WORKING WITH COUPLES IN CONFLICT

BY

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A Practicum Report
Submitted to the Faculty of Graduate Studies
in partial fulfillment of the requirements
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Abstract

This practicum was based on working with couples who were experiencing marital difficulties. Couples were assessed for their risk for violence as part of an evaluative phase of therapy. Based on the evaluation, therapy was provided using either individual therapy or conjoint therapy, or a combination of the two. Structural family therapy was utilized as the primary model of intervention. A psychometric measure, the Marital Satisfaction Inventory – Revised (Snyder, 1997) was used to track change over time. Client feedback at the end of therapy was also used. Four case examples are given, with similarities and differences highlighted.

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Chapter 1

Introduction and Learning Objectives

Many couples seek help to address the problems they experience, with the hope of improving their relationship, avoiding separation, or separating safely. Therapeutic services provided through community clinics can provide supports to these couples. The focus of this practicum was working with couples who were experiencing conflict, sometimes including violence, in their relationship. In an evaluative phase, couples were assessed for their current risk for violence then therapy was provided using individual therapy, conjoint therapy, or a combination of the two (depending upon the results of the assessment). Some sessions were provided with a co-therapist. Structural family therapy, based primarily on the work of Salvador Minuchin, was utilized as the model of intervention.

Learning Objectives

The following learning objectives were set out in the proposal for this practicum:

1. To increase my understanding about the theories and clinical treatment of marital conflict.
2. To enhance my clinical skills in a variety of therapeutic modes:
   a) individual, conjoint, and family therapy (when indicated); and
   b) working alone and as part of a co-therapy team.
3. To practice using clinical measures to aid in therapy and to evaluate the effectiveness of interventions.

4. To work in partnership with other systems involved in servicing domestic violence.

5. To integrate this learning into other spheres, such as my work with children and youth.

Chapter 2

Couples and Violence

Background

At the outset, it is important to decide on a definition of the problem. Wiebe (as cited in Frankel-Howard, 1989) defined "wife assault" as:

> ...violent acts by men against their wives/partners. The assault may be psychological, sexual and/or physical. The intent is to control women through isolation, inflicting pain and inducing fear. The physical assaults range from threats, to beating, to homicide. They are accompanied by varying degrees of psychological abuse designed to degrade and belittle. (p.57)

This definition incorporates a number of important components of spousal abuse:

1. It highlights that violence is involved.
2. There is an acknowledgment that spouse assault is not limited to physical or sexual abuse, that psychological abuse can also be assaultive.
3. There is "intent", it is not a random or accidental act.
4. A range of tactics is identified, "isolation, inflicting pain, and inducing fear". Fear is an important element, as it allows the abuser to exercise control without resorting to the use of physical violence every time.
5. There is an acknowledgment of the varying lethality of assaults, ranging from verbal abuse to homicide.

6. There is a long-range impact of abuse. Through being "degraded and belittled", the woman's self esteem is broken down, reducing her ability to take steps to change or get out of an abusive situation.

An illustration of this definition is the case of Rhonda and Roy Lavoie (which prompted a Commission of Inquiry in Manitoba in 1997). The Lavoie story is a one in which the couple played out many aspects of the above definition, culminating in a murder/suicide. The violence in the Lavoie home had been extreme enough to draw the attention of the police for over a year before the murder. Roy Lavoie used a combination of physical, sexual, and verbal abuse to control his wife. There was a range of violence in Roy's actions, from threats to rape to murder. He tried to control her through monitoring her telephone calls. He tried to isolate her by keeping her away from the people who were her social supports. Roy's abuse included insults designed to "degrade and belittle" Rhonda, such as comments about her weight. The composite is a sad illustration of what is an all too common situation.

Prior to the 1970's, wife abuse was not seen as a major problem in our society (Davis, 1987; Ganley, 1989; Trute, 1998). Occurrences that were deemed as extreme (such as that of the Lavoies) were thought to be isolated and caused by abnormal "personal pathology" (Gelles & Straus, 1979, p. 549). Less extreme violence was unnoticed, ignored, or accepted. Beginning in 1971, academics and practitioners began to publish papers exploring wife abuse as a societal problem, with common societal roots. Feminist authors began to write about social forces that contributed to the acceptance of wife abuse as a private matter and kept it a hidden crime (Burris & Jaffe, 1984; Cook & Frantz-Cook, 1984; Davis, 1986; Trute, 1998). One factor that received attention was

what we now call "traditional" male and female roles. This refers to the stereotype of the man as the "head of the family", a position with extended rights and privileges. The man was the dominant force in the family, while the woman was seen as a reflection of his light (e.g., Mrs. John Doe). To maintain his dominance, society allowed the man a great deal of latitude in the area of enforcement (Gelles & Straus, 1979).

In opposition to the expectations and permissions which were (and arguably are) bestowed upon men, the expectations placed upon women were to be a good wife and mother. The woman's job was to maintain the family. Much as the expectations on the man contributed to abuse, the expectations on the woman constrained her from leaving an abusive situation. Further, the woman was often made to feel that somehow she was to blame for her own abuse. The role of subservient wife also created a dependency on the husband (Schuyler, 1976).

In the 1970's, male therapists were more prevalent than female therapists. Since therapists bring their own values into therapy with them (attempts to the contrary notwithstanding) the dominance of men was an accepted reality, not an injustice to be railed against. In addition, many therapists working with violent couples grounded their work in systems theory, which focuses on interactions. By exploring the actions of both abuser and victim in the interaction of abuse (i.e., looking at their relative contributions to the abuse), therapists reduced the emphasis on holding the perpetrator responsible for the violence.

Feminist therapists and authors were instrumental in identifying these problems, and in forcing these issues to be addressed. Feminists contended that emphasizing the contribution of the victim in the abusive interaction was tantamount to blaming the

victim. They insisted that therapists re-think the manner in which wife abuse was conceptualized, emphasizing the importance of holding the abuser accountable for his actions. In this way, feminist thinking not only influenced how abuse was understood, but also how it was treated clinically.

In challenging the prevailing conception of wife abuse as a symptom of mental illness or "personal pathology" (Gelles & Straus, 1979, p. 549), feminists stressed the elements of power and control that pervaded the abuse. They argued that abusive men used the abuse as a means to an end, keeping the woman in a one-down position. Feminist advocates were instrumental in establishing support services for abused women, including shelters and therapeutic groups. These services were created to help address the power imbalance in abusive relationships by giving women a chance to find acceptance, support, and empowerment in a safe environment, out of the grasp of the abusive man.

The increased emphasis placed on studying and mitigating wife abuse has lead to an expansion of our knowledge in this area. We now recognize that wife abuse exists throughout the population, irrespective of demographic factors such as socio-economic status, race, age, and religion (Schulman, 1997). There have also been studies that focus on women who perpetrate violence upon their partners. These studies show that women, too, can be abusers, but their violence tends to be retaliatory and less injurious (Frankel-Howard, 1989; Orme, 1994).

There is a correlation between abuse perpetration and having experienced abuse as a child (Frankel-Howard, 1989). There is also a correlation between abuse perpetration and victimization, and having witnessed abuse as a child (Karpel, 1994;

Cappell & Heiner, 1990). Other problems experienced by children who grow up in families where wife abuse is present include childhood trauma, unmet emotional and developmental needs, anxiety, fear, conflict, and guilt (Elbow, 1982; Silvern & Kaersvang, 1989). The negative impact of children witnessing violence is also documented in the Statistics Canada (2001) report on family violence which states "children who witnessed violence in their homes ...were more than twice as likely to be physically aggressive, to commit delinquent acts against property, and to display indirect aggression."

There is a correlation between drug and alcohol abuse and wife abuse perpetration (Hindman, 1979; Karpel, 1994). However, the accepted way of understanding this relationship has changed over time. At first, alcohol was thought to cause the abuse, but that view is now considered to be an example of letting the perpetrator off the hook for his actions ("It's not my fault, I was drunk"). More recently, alcohol and drugs are thought to have a disinhibiting effect (i.e., contribute to the perpetrator giving himself "permission" to be abusive) (Frankel-Howard, 1989).

Another feature of abusive relationships that has gained attention is the element of fear that permeates the relationship. The perpetrator cultivates fear in his victim(s) through the combined use of violence and threats. Over time, the threats are invested with the ability to produce fear in the victim. She now truly believes that the abuser will follow through with his threat. The climate of fear functions to maintain the abuser's control while at the same time constraining the victim from acting, without the necessity of further violence (DeMaris & Swinford, 1996).

Prominent in the current body of knowledge is the "Cycle of Violence" (Walker, 1979). The basis of this theory is that violent relationships are characterized by a pattern of behaviour in which there are three distinct phases: i) the buildup phase, ii) the blowup phase, and iii) the honeymoon phase. In the buildup phase, the man experiences negative emotions, often wholly unrelated to his female partner. Feelings of rage and frustration well up in the man who lacks (and chooses not to chose) an adequate and/or appropriate outlet. All couples experience times of tension which ebb and flow, but in an abusive relationship, one in which this pattern is being repeated, the victim either consciously or unconsciously senses the build up and anticipates what is to follow. It goes without saying that this period is fraught with fear and anxiety for the woman. This tends to be the longest phase.

The blowup comes over an issue big or small, it does not matter. The man uses the woman as a scapegoat, blaming her for one or more perceived faults or transgressions. During the ensuing interaction the woman tries to placate the man, to calm the situation, and to emerge unharmed. In some cases, the build up phase may cause such anxiety and tension for the woman that she may trigger the man's explosive outburst to get it over with. It is during this phase that the risk for the victim is at its greatest. The blowup usually does not exceed one or two days in duration.

The next phase is a honeymoon period. During this phase, the man is loving and repentant, and begs for forgiveness. He may reinforce his contrition with gifts. The man will often make promises to change: he will never hurt her again, he will stop drinking, whatever he perceives as the "reason" for his abusive behaviour. In short, he may appear to be trying to become all that woman wishes he would be. In the cycle of violence, this

overt display of attention and affection is what convinces the woman that the abuse will stop, that the man will indeed change, and that the woman is instrumental to the man's successful transformation. Unfortunately, the painful reality of the cycle of violence is that soon the man's frustrations begin to build once again, leading to further incidents of abuse as the cycle begins to repeat itself. The psychological damage wreaked upon the woman stemming from the realization that she has been repeatedly duped into believing she has the power to create positive change only to find herself once again in the midst of abuse is of major importance in understanding and treating wife abuse. A number of authors have noted that over time, the effect of repeated cycles of abuse on the woman is akin to the psychological damage inflicted in a hostage taking situation (Bograd, 1992; Karpel, 1994). She may become inured to the violence, begin to believe the abuser's blaming, or lose the energy required to try to keep herself safe. This contributes to making it more and more difficult for the woman to leave the relationship, despite the tendency of abusive relationships to become increasingly violent over time (Karpel, 1994).

For his part, the man is "rewarded" for his violence by a period of time during which the relationship is joyful and positive (the honeymoon phase). His trivial suspicions and complaints about his wife are submerged by the flow of warmth and closeness. In one swift explosion, he has demonstrated his power and released his pent up rage. He has reasserted his control, not only through the violence itself, but also through reinforcing the threat of violence.

