building process. These sessions were geared towards the eliciting, amplifying and reinforcing (EARS) of personal strengths and resources that were contributing to Jack and Diane's successes. I took the EARS process beyond a simple affirmation of perceptions and behaviors to include deeper emotional expressions by having Jack and Diane share with each other what significant difference the positive changes made for them. This promoted an empathic emotional engagement between them. They became engaged in a close, respectful connection, sharing thoughts and feelings. Jack and Diane were feeling valued, accepted and understood. Their communication was congruent as they trusted each other to express themselves openly and honestly. As partners react less to one another, more room is made for them to share of themselves and as a result, "new descriptors, explanations, and meanings can be generated" (Caesar, 1999, p.374). Diane and Jack made a major shift from embattled positions of reaction to respectful positions of reflection.

The integrated components of ET were maintained throughout the SFT framework. Jack and Diane were continuously engaged as they scaled progress towards their preferred future. Diane reported being at a 9, while Jack was at an 8 on the scale. This was well past their original

goal of 6.5 . They were assigned behavioral tasks of "do more of what you're doing". Because Jack and Diane were practically living their identified miracle picture and they had exceeded their therapeutic goal value on the scale, I introduced the subject of termination. Jack and Diane agreed that it was appropriate to review goals, plan for setbacks and close.

End Phase

The end phase consisted of two sessions geared towards the goal review, planning for setbacks and continuing changes for future successes. The theoretical orientation employed maintained the SFT framework with the incorporation of experiential properties.

SESSIONS 14 & 15

It was important to conserve the intimate connection that existed between Jack and Diane. It was my belief that continuing the promotion of emotional connectedness while cultivating and exploring feelings regarding the significance of the affirmative relationship changes would serve to enhance and consolidate such changes.

Jack and Diane attended the final sessions as a transformed couple. Unlike their first session, they were holding hands, sitting close and were constantly laughing and smiling together. Scaling progress revealed that Diane was at a 9 and Jack was at an 8 on the scale. Their values exceeded their original goal of 6.5 for therapy. A full review of their initial goals set for therapy was undertaken. Employing the EARS process, I affirmed and complimented Jack and Diane on their efforts and accomplishments in meeting all of their identified goals. According to Diane and Jack, they were indeed living their miracle relationship.

Within the SFT process of reviewing, amplifying, and reinforcing personal strengths and resources, I promoted several emotional engagements between Jack and Diane. They were

encouraged to share with each other regarding their partners' efforts and changes. Jack and Diane were intimately connected as they communicated mutual validations and affirmations for one another. Diane and Jack reported a renewed sense of value and appreciation for one another. They were also experiencing an increased sense of safety and trust in the relationship, a result of the constant exploration and cultivation of exceptions. The revelation of various strengths and personal resources provided Jack and Diane with a vivid detailed picture of the necessary ingredients (solutions) to maintain change. Jack and Diane felt extremely optimistic and hopeful about the future of their relationship. In scaling their confidence that relationship changes would continue and that they could handle setbacks, both Diane and Jack rated a 10.

Evaluation of Outcomes

The scaling questions employed at the beginning and thoughout therapy were effective in providing ongoing evaluation of progress toward therapeutic goals. Defining goals in concrete, behaviorally measurable terms was also helpful in measuring clinical outcome. Jack and Diane reported, consistent with clinical observations, that they had reached all of their goals for therapy; they were living their miracle picture. Both Diane and Jack agreed they had established a renewed sense of comfort and trust in the relationship. Fights were no longer occurring as they were treating each other in mutually caring and respectful ways. Diane was satisfied that Jack was more approachable and open to her efforts at closeness and displays of affection. Jack appreciated Diane's respectful understanding of his need for space and reported that Diane was no longer "nagging or controlling" him.

Dyadic Adjustment Scale (DAS)

Jack and Diane's DAS scores are represented in Table 5-2 and Figure 5.2. One can attest

that their pre and post-test scores demonstrate a substantial increase in marital adjustment and satisfaction. Both Jack and Diane's changes represent an exceptionally momentous shift from extreme relational distress to non-distressed positions. The total DAS scores are consistent with both clinical impressions and Jack and Diane's reports.

Although the DAS was used only as a global measurement of marital adjustment and satisfaction, the sub-scales seem to represent a consistency with reported and observed relationship changes. Diane made considerable gains on all sub-scales, which was congruent with her report of a myriad of changes in almost every aspect of her relationship with Jack. Diane's primary concerns and therapeutic objectives were concerned with the amount of attention and affection she received from Jack, his lack of understanding her needs, their poor conflictual communication, and generally her satisfaction with the poor state of the relationship. The DAS sub-scales were sensitive to, and representative of, increases in the above areas. In particular, the greatest gains occurred on the affectional expression and dyadic consensus sub-scales. These substantial increases are consistent with Diane's reports of Jack's increased attention and affectional expression and his increased openness and understanding of her differences and relationship needs. These were the two areas of the most concern for Diane.

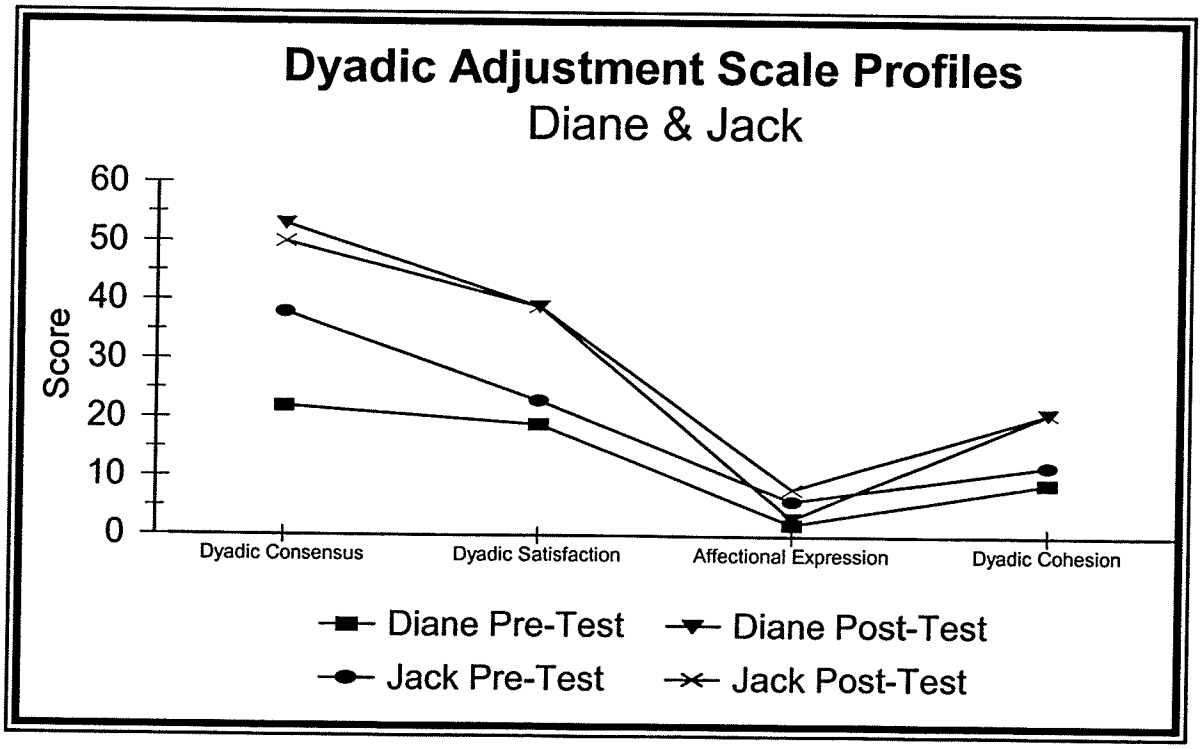
Jack's scores also represented significant changes in three of the four sub-scales. The affectional expression sub-scale was the measure with the slightest increase. Consistent with Jack's reports and clinical observation, Jack stated that at the beginning of therapy and throughout, he was satisfied with the amount of affection and attention demonstrated by Diane. Further to this, Jack did remark that although he was feeling increased safety to express emotions,

Table 5-2

	COUPLE "B"					
	Jack		Diane		Norm Scores for:	
DAS Sub-scales	**Pretest**	**Post-test**	**Pretest**	**Post-test**	**married couples**	**divorced couples**
Dyadic Consensus	38	50	22	53	52	35
Dyadic Satisfaction	23	39	19	39	41	22
Affectional Expression	6	8	2	10	9	5
Dyadic Cohesion	12	21	9	21	13	8
Total: Marital Adjustment & Satisfaction	**79**	**118**	**52**	**126**	114/115 (114.8)	70/71 (70.7)

* Total DAS *scores less than 101 represent distressed relationship functioning. Scores greater than 101 represent non-distressed relationship functioning*

Figure 5.2



openly, it would still take some time for him to feel fully comfortable with this new behavior. The aforementioned presumption may account for the marginal increase in Jack's score on the affectional expression sub-scale.

Due to the extent and variety of positive relationship changes, it is difficult to pinpoint the exact contributions to specific sub-scale increases. However, Jack's reports of Diane's increased understanding of him and his needs, his overall increase in relationship satisfaction and his comfort level with the time they spend together is consistent with the increases in the dyadic consensus, dyadic satisfaction and dyadic cohesion sub-scale scores.

Client Feedback

Jack and Diane's feedback portrayed, from their perspective, the most helpful aspects of therapy. Both clearly indicated that therapy was exactly what they needed. They agreed that they would probably not be together if they had not engaged in the counselling process. Jack and Diane's responses were consistent with clinical observations regarding their major relationship transformation.

Jack: *...it [counselling] brought us from fighting everyday...it showed us how really happy we can be.*

Diane: *Oh, yes...totally.*

Client feedback reflected key theoretical elements of both SFT and EFT that were integral in advancing Jack and Diane to their therapeutic objectives. A shift from problem talk to solution talk created increased space for viewing things differently in order to build on Jack and Diane's strengths, resources, and successes.

Diane: *We were focusing on the negative so much...we couldn't see the positives. Coming here showed us that looking at one little positive change can make a huge difference.*

Jack: *It was helpful to look at things differently...it showed us how happy we could be...and we can choose to stay that happy.*

While responding well to many of the SFT aspects of the integrated therapeutic intervention Jack and Diane indicated that being able to hear and understand the person was helpful in bringing about preferred relationship changes.

Diane: *a lot of our problems were in miscommunications and misunderstanding what's actually trying to be said...you helped us word things and hear things more clearly - what was actually trying to be said.*

Jack: *It was clearer for the other person to understand.*

Such feedback underscores the importance of levelling communication (Satir, 1991), a key element in ET, so that partners can engage on a more intimate and empathic level.

Both the DAS and the client feedback questionnaire demonstrate significant improvements in overall relationship satisfaction. Moreover, the quantitative data and the narratives provided by the clients indicate change on a variety of specified levels within the dyad. Both sets of evaluative feedback are consistent with clinical impressions and therapist observations. It is my unequivocal belief that the presented solution-oriented experiential modality was effective and successful in meeting the unique relationship needs of Jack and Diane.

Couple C: Aneka and Chakota

Presenting Problem and Case Summary

Aneka and Chakota presented to therapy relatively distressed and unsatisfied with the state of their relationship. They described their relationship as a roller coaster wherein the majority of the time, things were positive. Every several weeks, however, simple disagreements

and "bad moods" would result in arguments. Sometimes, the arguments would ensue into all out destructive battles which were extremely verbally and emotionally volatile. Invariably, arguments were not resolved, but set aside or ignored altogether. They both agreed that they suffered from poor communication and rarely compromised on personal views or decisions. Chakota described Aneka as intensely angry, who was constantly nagging and controlling. Aneka described Chakota as insecure and untrusting, who did not understand her needs.

In our collaborative efforts to co-create a preferred relationship for Aneka and Chakota, we made many helpful discoveries. Both Aneka and Chakota were experiencing a low sense of self worth. Aneka grew up in a family where she was unable to trust others to meet her emotional needs for safety, security and comfort. Her past relationships were characterized by deprivation and loss of trust and love. The relational context of many of these relationships were not conducive to functional communication or the expression of feelings other than anger. Aneka felt, for many years, that she was unlovable.

Chakota's past relationships were also characterized by poor communication and a lack of affectual bonds. Chakota, in several significant relationships, experienced abandonment and betrayal. He could not trust others to be there for him. In essence, Chakota developed an insecure attachment from his previous deficient relationships. Even early in his relationship with Aneka, the safe and trusting bond was severely threatened. Aneka's reactive threats to leave perpetuated Chakota's insecure bond. Like Aneka, Chakota often felt unlovable and had difficulty revealing vulnerabilities and expressing primary feelings such as hurt, loss, fear and confusion.

Both of them had a tendency to express two types of emotions; happiness and anger. There was very little expression of alternative emotions. Given the poor nature of communication

and their restricted emotional expression, Aneka and Chakota were left to interpret the other's behavior. Often, their emotional responses to the interpretation arose out of their view of self and self in relation to others, rather than out of an accurate understanding of the other's feelings. It was their fundamental representations of self and others that were developed from experiences in past relationships early in life. The poor state of their communication and inability to express accurate feelings contributed to, and exacerbated inaccurate interpretation and misunderstandings of each others' experiences and relationship needs.

Ironically, both Chakota and Aneka wanted and needed the same things; safety and trust. However, their poor communication, inability to express their emotion and relationship needs, and their emotional responses to the other's misinterpreted behavior left them immobilized by their hurt and anger. Chakota and Aneka's attack/attack stance, a common position among couples experiencing relationship difficulties (Satir, 1988; Johnson, 1999), was extremely destructive and volatile perpetuating an unsafe environment. Subsequently, their mutual stance of withdraw/withdraw left them disengaged, unapproachable and inaccessible for comfort and nurturing.

It was my belief that both Aneka and Chakota required a secure and trusting context in which to restructure their emotional responses and assert their relationship needs. Such mutual expressions would enable Chakota and Aneka to expand their experience and understanding of each other's needs. Empathic attunement would promote emotional engagement in a safe and trusting environment in which emotional responses and interactions can be restructured. Further to this, a greater understanding of each other's needs would lead to new, more adaptive responses, thereby altering the negative interaction cycle they were trapped in.

Beginning Phase

The beginning phase was quite brief, consisting of a single session. Within the first session, well-defined therapeutic goals were co-created. Given that collaborative efforts to work towards therapeutic objectives were initiated towards the end of the primary meeting, a natural transition was made to the next phase of therapy. Theoretical orientation within the beginning phase constituted a co-location of experiential and solution-focused approaches. An experiential approach was introduced at the onset in order to fully validate client experiences around the problem. However, due to client responsiveness and clinical objectives, a shift to a SFT stance was initiated, in the first session, and was maintained throughout most of this phase. Towards the end of the phase, clients responded well to the re-institution of experiential properties which were integrated within the SFT design.

SESSION 1

My primary goal at the beginning of the session was to join with Aneka and Chakota. My intentions, relying on an experiential frame, was to fully normalize and validate their experience so that they could feel valued, accepted and understood. In order to do this, I tried to give Aneka and Chakota as much time necessary to tell their story. However, talking about the problem seemed to engender a sense of negativity and pessimism. Aneka and Chakota began to point out and find fault with each other's behavior. Highly sensitive and reactive to negativity, Aneka and Chakota began to blame and accuse the other for their current relationship problems.

In order to avoid increased negativity and blaming, I shifted the focus from problem talk to solution talk (De Jong & Berg, 1998) to initiate a search for solutions. This SFT strategy was employed as an attempt to create hope and optimism and move away from unhelpful discussions

around the problem. By asking, "What would you like to happen in your relationship as a result of coming here today?", a future-oriented focus was established and the co-creation of therapeutic goals was initiated. Initially, Aneka and Chakota's goals were general and vague. Therefore, the miracle question (de Shazer, 1988, 1991; De Jong & Berg, 1998), "Suppose a miracle happened..". was posed to assist Aneka and Chakota in visualizing a detailed future free of the problem.

The miracle question created a positive connotation in which Aneka and Chakota were able to vividly co-imagine a future free of the problem. They became increasingly hopeful and optimistic as they collaboratively constructed therapeutic goals. Consistent with SFT guidelines for well-formed goals (De Jong & Berg, 1998), Aneka and Chakota's goals were realistic, perceived as achievable, and defined in concrete, behaviorally measurable terms. Their goals included improved communication, increased closeness and affection, finding "middle ground" and compromising on decisions and differences, and an increased sense of trust. Of specific and particular importance for Chakota was that Aneka would be more pleasant and approachable rather than angrily controlling and nagging. Aneka was hoping that Chakota would be able to gain a better understanding of her needs so that he could be more supportive and less insecure. Chakota and Aneka agreed that a major goal would be to put an end to the destructive fights.

Maintaining a SFT approach, we embarked upon a search for exceptions. In shifting their focus from the negative to an active search for positives resulted in several pleasant discoveries. Reflecting on the previous week, Chakota and Aneka were able to note a myriad of exceptions. To their surprise, their recollection reflected the description of their miracle picture. Employing the EARS process (De jong & Berg, 1998), I elicited, amplified and reinforced their personal

resources and strengths that led to the exceptions. As details were gathered in order to create a solution to their complaint, the possibilities for change increased with the discovery of so many exceptions. Chakota and Aneka's response to the SFT frame was exceptionally positive. They began to smile and laugh with each other.

Sensing an opportunity to increase the significance and meaning of the process, I introduced experiential properties within the SFT approach. A search for exceptions was continued, however, several of Johnson's (1996) experiential techniques (evocative responding, evocative questioning, heightening, empathic conjecture) were blended within the search for exceptions. This was done to incorporate emotions and expand upon deeper personal meanings and to create an intimate encounter between Aneka and Chakota. They shared with each other the personal significance of their individual efforts. This process went beyond a simple SFT cognitive/behavioral recounting of exceptions. It increased space for them to emotionally affirm, compliment, validate and acknowledge each other.