There is some hope that positive change is occurring in the form of decreased wife abuse. Straus and Gelles researched violence between spouses in 1975 and again in

1985 for a sample population in the United States. Their work showed a 27% decrease in self reported wife abuse over that time (Straus & Gelles, 1986). However, this result was not statistically significant and the authors, themselves, flagged a number of methodological issues that preclude accepting the reported decrease at face value. Information from Statistics Canada (2001) found a similar trend in Canada when comparing data from the five-year time period prior to 1993 with data from the five-year time period prior to 1999. After noting that the methodology of those two studies was not identical and therefore that comparisons should be made with caution, the report states that the five-year rates declined from 12% in 1993 to 8% in 1999. While these results may seem on the surface to be encouraging, there appears to be little change in the rate at which Canadian women are admitted to shelters for reasons of abuse. In 1998, 2,260 women were admitted, compared to 2,281 in 2000 (Statistics Canada, 2001). Even if one accepts the theory that self reported abuse is declining, this is not consistent with shelter statistics that probably describe a system operating at full capacity.

Over time, wife abuse has moved from being ignored or accepted, to being recognized as a major societal problem. Our understanding of the incidence, correlates, and pattern of wife abuse has increased. Society's supports for abused women have increased. Therapists' sensitivity to issues related to appropriate and inappropriate treatment of wife abuse has increased. Legislation has been created in the attempt to curtail wife abuse. Yet, wife abuse is still prevalent throughout our society. According to Statistics Canada, in 1993 three in ten women currently or previously married or living in a common-law relationship in Canada experienced at least one incident of physical or

sexual violence at the hands of their current partner or a former husband or common-law partner. Clearly, substantially more work is required on the issue of wife abuse.

Treatment of Couples Who Have Experienced Violence

Treatment of violent couples can be comprised of a variety of components including: (a) individual therapy (for the victim and offender), (b) group therapy (also for a variety of populations), (c) conjoint couple therapy, and (d) conjoint family therapy. Whatever treatment model is chosen, there are some therapeutic issues that supersede the model. Two of these issues are safety and sequencing.

An area of consistency across therapists and authors is that the safety of the victim from further abuse must be the primary concern. The ability to work effectively in therapy is jeopardized (or eliminated) by ongoing violence (e.g., any work done in therapy to correct imbalances in the power differential of the family would be undermined). But there are also less obvious problems that are created. "Certainly to treat a family where there is active abuse...reinforces for the abuser that he/she can successfully 'con' the professionals and manipulate the system with impunity" (Yegidis, 1989, p. 527).

Cessation of violence is generally seen as a precondition to therapy, especially conjoint therapy. However, some authors seem more exacting than others in their expectations and responses. While some authors mention safety in passing (e.g., McKain, 1987), others explicitly design facets of their treatment around ongoing evaluation of safety and openly express a willingness to either (a) move to individual sessions or (b) involve the legal system to enforce safety (Willbach, 1989; Lipchik, 1991).

The use of safety contracts is particularly well documented (e.g., Harris, 1986; Bograd, 1992; Steinfeld, 1989). Willbach (1989) utilizes acceptance and adherence to a contract of non-violence as a criterion for conjoint work:

> If the violent family member will not or cannot agree to stop the use of violence in all circumstances, or exhibits by his actions that he cannot live up to the agreement, then that person needs to be treated individually and/or within a group context. Couples or family therapy is not the appropriate modality: It will not be as effective in changing behavior as individual and/or group therapy and has negative consequences from an ethical point of view. (p. 48)

While emphasis on safety is crucial and safety contracts seem to be a popular tool for attempting to assure the cessation of violence, it is important not to make the false assumption that a contract actually assures safety. A safety contract is, after all, only as good as the therapist's judgement, and the assurances of the offender and victim that it is being honoured. It is especially important to be distrustful of the self report of the offender. The offender may deny violence to avoid sanctions, maintain power, or assuage feelings of guilt. The word of the victim, however, is often trusted. Bograd (1992) questions this trust, citing authors who point out that

> ...battered women have much in common with hostages held by terrorists who, unable to escape life-threatening situations marked by social isolation and dependency, form deep attachments to their captors and,

> because of trauma, are unable to assess their real plight or risk because the men's intermittent but persistent abuse has destroyed their subjective realities. (p. 250)

Clearly, there is reason for concern about just how much "safety" such safety contracts actually provide.

The use of conjoint therapy and the safety of spouses and children are issues questioned by many feminists, some of whom argue that a male abuser should not be allowed into any session with his victim(s) (e.g., Bograd, 1992; Schechter, 1987). Based on the review of the literature, it seems clear that whether or not a therapist supports the use of conjoint therapy, safety is the primary concern when working with families of violence.

Sequencing treatment (the order in which different forms of therapy are delivered) is closely connected with the issue of safety. Sequencing is preceded by the question of who, if anyone, needs to be removed from the home to help assure safety. In the case of childless couples, the final decision rests with the couple. For families with children, this decision is often made by a social worker and agency charged with the responsibility of assuring safety of the family members. If it is deemed unsafe for family members to live together, this has implications for sequencing treatment (i.e., withholding conjoint therapy until safety conditions are met).

A variety of specific models have been proposed for sequencing treatment (e.g., Furniss, 1991; Walker, 1979; Weidman, 1986; Wheeler, 1989). Some programs require the attainment of set goals or achievement of set criteria prior to beginning further steps.

In the model designed by Walker, for example, the first few sessions with a violent couple are individual, preferably with the couple separated and living apart. Walker believed that these circumstances not only provided greater safety for the victim, but also greater motivation for change. Additional benefits of early individual sessions are that the therapist (or co-therapists, as in Walker's model) is able to assess the level of commitment of the couple, the level of risk for the victim, and the degree to which the offender is able to control his behaviour. Of interest, Harris (1986) notes that Walker no longer advocates conjoint couple therapy as an appropriate mode for treating violent couples.

In general, authors agree that some combination of individual treatment and group treatment should precede the use of a conjoint mode (either couple or family) of therapy. Wheeler (1989) in her work with male sexual abuse offenders states:

> Individual, couple and family therapy are useful complements to group treatment, but are rarely sufficient in and of themselves. While individual treatment may begin immediately, couple and family work are best initiated after the offender and other family members have done some work on their own, either individually or in groups. (p. 30)

Blau (1993) echoes Wheeler's sentiments, suggesting that individual and group work must be successfully completed by the victim, the offender, and other family members prior to considering couple or family therapy. Wylie (1996) describes her program as depending almost exclusively on group work, with little or no individual or couple work

at all. For Willbach (1989), previously mentioned as a strong advocate for the safety of the victim, progressing from individual and/or group treatment to conjoint treatment is dependent upon the offender being able to contract for non-violence.

Lipchik (1991) sets out six criteria that must be met before she moves from individual sessions to conjoint: (a) the woman is safe, (b) the partners are more than objects of self-gratification for each other, (c) there is motivation to change, (d) there must be signs of bonding and personal caring for each other, (e) there is some feeling of healthy satisfaction from the relationship, and (f) there is a sense of responsibility for what happens next. Lipchik is also comfortable moving back and forth between individual and conjoint modes. She advocates for individual therapy if there has been further violence (or there is a high risk for). Lipchik moves back to conjoint therapy once safety is re-established.

Trute (1998) outlined five criteria that should be met before conjoint work is considered: (a) the woman is safe, (b) the woman (and children) have no fear, (c) the woman is not ambivalent to maintaining the relationship, (d) the man accepts responsibility for the violence, and (e) the man has adequate impulse control. Trute feels that this last is important because even if the first four criteria are met, there can be no real safety if the man cannot control his behaviour. If the therapist is concerned about safety, Trute recommends stopping the session and moving immediately to individual work.

While the above mentioned authors advocate for preparatory work before working conjointly, others express little or no concern in this area. Bedrosian (1982), writing about the treatment of marital violence, does not mention any form of therapy other than

couple therapy. Traicoff (1982) describes a model shelter program for abused women in which the abuser is contacted as soon as possible after the woman's admission. The abuser is encouraged to have open (though supervised) visits with his family. This contact can be concurrent with individual and couple counselling, if the couple is willing.

Interestingly, the articles and books that exhibit less concern regarding the potential negative effects of conjoint therapy tend to be a few (though not many) years older than those in which the potential negative effects are more painstakingly identified. This is likely the result of greater sensitivity to these issues, due to the critique of feminist authors.

There are several important points noted in the above discussion about sequencing. These include (a) accepting that the emotional and physical safety and well-being of the victim is the primary concern of the therapeutic process and (b) that erring on the side of caution is preferable to moving too quickly and risking further damage to the victim. There needs to be thorough preparation before conjoint therapy is considered. If the level of safety is not acceptable, conjoint therapy should not be considered.

Karpel (1994) suggests an evaluation framework for exploring the level of safety in a couple relationship and determining appropriate interventions. He begins by noting the importance of being able to recognize the characteristics and behaviours that are consistent with the profile of an abuser, highlighting: (a) problems with alcohol and/or drugs, (b) obsessive attachment to the partner, (c) pathologic jealousy, (d) a need to control the woman's every move and/or to isolate her from friends and family, (e) a narcissistic blow (e.g., loss of employment), (f) expression of rage but not loss, (g) a history of violent behaviour and/or relationships, (h) a history of witnessing abuse, and

possibly (i) a history of abusing children (pp. 295-6). Karpel recommends holding separate sessions for the man and the woman, as part of the evaluation. This allows the victim to speak freely without reprisal from the abuser, though the therapist is wise not to assume that this ensures her safety. Though not within this practicum, I was once informed by a woman with an abusive partner that the partner grilled her about what she revealed in the individual therapy sessions she attended, then intimidated and beat her when he did not believe her response that she had not mentioned his abusiveness. Despite the potential risk, use of individual sessions is generally supported as an important aspect of assessing couples (Cook & Frantz-Cook, 1984; Trute, 1998). Karpel also emphasizes the importance of assessing any children the couple may have, as a precaution against their being abused.

If there is violence in the relationship, Karpel (1994), citing Walker (1991) advocates for the immediate development of safety plans for the woman and the man. The woman's plan needs to be concrete and detailed, entailing an escape plan and a plan for accessing supports. The man's plan needs to focus on early identification of precursors to the build up phase and steps to remove the man from the situation. Karpel (1994, p. 298) incorporates a "decision tree" as a step by step guide to assessment and immediate action.

As outlined above, there are numerous issues regarding where conjoint therapy should fit in a sequence of treatment modalities. But why use conjoint therapy at all? What could conjoint therapy address that would not be dealt with in individual or group work? Under what specific circumstances is conjoint therapy indicated or contraindicated?

Gelles and Maynard (1987) feel that most family violence is rooted in dysfunction at the family system level, therefore the family is the appropriate unit for intervention. They do warn that conjoint therapy is only advisable in cases of "mild to moderate violence", and that "in cases of severe and life-threatening violence, it is clearly inappropriate and extremely dangerous to use conjoint or systems interventions" (p. 272). They feel that "a structured family systems approach is still appropriate for husbands and wives who push, grab, shove, slap, and throw objects at one another" (p. 272).

Citing Howling et al. Blau (1993) also supports conjoint therapy once individual and group therapy for the abuser, victim, and other family members has been completed. The author reasons that in the therapeutic environment, and with the guidance of the therapist, family members are better able to handle confrontation and the expression of feelings. While the author is referring to family therapy rather than couple therapy, the argument works for couple therapy as well, since the author is referring to focussing on interactions as a means of facilitating additional change. On balance, Blau (1993) also cites concerns voiced by Mann and McDermott (1983) and Sigler (1989) about the possible detrimental effects of forcing victims to face their offenders in therapy (i.e., retraumatization, anxiety, fear, guilt).