Therapist: Wow, so you made an effort, Aneka, not to nag or control Chakota? How did you do that? (*Exception question*).

Aneka: I'm trying to be better at controlling my anger . . . I know it's not helpful and it's not fair to Chakota or the kids

Therapist: How are you able to do that? Where does that control come from? (*Exception question*)

Aneka: I really care about the kids and Chakota . . . I appreciate that he works hard and let's me stay at home with the kids . . . and lately he's been helping out more around the house and with the kids.

Therapist: You appreciate that he works hard? (*Heightening*)

Therapist: Can you turn to Chakota and tell him that again? (*Promote engagement and Heightening*)

Aneka: I care about you and I appreciate you . . . Thank you for helping out more lately.

Therapist: Chakota, what does it feel like for you to hear that from Aneka? (*Evocative questioning*)

Chakota: It means everything to me... I like it very much . . . It feels good . . Thank you for saying that.

Therapist: It means everything to you? So, you appreciate hearing that?(*Heightening and Evocative responding*).

Therapist: What's it feel like for you, Aneka, when Chakota helps out without you asking? (*Evocative questioning)*

Aneka: It's awesome . . . I feel valued and respected, like he understands what I need . .

Aneka and Chakota became intimately engaged. Facing each other, holding hands and looking into each other's eyes they reinforced and affirmed each others' efforts. The search for exceptions uncovered many details, creating greater understanding on how to work towards their preferred future. I was surprised by Aneka's and Chakota's ability to connect so deeply and intimately. Indeed, this was one of their major strengths, and they were extremely responsive to the promotion of intimate engagements. Therefore, encouragement of such encounters whenever possible became an important therapeutic objective.

The scaling question (De Jong & Miller, 1995; De Jong & Berg, 1998) was employed to evaluate and maintain progress towards goals. This SFT technique was also helpful in identifying what small changes needed to happen to move up one point on the scale. With 0 being the worst things could be and 10 representing the miracle picture, Chakota and Aneka agreed that they were each at a 5. They also concurred that they moved up 2 points on the scale from the beginning to the end of the session. Aneka and Chakota reported that a value of 8 on the scale would indicate that therapy was no longer needed. Consistent with a SFT orientation, given the various detailed

exceptions, Aneka and Chakota were assigned observation tasks: "do more of those things that you know have been working".

Middle Phase

Given that therapeutic goals had been established and well defined and Chakota and Aneka were actively engaged in the pursuit of those goals, the therapeutic process moved to the middle phase. This phase consisted of nine sessions. Five meetings were conducted conjointly with Aneka and Chakota while four sessions involved two individual meetings with Chakota and two individual sessions with Aneka.

The theoretical orientation(s) utilized in the middle phase maintained an integrated ET-SFT approach similar to the latter part of session one. The individual sessions, however, shifted from a SFT framework, entirely, to a fundamental experiential stance. It was my understanding, in order to move beyond the emergence of an emotional impasse, a comprehensive assessment would be imperative. SFT, as stated, is governed by principles that are antithetical to a greater assessment of past relationships as they relate to underlying emotion and present relationship circumstances As experiential therapy holds past relationships and underlying emotions paramount in investigating present relationship positions, it was employed throughout conjoint meetings. When the couple was brought back together in sessions ET and SFT were re-blended in a technical, eclectic fashion, used simultaneously and mixed, on several different occasions, for the purposes of meeting clinical objectives and responding to client needs.

SESSIONS 2-4

Within the next several sessions Aneka and Chakota responded fovorably to both the SFT and ET techniques. Their gains were so great that they quickly reached their identified value on

the scale that signified therapy was no longer needed. However, Aneka and Chakota encountered a serious impasse that, if not dealt with directly, threatened to jeopardize the therapeutic process and positive relationship changes.

Sessions built on and complimented the first meeting. Chakota and Aneka reported great improvement in their relationship over several weeks. Focusing last session on the things that were going well in the relationship combined with efforts (following from homework) to "do more of what is working" had a positive impact on both Aneka and Chakota. Maintaining a blend of experiential techniques within a SFT framework, we continued the solution-building process. Throughout, Chakota and Aneka remained committed and intimately engaged as I facilitated several encounters in which they complimented, validated and affirmed each other's efforts. As stated, Aneka and Chakota responded exceptionally well to the promotion of emotional engagements. Therefore, the experiential process became a regular amalgamated component within the SFT EARS (De Jong & Berg, 1998) process as I elicited, amplified, and reinforced the details surrounding their efforts and successes.

SFT scaling questions (De Jong & Miller,1995) were a regular aspect of these sessions. Aneka moved from 3 to 8 on the scale. Chakota also made substantial increases on the evaluative scale, reporting that he had moved to an 8. Homework assignments were compatible with SFT behavioral tasks. Chakota and Aneka were encouraged to "do more of what you know is working". Further to this, we used the scale to develop mini-objectives which could be carried out in-between sessions. By asking, "What small thing needs to happen to move up, even half a point, on the scale?" Aneka and Chakota identified realistic actions they each could take that would move them closer to identified goals; their preferred future.

Towards the end of the fourth meeting, which was very upbeat, positive and successful, Chakota and Aneka came to a serious impasse. Aneka suggested that moving up one point on the scale would require that she be able to have a break from the kids so that she could have time alone and "reconnect" with herself. Chakota, who had been very supportive and accommodating to this point, was uncharacteristically resistant in understanding or supporting her need. Aneka became angry and resentful of Chakota's insensitivity and lack of understanding. Chakota responded by accusing and blaming Aneka for causing his insecurity and mistrusting behavior. Aneka and Chakota became increasingly negative and immobilized by overwhelming feelings of hurt and anger. Efforts to reconnect Chakota and Aneka and engage them in a process of empathic attunement were unsuccessful.

Attempts to continue discussion around the problem led to increased negativity. It was clear that the presenting issue, of which I had little information thus far, became an emotional stumbling block, tripping Chakota and Aneka as they worked towards a preferred future. In order to co-create a solution to this problem, it was necessary to engage in a more comprehensive assessment. Because of Chakota and Aneka's apparent stuckness and the tendency of this issue to evoke serious negative emotions, I suggested individual sessions with Chakota and Aneka. This was done to explore their individual perspectives and expectations regarding the emotional impasse that was blocking their forward motion. Because of the need to explore deeper meanings and emotion that were maintaining the block, a SFT approach was set aside to make room for a necessary experiential orientation.

SESSIONS 5-8

Chakota and Aneka were seen individually for two sessions each. They described the

exact pattern of negative interaction that existed in their relationship. Both Chakota and Aneka were extremely sensitive to the others' "bad mood". Any display of negativity or indifference would trigger an intense, seemingly irrational, emotional response with each of them. For instance, Aneka's indifference or anger would often provoke attempts by Chakota to placate or change her mood. As Chakota pursued, Aneka withdrew. As Chakota increased his assertiveness, he often became angry and hostile. His attack would often ignite Aneka's anger, causing her to counter the attack. Chakota's denigrations were often characterized by bringing up the past and belittling, or disparaging Aneka's personal qualities. Personal attacks regarding Chakota's character and inadequacies as a partner were commonplace within Aneka's arsenal of counter-attacks. Her last resort was to threaten to leave the relationship. The attack-attack stance often left Chakota and Aneka feeling alienated and alone. This resulted in their mutual withdrawal.

The past to which Chakota continually referred to involved a "rocky start" in the beginning of their relationship. It was a time when Aneka engaged in behavior of drinking, flirting and multiple break-ups with Chakota to return to ex-boyfriends. Further to this, Chakota had unfounded suspicions of Aneka's engagement in infidelity. These were some of the past issues that led to their recurring battles and relationship distress. Both Aneka and Chakota had a clear cognitive understanding of their fights, however, despite their efforts to change, they continued to be locked in the aforementioned cycle. Their intense emotional responses led me further to believe that we were dealing with an emotional issue. This position furthered my conviction that an experiential approach to Aneka and Chakota's sessions was necessary.

The goal of the individual meetings was to expand both Aneka and Chakota's awareness and experience of the emotions underlying the distinctive interactive cycle. This required an

exploration of past relationships and primary emotions as they related to their present dyadic circumstances. Consistent with most experiential approaches (Satir et al., 1991; Johnson, 1996, 1999) was the primary importance placed on safety and trust within the therapeutic context. According to Johnson (1996), creating a secure base for partners to explore relationship issues is critical to the change process.

Expanding Aneka's emotional experiences required an exploration of primary emotion, underlying her reactive response of anger; a secondary emotion. Aneka began to gain an understanding that beneath her anger existed painful feelings of hurt, fear, and worthlessness. She recounted a past childhood fraught with uncaring inattentive parents who were often drunk or engaged in violent behavior. Aneka experienced a variety of neglectful, abusive behavior as a child, resulting in feelings of low self-esteem and worthlessness. Aneka's sense of loss and sadness, which also fuelled her anger, was intensified following the tragic loss of her two only siblings earlier in her life. Relying on an attachment frame, a guiding principle within emotionally focused therapy (EFT) (Johnson, 1996, 1999, 2000), we understood that Aneka developed and was experiencing an insecure attachment from her early relationships. Two key messages that she learned about others and self were that she could not count on those closest to her for safety and nurturing, and that she was unlovable.

Individual sessions with Chakota entailed a similar exploration and an expanding awareness of his experiences. A key focus revolved around underlying emotion and past relationship experiences that created and were maintaining an insecure attachment. Chakota was aware of his insecurity and fear of losing Aneka, however, he came to understand how that fear had been intensified by previous experiences. Chakota revealed an estranged relationship with his

mother and siblings. His mother seemed inattentive to his needs, non-nurturing, and more interested in his older siblings. Much older than himself, Chakota's siblings did not treat him well, or want much to do with him. Chakota rarely felt comfortable or secure in his relationships with others. Further to this, Chakota was involved in two serous relationships which reinforced his insecure attachment, when each of those partners cheated on him. These experiences from past relationships contributed to feelings of fear, hurt and low self-worth. Chakota came to view others as untrustworthy and himself as unlovable.

Chakota and Aneka began to understand their behavior in a new context. Use of the attachment lens was helpful for them to reframe their experiences in light of past relationships and primary emotions related to their attachment needs. Using an attachment frame, Aneka's withdrawing behavior was viewed as a way to preserve or protect her self-worth. Her angry behavior was framed as a reactive secondary emotion that was overriding primary feelings of loss, fear, hurt and worthlessness. The aggressive outbursts of anger and threats to leave were understood as protective behaviors to avoid feeling the aforementioned vulnerable emotions. Aneka found it "easier" to resort to anger and be self-sufficient, a stance she found herself taking in past relationships.

Chakota's pursuing behavior was understood as his need to have accessibility to, and a response from Aneka. When she responded by withdrawing, his insecure attachment was reinforced, fuelling his attachment need for contact, comfort and safety. Unable to express his vulnerabilities and communicate his attachment needs, Chakota would become anxious, controlling, or demanding. Often, his need for contact was infused by fears of loss and would be expressed as anger. As Chakota's fear of rejection intensified, he protected himself from potential

hurt by bringing up the past. His hope was that reminding Aneka of her "inappropriate" behavior would lessen the threat that it may happen again.

Often, Chakota's angry behavior of bringing up the past and disparaging remarks would elicit, for Aneka, past feelings of worthlessness, hurt and fear of loss. For Aneka, Chakota's behavior was like "pressing a bruise on a broken bone", causing her to react aggressively. As a way to preserve her sense of self worth, Aneka would revert back to self reliance and threaten to leave the relationship. This was used as a final tactic to cease Chakota's attacks. Ironically, both Aneka and Chakota needed safety and trust in the relationship. However, their preoccupation with their own hurts and fears obscured their ability to understand each other's needs. Further to this, Chakota and Aneka's poor communication and inability to express primary emotion and attachment needs contributed to their perception and reaction to the other's behavior.

In individual sessions, Aneka and Chakota began to gain an increased understanding of their destructive pattern of interaction. They responded well to the EFT attachment lens. Both Aneka and Chakota were successful in uncovering and experiencing primary emotions as they related to their attachment needs for safety and security. By the end of session 8 they were prepared to share with each other newfound insights regarding their intra- and inter-personal discoveries made in individual meetings.

SESSION 9

This session built on the work accomplished in individual sessions. Consistent with Johnson's (1996, 1999, 2000) EFT approach, the main therapeutic purpose of this meeting was to access emotion in order to reframe and reconstruct Aneka and Chakota's negative pattern of interaction. Accessing Aneka and Chakota's emotions as they related to their inter-personal

processes was a crucial clinical objective. It was my contention that, simply talking about relevant emotions was not sufficient enough for significant relationship changes. Unlike SFT, a fundamental principle of experiential therapy is that emotion be evoked so that it can be expanded and worked with directly (Satir et al., 1991; Greenberg, Rice, & Elliot, 1993; Johnson,1996; Atkins, 1998).

In order to access and evoke the primary emotions operating beneath the surface of Chakota and Aneka's interactive pattern, I employed a sculpting exercise. Sculpting is not technique used within EFT, but is a common intervention used by Satir (1991). My intention was to evoke emotion immediately so that we could approximate the primary feelings contained within Aneka and Chakota's rhythm of interaction. I felt that simple recapitulation about the interaction would not recreate the necessary feelings that needed to be worked with directly. I asked Chakota and Aneka to take turns adopting various stances, body positions, and facial features which depicted and represented their destructive arguments. I invited them to comment on the feelings that were evoked in response to their partner's posture. The exercise promoted and fostered discoveries regarding the incongruencies between their partner's pose and the internal feelings underlying the sculpted surface. Taking turns sculpting postures that were indicative of their own attacking behavior, Aneka and Chakota learned of each other's emotions beneath the surface of the outward reaction of anger. They began sharing their subjective experiences revealing feelings such as worthlessness, loneliness, hurt, fear, and helplessness.

As emotional experience became accessible the EFT lens was reapplied so that Chakota and Aneka's past disastrous pattern of interaction could be reframed in light of their attachment needs. This process is consistent with Johnson's EFT stage of *de-escalation* (1996). Both were

familiar with the attachment frame within the EFT orientation from our work in individual sessions. Evoking relevant emotions assisted the couple to build on their insights gained in individual sessions. Aneka and Chakota were able to share their primary feelings, as they related to self and other, underlying their angry and damaging interactions.

Reframing their behavior and reciprocally reinforcing responses within an attachment lens created space for an accurate understanding of each other's behavior within their interactions. Both Aneka and Chakota began to understand each other's behavior in light of past experiences and unmet attachment needs. Rather than over identifying with and expressing anger and hostility, primary emotions and subjective experiences underlying their prototypical offensive reactions were expressed. Chakota expanded upon his constant pursuits in the relationship, which were originally perceived by Aneka as untrusting and controlling. This behavior was reframed in a context of his fear of rejection or loss of Aneka and need for positive reassurance of his worth. His aggressive and hostile behaviors were infused by fears of loss, which led to a protective defence against further rejection, loss and hurt. In Chakota's words he was "preparing for the inevitable"; betrayal and abandonment.

Aneka expanded upon her withdrawal from Chakota as a way to preserve her self worth and to avoid feeling misunderstood and devalued. Her own attacking behavior was reframed as a defence against Chakota's aggressive pursuits and hostility which often left her feeling worthless and unloved. Finally Aneka's perpetual threats to leave the relationship were understood as a way to protect herself from being harmed any further. Both Aneka and Chakota owned and expressed their attachment needs. They began to understand how unmet attachment needs and primary emotions activated their secondary reactions and reinforced the destructive negative interaction

they were both trapped in.

Expanding experience and expression of emotion and attachment needs is a necessary precursor in successfully altering interactional positions. Chakota and Aneka favored the metaphor, offered by Johnson (1996, 2000), of emotions as the music of the relationship dance. As they gained increased awareness of the music (emotions) conducting their dance (interaction), they were in a better position to evaluate and restructure the musical composition. This EFT process is known as *changing interactional patterns* (Johnson, 1996). Aneka and Chakota's revelations of each other's experience and commitment to change their subsequent responses were evidenced and articulated in several key remarks.

Chakota: I didn't see those things (*referring to Aneka's feelings of helplessness, worthlessness, aloneness*) before... I just saw anger...It (*his response*) would have been different if I knew how she was really feeling.

Aneka: I get angry...I fear that he stays with me for the kids...I feel unloved and alone when he is distant.

Aneka: (*Commenting on Chakota's worst fear; losing Aneka*)...I feel regret. I'm so sorry. I never meant to hurt you like that. I never meant for you to feel like this.

Chakota: I think we'll be able to handle the next disagreement or argument better.

Aneka: I'm willing to take the first step...I'm going to do something totally different next time.

Chakota and Aneka were beginning to initiate alternative responses to each others' needs. They were expressing themselves in a manner that created safety and reinforced a positive emotional engagement. Both Aneka and Chakota were more open and accessible, two elements which are key to establishing a secure attachment. Open, honest and congruent expression of emotions, increased awareness and understanding of relationship needs combined with mutually reinforcing efforts to be accessible for one another were necessary for the restructuring of

interactions. The remainder of the session was focused on promoting further articulation of Aneka and Chakota's relationship needs and the necessary responses required by each to meet those needs.

Aneka and Chakota were deeply engaged in the process of examining and restructuring their interactions. They both made commitments to use this newfound experiencing and responding from this session, and onward. It was their intent to continue accessing and expressing primary emotions and needs in a manner that promoted congruent communication, accessibility and reciprocal nurturance. Together, Aneka and Chakota co-created what "more appropriate" responses would look like in future interactions. At the end of this session they were well on their way to redefining restructuring interactions as they worked towards their preferred future, free of destructive fights.