In support of the use of conjoint therapy, systems theorists advocate for understanding the pathology of violence to exist at the family system level, rather than exclusively at the level of individual psychopathology (e.g., Pardeck, 1989). Pardeck states that if care is taken not to remove or reduce the responsibility of the perpetrator, this approach can offer some illumination into the workings of the family. This is useful as the ramifications of violence clearly reverberate through the relationships and

subsystems of the family.

Numerous treatment models have been utilized when working with couples and families, such as structural (e.g., Gelles & Maynard, 1987), strategic, solution focused (Lipchik, 1991), social learning theory (Ganley, 1989), ecological (or "ecosystemic", as coined by Flemons, 1989), non-violent action and conflict resolution skills training (Latham, 1986), and cognitive-behavioural (e.g., Steinfeld, 1989). While this diversity provides a great deal of "food for thought", it can place a therapist in a quandary. Choosing one model from which to work can be a perplexing process.

One model of intervention, particularly relevant for this practicum is Walker's model, which uses male and female co-therapists. Harris (1986) states that use of male and female co-therapists is

> ...singularly important in building trust and rapport with battering clients. Clients begin to depend on same-sex therapists to help express and clarify thoughts and feelings. They start to bring their problems to therapy rather than engaging in disruptive patterns of behavior. Moreover, clients are much more open to confrontation of thoughts and behaviors by same-sex therapist than by opposite-sex therapist. Seductive ploys on the part of the battered mate toward the male therapist are reduced or eliminated. (p. 614)

Despite noting that research by Mehlman, Baucom and Anderson (1983) showed no difference between the outcome of couple therapy using either a single therapist or co-therapists, Harris (1986) contended that co-therapy is more effective with couples whose

reason for attending therapy is violence.

There is divergence between authors regarding the role of the therapist when working with violent couples and also the manner in which the abuser should be approached. Jenkins (1993) espouses an approach that concentrates on engaging the perpetrator. The rationale for this is the very real possibility of the perpetrator dropping out of therapy. Jenkins suggests that by being respectful yet challenging, the therapist increases the chance of the man making some progress. Madanes, Keim, and Smelser (1995) advocate for a very up front and forceful method of treating the abuser. They feels that when the man enters therapy, he is at that moment motivated to change. Therefore, this is the moment when they bring into therapy family members, neighbours, anyone within the couple's social circle who might be able to act as an informal social control agent. After having the man accept responsibility for his actions (with help from the others, if necessary), they then ask the man to get down on his knees and beg his wife's forgiveness in front of the group.

While this approach may not fit for all therapists, the inclusion of social others is most interesting and raises the question, why shouldn't treatment for violence be made more public? Leeder (1994), too, involves extended family and members of the family's social network, both as part of the victim's safety plan and as a support to the abuser (which is seen to be indirect support to the victim). The technique of including people from the social network of the family echoes the Family Group Conferencing model that was first introduced in New Zealand in 1989 for use in child welfare cases (Sieppert, Hudson, & Unrau, 2000). One of the main elements of this type of intervention is to broaden the social circle of the family. This reduces the ability of the abuser to hide the

abuse and limits his ability to isolate the victim from social supports.

Two other innovations in the field of partner abuse that carry some promise and warrant mentioning. First, the Calgary Women's Emergency Shelter offers a Men's Crisis Service. This service is provided as a support to the women. It is an attempt to relieve pressure on the women by helping their partners through their own crises. This is also in recognition of the extremely high risk a woman places herself in when she tries to break away from a violent man. The second innovation is the use of mentors or "sponsors" in a program at the Institute for Family Services in Somerset, New Jersey (Wylie,1996). This connects successful graduates of the program with men entering treatment. This is included as an extension of group treatment.

A cautionary note is sounded, however, by Rosenfeld (1996) who found little difference in the rate of renewed violence when he researched perpetrators who have been court ordered for treatment and perpetrators who receive other court ordered sanctions. Further, the drop out rates for the two groups were similar, implying that the motivational effect of the court order was minimal.

There has been limited empirical research done to assess the effectiveness of conjoint couple therapy to promote lasting change for violent couples. Carden (1994) notes that although "the results of conjoint therapy outcome studies tend to favor intervention over no intervention. The methodological inadequacies and inconsistencies of these studies, however, render their findings inconclusive." (p. 569) Eisikovits and Edleson (1989) in their critical review of literature reach a similar conclusion. They identify several methodological problems that were prevalent in the studies that they reviewed. These include:

- the lack of control or comparison groups,
- the use of outcome variables other than violence reduction,
- the use of variable timeframes (e.g., a study may gather post test information anywhere from 2 month to 3 years after the conclusion of treatment), and
- inconsistent definitions of successful treatment.

They called for the development of standardized criteria for determining success and concluded that more stringent study was required.

Over the past three decades, strides have been taken in the understanding of family violence, including wife abuse. There is a more thorough understanding of factors that correlate with wife abuse. There is a clearer understanding of the cycle that often accompanies violence. Shelters and crisis systems have been created. Laws have been changed. Even the thoughts and actions of therapists have been questioned, criticized, and largely altered to be more sensitive to the issue of wife abuse. While there have been positive strides, wife abuse is still prevalent, shelters are full, and families are damaged on a daily basis. It is clear that more work is required to reduce the negative impact of the problem of wife abuse. One positive step would be more thorough research on the effectiveness of various therapeutic models and programs.

Chapter 3

Structural Theory and Therapy

Structural family therapy was developed by Salvador Minuchin and his colleagues in the 1970's (Breunlin, Schawartz, & Kune-Karrer, 1992). In the creation of this model, Minuchin drew from the work of systems theorist Ludwig von Bertalanffy (Breunlin et al., 1992), cybernetics theorist Gregory Bateson (Minuchin, 1974), and structural-functional sociologists such as Erving Goffman (Minuchin, 1974) and Talcott Parsons (Breunlin et al., 1992), as well as from his close professional relationship with Braulio Montalvo and Jay Haley (Minuchin, 1974) (although Haley is considered to be a strategic family therapist, these two models grew in parallel and share many ideas, see Todd, 1986). In part, the model came as a reaction to the view that human problems are based on intrapsychic pathology, a view that was dominant at that time. In contrast, to use Minuchin's words, structural family therapy is "...a body of theory and techniques that approaches the individual in his social context.... The theory of family therapy is predicated on the fact that man is not an isolate. He is an acting and reacting member of social groups" (1974, p. 2).

Structural family therapy is basically a problem-solving model that attempts to clearly identify goals for therapy, understand the family through its structure and transactional patterns, then create change by altering the structure and patterns. This model looks to identify and use the family's strengths and resources to solve problems in a manner that will be continuously reinforced through the new structure and patterns.

Structural family therapy is based on the premise that a person is a product of the basic social group, the family, which in Minuchin's terms is "the matrix of identity" (1974, p. 47). This means that a person draws his/her identity from his/her relationships and interactions with members of the family. Therefore, in order to understand the problems that an individual experiences and to attempt to create positive change for that individual, the family must be the unit of investigation and change. In turn, the family system is itself surrounded by and interacting with other systems (Haley, 1978). These external systems interact with the family, just as the individuals within the family interact with the other family members. Importantly, any change within a system necessarily creates change throughout the system, though Minuchin postulated that change can only flow from a larger system (e.g., society) to a smaller system (e.g., the family), not the other way around.

As can be inferred by the title, the structure of the family is central to this theory. Family structure is "...the invisible set of functional demands that organizes the ways in which family members interact" (Minuchin, 1974, p. 51). These demands are met through the "transactions" amongst the members of the family. When these transactions are repeated, they become the patterns that define the family structure. Transactional patterns are maintained by two mechanisms. First, there are universal rules for how families are organized. Second, each family develops a set of rules that is specific to that particular family. Minuchin calls this second type of rule "idiosyncratic" (1974). Idiosyncratic rules are based on the expectations of the family members. Each family, with its own set of expectations, rules, and transactional patterns, is self-correcting (i.e., when change occurs that affects the family, the tendency is for the family members to

react in ways that return the family to its former state of functioning). However, the circumstances of the family are constantly changing, either through external pressures or through internal developmental change. These changing circumstances require the family to adapt. When a family's range of transactional patterns is sufficiently broad, the family is able to adapt. When the range of patterns is limited, the family struggles to accommodate the required changes, causing strain within the family. One of the goals of therapy is to help the family develop a broad enough range of behaviour to allow the family to adapt to their changing circumstances (Haley, 1978).

Within the family system, there are subsystems based on function, such as the parent subsystem, the sibling subsystem, etc. Everyone is a member of multiple family subsystems. For example, Mr. X might be a member of the husband-wife subsystem, the executive subsystem, a father-son subsystem, etc. How these subsystems are organized within the family is crucial to structural theory. Transactional patterns between family members and with external systems, can illuminate the family's structure.

Within subsystems, roles are complementary. This is not to say that all roles work well and contribute towards the greater good. Rather, it implies that all roles fit with others within that subsystem to establish patterned transactions that are relatively stable in their occurrence. Within a subsystem, the participant's actions "aren't independent; they're codetermined, subject to reciprocal forces that support or polarize" (Minuchin & Nichols, 1998, p. 108). Complementarity allows for predictability. For example, if I say "Knock, knock" to my six year old daughter, I can predict with assurance that she will respond "Who's there?"

Closely related to transactional patterns is another key element of structural family therapy, the concept of "boundaries". Minuchin (1974) described subsystems as having a set of rules that defined the subsystem's boundary. Each subsystem has a function. To perform this function effectively, the boundary around the subsystem must be strong enough to prevent interference from outside the subsystem, yet the boundary must also be flexible enough not to exclude all outside influences. Minuchin (1974) envisioned a range of boundaries with inappropriately rigid boundaries (labeled "disengaged") at one end, inappropriately diffuse boundaries (labeled "enmeshed") at the other, with the majority of boundaries (labeled "clear") falling into the middle, normal range. These boundaries represented the subsystem's preferred transactional style. He felt that with the exception of extremes, transactional styles did not indicate abnormality. Therefore, it is not important for a therapist to discern what type of boundaries surround the subsystems within a family in order to label a type of pathology. Rather, understanding subsystem boundaries is important in order to understand what the family's transactional patterns are and to design interventions that will clarify boundaries and restore balance to the system. Minuchin feels that for families with boundaries characterized by the extremes of enmeshment or disengagement, family members could develop "symptoms". These symptoms were not to be seen as pathological, but as problematic attempts at adaptation, inappropriate solutions.

Enmeshed boundaries are so diffuse that the difference between subsystem members becomes blurred. As one thinks, feels, or acts, so too does the other. A small stress on one member is keenly felt and energetically responded to by the others in the subsystem. In contrast, disengaged boundaries are rigid, allowing little to cross.

Therefore, moderate stress in one member is not sufficient to be felt by and responded to by other subsystem members, only extreme stressors can penetrate and mobilize a family's resources to assist the member experiencing the stress. Since each family member is involved in multiple subsystems, it is likely that he/she experiences both enmeshed and disengaged transactional styles, depending upon the subsystem. For example, a woman could be enmeshed with her father and at the same time disengaged from her husband. This raises another important point, subsystems exist across generations, and therefore intergenerational boundaries must also be explored.

Systems with enmeshed boundaries have a difficult time allowing members to move away from the system. The classic example is when a teenager begins to place more emphasis on the importance of peer relationships and begins to pull away from the family. When this occurs, the family system will experience increased stress, especially if it is characterized by enmeshed boundaries. Disengaged family systems, on the other hand, allow members to come and go with little disruption. However, it is difficult to tap into the strengths of other family members, because the connection between members is so rigid.