SESSION 10 & 11

Review of the past several weeks revealed that Chakota and Aneka were feeling extraordinarily positive about their newfound understandings of each other and the subsequent "pleasantness" of their interactions. They both agreed that, "we successfully removed that stumbling block", referring to the transcendence of their unhealthy patten of communication and interaction. Given that Aneka and Chakota were moving beyond their emotional impasse I shifted back to a SFT stance. This decision was made for two reasons. First, Aneka and Chakota responded well to this approach in earlier sessions. Secondly, it was my intent to reinitiate forward motion towards remaining goals. However, because both Aneka and Chakota continued to respond well and intimately connect with the promotion of emotional engagements, I continually incorporated relevant experiential techniques such as evocative responding, evocative

questioning, heightening of emotion, and empathic conjecture within the SFT EARS process.

These sessions entailed a great deal of eliciting, amplifying and reinforcing efforts, successes, and personal resources in co-creating their referred relationship. SFT exception questions and the details around those questions were elicited to substantiate and fortify the rudiments of the emerging solution. The use of experiential elements within the EARS process facilitated a powerful emotional encounter in which Aneka and Chakota shared their feelings and the significant meanings their efforts had for each other. The engagement promoted reciprocal affirmations and validations which were crucial in consolidating and strengthening meaningful individual and relationship changes that had already occurred.

Scaling questions were also a regular component of these meetings. In session 10 Aneka and Chakota remarked that they were at an 8 on the scale, and by session 11, expressed that they were at a 9 and 8.5 respectively. They reported significant efforts and relationship changes which were consistent with therapeutic goals. Moreover, Aneka and Chakota's scaling representations exceeded the value of 8, a measure that they verbalized would signify that therapy was no longer necessary. These key factors led to my introducing the subject of termination and closure.

End Phase

Termination consisted of the final session. As discussed, Aneka and Chakota had successfully approximated, and actually exceeded, expected goals they had set from the beginning of therapy, thereby initiating a natural shift to termination. Given the positive response by this couple to the blended integration of SFT and ET components, the therapeutic construct represented a reflection of the last several sessions. Therefore, the final phase of therapy constituted the maintenance of an integration of ET components within a SFT framework. It was

important to conserve the intimate connection that had been fostered between Chakota and Aneka. I believed that continuing the promotion of emotional engagements, while cultivating and exploring feelings, regarding the significance of the changes, would enhance and consolidate such relationship modifications.

SESSION 12

Although we had planned for two more engagements this meeting was the last session. Chakota and Aneka indicated that they had reached all of their stated objectives, believed they were living their miracle picture, and did not need to attend counselling any further. Consistent with the SFT paradigm, a great deal of time was taken to review details around discovered exceptions, successes, and personal resources that led to solutions. Thorough examination and discussion around such details substantiated a type of resource inventory of the ingredients Chakota and Aneka needed to increase and maintain positive change. Scaling progress revealed that both Aneka and Chakota had exceeded their original projected scale value of 8. They both indicated being at a 9.9 on what they started to refer to as "the love scale".

Following a review of the manifested goals and objectives set for therapy, I reapplied the SFT EARS process. As I commended, complimented and affirmed their efforts contributing to the relationship changes, Aneka and Chakota were engaged in a physical (holding hands, almost sitting on top of one another, staring deeply into each other's eyes) and emotional intimate encounter. They shared appreciations, validations, and affirmations in expressing their thoughts and feelings regarding each other's efforts that made a positive difference in moving to their desired relationship.

Finally, before planning for possible setbacks and future challenges, my approach resembled Johnson's (1996, 1999, 2000) concluding step in the EFT process. This procedure "concerns the consolidation of the new more responsive position both partners now take in their interaction and the integration changes made in therapy into the everyday life of the relationship and into each person's sense of self" (Johnson, 1996, p. 146). Both Chakota and Aneka remarked that many of the new, positive ways of interacting have already begun to occur outside of the therapeutic environment.

Aneka and Chakota were engaged in an extended intimate encounter in which they validated each other's worth and the value of the relationship. They also reviewed and renewed their commitments to sustaining positive changes. I complimented both Aneka and Chakota on their efforts and shared my belief that they contained the individual and collective strengths and resources to continue living their preferred relationship reality.

Evaluation of Outcomes

The scaling questions employed throughout the intervention provided ongoing evaluation of progress towards target objectives. Goals were defined in concrete, behaviorally measurable terms which provided another informal type of evaluation. According to Aneka and Chakota they had reached all of their objectives defined at the beginning of therapy; their miracle picture. Aneka and Chakota felt that they had established an increased sense of trust and safety in the relationship. Both reported finding middle ground and were more compromising around differences and decisions. Because of a better understanding of their own and each others' needs, and better communication, they reported that there were less mis-communications or misinterpretations of behavior. There was an increase in positive interactions and time spent

together, as there was a substantial reduction in negative interactions.

Dyadic Adjustment Scale (DAS)

Aneka and Chakota's pre and post-test DAS scores are represented in Table 5-3 and Figure 5.3 . It is clear that the scores demonstrate significant improvements among all sub-scales and increased satisfaction overall. Both Aneka and Chakota's score changes represent considerable shifts from relationally distressed to non-distressed positions. DAS scores were compatible with reports made by the couple, that "every aspect of the relationship is better".

The greatest score changes occurred in the areas of dyadic consensus and dyadic cohesion, for both Aneka and Chakota. Among their greatest concerns, from the beginning of therapy were to gain a better understanding of each other's needs and to learn to find middle ground on opinions, discussions, and decisions. Meeting such targets would decrease arguments and the possibility of destructive confrontations. Therefore such changes were quite consistent with the scores represented by the relevant DAS sub-scales.

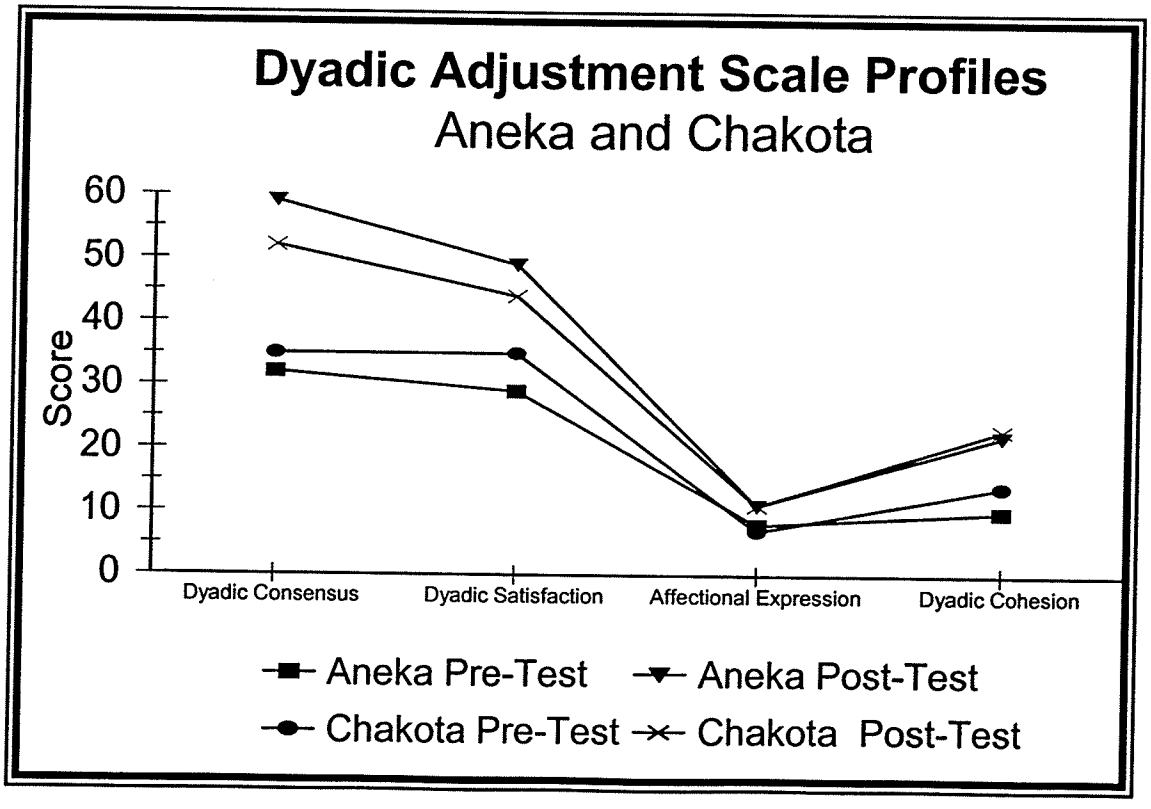
Chakota and Aneka scored the full range on the affectional expression sub-scale. This score was congruous with clinical observations of Aneka and Chakota's verbal and non-verbal affectional behavior. Towards the end of therapy Aneka and Chakota were completely and intimately engaged, often holding hands, sitting close, smiling, and staring deeply into one another's eyes. Occasionally Aneka and Chakota would remark on their increasingly satisfying sex life, and would often laugh and joke using sexual connotations and nuances in a flirtatious manner. As a matter of fact, Aneka and Chakota were "connecting" quite frequently outside the therapeutic context.

Table 5-3

	COUPLE "C"					
	Aneka		Chakota		Norm Scores for:	
DAS Sub-scales	Pretest	Post-test	Pretest	Post-test	married couples	divorced couples
Dyadic Consensus	32	59	35	52	52	35
Dyadic Satisfaction	29	49	35	44	41	22
Affectional Expression	8	11	7	11	9	5
Dyadic Cohesion	10	22	14	23	13	8
Total: Marital Adjustment & Satisfaction	**79**	**141**	**91**	**130**	114/115 (114.8)	70/71 (70.7)

* Total DAS *scores less than 101 represent distressed relationship functioning. Scores greater than 101 represent non-distressed relationship functioning*

Figure 5.3



Client Feedback

Chakota and Aneka's responses provided valuable information as to how they experienced therapy. Moreover, they clearly articulated, from their perspective, the most helpful aspects of the therapeutic encounter. Aneka and Chakota agreed that therapy was exactly what they both needed as it met all of their stated goals. They experienced the treatment as positive, flexible, and agreed that the one-on-one sessions were necessary and helpful in exploring past experiences to understand present relationship circumstances. Understanding the past as it relates to the present is a fundamental tenet of experiential therapy (ET). Aneka and Chakota felt they had a better understanding of each others' needs and wants, were communicating better, and were not attacking or hurting each other anymore.

While reflecting on many aspects of the experiential integration Aneka and Chakota also found aspects of the SFT approach beneficial. They found it very productive to set well defined goals, and to work towards those goals in almost every session. Further to this, they both responded well to the positive strengths-based nature of SFT.

Aneka: *Thank you for your positive focus...everything was positive, even in the tough times.*

Chakota: *Ya, you looked at the things that we were doing that were working, and not always looking at the bad stuff.*

Aneka and Chakota appreciated various aspects of both SFT and ET. Commonalities shared by both approaches, which I believe are among the core strengths of these methods are their constructive, client-cetered facets. Chakota and Aneka's feedback reflects, not only these factors, but touch on the importance of them within the integrated approach.

Aneka: *This was a lot better than the last therapist we saw...she told us what we needed...*

Chakota: *Ya, that's why I never went back...like she knew what was best for us...*

Aneka: *You let us decide what was important to us. That made a difference...you allow us to speak...you really got to know us.*

Clearly, the constructivist, strengths-based, client-centered approach allowed Aneka and Chakota to be the experts on their own lives. Fundamental tenets of both SFT and ET approaches, "made a difference" for Chakota and Aneka.

Both quantitative and qualitative methods of evaluation represent significant improvements in Chakota and Aneka's relationship. I am convinced that this particular therapeutic intervention was effective, and in a respectful manner, was successful in meeting the needs of this particular couple.

Case Synopses

Couple D: Mike and Sarah

Presenting Problem.

Mike and Sarah entered therapy following a discussion in which Sarah revealed to Mike her dissatisfaction with the state of the relationship. Mike was caught off guard, as he thought that "everything was fine". Sarah complained that she and Mike "had drifted apart" and no longer participated in activities together, nor were they any longer working as a team with familial responsibilities, or domestic chores. She also felt that there was an unequal distribution of the aforementioned life tasks. Both Sarah and Mike were working full-time, however, she was primarily responsible for the household chores and caring for the children, an immense task, as the kids were 13, 6, 5, and 15 months old. She was "feeling like a maid rather than an equal partner, or lover". Sarah was feeling as though she and Mike were growing apart, stating "we

don't know each other anymore, because I'm too busy to spend anytime with him". Mike was surprised to learn of Sarah's feelings and stated he was committed to "do anything to make the relationship work", especially if it made Sarah happy. Both agreed that Mike had "fewer" relationship needs than Sarah.

Theoretical Orientation/Therapeutic Intervention

Two major conditions guided my decision to utilize a SFT approach throughout treatment. Firstly, both responded favorably to the introduction of the miracle question and the positive, strengths-based search for exceptions that followed. Early on in our collaborative efforts we discovered a wealth of personal resources, strengths and past successes conducive to building solutions. Secondly, several attempts to integrate aspects of experiential therapy (ET) within the solution-building process (similar integrations were effective with couple C) were unsuccessful. From the initial session, and throughout, Mike and Sarah interacted and communicated with little affect, either positive or negative. They presented more as "thinkers" rather than "feelers", communicating thoughts rather than expressing feelings, often using phrases such as," I think... I thought.". rather than "I feel...I felt.". to voice their personal experiences. Efforts to promote emotional engagements, or intimate encounters to affirm each other's efforts, seemed to make them somewhat uncomfortable. I respected their perspective, ways of interacting, and manners of responding by maintaining the cognitive-behavioral orientation of SFT. Further to this, because the SFT frame seemed to be effective in moving Sarah and Mike to their preferred reality, there was less of a need to amend the therapeutic design.

Aside from periodic attempts to engage Mike and Sarah in a deeper emotionally meaningful experience, most sessions resembled a pure SFT approach (De Jong & Berg, 1998;

Hoyt & Berg, 1999). The first session entailed a brief description of the problem, the miracle question and the establishment of well-formed goals. This was followed by the continuous application of the EARS process, in which I elicited and reinforced exceptions in the co-creation of their preferred relationship. Scaling questions were used to establish a current relationship satisfaction rating and a value which would represent that goals were met and therapy was no longer required. Due to the number of exceptions to the problem Mike and Sarah were assigned a behavioral task and encouraged to "do more of what you know is working".

Consistent with the SFT paradigm, second and subsequent sessions built on the work done in the first meeting. The EARS process was continued as Sarah and Mike were affirmed and commended on their efforts to bring about positive change. Scaling questions were asked in each meeting to gauge the perceived changes towards their preferred future. Homework assignments, from meeting to meeting, involved behavioral tasks that were consistent with therapeutic goals and the successive steps required to meet those objectives.

Termination was initiated when Mike and Sarah reached their original scale values and felt that their stated therapeutic objectives were fulfilled. Both Mike and Sarah reported spending much more quality time together wherein they were able to talk, laugh, and get to know each other again. Sarah stated that she was feeling more like a partner and friend rather than a housekeeper and maid. Mike's efforts to contribute more to housework and childcare made a positive difference for both of them. Conclusion of therapy included a full review of the couple's personal strengths and resources that contributed to positive change. Sarah and Mike were complimented and affirmed on their efforts.

Outcomes

Sarah and Mike's DAS scores are presented in Table 5-4 and Figure 5.4 (Appendix D). The overall DAS score, and several sub-scale scores reveal changes that are consistent with client feedback and clinical impressions. Both Sarah and Mike experienced increased relationship satisfaction, which is evidenced in the overall DAS score. Sarah made the greatest individual gains on all sub-scales. She moved from a relationally distressed position to a non-distressed situation. This may have to do with the fact that she was more distressed with the state of their relationship, and she was the one who was most concerned, thereby initiating couples counselling. Mike was less distressed upon entering counselling and stated that he thought "everything was fine". Both Mike and Sarah's greatest sub-scale gains were in the areas of dyadic consensus and dyadic cohesion. Their score changes are consistent with mutual reports of positive changes with respect to increased time spent together and greater cooperation and teamwork around decision making, life tasks, and leisure activities.

Both Mike and Sarah agreed that they were living their miracle picture envisioned in the first session. Scaling progress and outcome was an effective method of representing positive changes and movement towards goals. In response to the feedback questionnaire, both Sarah and Mike agreed that therapy was exactly what they needed. They both appreciated the fact that they "could see change happening from sessions to session". They favored the organized structure of establishing well defined goals and "figuring out how to get there". It is my opinion, based on clinical impressions and client feedback that the intervention provided a valuable resource for Sarah and Mike in reaching their goals and meeting their relationship needs.

Couple E: Mark and Denise

Presenting Problem

Denise and Mark originally presented to therapy as being "slightly unhappy" with the state of their relationship. Overall, they remarked, the relationship was strong, but recently they were experiencing difficulties with communication and decision making around finances. The third session, however, revealed that there was a serious unresolved issue impacting both Denise and Mark. The concern that emerged was being triggered, as it was peripherally related to their original complaint.

Several years prior to counselling Denise's daughter, Mark's step daughter, made allegations of inappropriate touching that was sexual in nature. There was a formal investigation through the RCMP and Child and Family Services, Mark was removed from the home, and the family experienced isolation and loss of family members and close friends. Their individual and familial lives were impacted considerably. The investigations were inconclusive. Shortly after the investigation, the daughter moved out to live independently. Since that time Mark has not spoken to her, and Denise and Mark have not talked, at all, about the incident. They have tried to live, like it never happened. Because the daughter is almost eighteen, and the parents are no longer legally responsible for supporting her financially, Denise's concern about her daughter's well-being and finances precipitated the secondary crisis.

Theoretical Orientation/Therapeutic Intervention

The first two and half sessions were consistent with a SFT lens as Mark and Denise had a good idea what their problem was, were able to find exceptions to the problem, and set realistic well-formed goals for themselves. Exception finding questions were used within the SFT EARS

process to cultivate and reinforce, personal resources, strengths, and successes that contributed to solution-building. Scaling questions were also an aspect of these sessions. In the third meeting scaling progress towards goals revealed that they were quickly approaching identified objectives. However, when setting the next behavioral task that would assist them in moving even closer to their goals, we hit the aforementioned unresolved issue. It was like opening an intense emotion-laden can of worms.

Denise's goal, to communicate more openly about finances, shifted to include openly addressing financial issues concerning their daughter. This was Denise's way of introducing her need to talk more directly about the past incident, and the multifarious implications that ensued as a result, rather than "pretending like it didn't happen". Mark was clear that he did not want or need to talk about the incident. There was significant incongruence between Mark's verbal response and his non-verbal reaction. He began to shake, turn red, and fight back obvious tears. He was in a great deal of emotional pain. Increased negativity ensued as Denise demanded that Mark begin dealing with the issue.

Due to the significant emotional nature of the presenting issue, the theoretical orientation/therapeutic intervention shifted to an experiential paradigm. If this issue was going to be dealt with directly and effectively, a greater assessment around the problem was warranted. Further to this, consistent with an experiential paradigm, the therapeutic alliance would require fortification, and an atmosphere of safety, warmth and acceptance in order to provide a non-threatening environment to deal with the difficult and complex nature of the presenting issue. I suggested individual sessions in order to carry out above-mentioned experiential functions.

For Denise, individual sessions entailed the full validation and normalization of her

experiences. These sessions were emotionally intense as Denise released and shared pent up frustration, hurts, fears, feelings of loss, sadness and confusion. It became clear that her needs required substantial individual and family intervention, well beyond what I could offer. Individual sessions with Mark were also experiential in focus, however, we did not deal directly with emotions underlying the relevant past issue and its implications. Compatible with the goal to create safety, my objective was to validate Marks' manner of expression and his way of coping. Although mark did not want to deal directly with the issue surrounding his daughter, he was willing to try and support Denise's need to begin addressing the issue. Continuing to strengthen, to the greatest degree, the therapeutic alliance, I affirmed his strengths and reinforced his commitment to his family.

Both Denise and Mark gained an awareness of how the past incident, with their daughter, had been constricting their interactions, stifling communication, and limiting their intimacy. These were some of the dyadic, or inter-personal consequences. Realizing the need for individual and family counselling, Denise and Mark restated a new goal for the remainder of our work together; "we want to begin talking about this". Given the vague nature of their new target, I shifted back to a SFT approach in order to define well-formed goals that were behaviorally measurable. This was done using the miracle question, exception finding questions and scaling questions. The SFT shift was also helpful in moving away from dealing with intense emotional manners, that the couple was not quite ready to manage. The SFT method, with it's cognitive-behavioral orientation, and task centeredness, facilitated the accomplishment of such a therapeutic end. Moving little by little up the SFT scale assisted Mark and Denise to take small steps towards a very serious and delicate issue. The final session comprised a review of

objectives, planning for possible setbacks as I commended, complimented and affirmed their efforts to reach their goals. Denise and Mark believed that this was "just the beginning" and planned to seek individual and family supportive services to begin dealing with the "real issues".

Outcomes

Mark and Denise's DAS scores are presented in Table 5-5 and Figure 5.5 (Appendix E). Denise moved from a relationally distressed experience to a more satisfying, non-distressed relationship position. Consistent with self-reports and clinical impressions that Denise and Mark were talking more, communicating better, and making decisions together regarding supporting their daughter with finances and practical support, were the increases in the dyadic consensus and dyadic cohesion sub-scales. Interestingly, Mark's overall DAS score remained the same, however, there were changes among two sub-scales. There was an increase in the area of dyadic cohesion and a decrease in the dyadic consensus sub-scale. In light of Mark's increased activity and increased communication with Denise, the elevation of the dyadic cohesion sub-scale is congruous with Mark's reports and clinical impressions. My hunch concerning the decrease in the consensus sub-scale has to do with the difficult nature of the issues being discussed. It is less likely that there will be an increase in consensus given Denise and Marks' vastly different coping methods and ways of problem solving. It is my belief that consensus will be less forthcoming, until Mark and Denise gain an increased understanding of each other's needs.

In response to the feedback questionnaire, Denise reported that therapy was exactly what they needed while Mark felt that it was very helpful. Both agreed that they were communicating and beginning to understand each other's needs better. Denise and Mark agreed that one of the most helpful aspects of therapy was that the therapeutic context provided a safe place to "open

up". Mike appreciated that I did not "push too hard", and that I respected his way of coping with the issue. Although the DAS did not exhibit remarkable changes for Mark as it did for Denise, he did state, however, that he achieved greater relationship satisfaction. The intervention appeared to provide Denise and Mark a respectful and valuable resource for activating relationship change and meeting their needs.

Couple F: Bob and Terri

Presenting Problem

Bob and Terri presented to therapy confused and uncertain about the future of their relationship. Several months prior to counselling, following Terri's suspicions of infidelity, Bob disclosed his second affair. Terri was immobilized by anger and confusion. She was uncertain as to whether the relationship was salvageable. Bob took full responsibility for engaging in the extramarital relationship, however, he insisted that he did not know why the affair occurred. Bob was committed to doing "whatever it takes to repair the damages from this mistake". Terri was stuck in a perpetual state of anger and obsessiveness, demanding to know for certain why and how the affair happened. Terri was having difficulty concentrating on anything other than thoughts and facts surrounding the affair. It began to seriously disrupt her family and work life.

In interactions with Bob, Terri perpetually demanded an explanation for his actions. Simultaneously, she bolstered her attacks by letting him know how angry she was, and constantly reminded him how he had ruined their lives. Terri's attacks resulted in Bob becoming defensive, angry, frustrated and withdrawn. This interactive pattern constrained their interactions, limited intimacy and obstructed effective communication; essentially denying the necessary elements in

successfully working together, through their difficult circumstances.

Further exploration also uncovered important facts about past experiences, that contributed to poor self-esteem, and an ineffective capacity to acknowledge and deal directly with difficult emotions, painful situations, and inter-personal conflict. Terri often subjugated her own needs to meet the needs of others. Family rules and early life experiences contributed to her own way of denying, or under regulating her emotions, and set the stage for avoiding inter-personal conflict. We also discovered that Bob's past experiences limited his ability to develop a strong sense of self. He avoided paying attention to his own needs as he was determined to keep others happy as he worked diligently at presenting an image people liked. This limited Bob's capacity to tune into his own needs, or communicate and express emotions openly and honestly. Like Terri, Bob also learned to avoid conflict.

An understanding that we co-created, well into therapy, was that it appeared Bob and Terri's past experiences led to relationship interactions that limited and denied true expression of thoughts and feelings. Further to this, their inability to express differences and deal effectively with conflict may have also contributed to the creation of a "gap" in the relationship, which "permitted" the affair to occur.

Theoretical Orientation/Therapeutic Intervention

A clear rationale existed for my application and utilization of an experiential orientation at the start and largely throughout the duration of therapy. There were, however, several occasions in which SFT components were blended within the ET procedure in order to effectively meet clinical objectives.

An ET lens is necessary in dealing with a multifarious issue such as infidelity. Infidelity is

unequivocally an emotional issue (Brown, 1991, 1999). Failure to apply an ET framework would undoubtedly obscure and miss the reality of the complex nature of such an emotional-loaded incident. Further to this, empirical and theoretical scholarship (Glass & Wright, 1985; Imber-Black, Roberts, & Whiting, 1988; Lawson, 1988; Pittman, 1989; Brown, 1991, 1999; Freeman, 1992; Kaslow, 1993) regarding infidelity confirm its diverse and complex nature and attests to the intricate, complicated set of subjective intra- and inter-personal realms of experiencing.

Concomitantly, there were several important reasons, SFT was not adopted as the primary theoretical model. Firstly, given the complex character of adultery and the need for a thorough assessment surrounding the issue, SFT's priority on brevity and movement away from talking about the problem would be insufficient. Secondly, a successful SFT search for exceptions is built upon problem-free times when the relationship was experienced as satisfying. The most recent affair lasted twenty-two months, during that time Terri's reality of relationship trust, honesty, and loyalty, within the dyad, were an illusion. Trying to build solutions from recent relationship satisfaction and problem-free times would prove difficult, as many of those times were characterized by Bob's lies and deceit. Finally, SFT is not conducive to working with emotions directly, nor is it effective in building a strong, safe, and trusting therapeutic alliance; necessary therapeutic elements when dealing with a sensitive and complex issue as infidelity.

Terri's general goal was to gain an understanding as to how and why Bob engaged in an affair, so that they could make the necessary arrangements to avoid future incidents'. However, meeting that goal would require that Terri and Bob work together. As long as they were trapped in the aforementioned interaction that left no space for expression of emotions and needs, honest, open communication and intimacy, they would not be able to move through their difficult

predicament. Further to this, Terri really needed and wanted Bob to understand the anguish that he had caused her. Her experiences needed to be affirmed and validated. Until this happened Bob would not be able to restore Terri's faith and respect for him, which was necessary to begin rebuilding relationship trust.

This would call for an awareness of self and one's own needs, expression of emotions, clear and honest communication, empathic attunement, and validation and affirmation of expressed needs and desires in a safe, trusting and respectful environment. Given their past experiences and poor functioning in the aforementioned areas, Bob and Terri required individual sessions in preparation for emotionally engaged encounters in which they could begin dealing directly with the issues that resulted from, and led to the affair.

Terri's sessions entailed an intensely directed focus on her self and her own needs. Relying on Greenberg's emotionally focused therapy (Greenberg, 1993; Greenberg & Paivo,1997) we concentrated on shifting Terri's preoccupation with anger, blaming and intellectualizing about the affair to focus on her underlying emotions and the painful feelings she was trying desperately to avoid. Before she could succeed in having Bob understand her pain, she was going to have to understand and fully experience it herself. An intense and lengthy experiential process was undertaken wherein underlying emotions were evoked and symbolized in a way that Terri began to gain a greater understanding of her painful experience and needs. This process was empowering as it affirmed, validated, and strengthened her sense of self.

Individual sessions with Bob involved a thorough exploration of his sense of self, past relationships, family of origin rules, and other areas. Together we tried to gain a greater understanding of the "gap" that existed in the relationship which permitted the affair. During

Bob's sessions I educated him on Terri's experiences and needs. I also tried to help Bob understand the dire necessity to rebuild trust and safety within the relationship. Preparing Bob for the difficult process of hearing, understanding, and working through Terri's raw emotions was an important aspect of our work together.

When we reconvened conjointly I worked diligently at creating a safe, respectful and trusting environment, conducive to the honest, open expression of thoughts and feelings and relationship needs. We worked at levelling communication (Satir, 1988, 1996), so that it was congruent, meaning expressing outwardly what they were feeling on the inside. We also concentrated on expressing underlying primary emotion (Greenberg, 1997; Johnson, 1999). Several intense experiential encounters were facilitated in order to meet the abovementioned clinical objectives.

Once Terri worked, almost cathartically through her anger, which was directed towards and in the presence of Bob, she was for the first time able to share the depth and magnitude of her pain, the loss, betrayal, fear, embarrassment, and humiliation, among dozens of other newfound feelings and emotions that existed beneath the anger. Bob was able to reflect back her impassioned message until she felt that he truly understood, validated and affirmed her experience. As trust and respect began to be reestablished, and Terri was able to move beyond her anger and constant, aggressive demands for Bob to explain himself, greater room was created for connectedness and renewed intimacy. Terri began to allow Bob to comfort and sooth her. They began to express honest feelings and relationship needs openly. As safety, trust and respect increased within their dyad, they began to take greater risks in expressing differences and chancing vulnerability. They became better able to work as a team in understanding the

relationship dynamics and experiences that may have led to the affair.

A major transformation occurred regarding Bob and Terri's perceptions, expectations and experiences of self and self in relation to the other. Terri became less fixated on finding out exactly why the affair had happened. For both Terri and Bob treatment goals shifted to creating a new type of relationship where there was trust, honesty, comfort, and safety. Because many goals created using an ET paradigm are general, vague, and individually subjective, SFT components were incorporated to facilitate the development of concrete goals whereby Bob and Terri could vividly define their new preferred reality. For instance, the miracle question was posed and questions such as, "what will trust look like?...what will be happening when things 'feel right..feel safe'?", "what needs to, or will, be happening for you that will tell you things are better, this isn't going to happen again?", helped define behaviorally measurable targets that would indicate movement towards, and the accomplishment of stated objectives.

SFT exception finding questions were also blended into many of the emotional encounters and experiential exercises (levelling of communication, family chronology and family maps), in order to draw out details around individual efforts and personal strengths that led to positive change and moved them towards their miracle picture. A variety of experiential questions and techniques were blended with exception finding questions. Responses to the amalgamation of exception questions and evocative conjectures like, "...wow Bob, how were able to sit through Terri's expressions of intense negative feelings and disappointment in you as a husband and father? That must have been painful and difficult for you. What was that like exactly?", were integral in gaining access to solution building elements such as personal resources, strengths and successes. Further to this, the experiential component created access to and awareness of deeper

emotional meanings and created greater opportunity for validating and affirming valued efforts.

SFT observation and behavioral tasks were integrated into the ET orientation. Homework tasks were often geared towards encouraging Terri and Bob to observe or recreate behavior that was consistent with their goals. Reviewing assignments provided rich solution building materials as the SFT EARS process was used to elicit, amplify, and reinforce their efforts and successes. The use of SFT scaling questions were beneficial in scaling progress towards goals. Incorporation of the SFT components seemed to increase forward motion towards goals, and also contributed to the ET process in producing a variety of successes that could be validated and affirmed.

Outcomes

Bob and Terri completed the DAS and the feedback questionnaire as a mid-term type of evaluation partway through the middle phase of therapy. Before the project was initiated, they were aware that they would leave the community before the end of the scheduled practicum, and would return at a later date. We contracted to continue our work together, even after the project was complete. Bob and Terri called upon their return to the community and stated that they were doing better than they had imagined, and believed that they were "headed in the right direction", and no longer required formal support. She reported that they were continuing to talk more openly and honestly and were learning a great deal about each other and their relationship.

Terri and Bob's DAS scores are presented in Table 5-6 and Figure 5.6 (Appendix F). Terri made an increased gain in overall relationship satisfaction. Her reports of increased satisfaction and greater communication regarding emotional issues are compatible with an elevated score on the dyadic consensus and dyadic satisfaction sub-scales. Bob's DAS score decreased overall. This was perplexing as Bob described an increase in general satisfaction with

the relationship. The DAS sub-scale scores, however are consistent with his declarations that he was enjoying more time with Terri, but admitted he was still uncomfortable talking about some areas, and was not in agreement with some of Terri's conditions. For instance, Terri felt that Bob should tell his parents about the affair, and he was not yet willing; still a source of much contention.

In response to the feedback questionnaire both Bob and Terri agreed that therapy was exactly what they needed. Terri stated that the individual sessions were valuable. She shared, "I needed to get in touch with my feelings". They both found it helpful to begin talking openly and sharing feelings. Bob remarked, "it's a breath of fresh air to say how I feel". Terri and Bob acknowledged that they were gaining a better understanding how past experience and subsequent relationship circumstances allowed room for the affair. For them it was "just the beginning", but they felt that the intervention was an exceptionally valuable resource.

Couple G: Sherri and Tom

Presenting Problem

Sherri and Tom presented to therapy extremely disillusioned and distressed. They were extremely negative and critical towards each other, stating that, "there is no more trust, or good things left in this relationship". Sherri complained that Tom was controlling and uncaring. Tom criticized Sherri for being manipulative and untrustworthy. They accused each other of being insensitive and uncaring and agreed that they could "never talk to each other without getting into a fight". Their arguments were intense and destructive, and although they were not violent, they were emotionally and verbally abusive.

Further along in our work together, fuller assessment revealed that Sherri was struggling with some serious individual issues that were complicating the relationship. Sherri was contending a long history with severe depression, she was drinking everyday, and was borrowing or stealing money to play the slot machines. As stated, serious addiction issues are contra-indicated for effective marital therapy. As soon as the reality and seriousness of Sherri's addictions emerged, plans were discussed to refer Sherri to more appropriate services.

Theoretical Orientation/Therapeutic Intervention

Given the extreme level of hurt and anger both Tom and Sherri were experiencing, an ET frame was applied for the purposes of fully validating and normalizing their relationship struggles. Further to this, the ET design was employed at the beginning in order to join, develop a safe and trusting environment, and to strengthen the therapeutic alliance. Discussion around the problem, however, produced intense negativity of criticism and blame, heightening negative feelings and anger. The arguments were destructive, overwhelmingly volatile, and hurtful. The ET approach was not beneficial.

A quick shift was made to a SFT stance in order to move away from unhelpful discussions of the problem, towards solution talk. It was my intention, in applying the SFT frame, to move Sherri and Tom towards a positive collaboration wherein they could envision a future free of the problem. The theoretical shift made a difference for Sherri and Tom as a sense of hope and optimism was engendered. In response to the miracle question, Sherri and Tom were able to set goals as they envisioned their preferred relationship. A search for exceptions was embarked upon with application of the SFT EARS process. Exceptions, however, were not readily available. Given this circumstance, a SFT observation task known as the Formula First Session

Task (de Shazer et al., 1986) was employed which encouraged Sherri and Tom to shift their focus from the negative things happening, to look for the things in the relationship that they appreciated and wanted to have happen more often.