The basic premise of structural family therapy is that by helping the family clarify the boundaries around the various subsystems, the therapist helps the family develop new, more flexible transactional patterns, which in turn help the family (and each family member) adapt to changing circumstances. If, for example, a father is disengaged from the rest of the family and the mother is enmeshed, the system needs to be rebalanced by bringing the father closer to the rest of the family and helping the mother become less involved.

Subsystems can be of varying sizes, from dyads to much larger groups. Haley (1978) suggested that triads are the minimum size of subsystem that should be considered. Haley placed emphasis on triangulation, how the three persons interact. The focus of this practicum is primarily conjoint couple therapy, which automatically forms a triad, since the therapist is considered as part of the couple-therapeutic subsystem. Haley (1971) states that a family therapist "assumes that the way the family is behaving is influenced by the ways he deals with them, and therefore he includes himself in the diagnostic unit.... He is examining not merely how the family members respond to each other but how they respond in his presence" (p. 282).

Structural family therapy looks at the organization of the family, particularly the family's balance of power and hierarchy (Haley, 1978; Todd, 1986). Within and across subsystems, members have different levels of power. These differing levels of power describe the hierarchy. All organizations are assumed to have a hierarchy that allows efficient functioning of the system. In the case of a family, there is an executive subsystem, usually comprised by the parents. In single parent families or households that include extended family members, the hierarchy may be different, with the inclusion of a parental child or a grandparent. Minuchin is clear that these different organizational characteristics are not automatically problematic, provided the rules (boundaries) around the subsystem are clear.

Minuchin (1974) also identified the tendency for families to form alliances and coalitions. Alliances occur when family members join together toward a common cause that helps to meet the needs of the family. Coalitions have a more negative connotation, occurring when family members band together against another member of the family. A

related concept is "detouring", which occurs when a member or members of a subsystem misplace conflict by forming a coalition against another member of the family. For example, parents may avoid open conflict by detouring the conflict through the eldest child. In this fashion, it can appear that the conflict is between a child and the parents, when in reality the conflict is between the parents.

The work of Carter and McGoldrick (1982) in developing a model of the family life cycle is seen by Minuchin and others (e.g., Breunlin, Schwarz, & Kune-Karrer, 1992; Goldberg & Goldberg, 1991) as providing another layer of understanding to structural family therapy. The family life cycle identifies stages through which families typically progress. Various authors have described different stages, but generally these stages can be described as (1) single young adults, (2) the newly married couple, (3) families with young children, (4) families with adolescents, (5) families launching children, and (6) families in later life (Goldberg & Goldberg, 1991). Movement from one stage to the next requires the family to change and adapt in order to accommodate new roles and functions. These transitions are stressful for all families, but particularly so for families with limited transactional patterns. The theoretical model of the family life cycle is based on the experience of the "normal" nuclear family. In reality, families can experience more than one transition at a time, which amplifies the stress. An example of this is a blended family in which there are adolescent children from a previous marriage and young children from the current marriage.

From the first contact with the family, one of the tasks of the structural family therapist is to "join" with the family. This is an active process of learning and taking on the characteristics of the family's interactive style. This can mean the therapist must

modify his/her language, adopt phrases used by the family, and use a level of affect and proximity that is similar to that used by the family. The purpose of joining is twofold. First, through this means the therapist becomes a temporary part of the family system and actually experiences the feelings that are shared by the family. This allows the therapist's understanding of the family's troubles to transcend contemplation of their self-report. Second, joining is intended to build trust and rapport with the family through the respectful demonstration of attention paid to the family's story. This is important as the relationship between the therapist and the family must be strong enough to withstand the stress that the family may experience in relation to the challenges and directives of the therapist. However, Minchin (1974) cautions that the therapist must achieve a delicate balance between joining with the family and maintaining enough distance to retain the role of leader within the therapeutic process. If the leadership role is not maintained by the therapist, he/she will not be in a position to assist the family to effect change.

Based on the knowledge of the family gained through joining, the family's self report, and observation of the transactional patterns of the family members, the therapist and family set goals for therapy. In Minuchin's opinion (1974), goal-setting or therapeutic contracting, is imperative, though he stresses the importance of flexibility. He believes that contracting does not need to be exhaustive, but must achieve a minimal level, and can be renegotiated over time.

Intertwined with joining is the process of restructuring the family, which is the core of structural therapy. Minuchin (1974) identified seven categories of restructuring operations: (a) actualizing family transactional patterns, (b) marking boundaries, (c) escalating stress, (d) assigning tasks, (e) utilizing symptoms, (f) manipulating mood, and

(g) supporting, educating, or guiding. He did not consider this list to be complete, allowing for variations in the individual styles of therapists and specific characteristics of families.

"Actualizing family transactional patterns" refers to the process of having the family enact problem-solving scenarios in the therapy session. By observing the family interacting with each other, the therapist is able to avoid two potential problems that can stem from a reliance on the family's self-report. First, the degree to which the therapist inadvertently becomes central to the interaction (and therefore creates a different interaction) is reduced. Also, direct observation of the family's interactions decreases reliance on the family's self-report, which can be skewed by their beliefs. An emphasis is placed on the process (the interaction) rather than the content (the story). Actualizing family transactional patterns can be used for gathering information or for intervention. Intervention can include directing who interacts, how the interaction is structured, purposeful intervention by the therapist, altering the physical proximity and orientation, etc.

"Marking boundaries" refers to the process of identifying boundaries that are too disengaged or too enmeshed, around and within the family, then working with family members and subsystems to strengthen those boundaries that are too diffuse and create more flexibility for those that are too rigid. Interventions designed to address problems with subsystems (e.g., spouse, executive, sibling, etc.) are common. These can include altering attendance in the therapeutic session, the therapist forming alliances with specific individuals and placing family members in the role of observer. Structural therapists are watchful for rigid triads, such as parents becoming locked into a struggle with a child.

Repositioning family members within their subsystems alters the interactional patterns and the nature of the subsystem boundary.

Families develop transactional patterns for handling stress. These patterns are not always helpful for addressing the root of the stress. Families can also become locked into these patterns, with limited ability to test alternatives. By "escalating stress" at different points within the subsystem, the structural therapist can force the family to experience different patterns. According to Minuchin (1974) this must be done with a clear understanding of the family, so that the stress that is induced is sufficient to create change, but not so significant as to traumatize the family. Stress can be escalated by forming alliances and coalitions with individuals within the family or by blocking the family's regular interactions.

"Assigning tasks" occurs both within and outside of the therapeutic session. Within the session, this often takes the form of the therapist directing family members to interact in ways that are not usual for them. A variation is to have the family replicate regular patterns, but with different participants. The point of this process is to highlight the patterns for the family and provide some practice at using alternatives. The family can be given tasks to work on outside the therapeutic session (i.e., homework). These can help highlight the existing strengths of the family or to sensitize family members to processes of which they had been unaware. Since the family spends the vast majority of their time outside the therapeutic sessions, homework helps the family to develop new patterns on their own, or practice patterns learned in therapy, while de-emphasizing the role of the therapist.

Minuchin (1974) incorporates a variety of vehicles for "utilizing symptoms". As stated previously, Minuchin believed that symptoms are often or usually the result of dysfunctional interactions, rather than intra-psychic problems. He suggests emphasizing, de-emphasizing, or exaggerating the symptom, or even shifting focus to a different symptom, all dependent upon the situation with a family. One of the most widely accepted interventions he called "relabeling the symptom", which has since become known as "reframing" (Goldberg & Goldberg, 1991). In this technique, the therapist takes a description provided by the family and deliberately restates it in such a way that the meaning of the situation is changed. This is done by describing the situation in interactional terms.

As the therapist joins with the family, he/she begins to understand the affective mode of the family's interactional style (e.g., serious, depressed, incessantly happy, etc.). Minuchin (1974) states that once the therapist is alert to the family's affective style, he/she can use this as another tool for creating change in the interaction ("manipulating mood"). This can be done by modeling more appropriate affective behaviour (e.g., if the family seems continually angry, the therapist can behave in a more low key manner). In contrast, the therapist can chose to change the family's affect by taking on and exaggerating their affect (e.g., by presenting as even more angry than the family, until the family calms down).

Finally, Minuchin (1974) advocates "support, education, and guidance". Related to his view of the therapist as the leader of the therapeutic system, Minuchin suggests that when the therapist senses that the family (or a given family member) has not learned a skill, the therapist can join with the family, provide guidance, then move out again,

leaving the family with new alternatives for interacting. Using this concept to work with couples, Todd (1986) states "the therapist should intervene as economically as possible while still achieving major therapeutic goals. Ideally, this means identifying and activating skills already possessed by the couple. Failing this, the therapist may need to instruct the couple in necessary skills, such as communication or problem solving" (p. 77).

The above discussion has focussed upon structural family therapy, since that is the origin of the structural model. For the present practicum however, couples (not families) were seen in therapy. While Minuchin (1974) clearly stated his personal preference for working with nuclear families (at times including extended family members), he also stated that "some therapists prefer to work only with the spouses or parents" (1974, p. 147), noting that "inappropriate rigidity or diffusion of the spouse subsystem boundary is a common source of dysfunctional transactional patterns" (1974, p. 145). Haley (1978) is not averse to working with couples, but cautions that the therapist must remain aware of his/her own role in the interactions. As mentioned, Haley advocates for considering the couple as minimally a triad, rather than a dyad, noting that during therapy the presence and/or participation of the therapist influences the interactions. As a caution, Karpel (1994) cites Haley as stating that an emphasis on working with a couple obscures "the structure in which the dyad functions". Perhaps the last word should go to Nichols who states that "most family therapy eventually becomes marital therapy sooner or later and if you're smart you get there sooner" (1988, p. 5).

Structural theory and therapy borrow heavily from systems theory. Both systems theory and structural theory have come under criticism from feminists who feel that

exploring the contributions of all participants to circular interaction patterns necessarily searches for balance, rather than holding people accountable for their actions. They argue that this is particularly evident in cases of wife abuse. "Theoretical constructs that emphasize the 'circularity' of interactional sequences, the 'needs of the system,' and the 'function of symptoms' may make it difficult to place the attribution of responsibility...where it belongs" (Karpel, 1994, p. 295). There is also concern that these theories do not place enough emphasis on the issues of gender and power imbalance that stem from our patriarchal society (Davis, 1987; Gardiner & McGrath, 1995). Cook and Frantz-Cook (1984) provide a balance to this position, stating "the feminist view that the man is fully responsible for the battering and the systemic view that the couple are locked into a recurrent vicious cycle which each has a part in maintaining are not mutually exclusive" (p. 84). This ongoing debate over the positive and negative contributions of systems and structural theory, seems to have had an effect in changing the way in which structural therapy is used (or at least described) by some practitioners. In 1998, Minuchin and Nichols describe a case study using structural therapy with a couple experiencing "marital problems", in which the husband had been physically abusive the wife. Minuchin's efforts to hold the abuser accountable are clear in his statement to the couple "I don't work with primitive people.... Therapy is a privilege. People who hit people are too primitive to take advantage of it" (p. 112). This statement was intended to set the stage for safety and holding the man solely responsible for the abuse.