Upon return to the next session, Sherri and Tom "were doing worse". They were intensely negative and pessimistic about the future of their relationship. They could not interact without attacking or hurting each other. They became immobilized by their hurt and anger. Attempts were made to continue with a SFT frame in order to reinstate some of the hope they were feeling from the last session. I applied SFT coping questions (De Jong & Berg, 1998) in order to search for exceptions, no matter how small. Questions such as, "How have you made it this far?....How come it's not worse than it is?", were used to uncover several relationship affirmatives. Responses such as "Well, I still love him..." and "it's not always this bad..." created space for a positive connotation. It was at this point I shifted back to an ET frame in order to build on the positive moment. I spent a great deal of time validating and affirming their experiences. I normalized their hurts and anger and attempted a dialogue in which they could begin to do the same for each other. Sherri and Tom were still too preoccupied with their own needs, to be acknowledged and understood, that they were not able to give what their partner needed. Because Tom and Sherri were stuck and unable to hear or acknowledge their partner's needs, I suggested individual sessions.

Individual sessions were suggested for several reasons. It was necessary to give each Sherri and Tom individual time to be heard, affirmed, validated and understood. They each needed this desperately. It was my contention that, until their feelings are validated, they were going to be unable to move beyond their hurts and anger and unable to connect intimately. A safe

and trusting engagement was a necessity for effective communication and working together on relationship issues. Strengthening the therapeutic alliance between Sherri and Tom was also important. Further to this, individual sessions would give them time to tell their story without attacks or interruptions from their partner. Therefore, in order to accomplish the aforementioned clinical objectives, individual meetings, maintained an ET orientation

Tom's sessions consisted of an ET frame with SFT components. For instance, my attempts to validate, normalize and affirm Tom's experiences, included a blend of SFT coping questions to simultaneously search for exceptions that were consistent with his goals. Tom responded well to the SFT approach. Increasingly positive and motivated I employed the SFT EARS process and elicited, reinforced and affirmed newly discovered strengths, personal resources and successes. Tom was feeling positive and hopeful about reconvening sessions with Sherri. He did, however, suggest that she was struggling "with demons" despite some of his best efforts.

Sherri was less optimistic than Tom. I maintained an ET orientation in her individual sessions. Her meetings revealed that she had a history of serious depression. She was non-compliant with her medication, which she stated, "causes me to do things I wouldn't normally do". Further to this, Sherri expressed her recent on-going struggles with alcohol and gambling addictions. She stated that her relationship problems would probably not exist if she was able to deal effectively with her individual afflictions. She agreed, "these are the 'demons' that Tom referred to.

Tom and Sherri agreed that they were not able to deal directly with relationship, given the seriousness of Sherri's personal issues. They understood that even their best efforts to work on

the relationship were being complicated by the addictions and Sherri's depression. Their goals shifted to how they could best support Sherri to begin getting her needs met. They were agreeable to putting their relationship on hold, to just cope and maintain, until they both had the strength for the necessary couple work. Understanding the limitations of the support I could provide as a couples therapist, in the seventh meeting, we contracted for several more sessions to plan for and refer Sherri and Tom to appropriate individual services.

Outcome

Tom and Sherri did not return following the seventh session. Follow-up contact was unsuccessful, therefore, the DAS post-test and the feedback questionnaire were not completed. It will be impossible to ascertain the reason for Sherri and Tom's unwillingness to return to counselling. However several assumptions were made based on clinical impressions. Their DAS pre-test scores are represented in Table 5-7 and Figure 5.7 (Appendix G). The level of their distress was quite serious upon entry into therapy. Moreover, it became clear that there were serious individual issues that needed addressing before relationship problems could be considered. It seemed as though that even their best relationship efforts were being undermined and complicated by the individual troubles that existed. Further to this, Tom and Sherri stated early in therapy that they have seen counsellors in the past, and failed to return when they thought they could mange things better on their own. Finally, the fact that they failed to show up for five of their scheduled appointments, leads me to believe that even from the beginning they were struggling to make it to our sessions. I can only hope that Sherri and Tom found the necessary support that they were searching for.

CHAPTER SIX

Reflections on the Practicum Experience

This chapter delineates my experiences and insights gained throughout the practicum encounter. In reviewing established practicum objectives I will expound upon the theoretical and practical application of the SFT-ET integration. I will provide a clear rationale for various theoretical and technical shifts that occurred in practice, with clients, throughout the application of the integrated model.

Given the ease of both the theoretical integration and the practical amalgamation, I begin to refer to the SFT-ET paradigm as the solution oriented experiential (SOE) approach. Strengths and limitations of the SOE design are offered, and in light of favorable outcomes the design is compared to current theoretical, empirical and clinical research and offered as a very efficacious model of couples counselling. A discussion of future efforts needed to further develop and apply the SOE approach as an effective modality for couples seeking therapy is presented. Finally, a brief discussion is provided pertaining to the practicums relevance and contribution to social work practice.

The integration: From Theory to Practice

The theoretical proposition outlined at the beginning of this endeavour postulated a flexible client-centered integration of solution-focused (SFT) and experiential therapy (ET) in the context of couples' counselling. It was the general goal of this project to theoretically develop and present the approach and to demonstrate its applicability and effectiveness in practice. Because this particular integration had not been attempted before, developing the theoretical

component was formidable, as it was difficult to envision. However, as the theoretical construct emerged, the complementarity of the two paradigms became increasingly evident.

At first glance, they appeared contradictory in their respective theoretical orientations and methodological and technical procedures, however, they in fact shared many commonalities with regards to their underlying assumptions and core beliefs. Both approaches share the belief that human beings are motivated and have necessary personal resources to change. SFT and ET are strength-based, constructivist, client-centered approaches that adopt a collaborative therapeutic stance in which clients are experts on their own lives and experiences. When fundamental core values are similar, a successful integration of two approaches becomes increasingly possible. Further to this, as anticipated, the limitations or deficits of SFT were enhanced and elevated with the integration of ET, while ET weaknesses and limitations were complemented by SFT elements.

The theoretical integrated construct presented was confirmed in practice with all seven couples. Because couples present with a variety of complex problems, have unique experiences, and organize emotions and experiences in a variety of ways, the theoretical construct presented in chapter three was developed and organized to be sensitive to those relevant domains. It is understandable then, that the practical application of the integrative model was just as diverse and complex as the clients with whom it was applied. Given this practical reality, the different ways SFT and ET can be integrated were, and are, limitless.

However, even though a unified model of integration could not exist, practical, theoretical, and empirical markers emerged during the application of the integrated approach. It was these process indexes that supported a rationale and justification for shifting gears from one

theoretical orientation/intervention to the other, or designated a synthesized integration of both SFT and ET methodologies. It is important to note that treatment decisions such as choice of orientation, integration, and specific SFT or ET techniques were arrived at based on several key factors which formed the contents of the treatment indicators. They were: (1) the needs and goals of couples and the individuals within the couples (2) the response of clients to a particular theoretical orientation or therapeutic intervention (3) clinical objectives.

Clinical objectives represented either client, therapist, or client-therapist goals, and a given theoretical set that guided initiatives, techniques, or exercises. Theoretical sets arose from clients' experiences, needs, goals, and responses, and from a combination of my personal practice experience and relevant theoretical knowledge. Given the collaborative, client-centered nature of this approach, continuous efforts were made so that couples understood and consented to the process, content, and various methods and techniques of therapy. This process was helpful in limiting hierarchy and sustaining the status of clients as the experts; knowing and feeling what was important for them. Further to this, the collaborative, co-creation of the clients' reality in this manner ensured that I was fitting theories onto people and not forcing clients into theories.

As stated, the decision to shift gears, to integrate or maintain a specific methodological approach was primarily dependent upon the aforementioned key therapeutic indicators. A secondary set of factors emerged within the integrated approach that were serious constituents in treatment decisions. It was the limitations and strengths of the SFT and ET approaches that formed the auxiliary component, in conjunction with treatment indicators, for most therapeutic choices and, in essence, comprised the complete rationale for shifts in theoretical orientation, or integration of interventions, methods and techniques (See Figure 6.1).

Figure 6.1

Primary Constituents in Treatment Decisions

1) NEEDS AND GOALS OF COUPLES

- What do clients want?
- What is important to clients?
- How do they communicate and organize their experiences?
- Do they need to see results? Are they patient?
- What is the trust level?
- To what extent do they need to be validated and affirmed?

2) RESPONSE OF CLIENTS TO PARTICULAR THEORETICAL ORIENTATION/INTERVENTION

- Are they responding favorably/unfavorably to a particular approach?
- What is the rapport like? Is the therapeutic alliance strong?
- Do they prefer cognitive, emotional, behavioral approach, or combination?

3) CLINICAL OBJECTIVES

Client, Therapist, or Client-Therapist Goals

And

Given "Theoretical Set" (*Theoretical sets arose out of a unification of clients' experiences, needs, goals, and responses combined with my personal practice wisdom and relevant theoretical and empirical knowledge*)

Secondary Constituents in Treatment Decisions

1) SFT LIMITATIONS AND ET STRENGTHS

2) ET LIMITATIONS AND SFT STRENGTHS

While navigating through the theories to meet client needs, goals, and clinical objectives, the various limitations of SFT and ET encouraged a shift to the strengths of the respective orientations. Many of the limitations and strengths of both SFT and ET models, presented in chapter two, were revealed in my work with all seven couples. An attempt in adhering to a uni-modal approach of either SFT or ET would have proven ineffectual given their respective limitations and constraints. This actuality further reinforced the necessity for integration.

A significant weakness experienced with SFT was its assumption that little information needed to be known about the problem in order to find a solution. All of the cases, but couple "E", required a greater understanding of the problem, intra-personal emotions and experiences, and inter-personal dynamics including an assessment of how past experiences and emotions were impacting current relationship functioning. The ET frame was essential in complimenting this particular SFT limitation. The ET adaptation provided necessary theoretical knowledge and techniques, from the approaches of Satir, Johnson, and Greenberg, to successfully manoeuvre through necessary therapeutic areas of investigation and intervention.

Often complex emotional issues such as infidelity, unmet attachment needs, emotional suppression, low self-esteem, trust, abandonment, and lack of inter-personal safety were presented and were blocking couples' forward motion towards goals. Given that the SFT model focuses on cognitive and behavioral issues at the exclusion of emotions and greater client experiencing, the introduction of ET was a fundamental component in dealing with such intricate inter-personal issues. For instance, couples "A", "B", and "C" experienced serious emotional impasses in our collaborative efforts to co-create solutions. Clearly SFT did not contain the theoretical or technical capacity to deal with the emerging difficulties. It was clear that past

experiences and emotions required serious consideration in order to effectively work through emotion-laden blockages.

Further to this, on numerous occasions, clients clearly needed to be heard, validated, and understood before they could begin to focus on the future or initiate the development of goals for therapy. The SFT method of moving clients, as quickly as possible, from talking about the problem towards a positive solution-focused future orientation was inefficient at these particular times. Often times clients were unable to look beyond their presented problematic experiences, until they felt listened to, validated and their experiences normalized and affirmed. The ET orientation was integral in interceding and attaining such therapeutic ends. Continuous application of the SFT process, when client emotions and experiences relevant to their problematic circumstances required attending, may have been to the possible detriment of clients and may have seriously jeopardized the therapeutic alliance.

Of significant importance to note is that recurrently, particular SFT weaknesses were indeed strengths at different points in the integration, either with the same couple as needs and goals shifted, or with different couples. For example, with several couples, "B", "C", and "F" in particular, and to a lesser degree with couples "A", "D", and "G" , discussion and assessment around the problem, including pertinent emotions and experiences, in actuality, became negative, unproductive, volatile, and at times seriously destructive. It was at these moments in therapy that a SFT orientation was introduced to shift client focus away from unhelpful dialogue pertaining directly to the problem to a more positive, problem free, future orientation. These shifts of focus were integral in decreasing negativity and created a sense of hope and optimism that things can be better. Once a positive atmosphere was established, greater room was created to re-introduce

ET components. As the positive ramifications of the SFT elements permitted couples to feel better about each other and their relationship, they were subsequently more receptive to intimate engagements and productive discussions around the problem.

In another instance, the SFT method of central focus on cognitive and behavioral aspects of client functioning to the exclusion of their emotions and experiential processes was deficient in meeting the needs for most couples. However, this specific SFT deficit became a valued strength when utilized with couple "D" and couple "E". In order to meet the needs of these particular couples, it was important to engage them in their particular manner of communicating, organizing their experiences, and problem solving. Couple "E" were very cognitively and behaviorally oriented in their way of interacting and organizing their experiences. They were more "thinkers" and "doers" rather than "feelers" and were unreceptive to experiential engagements or encounters. They responded favorably to the task-centeredness and cognitive-behavioral aspects of SFT. ET components were only integrated to the extent necessary to fully validate and affirm their perspective and experiences. The monitoring and strengthening of the therapeutic alliance was also an important ET consideration with this couple.

Mark, of couple "E", found the ET focus on his emotions threatening, as he was yet not able to deal with past or present painful and distressing experiences. The cognitive-behavioral, non-emotional focus of SFT served as a strength for Mark, as conserving a detachment from painful emotions and uncomfortable experiences, respected his way of coping and also preserved his sense of safety and trust within the therapeutic domain; a necessary element contributing to a strong therapeutic alliance that increased the prospects that Mark may eventually risk vulnerability. Adhering to the ET process, and demanding that Mark to risk more than he was

able to would have seriously ruptured the therapeutic alliance thereby undermining a significant ingredient in the change process.

Another area in which the ET approach was experienced as limiting was with respect to goal setting. For instance, the ET framework gives primary attention to clients' experiencing and emotions which are often analogous to vague and subjective goals such as trust, love, comfort, respect, closeness, etc. Such global objectives are difficult to define and measure, which creates challenges in approximating or working towards definite therapeutic ends. The SFT formula for well-formed goals provided a remedy for overcoming the challenge of vague and global goals. All goals were defined in concrete, behaviorally measurable terms, they were observable, tangible, and realistic to clients. Further to this, multiple targets constituting smaller steps within the overall goals were clearly defined so that we could conceive movement towards therapeutic objectives. Moreover the SFT approach to goal setting and solution building permitted a clear understanding of how and when goals were being accomplished.

Finally, I personally experienced a limitation to the ET approach, that may or may not have directly impacted clients. Because clients' emotions and problems can be so diverse and complex, the reality of fully understanding and successfully navigating through them consistently and confidently, without periodically feeling lost, is unlikely. If I was unable to overcome this limitation clients and I may have found ourselves "lost" or "stuck" in the process of therapy. Occasionally, clients and I were mired in negative, unhelpful problem talk, or became overwhelmed by a multiplicity of complex and powerful emotions. These moments fortunately were few, however, they did complicate or cloud our treatment initiatives. It was sometimes difficult to discern which explorations of the problem, or which emotions and experiences were

helpful and which ones were unhelpful in working towards our therapeutic ends.

Well formed goals brought about by the SFT goal setting process were helpful in countering the emotional abyss and problem saturation occasionally induced by the ET paradigm. Keeping our sights on well defined future-oriented treatment goals was fundamental in firmly grounding one foot in concrete therapeutic ends as I entered the clients' intricate emotional worlds. Consistently asking myself and clients, "how is this helpful" and invariably monitoring how certain emotional and experiential expeditions were related to therapeutic objectives, facilitated forward motion to couples' preferred reality.

Three distinct SFT components within the integrated approach were experienced consistently as strengths, with either individuals or couples, and regardless of stage or phase of therapy they did not pose barriers to effective treatment. Additionally, these specific SFT facets blended consistently and remarkably well with the ET components. They were: (1) the SFT search for exceptions (2) the SFT EARS process (3) observational and behavioral homework tasks. The positive therapeutic atmosphere generated by SFT formulations proved an effective ingredient that was likewise a significant strength.

Exception finding was carried out throughout all aspects of the integrated approach, regardless of stage, phase, or theoretical feature. Exceptions to problems were discovered within every case and were used as integral ingredients within the solution-building process. It is important to note that exceptions were cultivated beyond the orthodox SFT domains of cognition and behaviors to include significant areas of emotions and meaningful client experiences.

The SFT EARS process was perpetually utilized to elicit, amplify and reinforce clients' strengths, personal resources and successes that led to those exceptions. Although exclusively an

SFT procedure, the EARS method was successfully integrated with experiential techniques and became a customary aspect of the integrated composition. The successful EARS-ET integration was a powerful tool that heightened and facilitated deep emotional expression between partners' as they validated and affirmed each others efforts in bringing about preferred change. The EARS process and ET adjunctive techniques blended so well that it was difficult to differentiate the two, at times, within the therapeutic process.

Homework tasks were assigned between each and every session regardless of SFT, ET, or consolidated frames. Observation and behavioral assignments encouraged couples to direct their focus or behaviors towards areas that were consistent with therapeutic targets. Details gathered from the successful completion of homework tasks were built on, complimented and used as important elements in the solution-building process. The EARS process was applied following completions homework assignments in order to draw out details, heighten emotional experiencing, and create intimate encounters in which couples' could validate and affirm efforts made to bring about positive changes between sessions.