A review of the literature shows that there has been limited empirical study of Structural Family Therapy. The research that has been done tends to be based on case studies, rather that aggregate data. In 1987, Gelles and Maynard performed a case study

using Structural Family Therapy with a couple who had a background of intergenerational violence. Their rationale for using this model was that in their opinion "social factors explain as much as 90% of the variance in family violence" (p. 271) and since Structural Family Therapy is designed to address such issues, it is a natural choice. After describing the process of therapy, they conclude:

> Roles, rules, boundaries, and communications patterns were set up over a long period of time to that violence was structured into the family system. By implementing structural rearrangements within the family's system, the family members were able to reduce the violence because it was no longer needed for the family to interact. (p. 274)

In a similar vein, Cook and Cook-Frantz (1984) write that couples who have experienced violence in their relationship develop patterns of interacting that require "not only work on controlling individual behaviour, but also interventions that will help to break the homeostatic cycle that maintains the violence" (p. 87). Several authors have written about the effectiveness of Structural Family Therapy based on their clinical experience. Overall, the literature shows that Structural Family Therapy has been used across a variety of populations to address a wide range of difficulties, including family violence (Gelles & Maynard, 1987; Cook & Frantz-Cook, 1984), anorexia nervosa (Liebman, Sargent, & Silver, 1983), alcoholism and substance abuse (Foley, 1976; Preli, Protinsky, & Cross, 1990; Protinsky & Shilts, 1990), and cross-cultural populations (Jung, 1984). What emerges is a picture of a therapeutic model that has been used to address a wide

range of issues. The focus on the family system, the flexibility of the model to address wide ranging issues, the emphasis on the family life cycle, and the attention to transactional patterns and power imbalances combine to make Structural Family Therapy an appropriate model for intervention with couples who have experienced conflict.

In summation, structural therapy focuses primarily on transactional patterns. The field of view is the family within the context of external systems. Within the family are various subsystems that similarly interact with the other parts of the family. By attending to the nature of transactional patterns and by creating change, the subsystem can be assisted to develop new ways of transacting, which in turn allows the system greater flexibility for adapting to change. Within the family, the couple subsystem, which often also functions as the executive subsystem, often experiences difficulty. The family attempts, within its range of behaviour, to find solutions to these difficulties. Unfortunately, these solutions are sometimes unsuccessful, and can contribute to further problems. This practicum focuses on the couple subsystem and explores the creation of alternate solution patterns, with an eye to utilizing the strengths of the family.

Chapter 4

The Practicum Site And Procedures

Background

Initially, this practicum was intended to carry on the Couple's Counselling Project. This project has provided "second stage therapy" to couples who have experienced violence in their relationship, but are not currently physically violent. Later the practicum was expanded to include couples who had not experienced physical violence. Mr. David Charabin, Director of Elizabeth Hill Counselling Centre, was my advisor and clinical supervisor for this practicum.

Practicum site

The practicum was conducted at the Elizabeth Hill Counselling Centre (EHCC). This clinical training centre is operated by the University of Manitoba Faculty of Social Work and is affiliated with the Department of Psychology. The EHCC provides Undergraduate, Masters, and Doctoral level students with a professional-quality setting for clinical training. The Centre's location in downtown Winnipeg aids accessibility, allowing people from all parts of the city to make use of therapeutic services. This is particularly important for residents of the "core area" (a low-income district located near the downtown area) who often find transportation problems to be a significant obstacle to attending therapy. Services are offered free of charge, which is of significant benefit to clients with limited income.

The services offered by the Centre are dependent upon the clinical path of the students and supervisors, and can include group, family, couple and individual therapy for all ages of children and adults. Since the Centre is usually busy with students, advisors, and clients, it is also a good situation for students to learn from one another, through discussing cases, successes, failures, etc. Through this cross-pollination, I was able to spend time working on two cases with one of the Centre's part-time female therapists, as an adjunct to the main body of this practicum.

Supervision

This practicum began as a co-therapy team working to provide conjoint therapy for couples who had experienced physical violence in their relationship, but were not actively physically violent at the time of the therapy. Part way through the practicum, my co-therapeutic partner, left the practicum to work exclusively with women who had been in violent relationships. In consultation with my advisor, Mr. Charabin, I broadened the focus of this practicum to accept couples who had not experienced physical violence in their relationship. For these couples, I worked as a sole therapist.

For the first portion of the practicum, clinical supervision was provided by both Mr. Charabin and Dr. Diane Hiebert-Murphy. The couples with whom my co-therapist and I worked were assigned to either Mr. Charabin (my advisor) or Dr. Hiebert-Murphy (my co-therapist's advisor). We met with the supervisors on alternate weeks. Supervision was provided specific to each couple. Once my co-therapist left the practicum, supervision was provided exclusively by Mr. Charabin on approximately a weekly basis.

Supervision took the form of either case discussion (based on my notes and observations, and initially those of my co-therapeutic partner) or review of session videotapes. Use of videotape allowed a critique of a range of clinical skills, including use of language and inflection, and the formation of therapeutically useful questions. It also provided the Clinical Supervisor with a more accurate idea of the work of the writer. Clinical supervision sessions incorporated analysis of the content and process of the sessions, preparation for upcoming sessions, and discussions regarding the overall progression of each case.

Co-Therapy Team

My co-therapist was also a student in the faculty of Social Work seeking a Masters degree. The workload was divided, with each making initial contact calls to potential clients, setting up intake sessions, and writing initial assessment reports. There are many advantages for using both a male and a female therapist. These include:

- Helping to facilitate the formation of positive therapeutic relationships with clients;
- Increasing the likelihood that clients will feel understood and heard by the therapist;
- Allowing role play in the sessions (including having the therapists take the roles of the couple);
- Decreasing actual and perceived gender-bias on the part of the therapists;
- Allowing one therapist to observe non-verbal interactions and formulate further questions, while the other therapist managed the session; and
- Facilitating the use of simultaneous individual sessions for the couple.

Client Population

This practicum provided the opportunity to work with a variety of clients, both on my own and with two different clinicians. During the co-therapy phase of the practicum, my co-therapist and I worked with a total of four couples who had experienced violence in their relationships. Two of these couples attended therapy sessions over the course of several months, from the intake session through to the termination session. Of the other two couples, one arrived at the centre in an extremely angry state. They engaged in verbal conflict in the Elizabeth Hill Centre waiting room, but accepted our offer for individual sessions. The woman met with my co-therapist, while the man met with myself. The couple had already decided to separate, and the man had decided to move to another city, so the focus of the session was on how to separate safely. This was the only session I was able to provide in this case, because the man followed through with his plan and moved away shortly after this session. The woman attended additional sessions with my co-therapist. The second couple attended for only two weeks, during which we provided an initial intake session and one individual session. The following week, the female client called to say that her husband had been physically violent towards her, the police had been called, and the man was removed from the home. At that point, the couple was offered individual therapy, but both declined and the case was closed.

As mentioned above, I was also able to work, on a limited basis, with one of the staff therapists at the Centre. Among her clients, this therapist had been providing therapy for two women who were in relationships in which violence had been an issue. She invited me to work with the male partners of these two women, with the intention of providing conjoint co-therapy if or when the couple was ready. This would have been an

interesting addition to the practicum for several reasons. First, it would have offered me the opportunity to work with another therapist in a co-therapy team. Since every therapist is different, this would have been an excellent learning experience. Second, the client population for the main focus of the practicum was couples requesting couple therapy. These cases presented an opportunity to work with men whose partners had requested individual therapy. The focus of the work would have been to assess the couples' readiness for conjoint couple therapy and provide some preparation. Unfortunately this was not to be, as one of the men attended only a single individual session and the other attended seven individual sessions then did not return.

After my co-therapist shifted her practicum, I began to work with couples who stated that they had not experienced physical violence in their relationships. I worked with four couples, in this phase of the practicum. Of these, one couple attended only a few sessions before deciding to terminate therapy. The other three couples attended multiple sessions, from intake through termination. In each of these cases, the termination came through the mutual agreement of the couple and myself, and was supported by my advisor.

In all, I worked with seven couples and three individuals who were expected to participate later with their partners (see Table 1). Most of the couples were between the ages of 20 and 40. In all but two of the cases, the couples had children. The couples came from a variety of family backgrounds, socio-economic strata, and locations within the city of Winnipeg.

Table 1

Total Number of Therapy Sessions by Client

Number of Sessions		
Couples	**Conjoint**	**Individual**
Brown, Reggie	14	3
Brown, Gail		*
Davis, Martin	4	22
Green, Penny		*
Roberts, Malcolm	1	1
Roberts, Jennifer		*
Smith, Arthur	23	1
Smith, Hanna		1
Jones, Oscar	21	1
Jones, Genevieve		1
Worth, Bob	22	1
Hall, Susan		1
Warren, Doug	3	1
Winter, Karen		2
Morton, Richard **	--	7
Burton, Terry **	--	1
Fontaine, Jack ***	--	1

Sessions were approximately 1 hour in duration

* Individual sessions for these clients were provided by my co-therapist.

** The spouses of these two clients were seeing another therapist at EHCC. The intention was to work towards conjoint therapy, but both dropped out of therapy.

*** This client attended a single session, before separating from his partner and leaving the province.

Evaluation Measure

In this practicum, two psychometric measures were initially chosen to aid clinical work and to provide an objective measure of the effectiveness of the therapy. These measures were the Marital Satisfaction Inventory - Revised (MSI-R) (Snyder, 1998) and the Partner Abuse Scale (Hudson, 1992). Once the practicum shifted to couples who had not experienced violence in their relationship, it was decided to discontinue administration of the Partner Abuse Scale. This decision was reached after careful consideration of the potential negative impact of administering an "abuse" scale to couples who reported during the intake process that there was no physical abuse in their relationship. Potential problems included (a) giving the couple the impression that the therapeutic process would be inappropriate for their situation and (b) that the therapist was not attending to or respecting their self-reported information. Further, the MSI-R incorporates an aggression subscale designed to assist in the identification of abuse, therefore if a couple had experienced abuse and attended therapy without disclosure, the abuse could have been identified through the the MSI-R and the initial clinical interview. Since the Partner Abuse Scale was only administered on a few occasions its use will not reported.

The MSI-R is a multi-dimensional, self-report measure of marital interaction based on *T* scores. Douglas Snyder began developing this measure in the 1970s. The version used in this practicum was revised in 1996. There have been numerous empirical studies to test the reliability, validity, and utility of this measure (Snyder et al., 1981, 1988). The respondents are asked to respond to a battery of 129 or 150 "true or false" statements, depending on whether the couple has children. After completion of the

measure, the responses are grouped to form a series of scales. There are two validity scales (Inconsistency and Conventionalization), one global satisfaction scale (Global Distress), and nine additional scales designed to measure specific areas of couple functioning. These additional scales are (a) Affective Communication, (b) Problem-Solving Communication, (c) Time Together, (d) Disagreement About Finances, (e) Sexual Dissatisfaction, (f) Role Orientation, (g) Family History of Distress, (h) Dissatisfaction with Children, and (i) Conflict over Childrearing.

As the label suggests, the Inconsistency scale measures the extent that a respondent has been inconsistent with his/her answers to similar statements. Snyder conjectures that this may occur for a variety of reasons including respondent error, purposeful deceit, or random response. The Conventionalization scale is designed to assess "individual's tendencies to distort the appraisal of their relationship in a socially desirable direction" (Snyder, 1997, p. 20). Snyder predicts that couples entering counselling will score low on this scale. The incorporation of these two scales helps the administering clinician to determine the extent to which the couple's responses are accurate and dependable. The Global Distress scale is designed to be a general measure of overall satisfaction with the relationship. The other scales (listed above) are designed to provide the clinician with information that is more specifically targeted to areas of couple functioning. The specific scales provide feedback to the clinician and the couple that can help to identify areas to be addressed in therapy. Of note, Snyder has been involved in much of the research performed on the measure. However, any bias this may have introduced would have been attenuated by the selection and peer review processes of publishing in reputable journals.