As stated, the therapeutic alliance within the integrated paradigm is paramount, considered a critical element in the change process, and has been related to positive outcomes. Many of my efforts were geared towards monitoring and maintaining a positive therapeutic alliance. SFT methods contributed to such an important undertaking. In fact, as demonstrated in the case illustrations (Chapter 5), occasionally the employment of ET initiatives around the couples' presenting problem generated increased negativity, hurt feelings, arguments, in addition to other "counterproductive" behaviors and interactions. SFT contributed significantly to the therapeutic alliance by facilitating the movement away from "unproductive", problematic,

negative interactions towards an optimistic, hopeful future-orientation in which couples could envision a more satisfying relationship. The instillation of hope within a affirmative atmosphere created a buffer or type of resilience that grounded clients through difficult, trying, or painful moments in the therapeutic process, and allowed them to feel confident that things will get better. Further to this, therapist-client joining, expression of vulnerability, taking risks, doing something different, or working through difficult emotions, seemed easier for both therapist and clients within a positive environment.

Strengths of the Integrated Solution Oriented Experiential Model

Given the fact that the integrative approach counters the limitations of the internal working models and capitalizes on the effective characteristics of each, it is no surprise that its strengths are multifarious. The flexible and liberal adherence to the SFT solution-building process as a predominant framework within the approach translates into numerous benefits for clients seeking enhanced relationship satisfaction. Right from the beginning and throughout therapy, clients are encouraged to envision a future free of the problem. A sense of client competence and mastery is co-created as client strengths, personal resources and successes are cultivated through the perpetual pursuit of exception finding. Solutions based on what clients are already familiar with increases the chances that changes will ensue. Further to this the solution-building process moves away from what is unhelpful to positives often resulting in a sense of hope and optimism, thereby increasing client motivation and confidence that preferred change is possible.

The solution-oriented formula for well-defined goals which are realistic, achievable, and

behaviorally measurable, and important to clients, provides measurable indicators that concretely and specifically outline what it is the clients are working towards. Concrete indicators also provide feedback to clients and therapist that forward motion towards goals is occurring, and provide indicators as to when goals have been met and therapy done. Further, well defined goals that are future-oriented act as anchors that guide the forward motion of the therapeutic process. If at times the focus gets "off track", therapist and client become mired in the problem, or there is a requirement to explore complex emotions and client experiences as part of a complete assessment, well defined goals provide the beacon to get back on track and move forward as soon as possible. Further to this, solution-oriented observation and behavioral tasks generate a shift in clients' cognition, behavior and emotional experiences that are consistent with therapeutic objectives.

The breadth and depth of empirical and theoretical knowledge ET brings to the integration approach is invaluable. I had at my disposal a wide range of knowledge that contributed to my understanding of adult, intimate relationships. In addition to comprehending inter-personal interactions, ET provides valuable insight into intra--personal development of self, and intra-psychic dynamics that impact relationship functioning. Moreover, an equally diverse set of methodological and technical procedures exist within the ET frame that facilitate effective interventions at either intra- and inter-personal domains, separately or conjunctively.

As demonstrated in the detailed case illustrations, the SOE design is capable of meeting the diverse and complex needs of a variety of clients with complex problems. The integrative framework is responsive to various cognitive , behavioral, and emotional realms of functioning. The constructivist, humanistic principles translate into a client-centered therapeutic stance which

begins where the clients' are at, either individually or as a couple. The approach is sensitive to clients ways of communicating and organizing their experiences and interactions.

Given the versatile and flexible nature of the SOE design to meet the diverse needs of couples, efforts at change are directed towards a variety of areas. Change efforts can be directed at the intra-personal level or the level of inter-personal interaction. Some clients may only require a simple shift in cognition and behavior to move away from problematic interactions, or they may have greater needs that require the accessing, evocation and reprocessing of emotion and experiences that are directly impacting self and self in relation to others. Often, change is directed at all spheres.

The SOE design contains the necessary theoretical knowledge, methods and techniques for instituting change in the various realms of client functioning. Further to this, unlike most theoretical methodologies that focus primarily on either past, present, or future time-frame orientations, the SOE design is adaptable to align with clients' world views and positions significant to their needs. The SOE arrangement can amiably adapt to, or simultaneously integrate, a present "here and now" encounter, a future-orientation towards a better future, or when required, a symbolic journey to the past.

The therapeutic alliance is one of the SOE design's greatest strengths. An extensive deal of effort and energy are given to the development of a positive, safe, trusting, genuine environment in which clients feel heard, valued, understood, and their experiences fully validated and affirmed. Because of the subjective process-oriented nature of the therapeutic alliance, its extent is difficult to measure exactly. However, there are many facets that contribute to its development. The underlying core assumptions of the SOE (presented in chapter three) create a

process in which clients are respected and honoured as experts on their own lives and experiences. Such values, thereby, contribute to a sense of value and respect. The positive nature of the solution building process engenders a sense of hope and optimism that change is possible. A positive atmosphere can sustain clients through difficult or painful aspects of the therapeutic process by providing an assured sense of hope for a better future.

Further to this, a strong therapeutic alliance can be described as a felt sense of trust, safety and comfort that is experienced by both client and therapist. The importance of the therapeutic alliance cannot be understated. A safe and secure context was necessary if clients were going to make efforts to change, risk vulnerabilities, express themselves openly and honestly, or even simply try something different. A strong alliance allowed both client and therapist the room to take risks and be spontaneously creative.

Limitations of the Integrated Solution Oriented Experiential Model

Although I did not experience serious limitations with the integrated approach, I was beset with several challenges during my work with couples. Firstly, my decision to rely solely on Satir's framework for working with couples and Johnson's emotionally focused therapy (EFT) as the ET adjunct with the SFT model, led to a serious obstacle. Satir and Johnson's approaches albeit very effective interventions for treating couples, were at times constraining due to their limited theory for understanding the diversity of complex human problems and interactions.

While Satir's approach covers a vast area of theoretical and practical knowledge pertaining to self development, self-esteem, patterns of communication, and family of origin issues as they relate to clients' relationship interactions, there were issues that emerged for clients

in therapy that went beyond these realms of experiencing. Johnson's use of attachment theory within the EFT framework provided a useful map for understanding adult intimacy and couple interactions. Although I utilized many therapeutic techniques offered by Johnson's EFT, and occasionally employed well defined steps from her approach, I found attempts to apply the attachment theory to couples interactions limiting and considerably reductionist in its scope on explaining and intervening in diverse set of problematic couple interactions. Of the seven couples, I found that the EFT framework fit almost entirely well with couple "C", and components of the model were helpful in understanding and intervening with couple "B". Generally, I found most components of Satir's methods more helpful and effective in meeting couples' needs.

The constraints posed by Satir and Johnson's ET approaches were countered with the introduction of alternative ET theory, methods, and techniques which were better able to guide work with couples in their unique and subjective realms of experiencing. For instance, there were several instances throughout my work with couples which required exploration of one of the partners' experiences, emotions and sense of self, as these areas were posing barriers or constraining the couples' interactions. In such circumstances, wherein I experienced Satir and Johnson's approaches limiting, I found Greenberg's process-oriented emotionally focused theory and interventions (Greenberg, 1991; Greenberg, Rice, & Elliott, 1993, Greenberg & Paivio, 1997) much more relevant and helpful. Greenberg offers a comprehensive theoretical construct complete with practical interventions and techniques that guide individual explorations, evocations, and processing of a diverse set of complex emotions.

As stated, experiential theory and therapeutic approaches cover a vast range of practice

methods and techniques geared towards increasing emotional awareness and heightening, understanding, and experiencing of self and self in relation to others. The limitations encountered with Satir and Johnson's approaches were neutralized following the adoption and reliance on better fitting ET theory, methodologies, and techniques.

Secondly, I was challenged by the difficulty of focusing simultaneously on both internal (intra psychic) experiencing of individuals and couples and the dynamics of inter-personal interactions between partners. Additionally, working concurrently on intra- and inter-personal objectives proved challenging with the emergence of multiple goals and targets relating to seemingly disparate, but importantly related areas of functioning. Operating with so many variables occasionally seemed overwhelming, and keeping numerous mini-objectives and multiple treatment targets organized and prioritized occasionally was experienced as bewildering. However, a partial remedy to this challenge emerged with a firm grounding and clear focus on the therapeutic end point. Concrete well defined goals that were important to clients proved to be a helpful beacon that guided our steady forward motion towards clients' preferred reality. When ever we felt lost, overwhelmed, or off track in our work together, a review of well established therapeutic ends sufficed to re-institute a clear productive focus.

Thirdly, the solution oriented experiential paradigm can be criticised for exclusive focus on clients' cognition, behaviors, and emotions at the exclusion of important gender, cultural and spiritual aspects of client's experiences. Both internal working models of the design (SFT & ET) do not directly incorporate or account for issues of gender, culture, or spirituality. However, the constructivist, strengths-based, client centered approach honours clients experiences, perspectives, and world views. As experts on their own lives, clients can determine which aspects

of their experiences and circumstances are related to their presenting concerns. In this light gender, culture, or spiritual components of clients' lives would be incorporated to the extent that clients feel these domains are important. For instance, several discussions and interventions were based on couple "A"'s resilience and strong faith in their particular religious outlook. Significant spiritual components, incorporated from their perspective, were used as integral elements in the solution-building process. With couple "D," a clear issue of gender inequity based on a traditional sex-role division of labour was part of the problem. Sarah felt as though she had an unfair burden of responsibility for housework and child care. Gender inequity was dealt with directly through the development and successful attainment of goals that were important to both Sarah and Mike.

Finally, the SOE model's focus on intra-personal processes and inter-personal interactions is limited to the microcosm of human experiences. The integrated approach can be criticized for excluding larger gender, cultural, social, political, and economic factors that may be impacting on clients' lives and contributing to their presenting concerns. A serious implication of failure to examine larger systemic and structural factors is that the therapist may unknowingly or inadvertently perpetuate, to the possible detriment of clients, sexist, racist, or other unaccommodating dominant discourses. Such unhelpful discourse may, in fact, be impacting on their lives and actually contributing to their presenting problems.

Outcome: An Effective Treatment Modality for Couples

An important learning objective was to demonstrate the proposed integration as a respectful and effective modality for couples seeking therapy to improve relationship satisfaction.

In demonstrating therapeutic effectiveness, measurement and evaluation of clinical outcomes was essential.

The Dyadic Adjustment Scale (DAS) was used, within a pre-experimental design of pre and post-test measurement, as a global measure of marital quality, specifically marital adjustment and satisfaction. Six of the seven couples completed the DAS prior to and following the therapeutic intervention. I found the DAS very simple to administer and score. Couples managed to have the questionnaire completed in approximately fifteen minutes.

Couples "A", "B", "C", "D", "E", and "F"'s, DAS scores are represented in Figure 6.2 (Appendix H). It is clear that there were marked improvements in marital quality following therapy. With the exception of Mark's (couple "E") score which remained the same, and Bob's (couple "F") score which decreased, all individual post-test DAS scores exhibited increased values. The DAS post-test scores for couples' "A", "B", "C" and Sarah (couple "D"), demonstrated profound transformations in marital quality following the completion of therapy. These scores represented a decisive shift from severely relationally distressed to relationally non-distressed positions. Although Mike (couple "D"), Denise (couple "E"), and Terri's (couple "F") pre-test scores did not signify relationally distressed positions prior to therapy, their scores do indicate that they were below the total mean DAS normative score for married couples (107). At termination, their DAS post-scores indicate a marked improvement to shifts well beyond the identical established DAS norm.

The primary use of the DAS within the measurement package was entirely as unidimensional global measure of marital quality. The controversy in the literature concerning the reliability and validity of the sub-scales when using the DAS as a multidimensional measure

(Baillargeon, Dubois, & Marineau, 1986; Kazak, Jarmas, & Snitzer, 1988; Bouchard, Sabourin, Lussier, Wright, & Boucher, 1991) contributed to the decision in forging reliance on the DAS sub-scales for evaluation. However, as stated, the sub-scales were considered only in light of qualitative data gained from individualized rating scales (IRS) and the client feedback questionnaire. Discussion regarding client feedback offered in chapter 5 clearly demonstrated that there was strong agreement between changes demonstrated in DAS sub-scale scores and changes in target areas reported by clients. Given the strong reliability and validity of qualitative methods of measurement, the discovery of the DAS sub-scale accuracy was not only informative, but may serve as a contribution to the literature supporting the DAS as a valid and reliable multi-dimensional measurement tool (Sabourin, Lussier, Laplante, & Wright, 1990; Kurdek, 1992; Shek, 1995).

The feedback questionnaire was administered at the end of therapy. All couples chose to answer the questions in an interview format. Most commented that it was a good way to end therapy, as it served as a review of our work together. The feedback questionnaire offset a major limitation of the DAS. Like most quantitative standardized measures, the DAS was limited to understanding "what" changes were made and was unable to capture essential descriptions of the clients' reality regarding "how" changes were created. The "how" depicts key elements within the change process. Detailed client narratives, in response to the qualitative feedback questionnaire, provided rich data concerning two crucial areas of the therapeutic experience; perceived helpfulness of therapeutic intervention and; perceived elements of therapy that were considered most helpful.

Five of six couples ("A", "B", "C", "D", "F") indicated that therapy was very helpful for

the issues that brought them to counselling. All partners designated the highest likert value on the feedback questionnaire, representing that therapy was *Exactly What We Needed.* Couple "F" also remarked that therapy was very helpful in facilitating the completion of their therapeutic objectives. Denise indicated that "therapy was exactly what we needed" while Darren remarked that therapy "helped very much". Consistent with the affirmative feedback regarding degree of helpfulness, clients unanimously responded that there was nothing they felt the therapist left out or could have done differently. Collective recommendations given to the therapist for future work with couples with similar issues reinforced positive endorsements regarding therapeutic helpfulness. Most couples made suggestions such as, "Keep up the good work. Keep doing what you're doing. Do the same things as you did with us. Don't change a thing".

Data gathered from the feedback questionnaire also informed which particular aspects of the SOE design were the most helpful, thereby illuminating valuable elements of the change process. Numerous client responses underscored many of the aforementioned strengths of each SFT and ET ingredients within the integrative framework.

Clients found the client-centered approach was both an effective and respectful way of working.

Mark: *...you respected the way we each deal with things differently, and where we were at. You didn't push, pry, or push too hard...you were very respectful of what I wanted. I'm not ready to deal with that yet, and you understood that.*

The positive strengths-based focus of the solution-oriented frame was perceived by most clients as helpful.

Diane: *I don't think we would be together if we didn't come here. We were focusing on the negative so much...we couldn't see the positives. Coming here showed us that looking at one little positive change could make a huge difference.*

Several clients responded well to the systematic and tangible way of constructing well-formed goals and defining small steps to meet those goals in a future oriented, forward movement towards therapeutic ends:

Sarah: *I liked the way we set clear goals in our first time together at that meeting. You helped us in figuring out how to get there, and we did it. We could actually see the changes happening from session to session.*

In the process of eliciting client feedback, prominent ET elements also surfaced as important change components. Of significant importance to most clients was the strong treatment alliance and a safe and trusting atmosphere:

Denise: *...this provided us with a safe place...to be ourselves, to be honest and take risks. ...now it's easier for me to open up and tell Mark how I'm feeling.*

Several client's felt that the exploration, evocation and processing of emotions was a necessary part of therapeutic change:

Terri: *It was hard at the beginning to sit together and talk about the really deep feelings. When we came back together, I didn't think I would have been able to share those feelings. If I didn't take the time I needed to, or we hadn't prepared and worked through them...I needed to get in touch with how I felt.*

Finally, the fundamental component within the ET lens of focusing on the interconnection between intra- and inter-personal processes as they impact the relationship was commented on by several clients as beneficial.

Nora: *I also liked the fact that you not only focused on us as a couple, but also on each of us as individuals...it's true, if I'm not good, we're not good. And the same with him...if things aren't right with him, there not right with us. You helped me reconnect with what my needs were. I think we're both better for that.*

In conjunction with the DAS and feedback questionnaire, SFT scaling questions, although not a formal component of the measurement package, provided valuable information regarding the setting and completion of therapeutic goals. Individualized rating scales (IRS), an integral

component of SFT, were developed out of couples' language and meanings, and were used to measure perceptions of progress towards therapeutic objectives. The numbers on the scales represented a quantitative measure, while the meanings given to those values portrayed an accurate narrative description of clients' reality. IRSs and self-anchored scales have exceptional reliability and validity (Bloom, Fischer, & Orme, 1999) and are comparable to standardized measures with outstanding psychometric properties (Nugent, 1992).

All couples, with the exception of couple "G", used scaling to move towards their preferred reality and accomplished their stated objectives set in therapy. Invariably, client self-reports and clinical impressions gained from scaling were consistent with overall DAS post-test scores, including areas related to specific DAS sub-scales. This fact not only strengthens the integrity of the evaluative results concerning outcome, but further contributes to the literature on the DAS, supporting the use of the standardized measure as a multidimensional tool.

Pre-experimental designs are exceptionally weak for deducing a causal relationship between the intervention and therapeutic outcome. However, given the mixed methodological evaluative design which incorporated quantitative and qualitative measures, approximating causal inferences became increasingly possible. Further to this, the triangulation of the multiple measures enhanced the credibility of even this simplest pre-experimental design, and increased the accuracy that the intervention was indeed responsible for successful outcomes.

My opinion as to whether the SOE design was meaningful and beneficial to couples seeking therapy is albeit important, but not unqualified without the critical feedback from clients themselves. The qualitative methodologies were crucial in providing clients a voice within and throughout the entire process of therapy. It is from their perspective that I possess the confidence

to assert that we have unequivocally established that therapeutic changes were clinically significant. According to Letich (1992), clinical significance can be understood as responding in the affirmative to the questions, "Did therapy really produce change in the clients' lives? Are they demonstrably better off as a result of having been in therapy?"(p. 70). The SOE design contributed to preferred relationship changes in all couples' lives.

My goal was to provide an effective and respectful way of bringing about preferred relationship changes for couples seeking to increase relationship satisfaction. The methods of measurement within the evaluation design have confirmed that this was accomplished with couples that sought therapy for increasing relationship satisfaction.