As mentioned above, during the first portion of this practicum, in which the client couples had a history of violence, both the MSI-R and the two PAS scales were administered. Three of the couples who worked with myself and my co-therapist, completed both measures as a pre-test. Of the two couples who attended multiple sessions, one female and one male completed the Marital Satisfaction Inventory as a post-test. The other male was cognitively impaired and illiterate, so I administered the pre-test measures verbally. For example, if the client did not understand a statement due to his cognitive and verbal limitations, I was forced to re-state the statement using different words. This process took a great deal of time and may have introduced significant bias. The other female was a client who was referred for couple therapy, but who completed her therapy as an individual client (though not as my client). For this woman, there was no post-test MSI-R on file. Of the clients I shared with the staff therapist, neither completed any psychometric measures. Of the two couples that dropped out of co-therapy, one couple completed the measures as a pre-test. Neither couple completed the post-test. The actual administration of the measures is displayed in Table 2.

As mentioned, the MSI-R was used both as a pre-test and post-test. This allowed for objective measurement of change. It is important to understand, however, that there are two scales within the MSI-R that are designed to screen for information at intake, rather than show change over time. The Aggression scale is comprised of statements such as "My partner has never thrown things at me in anger." Clearly, the use of the word "never" does not allow the respondent to change his/her response, regardless of the length of time that may have elapsed or the amount of decrease in physical violence.

Table 2

Table of All Psychometric Measures Administered During Practicum

Measures Administered				
	MSI*		PAS**	
Couples	Pre	Post	Pre	Post
Davis, Martin	X	X	X	
Green, Penny	X		X	
Brown, Reggie	X	X	X	X
Brown, Gail	X	X	X	X
Jones, Oscar	X	X		
Jones, Genevieve	X	X		
Smith, Arthur	X	X		
Smith, Haley	X	X		
Worth, Bob	X	X		
Hall, Susan	X	X		
Warren, Doug	X			
Winter, Karen	X			
Roberts, Malcolm	X		X	
Roberts, Jennifer	X		X	

* Marital Satisfaction Inventory (Snyder)

** Partner Abuse Scale (Hudson)

Similarly, responses to the Family History of Distress scale, which uses statements such as "I had a very happy home life", can only change over time with changes in the client's memory or interpretation of past. This being said, administering the measure twice and comparing the answers to specific statements, can provide information about how consistently the client remembered, interpreted, and responded.

Initially, the MSI-R was to be administered and scored at time of intake, and used as a guide to setting the goals of treatment. However, once my co-therapist left the practicum, I needed to obtain new self-scoring copies of the test from outside the country, which caused a significant delay. The result was that while I was able to administer the test and review the clients' answers to specific questions at time of intake (e.g., their answers to the questions related to aggression), I was not able to score the measures until later. The result is that the use of the measures as a tool in initial evaluation was limited. Rather, they were used as a check and balance part way through the course of therapy. Their use of the measure to compare pre- and post- scores was not impeded.

Intake Process

Clients were selected in two ways. A "Waiting List" of potential clients who have called requesting services is maintained by the staff of the Elizabeth Hill Counselling Centre. Once a call is received, an intake form is completed highlighting contact and background information, and the presenting problem(s). My co-therapist and I explored the details of the intake sheets, and discussed with our advisors which clients fit the criteria of the practicum. My co-therapist and I also attended meetings with social

services agencies to attempt to attract potential couples. I created a pamphlet describing briefly the focus of the practicum (see Appendix A).

Once appropriate couples were identified, either my co-therapist or I called them on the telephone. Unfortunately, for a variety of reasons, many of the potential clients did not work out. Below are a list of some of the reasons for which couples were not accepted into the practicum:

- The couple had separated,
- The couple was actively violent,
- The couple decided not to attend therapy,
- One of the partners declined to attend therapy,
- The couple agreed to attend therapy, but did not show up for several scheduled intake appointments,
- The contact information was no longer accurate, and
- Issues of addiction were prevalent, decreasing the advisability of conjoint therapy.

It was partly on the basis of the difficulty that we experienced identifying suitable clients that my co-therapist changed the focus of her practicum. Of note, when I began accepting non-violent couples, there was little difficulty finding suitable couples from the Centre's "Waiting List".

Some of the intake processes remained consistent despite the shift in the focus of the practicum. Clients were contacted by telephone and asked i) if they were still interested in attending therapy and ii) to provide updated information. Couples were then invited to attend an intake session. The initial telephone contact and the first few sessions

with the couple were modeled after the couple evaluation work of Mark Karpel (1994). Karpel advocates using a defined evaluation phase prior to determining recommendations for the course of therapy. This evaluation consists of a conjoint session (where not contraindicated by issues such as domestic violence), an individual session for each partner, then a further session, in which the evaluation and recommendations are shared with the couple. It is important to note that consistent with this practicum, Karpel places strong emphasis on assessing the level of risk and safety in the couple at the outset, and using this information in deciding whether or not conjoint couple therapy (or some other intervention) is advisable.

There was an initial session for each couple. The first session included:

- Introductions,
- Description of the Centre and its confidentiality policies,
- Description of the focus and expected course of the practicum,
- Signing of release of information sheets, and permission to videotapes, and
- Contracting for several sessions for the evaluation.

The main goals of the initial session involved beginning to develop a rapport with each member of the couple and gathering information about the couple, including their understanding of the problem and what attempts they had already undertaken to address the problem (e.g., previous or concurrent therapy).

The second session began with the administration of the pre-test measure(s), followed by a conjoint session in which a family history was taken including the use of genograms (McGoldrick & Gerson, 1985). Genograms are pictorial representations of families. The genogram is useful for identifying roles, relationships, similarities,

intergenerational patterns, alliances and coalitions, boundaries, etc. In my experience, it also facilitates the information gathering process by allowing the therapist and the couple to focus on the task of creating a diagram that gives an accurate picture of the family. Karpel (1994) suggests gathering family of origin information during individual sessions. However, in this practicum, the family of origin information was gathered during a conjoint session, which had some advantages. In a number of cases, one spouse appeared to be the family historian, remembering more information about the other spouse's family than the partner him/herself. There also seemed to be a growing understanding of how the current problem might be related to broader family or family of origin experiences.

The next step was to have separate individual sessions for the man and the woman. This allowed each member of the couple to speak more freely about their concerns. One of the reasons for the individual sessions was to try to assess level of risk (i.e., offer a safe time during which the woman or man could report any physical violence or intimidation that occurred in the relationship). If the couple was assessed as safe for conjoint therapy, the next session was used as a conjoint session. This session was used to further clarify the couple's definition of the problems and to gather additional information about the couple.

The next session marked the end of the evaluation phase of therapy. During this session, the therapist(s) presented the couple with an initial assessment of their resources and strengths, a description of the therapist's understanding of the problem(s), and a recommendation for continuing or discontinuing therapy. If the recommendation was for continued therapy, there was a further recommendation of the form therapy would take (e.g., conjoint couple therapy, individual therapy, individual therapy for one of the

partners, etc.). Goals for therapy were also identified at this point which is referred to by Karpel (1994) as "setting the trajectory" for therapy. Attention was paid to ensuring that the couple's perception of their problem was addressed in the evaluation and that the goals were congruent with the couple's goals. This is a respectful stance recommended by Karpel (1994) who states "Unless treatment goals are congruent with the clients' goals, the accuracy of the formulation is academic and its clinical utility is nil" (p. 169). If the couple was in agreement with the evaluation and goals, the therapist and the couple then contracted for a specified number of additional therapy sessions, after which the initial goals would be reviewed and a decision reached about renewed goals or termination.

Termination Session

Each couple that was seen during this practicum was offered a "termination session". This session was designed to accomplish three things (1) have the couple complete the psychometric measures as a "post-test", (2) review the accomplishments of the couple over the course of therapy, and (3) elicit feedback from the couple about their experiences in therapy. The questions varied a bit for the couples seen by my co-therapist and I. The questions used to elicit feedback from the couples I saw in therapy as a single therapist remained consistent. These were:

1) Check In - how have things been for the past _____ weeks?
2) Have you found it helpful to come to therapy at the Elizabeth Hill Counselling Centre?
3) Was there anything that you found that was particularly helpful?

5) What do you think you have learned over your time here?

6) What advice would you give to other couples who are experiencing difficulties in their relationships?

7) What advice would you give me, to further my work with couples?

8) Do you have any further comments?

Chapter 5

Two Couples

The Brown Family

Background

This couple participated in the first portion of the practicum. The focus was on working with couples who had experienced violence in their relationship, utilizing a male and female co-therapy team.

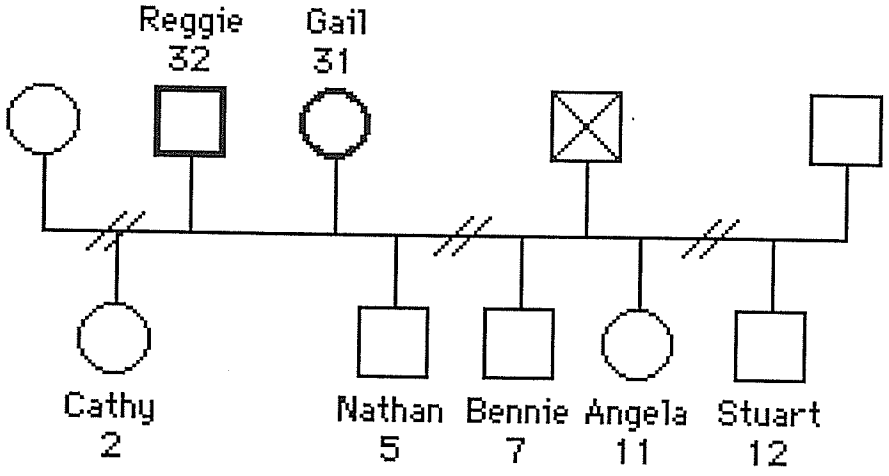
The Browns (see Figure 1) are a couple of mixed race (Reggie is Caucasian, Gail is Aboriginal). Both Reggie and Gail have been in previous relationships from which each has children. There are no children born of the current relationship. At the beginning of therapy, Gail's two youngest children lived with the couple and Reggie was focussing a great deal of energy on having his daughter, Cathy, come to live with them.

Neither Reggie nor Gail was employed, though Gail was attending Adult Education. A local Child and Family Services agency had some peripheral involvement with this family. Reggie had not attended therapy before. Gail had previously participated in several years of individual therapy.

When Reggie and Gail attended their intake session, my co-therapist and I provided information regarding the Centre, our backgrounds, and the purpose of our practicum. We also advised the couple that it was the practice of the Centre to videotape therapy sessions. At first, Reggie seemed suspicious about the purpose of the videotape, but eventually both he and Gail gave their consent. The remainder of the session was

Figure 1

Genogram



spent gathering information about the family and the history of the problems they had been experiencing.

The second session began by having Reggie and Gail complete the Partner Abuse Scale and the Marital Satisfaction Inventory, then concluded with individual therapy sessions (Gail with my co-therapist and Reggie with myself). The individual sessions were part of the assessment to determine whether conjoint therapy would be appropriate for this couple and to gather background information. The use of individual sessions allowed Reggie and Gail some time in which to speak, without having to be concerned about the other's feelings or reactions.