Formal follow-up was not an aspect of the design within this project. However, residing in the same community as clients led me to gather informal feedback from several couples upon various casual encounters. I had contact with five of the seven couples roughly one year following our work together. Couples "A", "B", "C", "E" , and "F" report that they are still doing quite well and that many of the changes made in therapy have been lasting. Further to this, three of the seven couples ("A", "B", "F") had an opportunity to read a rough draft of this document. I was unable to connect with the other four couples, however, they will be contacted and given an opportunity to read the document when it is finished. All three couples described that the report was an accurate depiction of their circumstances and how they experienced therapy. Two of the three couples enjoyed the process of reading the document one year following therapy, stating that it was a good review. Nora, of couple "A" stated that because her relationship with Bill is going so well, that it was difficult for her to imagine just how bad things were when they entered couples counselling.

Although very informal, long-term feedback of sustained changes brought about by the SOE approach is encouraging. Moreover, it is important to know that the document represents and accurately depicts clients' experiences, as they were key collaborators in the overall process. Accurately capturing their lived experiences was important for me. Further, the veracity of the report increases its general reliability, validity , and overall integrity.

Promise of an Effective Approach to Marital Therapy

The idea to integrate the SFT and ET paradigms emerged in order to capitalize on the strengths of the two approaches to better meet the unique needs of couples seeking therapy. I could not have imagined the degree of positive outcomes most couples experienced. All couples that completed therapy encountered an increase in relationship satisfaction. Several couples experienced significant relational transformations. Practicum experiences and therapeutic outcomes were compared with existing theoretical, empirical, and clinical literature regarding the effective elements of successful therapy. My initial belief that the SFT-ET integration would produce an effective modality for couples was appropriating an established reality

Several clinical investigations (Jacobson & Adis, 1993; Johnson, 1997; Lebow, 2000) centred on the success rates of marital therapy, placed the estimate of success at approximately 50%. However, Bray and Jourilles's (1995) research efforts revealed that only 41% of couples moved from distressed to non-distressed positions following therapy. In light of these results, the clinical outcome established in this paper is encouraging.

Further to this, there is a growing body of research illuminating effective ingredients of successful marital therapy (Smith & Brown, 1994; Bowman & Fine, 2000; Lebow, 2000). Such

theoretical and empirical endeavours are beginning to uncover helpful aspects of the therapeutic process that create preferred change and lead to increased positive outcomes for clients. Likewise, the efforts of this project have exposed integral change components within the SOE process that have directly contributed to the success of couples in therapy. Moreover, many of the aforementioned strengths of the SOE design appear in the emerging scholarship regarding beneficial therapeutic elements and processes that generally lead to increased treatment success in couples therapy.

Important elements within the therapeutic process, at the heart of the SOE framework, are supported by clinical research regarding their contributions to the change process, increased positive outcomes, and treatment success. These critical features are: (1) the therapeutic alliance and environment (2) goal-setting (3) homework tasks (4) positive interactions and the instillation of hope (5) creativity and flexibility.

Treatment initiatives that are given the highest priority, within the SOE frame are the therapist-client alliance and the creation of a safe and trusting therapeutic environment. The therapeutic alliance has been clearly established as a significant change agent in therapy by both clinical researchers (Walker & Patten, 1990; Smith & Brown, 1994; Watson & Greenberg, 1998) and investigations based on the perceptions of clients (Kuehl, Newfield & Joanning, 1990; Sells, Smith & Moon, 1996; Bowman & Marshall, 2000). A positive therapeutic alliance characterized by trust, warmth, empathy and caring within a safe and accepting environment have been directly related to positive therapeutic outcomes (Llewelyn, Elliott, Shapiro, Hardy & Firth-Cozzens, 1988; Smith & Brown, 1994; Coady, 1999; Bowman & Marshall, 2000; Lebow, 2000).

Another key factor of the SOE design is the firm establishment of well-defined, realistic,

client-determined goals, as early as possible in the therapeutic process. Sells et al., (1996) discovered that interventions that encourage goal development directed by clients, rather than by the therapists, are consistent with increased therapeutic success. Further to this, there is a wealth of research testifying to the relationship between well defined goals and positive treatment outcomes (Apponte & Van Deusen, 1981; Margolin, 1987; Horvath & Greenberg, 1989; Sells et al., 1996).

A fundamental method within the SOE approach, employed for linking work from session to session and encouraging clients to generalize their treatment efforts outside of therapy, is between-session homework tasks. Kazantzis and Lampropoulos (2002), in a thorough review of empirical data concerning homework assignments in psychotherapy, conclude that there is a direct link between homework and positive treatment outcomes. These finding have strengthened previous research (Bischoff & McBride, 1996; Sells et al., 1996; Bowman & Mashall, 2000) that speak directly to the importance of utilizing homework tasks in treatment as a means of increasing therapeutic effectiveness.

Creating positive interactions is another key feature of the SOE design. The future-orientation of better times engendered a sense of hope and optimism with most couples and created increased room for affirmative collaborations between partners' and with the therapist. A sense of hope seemed to sustain both a positive atmosphere and favorable interactions even during the trying, or "difficult" points in therapy. Research has demonstrated that positive interactions and the instillation of hope have been correlated with enhanced therapeutic outcomes (Smith & Brown, 1994; Bowman & Marshall, 2000; Lebow, 2000).

Finally, the SOE model was developed as a means to meet the complex needs of a diverse

set of couples with a variety of relationship complaints. Therapeutic effectiveness and overall couples success was directly related to the models sensitivity and capacity to meet those needs through the flexible, adaptable, and creative nature of the design. Research efforts have demonstrated that there is a correlation between increased therapeutic effectiveness and the flexibility and creativity of an eclectic approach (Smith & Brown, 1994; Bowman & Marshall, 2000; Lebow, 2000).

Given the number of effective ingredients for successful therapy contained within the SOE design, it is not surprising that overall, treatment was successful and relatively brief. The greatest number of sessions required by any couple to meet stated clinical objectives and to complete therapy was 15. Brief therapy was not an ambition of this particular project, however, this consequence should be seriously considered. The current reality of fiscal restraint and the expanding nature of managed care has had serious implications for both social work practitioners and clients. There is greater demand on therapists to be increasingly effective and more accountable both within a shorter time span and with fewer sessions. According to Mitchell (1998), managed care has depersonalized the therapist-client relationship and has severely undermined the treatment alliance and the safe and empathic counselling environment. In the era of managed care there is an increased necessity to develop and employ interventions that are exceptionally effective and brief. The SOE model may provide just that.

Future Directions

The positive outcomes of this endeavour combined with the discovery of empirically verified ingredients of successful therapy within the SOE approach are encouraging. Although

the promise of an exceptionally effective modality has emerged, there is still much work to be done. The favourable results and findings are overshadowed by serious limitations within the overall project and general research design. There is a need for further disciplined and increasingly precise investigation into the complexities of clients, treatment, process, and outcome as they relate to the future application of a SOE paradigm with couples.

The couples who took part in this project represented an exceptionally small client population and therefore encompassed a minor range of relationship problems. Further to this, the client population was quite homogeneous and despite diligent efforts to appeal to various couples of diverse backgrounds and cultures, all couples were Caucasian, dual parent families, differentiated mainly by family structure. Generalization of the results could only be minimally considered given the limitations in size and diversity of the client group. This indeed is one of the practicums main limitations.

In addition, it is important to keep in mind that both internal working models of the SOE design were created and developed by white, middle-class, heterosexual men. It is critical to caution against the universal generalization of the results of the practicum, and seriously question the appropriateness and applicability of employing the approach with couples of different races, cultures, socioeconomic status, and sexual orientations. Future clinical investigations will require a larger, more diverse client cohort in order to better understand which SOE processes, methods, techniques, and exercises would affect preferred changes, in a respectful and dignified way, with a variety of clients experiencing an array of complex relationship problems.

Prospective clinical and empirical ambitions will require a more methodologically rigorous and sound research design. Although the use of a mixed methodology of quantitative

and qualitative measures encompassed within the pre-experimental evaluation scheme of this practicum strengthened the integrity of the findings, pre-experimental designs are exceptionally weak for deducing causal relationships. Future designs should encompass increased comprehensive outcome measures for both client targets and therapeutic processes. This will be crucial in order to gain an increased understanding of the diverse interconnection between specific therapeutic processes, methods, techniques, and successful outcomes. A variety of single-system designs may prove useful for such initiatives as they fit well within clinical practice contexts and they allow for sophisticated and rigorous evaluation of specific therapeutic variables as they relate to specific therapeutic objectives.

Understanding the long-term effects of the SOE model would be beneficial in understanding the stability of successful therapeutic changes. Within the present endeavour outcome was measured during and immediately following therapy. Future methods of investigation should include follow-up intervals at the end of therapy and, at least on two separate occasions, beyond the point of termination.

Finally, an area that is worth considering within the practicum was the utilization of individual sessions and the subsequent impact this had on the process of change and overall therapeutic outcome. This area is significant as individual sessions were employed with six of seven cases. General guidelines for adopting the use of individual over conjoint sessions were provided within the report. For the most part, individual sessions were introduced when conjoint sessions were becoming intensely negative, destructive, or unproductive. They were also employed in order to gain a fuller assessment of the problem from each partners' perspective without interruption or distractions arising from couple disagreement or discord.

Following individual sessions, it seemed as though the therapeutic alliance, with each partner, was strengthened. Couples returned to conjoint sessions with a better understanding of self and self in relation to their partner. There were fewer negative reactions and partners' were better able to work productively and collaboratively towards shared goals. Overall, it appeared as though individual sessions expedited the therapeutic process as couples were approximating treatment goals quicker and with more ease upon return to conjoint meetings.

Unfortunately, as valuable as clinical impressions are, a formal method of measurement was not applied to capture the impact of individual sessions on the process of change and overall therapeutic outcome. Hereafter, efforts may need to incorporate methods of evaluation such as standardized measures, or specific client feedback forms to better understand the effect of individual sessions within the SOE approach to couples therapy.

Information gained from future explorations will be critical in guiding the development and further refinement of a SOE approach to couples counselling. Valuable insights gleaned from improved clinical applications of the integrated design will move researchers and practitioners alike, one step closer in the pursuit of knowing and effectively doing what really works for all clients.

Contribution to Social Work Practice

The social work profession has long recognized that close, healthy, functional relationships are integral to the stability of the family unit. Healthy families are critical to the biopsychosocial development and growth of individuals and form the cornerstone of healthful communities. Clinical social work practice aimed at the micro-level of dyadic relations is a direct

form of family intervention and constitutes an indirect mode of valuable community support.

Now, more than any other time in our history, there appears to be an increased need for social work intervention at the dyadic level of social systems. The steady rise in the separation and divorce rate confirms the reality that todays couples are experiencing serious challenges in making their relationships work. While separation and divorce can have adverse consequences for couples, the negative biopsychosocial implications of remaining in an unhealthy, stressful, or conflicted relationship are multifarious for coupled partners' and other members of the family system. Fortunately, couples counselling is a proven effective modality for alleviating a multitude of dyadic problems, enhancing relationship satisfaction, and strengthening relational bonds.

Clinical social workers intervening at the couple level have available a vast array of modalities and technical interventions to choose from. However, research demonstrates that the rate of success for most couple therapies range from poor to meagre (40-50%), and therefore, available interventions for couples seeking therapy require ample improvement. Further to this, in todays climate of government cut-backs, fiscal restraint, and managed care, services available for couples are being eliminated or taken on by insurers and private service providers. Many couples are not covered by insurance, nor can they afford private counselling services, and because of the decrease in no-cost programs and lengthy waiting lists with existing cost-free services, are unable to access the support they need.

In light of the preceding discussion, it is increasingly imperative that social workers develop and test social work knowledge and skills in order to increase their capacity to provide the most effective, efficient, and ethical services to clients. It was my hope in accomplishing this practicum, that the SOE approach would offer clients just that; an effective, efficient, and ethical

modality for couples seeking to improve the quality of their relationship.

The effectiveness of the SOE design with couples was well established in the discussion regarding outcome. Despite constraints regarding applicability of the results to more diverse populations, the SOE approach demonstrated significant success with a variety of clients experiencing diverse and complex relationship problems. In addition, the SOE design showed potential for brevity and efficiency, given that successful outcomes were established in relatively short periods of time. The greatest number of sessions required for a couple to meet therapeutic objectives was 15. On average, couples required approximately 11 sessions to accomplish preferred relationship changes.

While the effectiveness and efficiency of an intervention are critical in appraising its value, it is a designs ethical integrity that establishes its fit within the philosophy and domain of social work practice. The SOE approach is significantly consistent with, and directly reflects in practice, many core social work values. The underlying values of both internal working models honour the value, uniqueness, and growth potential of all human beings. The strengths-based, client-centered approach of the SOE design capitalizes on clients' potentialities and strengths, and espouses that individuals be fully supported in their self-determined efforts to bring about preferred changes. The constructivist element which honours, values and incorporates clients' subjective realities and world views, translates into a deep respect fo the diversity and uniqueness of all people regardless of gender, race, culture, class, and sexual orientation.

Although early in its theoretical and practical development, the SOE model shows considerable promise of being an effective, efficient, and ethical modality for couples seeking to improve relationship quality. Given the merit of couples counselling as a valued constituent of

direct social work practice, and the goodness of fit between the SOE design and the philosophy and domain of social work, I believe that this practicum has made a valuable contribution to current social work theory and practice knowledge.

Conclusion

This chapter has demonstrated that I have achieved the objectives established at the beginning of this endeavour. The ongoing literature review of SFT and ET approaches expanded my theoretical and practical knowledge of the respective methods and significantly strengthened the clinical application of that knowledge in my work with couples. Continuous feedback from my academic advisor and placement supervisor were essential in accomplishing my learning objectives.

In meeting my personal and professional aspirations, I preserved as my fundamental priority the provision of a valuable and respectful supportive service for couples seeking therapy. According to clients, my most esteemed collaborators, this was certainly accomplished.

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APPENDIX A

PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: M.S.W. Practicum - Solution-Oriented Experiential Couples Therapy

Protocol Number: 11/02/01

Graduate Student/Researcher: Stephen De Groot, 144 Brandon Cres., [redacted] MB.,(677-1456)

Faculty Advisor: Maria Cheung, 605 Tier, University of Manitoba, Winnipeg, Mb., (474-6670)

Sponsoring Agency Supervisor: Heather Funk, Family Services, [redacted] Mb., (677-7260)

You are being requested to participate in an clinical exercise. Please take time to read the consent form and discuss any questions you may have with the graduate student doing the project. Although you have verbally agreed to participate in this exercise, you may take time to reconsider your decision. This form may contain words or ideas that you do not understand. Please ask the student conducting the project to explain information that you do not fully understand.

Purpose of the study

This clinical intervention is being conducted as the final requirement of a Master in Social Work degree from the Faculty of Social Work at the University of Manitoba.

The focus of the practice requirement is to apply a solution-oriented experiential approach within couples therapy. The main objective of the student is to gain increased skill and knowledge in the understanding and application of this particular approach to couples seeking counselling for the purposes of increasing marital/relationship satisfaction.

Study Procedures

In this project you and your partner (significant other), following a referral, will meet the therapist (graduate student) for relationship issues that are causing relationship tension, conflict, distress, or dissolution.

If you take part in this study you will be asked to fill out the Dyadic Adjustment Scale (DAS), a standardized questionnaire that measures the level of marital satisfaction in the relationship. This test will be administered before the first meeting and again at the end of the final session. The questionnaire takes approximately 10 to 15 minutes to fill out. The questionnaire is used to identify changes in relationship satisfaction that occur over the course of therapy.

Following the end of the last session you will have a choice to answer a brief open-ended questionnaire in pencil-paper manner or verbal interview. This was developed to find out, from you, what was most helpful aspects of therapy.

The sessions will be conducted once a week for a maximum of 10 weeks. The maximum number of visits will be 10. However, therapy may be shorter in duration if you meet identified goals before the end of the 10 sessions. Meetings may last from 1 to approximately 2 hours.

Risks

The risks involved in this study are minimal. The potential harm is not greater than that which you might experience in the normal conduct, within your relationship, in everyday life.

Benefits

By participating in this practicum exercise, you will be involved in an intervention that is designed to increase relationship satisfaction between you and your partner. You may or may not experience increased marital/relationship satisfaction. Information and feedback gained from the practicum may contribute to the therapist's increase in knowledge and skills involved in understanding and application of this particular intervention. This may benefit you and your partner by facilitating more effective therapy to meet you goals. Feedback and information gained may also help this therapist support other couples dealing with similar issues.

Costs

There are no costs for participation in this study. The service of couple counselling that is being provided is free of charge.

Confidentiality

All therapeutic sessions will be videotaped for the purposes of feedback and student evaluation. Videotapes will be viewed only by the student, advisor, and supervisor (named above). They will be kept with case notes in a locked cabinet and/or file room. Videotapes and notes will be destroyed immediately following the duration of the intervention.

Information gathered in study may be published or presented in a public forum, however, your name will not be used or revealed. All personal information provided is confidential and preserved by the Freedom of Information and Protection of Privacy Act. Absolute confidentiality can not be guaranteed. Personal information may be disclosed if; you or someone else is in danger of being harmed; there is disclosure of child abuse; or your information is required by law.

Voluntary Participation/Withdrawal from Study

Your decision to take part in this study is voluntary. You have the right to refuse providing any information that you do not feel comfortable with. You may refuse to participate or withdraw from the study at any time, without consequences or penalty.

Questions or Complaints

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers. Feel free to call any of the individuals involved in the practicum (named above). This study has been approved by the Joint Faculty Research Ethics Board (JFREB). Any complaints regarding procedures may be reported to the Human Ethics Secretariat at the University of Manitoba (474-7122), or to the faculty advisor, Maria Cheung (474-6670).

Statement of Consent

I have read the consent form. I have had the opportunity to discuss this project with Stephen De Groot. I have had my questions answered in a language that I understand. I understand that I will be given a copy of this consent form after it is signed. I understand that my participation in this study is voluntary and that I may withdraw at any time. I understand that my identity and personal information will be kept confidential, but confidentiality is not guaranteed. I agree to participate in this project

Participant signature_____ **Date**_____

Participant's printed name:_____

Witness signature_____ **Date**_____

Witness printed name:_____

I the undersigned have fully explained the relevant details of this project to the participant named above and believe that the participant has understood and knowingly given their consent.
Printed name:_____ **Date**_____

Signature:_____

APPENDIX B

DAS

Most persons have disagreements with their relationships. Please indicate below the appropriate extent of the agreement or disagreement between you and your partner for each item on the following list.

5 = Always agree
4 = Almost always agree
3 = Occasionally disagree
2 = Almost always disagree
1 = Almost always disagree

___ 1. Handling family finances
___ 2. Matters of recreation
___ 3. Religious matters
___ 4. Demonstration of affection
___ 5. Friends
___ 6. Sex relations
___ 7. Conventionality (correct or proper behavior)
___ 8. Philosophy of life
___ 9. Ways of dealing with in-laws
___ 10. Aims, goals, and things believed important
___ 11. Amount of time spent together
___ 12. Making major decisions
___ 13. Household tasks
___ 14. Leisure time interests
___ 15. Career decisions

Please indicate below approximately how often the following items occur between you and your partner.

1 = All the time
2 = Most of the time
3 = More often than not
4 = Occasionally
5 = Rarely
6 = Never

___ 16. How often do you discuss or have you considered divorce, separation, or terminating the relationship?
___ 17. How often do you or your mate leave the house after a fight?
___ 18. In general, how often do you think things between you and your partner are going well?
___ 19. Do you confide in your mate?
___ 20. Do you ever regret that you married? (Or lived together)
___ 21. How often do you and your partner quarrel?
___ 22. How often do you and you mate "get on each other's nerves?"

23. Do you kiss your mate?

Every day	Almost every day	Occasionally	Rarely	Never
4	3	2	1	0

24. Do you and your mate engage in outside interests together?

All of them	Most of them	Some of them	Very few of them	None of them
4	3	2	1	0

How often would you say the following events occur between you and your mate?

1 = Never
2 = Less than once a month
3 = Once or twice a month
4 = Once a day
5 = More often

___ 25. Have a stimulating exchange of ideas
___ 26. Laugh together
___ 27. Calmly discuss something
___ 28. Work together on a project.

There are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or problems in your relationship during the past few weeks. (Circle yes or not)

Yes No 29. Being too tired for sex
Yes No 30. Not showing love

31. The numbers on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please circle the number that best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
Extremely unhappy	Fairly unhappy	A little unhappy	Happy	Very happy	Extremely happy	Perfect

32. Please circle the number of *one* of the following statements that best describes how you feel about the future of your relationship.

5 I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
4 I want very much for my relationship to succeed, and will do all that I can to see that it does
3 I want very much for my relationship to succeed, and will do my fair share to see that it does
2 It would be nice if my relationship succeeded, but I can't do much more than I am doing now to make it succeed.
1 It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
0 My relationship can never succeed, and there is no more that I can do to keep the relationship going.

APPENDIX C

FEEDBACK QUESTIONNAIRE

1. How helpful was therapy for the issues that initially brought you to counselling? Check one of the following.

___ 1 - Not at all helpful
___ 2 - A little helpful
___ 3 - It was O.K.
___ 4 - Helped very much
___ 5 - Exactly what we needed

Please give a brief explanation for your answer.

2. What has been the most helpful aspect of therapy?

3. What aspect of therapy has been the least helpful?

4. Was there anything that you think the therapist missed, or could have done differently to best help you?

5. What advice could you give to the therapist for his future work with couples, seeking therapy, that have similar issues?

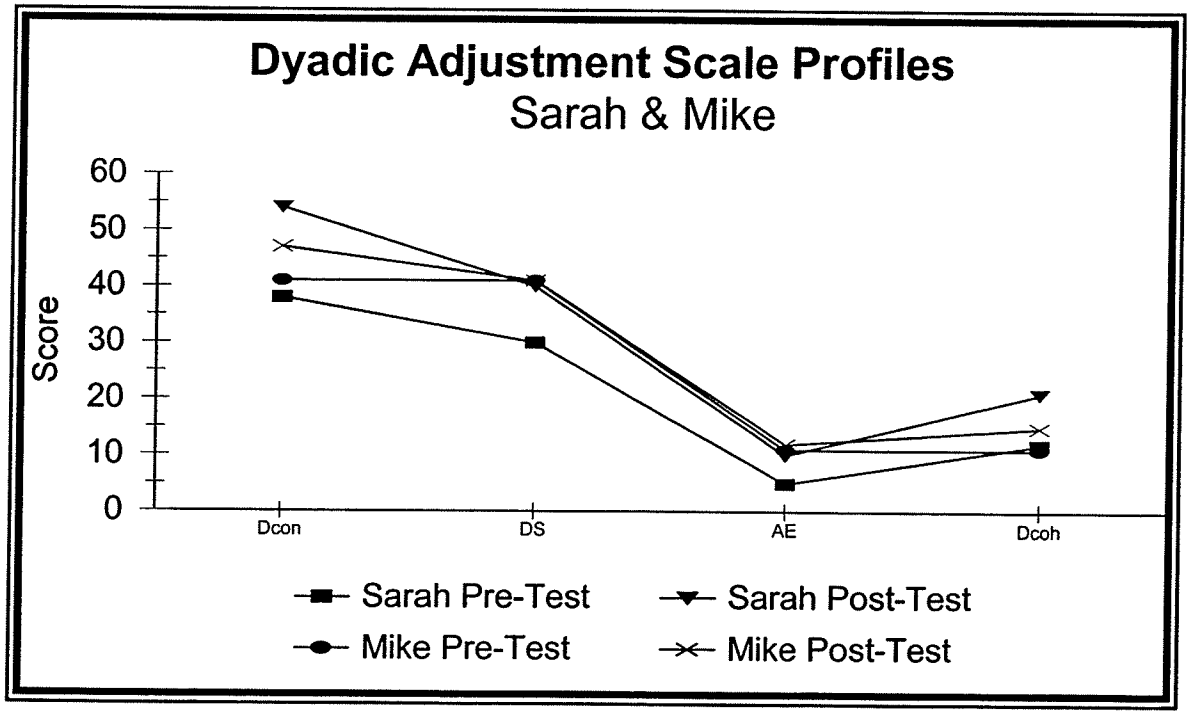
6. Are there additional comments or concerns that you would like to provide?

APPENDIX D

TABLE 5 - 4

	COUPLE "D"					
	Mike		Sarah		Norm Scores for:	
DAS Sub-scales	Pretest	Post-test	Pretest	Post-test	married couples	divorced couples
Dyadic Consensus	41	47	38	54	52	35
Dyadic Satisfaction	41	41	30	40	41	22
Affectional Expression	11	12	5	10	9	5
Dyadic Cohesion	11	15	12	21	13	8
Total: Marital Adjustment & Satisfaction	**104**	**115**	**85**	**125**	114/115 (114.8)	70/71 (70.7)

Figure 5.4

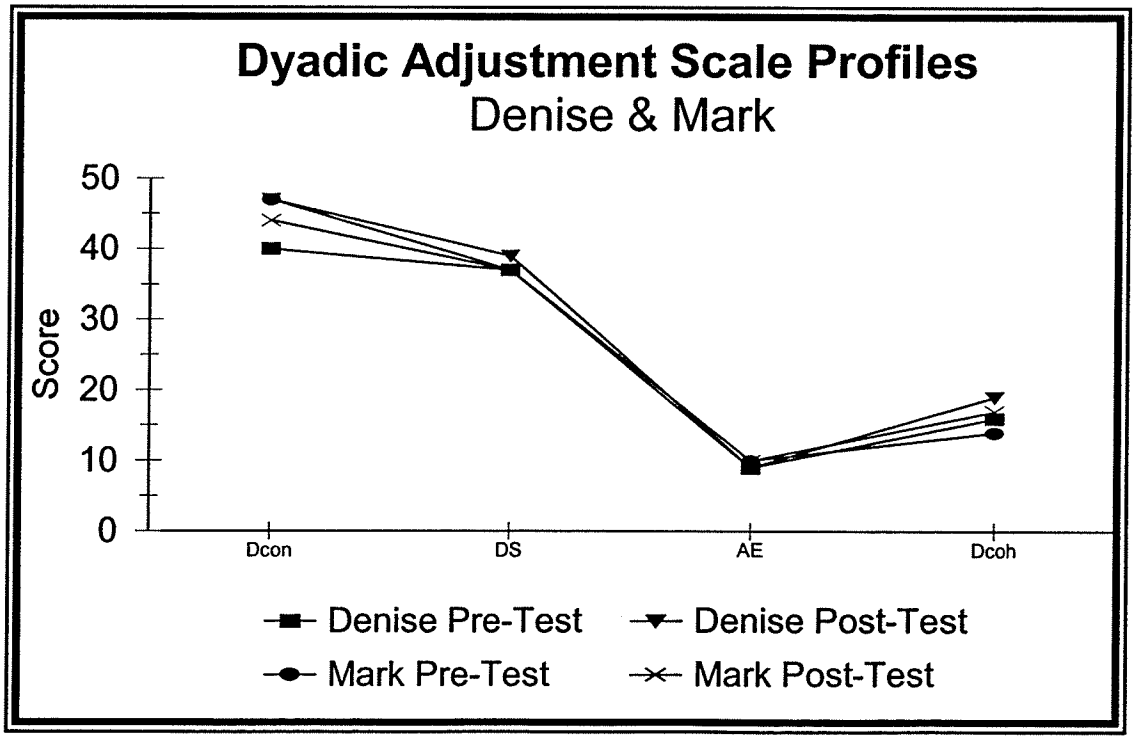


APPENDIX E

TABLE 5 - 5

	COUPLE "E"					
	Mark		Denise		Norm Scores for:	
DAS Sub-scales	Pretest	Post-test	Pretest	Post-test	married couples	divorced couples
Dyadic Consensus	47	44	40	47	52	35
Dyadic Satisfaction	37	37	37	39	41	22
Affectional Expression	10	10	9	9	9	5
Dyadic Cohesion	14	17	16	19	13	8
Total: Marital Adjustment & Satisfaction	**108**	**108**	**102**	**114**	114/115 (114.8)	70/71 (70.7)

Figure 5.5

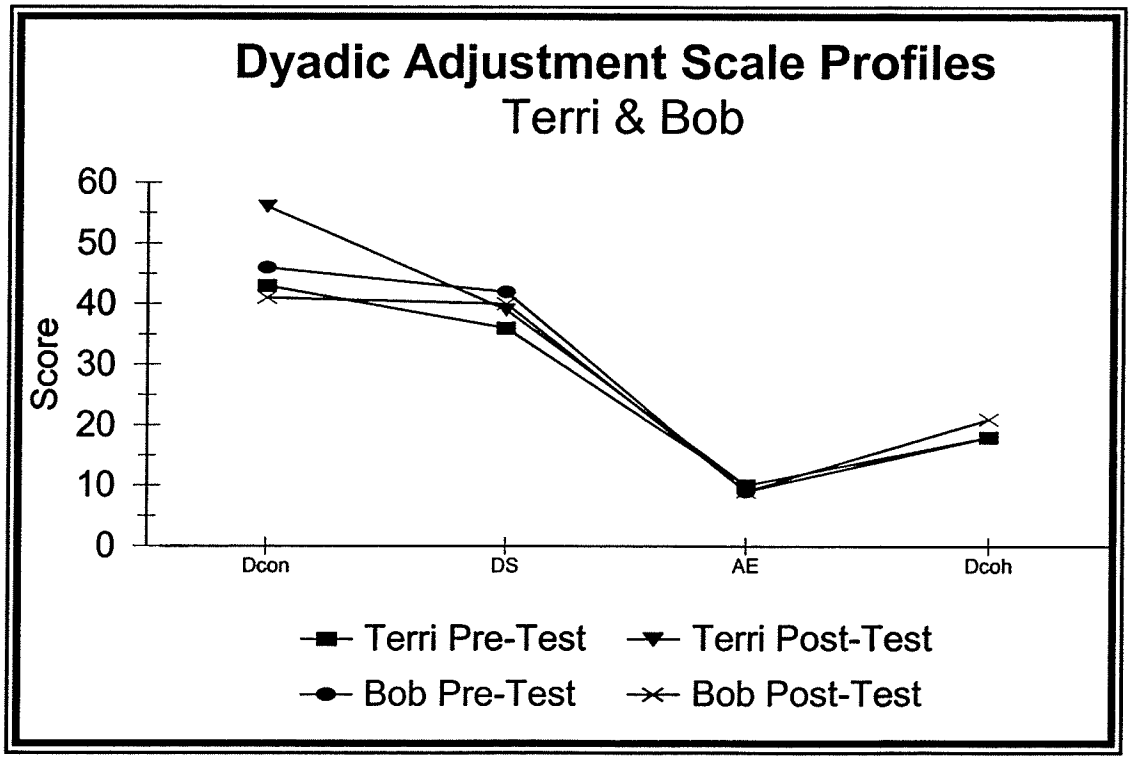


APPENDIX F

TABLE 5 - 6

	COUPLE "F"					
	Terri		Bob		Norm Scores for:	
DAS Sub-scales	**Pretest**	**Post-test**	**Pretest**	**Post-test**	**married couples**	**divorced couples**
Dyadic Consensus	43	56	46	41	52	35
Dyadic Satisfaction	36	39	42	40	41	22
Affectional Expression	10	10	9	9	9	5
Dyadic Cohesion	18	18	18	21	13	8
Total: Marital Adjustment & Satisfaction	**107**	**123**	**115**	**111**	114/115 (114.8)	70/71 (70.7)

Figure 5.6

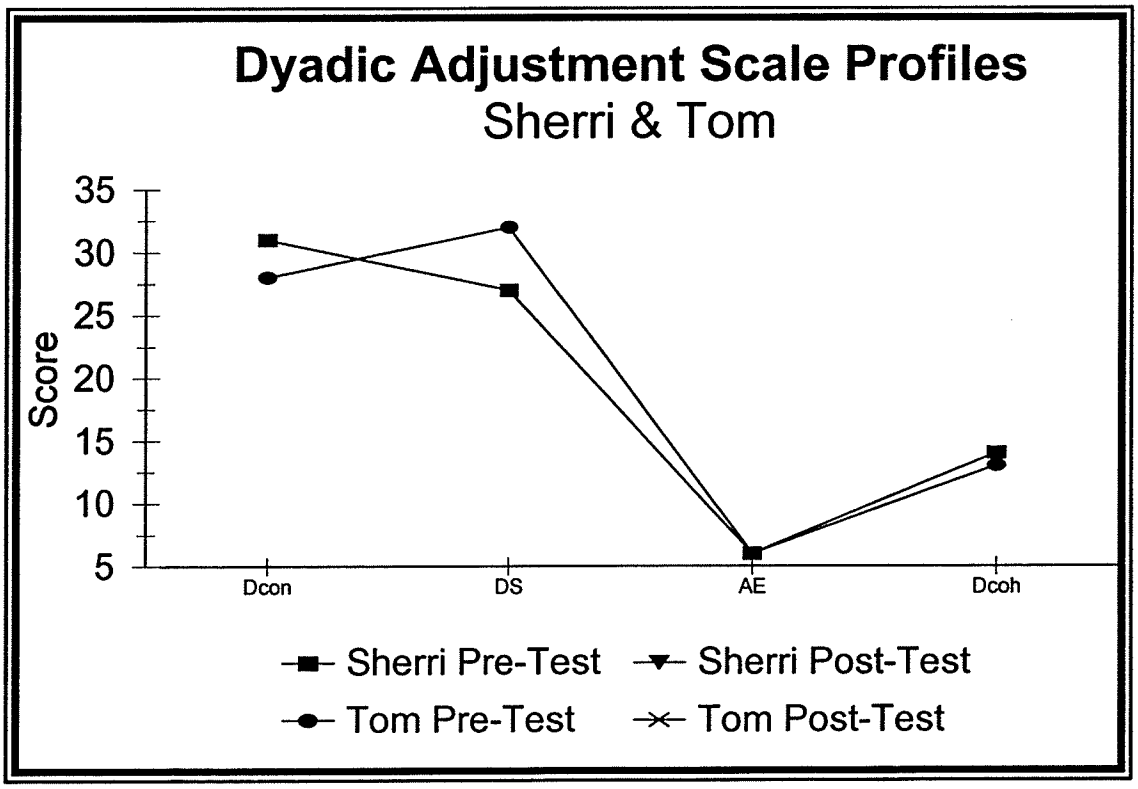


APPENDIX G

TABLE 5 - 7

	COUPLE "G"					
	Sherri		Tom		Norm Scores for:	
DAS Sub-scales	Pretest	Post-test	Pretest	Post-test	married couples	divorced couples
Dyadic Consensus	31	incomplete	28	incomplete	52	35
Dyadic Satisfaction	27	incomplete	32	incomplete	41	22
Affectional Expression	6	incomplete	6	incomplete	9	5
Dyadic Cohesion	14	incomplete	13	incomplete	13	8
Total: Marital Adjustment & Satisfaction	**78**	incomplete	**79**	incomplete	114/115 (114.7)	70/71 (70.3)

Figure 5.7



APPENDIX H

Figure 6.2

Dyadic Adjustment Scale Results of Seven Couples