The issues that the couple identified at the outset of therapy included frequent, severe arguments and problems with communication, parenting, and their division of labour. The couple also mentioned that Gail had had a one-night "extra marital involvement" (term borrowed from Karpel, 1994). As the therapeutic process unfolded, both therapists became increasingly wary that Reggie's true purpose for attending therapy was to have the therapists "fix" Gail and to make the couple look better in court, where a decision was to be made regarding the guardianship of his daughter.

The issue of physical abuse was complex in this case. Reggie had once been charged with physically assaulting Gail, though the couple stated that this was a misunderstanding. The couple described the incident as an argument during which Gail had thrown something at Reggie, then gone to a friend's apartment. Reggie followed to try to resolve the situation. The friend witnessed Reggie holding Gail's wrist and called the police, believing that Reggie was the aggressor. The couple stated that Reggie had been holding Gail by the wrist to keep her from hitting him, therefore he acted in self-

defence. It was not possible to determine whether the couple's version of the incident was accurate or a representation slanted to exonerate Reggie. Although the couple did not describe any incidents in which Reggie perpetrated physical violence towards Gail, both recounted numerous occasions in which Gail had hit Reggie or thrown an object at him (e.g., a plate or a pot). Reggie also described locking himself in the bathroom for protection and to avoid escalating conflicts. Further, Reggie complained that Gail yelled, screamed, swore, and lost self-control when she became angry.

After these initial sessions, and in consultation with Dr. Hiebert-Murphy (my co-therapist's clinical supervisor), it was decided that Reggie and Gail met the criteria for conjoint therapy. This was discussed with the couple during the third session, with the caveat that we would return to individual therapy sessions, if the need arose. We contracted with the couple to have five sessions, focussed on specific goals, then review. The goals for therapy included:

1. Exploring the aftermath of violence;
2. Taking responsibility for actions;
3. Improving communication skills;
4. Improving problem-solving skills;
5. Balancing the power and control in the relationship;
6. Assisting Reggie to continue to build up his trust and faith in Gail, in the aftermath of her extra marital involvement;
7. Assisting Gail to develop a greater sense of security in the relationship; and
8. Addressing blended family and co-parenting issues.

Intervention Highlights

From the outset, this couple's relationship was seen as volatile, but not actively physically violent. This was also the view of the Child and Family Services Family Reunification worker who had a significant amount of direct contact with the family. There seemed to be genuine commitment to maintaining and improving the couple relationship on the part of both Reggie and Gail. As the first step of working with this couple, safety plans were established for Reggie, Gail, and the children. These plans consisted of the partner who felt at risk taking the children and leaving the house, allowing the other time to regain control of his/her actions. If it was warranted, the police, Child and Family Services, or other intervention services were to be called. The continued involvement of the Family Reunification worker added to the belief that the couple could remain safe.

While there was some question about the level and direction of physical abuse in this relationship, the couple was clearly verbally and emotionally abusive to each other. While Gail's abuse (e.g., screaming, yelling, throwing objects) was more overt, Reggie portrayed himself as being a kind and considerate husband and father. However, some of Reggie's behaviours stood in stark contrast to this image. For example, the couple stated that Gail went into "moods". These moods were times during which Gail became lost in her own thoughts and tended to be a precursor of a period of depression and acrimony. Reggie confided that he had unsuccessfully tried to help Gail out of these moods by being nice to her. His current strategy was to be insulting and verbally cruel to Gail during these times, claiming that this behaviour jostled Gail out of her mood and allowed the couple to go on with their lives peaceably. At outset of therapy, Reggie seemed oblivious

to the abusive nature of his actions, focussing solely on their success (the end justifying the means) and proud of his own ingenuity. The nature of this "ingenuity" was explored with Reggie during an individual session, re-framing it as abusive behaviour for which he needed to take responsibility. Reggie was reminded that while he was in control of his own actions, he could not control Gail. Gail's moods were also re-framed as behaviours over which she needed to exercise control. The couple's pattern of interaction regarding Gail's moods was identified, then Reggie was asked to suggest other more positive responses. He was asked as homework to practice these alternate responses, and note what changes occurred.

An undercurrent to the problems the couple were experiencing was Gail's willingness to accept the blame for all of their difficulties. Reggie, while stating that he played a role in their problems, also seemed invested in Gail being "the problem". One hypothesis for Gail's willingness to accept blame was that she had been in previous relationships with extremely violent and abusive men. Compared to them, she saw Reggie as her knight in shining armour. Therefore, if he was so good, their problems must be her fault. Reggie strengthened this belief through overt and covert statements and actions that consistently emphasized Gail's faults and his own virtues. The idea that Gail was solely responsible was neither consistent with our assessment, nor seen as helpful. In a conjoint session, the couple was reminded that each was responsible for his or her own behaviour.

A major hurdle was to help the couple attune to Gail's emotional state. It was posited that the couple did not anticipate Gail's explosions of anger and her "moods" because they were not sensitive to her early physiological and behavioural indicators.

Reggie was more concerned with his own needs and wants than he was with paying attention to Gail. The rigid boundary that existed between them, inhibited Reggie's recognition of Gail's stresses and frustrations. The combination of neither partner noticing, heeding or altering behaviour based on Gail's emotional state contributed to their pattern of arguing. With Reggie, intervention included discussion of the need for him to attend to his wife's emotional state, appealing to his self-professed intellectual powers, and assigning "homework" related to noticing and identifying emotional states (both Gail's and his own). With practice, Reggie was somewhat more able to notice when Gail was becoming upset, and anticipating her pattern of withdrawal and explosion. This provided him with the opportunity to alter his behaviour, which in turn modified the interaction. Becoming more sensitive to his wife's emotional state also helped Reggie perceive and understand the pain he inflicted with his verbally abusive behaviour. Gail also received homework, tracking her own emotional state, as a means of increasing her awareness of her own feelings and needs, and in turn helping her to take direct action when she was upset, rather than let the feelings build to the point where she lost control. By becoming more sensitive to Gail's emotional state, the couple was better able to decide on a course of action earlier on in the cycle of their arguments.

From the outset, a pattern of interaction between the couple became evident to myself and to my co-therapist. Reggie was extremely verbose, often dominating the discussions with lengthy discourses about his frustrations with "the system", which he perceived as unjustly denying his right to parent Cathy. Reggie was quite open about (and proud of) his tendency to dominate conversations, stating that he always got his way over others, including Gail and his friends (and likely, by tacit extension, social workers,

judges, and therapists) due to the superiority of his verbal, logical, and debating skills. In contrast, Gail at times struggled to express herself and retreated into her own thoughts when Reggie began to dominate. When this occurred, Gail's level of frustration would slowly build, while simultaneously her thoughts appeared to move further and further from the flow of the conversation. Eventually, she would burst back into the conversation with a comment that was unrelated to the topic of discussion, often a stinging complaint about Reggie. This pattern of interaction seemed to be a microcosm of their home life. When there was a disagreement, Reggie would dominate using his verbal and logic skills maneuvering Gail towards agreeing to his point of view. Unable or unwilling to compete with Reggie, Gail withdrew then exploded. Interestingly, Minuchin, in an article penned with Nichols (1998), described a couple with a strikingly similar transactional pattern in which the husband spoke at great length while the wife tuned him out, together turning dialogue into monologue.

During one session we witnessed how this pattern contributed to the volatility in their relationship. Reggie was complaining about the system, Gail seemed lost in thought. Suddenly, Gail stood up, swore at Reggie, then ran out of the therapy room. We waited a moment, then when Reggie remained inert in his chair, my co-therapist left the room to make sure that Gail was all right. While the women were out of the room Reggie sat deep in his chair seemingly unmoved by Gail's obvious distress, and stated "See, that's what I've been telling you about!" When Gail and my co-therapist returned, Gail had calmed down, but the couple spent the remainder of the session leaning as far away from each other as their chairs would allow. In structural terms Reggie was attempting to control the relationship, which caused stress on the system until Gail responded by

exerting power to re-balance it. This is an example of an idiosyncratic constraint on the system (Minuchin, 1974). That is, a constraint that is particular to that subsystem. We tried to create a better balance in the relationship by alleviating this constraint by working with the couple to empower Gail and to help Reggie reduce his tendency to be controlling.

The goal of assisting the couple to become more in step with Gail's emotional state included working with the couple to improve their communication skills. Karpel (1994) considers communication difficulties to be primarily due to trouble "listening", rather than an inability to express one's self. This was certainly the case for Reggie. Early in the therapeutic process, my co-therapist and I struggled to keep the sessions on track when Reggie would begin to speak on one of his favourite topics (e.g., frustrations with the "system" or his struggles to gain custody of his daughter). Once started, he would speak passionately and unceasingly. He seemed unable to allow others into the conversation while diverting the topic of the discussion away from the couple and toward outside stressors. Through discussions during our supervision sessions, it became clear that we were inadvertently replicating a pattern of interaction that was common for Reggie and Gail. When my co-therapist and I began to be more direct in our management of the sessions, bringing Reggie back from his monologue, this created more opportunity for others (in particular, Gail) to speak. Since Reggie's tendency was to take control of interactions, having therapists politely but firmly point out that it was important for each persons' ideas to be heard gave him the opportunity to practice his listening skills.

One of the methods used to help the couple explore their communication patterns was the use of role play. This was done through having my co-therapist and I act out the "parts" played by Reggie and Gail, then switching to play their roles using more cooperative listening. After this, the couple was asked to critique what they had witnessed. The couple was also asked to play each other's roles. Finally, the couple was asked to play their own parts again, but to incorporate other ways of interacting. Not only did this session prove to be interesting and fun, but it was one of two sessions that stood out most clearly for the couple at termination. One reason for the success of this intervention may be that this session emphasized experiential learning, perhaps providing a clue about how best to work with this couple.

Another technique that was used to help the couple work on their listening skills was to select an inanimate object (we used a whiteboard eraser) then use it as a symbol of whose turn it was to speak. Gail enjoyed this for two reasons: first, it gave her the opportunity to speak uninterrupted; second, it gave her more control over the process of the interaction, forcing Reggie to wait his turn. In this exercise, Reggie struggled to remain silent while awaiting his turn, but he made a sincere effort. Since there is an element of childishness in being constrained from speaking due to the lack of a whiteboard eraser, this imbued the session with an element of humour. A sense of cooperation was also achieved, as Reggie and Gail delighted in reminding my co-therapist and I to be quiet if we spoke out of turn. Providing the couple with this opportunity was in itself reinforcing the importance of listening.

Based on later comments from the couple, the sessions on communication were well received. Gail reported having appreciated feeling like her opinions were important,

which helped to empower her. Reggie mentioned that he hadn't realized how strongly Gail felt on some issues until he was constrained to sit and listen. The couple was encouraged to find their own solutions, as well. One such solution was suggested by Gail. She noted that when an issue was important to her, but not to Reggie, he would just ignore her, writing the issue off as unimportant. Gail suggested that if this circumstance occurred, she would gently take Reggie's arm and lead him away to another part of the house. This would be her concrete signal to him that he needed to heed, not later, but now. We had the couple practice several times in the therapy room, which afforded some levity, while simultaneously giving my co-therapist and I the opportunity to congratulate the couple on their ingenuity. Since this solution came from the couple, there is reason to hope that the couple will feel more invested in its use, therefore enhancing the likelihood of success. When we asked in later sessions how this solution was working, the couple confirmed that they had tried it on a few occasions, with varying success. While the content of these interventions was enhancing the couple's communication skills, several process goals were addressed, as well. The couple worked on their problem-solving skills, which in turn helped to clarify the boundaries both between and around the couple. There was also a balancing of power, as the communication interaction was balanced.

A problematic element of Reggie and Gail's relationship was their division of labour and responsibility. Although the couple generally tried to share responsibility, if they experienced difficulties Reggie was quick to insist on a rigid division. For example, if Gail tried to initiate discussion about how they divided housework, Reggie pushed for a rigid division of labour (with Reggie responsible for himself and Cathy, while Gail was responsible for herself and the other children). If Reggie was upset by the type of

groceries Gail purchased, he pressed for a rigid division of finances (with Reggie taking responsibility for the Social Allowance money received for himself and Cathy, and Gail taking responsibility for the money received for herself, Nathan, and Bennie). These rigid divisions would have decreased Reggie's workload and responsibilities while increasing Gail's, since she attended school and had two children with special needs. The rules that governed this family were very rigid, with the parents demonstrating limited ability to creatively adapt to changes and stresses. Having the couple develop alternate solutions and utilize different problem-solving processes while in session, tapped into some of the skills that they had not been using. With practice, the couple was able to work out mutually acceptable compromises, such as developing a grocery list together with some allowance for the shopper to make purchasing decisions while at the store. This demonstrated the couple's growing ability to create more flexible rules.

Another issue with which Gail and Reggie struggled was the balance of power in their relationship. Perhaps stemming from his lack of control in other areas of his life (e.g., the court system controlled his relationship with his daughter, CFS controlled his actions, Social Assistance controlled his income, etc.) Reggie was very controlling with Gail. He made most of the important decisions for the couple and controlled their communication. He also had the final say in all activities and scheduling. One of the trump cards that Reggie used to ensure his continued dominance was threatening to leave Gail. Especially since Gail felt that her relationship with Reggie was the best relationship she had ever experienced, this threat was very powerful. Reggie used this threat frequently (e.g., when she was angry with him, when she swore, when she brought the "wrong" groceries home from the store, etc.). When we realized the extent to which

Reggie used this threat as a means of organizing and dominating the relationship, a therapy session was devoted to having the couple talk about what would happen if Reggie followed through with his threat. This was a very powerful session, in which Gail was able to speak quite dispassionately of the steps that she would have to take to continue to care for herself and her children. She was clear that she would chose to continue her relationship with Reggie if possible, even if they lived apart for a period of time. By the end of the session she seemed much more settled and confident about her ability to carry on without Reggie, if necessary. Through this process, much of the power of Reggie's threat appeared to dissipate. For his part, Reggie contributed appropriately to the discussion. In fact, it seemed that when Gail ceased pursuing Reggie and demonstrated her strength, she seemed to grow in Reggie's eyes.

This situation, viewed from a structural-strategic perspective, can be seen as a microcosm of the couple's relationship (Madanes, 1981). In the interaction pattern, Reggie dominates the relationship (exerts power). As the balance of power between Reggie and Gail is skewed with Reggie in the dominant position, Gail developed the symptom of explosive behaviour. Both directly, through exerting her own power, and indirectly by drawing Reggie in to unsuccessfully help her with her symptom, Gail is simultaneously subordinate and dominant. This also allows the couple to focus their efforts on Gail's symptom (explosive behaviour) rather than directly addressing the imbalance of power in the relationship. As the power of Reggie's threat to leave subsided, the balance of power in the relationship became more equal, which in turn did not require Gail to be as symptomatic.

Reggie's use of power was also illustrated through the couple's problem-solving pattern. Despite paying lip service to collaborative decision-making, when an important decision was to be made, Reggie made it. While this is not inherently "bad", it was reflective of and reinforcing for the skewed balance of power in the couple's relationship. In an effort to assist the couple to explore more collaborative and balanced options for problem-solving, we helped the couple work through decisions, both in therapy and on their own. This process is exemplified by the couple's struggles with establishing a bedtime routine for Cathy. Reggie had been in charge of his daughter and had established a schedule that worked well with his own. He let her sleep late in the morning (while he slept) then had her nap after lunchtime (which provided Reggie with some free time). At the end of the day, when it was bedtime for the other children, Cathy was not sleepy so would stay up late. Since Reggie also stayed up late, he did not find this problematic. However, this schedule did not work well for Gail. She rose early to get herself and the boys ready for school. By the end of the day, she was tired and didn't feel like either providing protracted childcare or sharing Reggie's attention. During a therapy session, the couple was asked to discuss possible solutions. They were then given the homework of working out a mutually acceptable solution on their own, and reporting back during the next session. This intervention was successful. The couple did discuss the issue and come to a solution (Reggie agreed to keep Cathy awake more during the daytime, then put her to bed earlier). By providing the couple with a framework for collaborative problem-solving, then having them practice this process, the couple was helped to be more flexible in their response to problems, while the power between the partners became more balanced.

The manner in which decision-making was handled in the family stemmed in part from Gail's system of beliefs. For the most part, Gail accepted Reggie's propensity to make all decisions. At one point, she stated that in a relationship, the man should make the final decisions. While it is important to be respectful of clients' ideas and values, we did follow up this statement with some discussion about other, more collaborative ways of making decisions. The purpose of this discussion was to help ensure that the couple was making active, informed judgements about how to act, rather than maintaining this pattern because it was the only way of relating with which they were familiar. Of note, Reggie's actions were inconsistent with his answer to the statement "Some equality in marriage is a good thing but, by and large, the man ought to have the main say-so in family matters" to which he responded "false" in the Marital Satisfaction Inventory. At some level, he believed (or wanted others to think he believed) in equitable decision-making. Discussion about this incongruity appealed to Reggie's predilection for intellectual debate, heightening and holding his interest.

Like the majority of men in the couples that were seen over the course of this practicum, Reggie had been thrown abruptly into the role of "father", a common feature of blended families. Before winning his custody case, Reggie had limited contact with his biological daughter. However, when he and Gail wed, he immediately became the parent of two of her children. This impeded successful negotiation of the transitions from (a) emancipated adult through (b) married couple to (c) family with young children (Karpel & Strauss, 1983). That Reggie, in particular, struggled with these transitions was evident throughout the course of therapy. There were many times when Reggie readily accepted the responsibilities and workload of his role as the father, such as when he

attended Bennie's class to help him with some of the schoolwork that he found difficult. Reggie was also very supportive of Gail going to court to try to change the custody status of her eldest two children. The other side of the coin was illustrated by Reggie's sometime insistence on a rigid division of the parenting workload and decision to play video games all night. This pattern of swinging back and forth from self-centered behaviour (not unlike a teenager) to family-centered behaviour reflected the unsuccessful transition to being the father in a family with young children. The couple was assisted to negotiate this life cycle transition by improving communication and problem-solving skills, by re-balancing the power structure of the relationship, and by strengthening their identity as a parental unit.

As mentioned earlier, the boundary between the couple was extremely rigid. The boundary around the couple, however, was very diffuse. This was illustrated in a discussion about what they should or should not talk about in front of their children. Reggie felt that there were some things that should only be discussed between parents. Gail's opinion was that parents should be "open" with their children and should not withhold any discussions. The lack of an appropriate boundary between the parents and the children was further shown in Reggie's description of locking himself in the bathroom to avoid one of Gail's angry outbursts, then calling to Bennie through the door and asking for assistance in calming Gail down. This not only displayed questionable judgment on Reggie's part (bringing Bennie into a situation in which he, himself, felt unsafe), it also showed Reggie forming a coalition with a 7 year old child against the child's mother, and elevating the child to a position of "parent" for Gail. To help strengthen the parental system, the couple was asked to work through some parenting

issues first in the therapeutic sessions and then as homework outside of the therapy setting (e.g., the previously mentioned solution to the issue of Cathy's bedtime). As they worked through parenting issues together in a balanced way, then followed through with their parenting decisions in a consistent manner, this helped to clarify the boundary between the parents and the children.

Over time, the cares and stresses of their lives, combined with their childcare responsibilities and limited finances, had reduced the amount of time Reggie and Gail spent on nourishing the bond between themselves. Since Child and Family Services provided them with some homemaker assistance, we encouraged the couple to take the time to re-experience some of the things that they enjoyed about each other, things that brought them together in the first place. With some prompting, the couple did take a few evenings off. During the sessions that followed these outings, Reggie and Gail seemed closer and happier. This intervention worked on two levels. These excursions appeared to bring back positive memories of their earlier days and helped to inject some vitality back into the relationship, while reinforcing collaborative decision-making.

One further issue that bears mentioning is that prior to coming to therapy, Gail had been involved in a sexual relationship outside the marriage. One evening, after an argument, Gail had gone to her ex-husband's home and wound up having sex with him. The spectre of that night continued to haunt Gail and Reggie's lives. The occurrence of an extramarital sexual relationship can be very damaging to the "primary couple relationship" and many couples do not recover (Karpel, 1994). One of the elements of the relationship that can suffer is "trust". Reggie's difficulty trusting Gail, was underlined by an incident in which Gail went for a walk and but did not return as quickly

as Reggie anticipated. When Gail did not return, Reggie concluded that she must be out with her ex-husband again. His response was to lock her out of the house. When Gail returned and could not gain entry, she asked for assistance from a passing police car. Eventually Reggie opened the door and the situation was defused. He claimed not to have heard Gail's repeated knocking and calling.

The couple and the therapists agreed that Reggie needed to re-build his trust in Gail. In an individual session, Reggie was asked how he would know when he could again trust Gail's fidelity. He stated that it would take time, during which she would have to remain faithful. Reggie was then asked to recount how often Gail had cheated on him (once), how long ago that had occurred (many months), whether she had given him any indication that she would behave in this way again (she had not), whether she had given any indications that she was sorry and assurances that this behaviour would not happen again (she had). In fact, Gail had gone to great lengths to assure Reggie that there would not be a recurrence, and had made sincere statements to this effect in previous sessions. As Reggie responded to these questions he visibly relaxed. The change of focus from negative imaginings to the positive reality, helped him to acknowledge that he needed accept Gail's statements and actions, and not cling to the past.

Termination

After the sixteenth session, Reggie left a message at the Centre to inform my co-therapist and I that he and Gail would not be coming to sessions anymore. He stated that the therapy had been helpful, but that it was time to get all the helpers out of his life for a while. We responded by writing a letter, requesting that the couple come back for a

termination session and inviting the couple to re-contact the Centre if they decided to request further therapy.

Approximately three months later, Reggie called and set up an appointment for a termination session. At that session, the couple again completed the Partner Abuse Scale and the Marital Satisfaction Inventory. Once this was complete, my co-therapist and I reviewed the initial evaluation that we had shared with the couple, summarized the work that the couple had done and the gains we felt they made. Then the couple was asked for their feedback about the therapy. Reggie stated that he felt that he understood his relationship with Gail better and that he also understood the role he played in their arguments. He was not able, however, to remember specific sessions, moments, or ideas that had a significant impact. Gail, too, expressed the general feeling that their relationship was better and that she was feeling stronger than before therapy. She specifically mentioned two sessions as being the most significant for her. The first was the session that focussed on communication in which my co-therapist and I played the roles of Gail and Reggie. The second was the session during which we asked the couple to describe in detail what would happen if Reggie followed through with his threats to leave Gail.

Marital Satisfaction Inventory

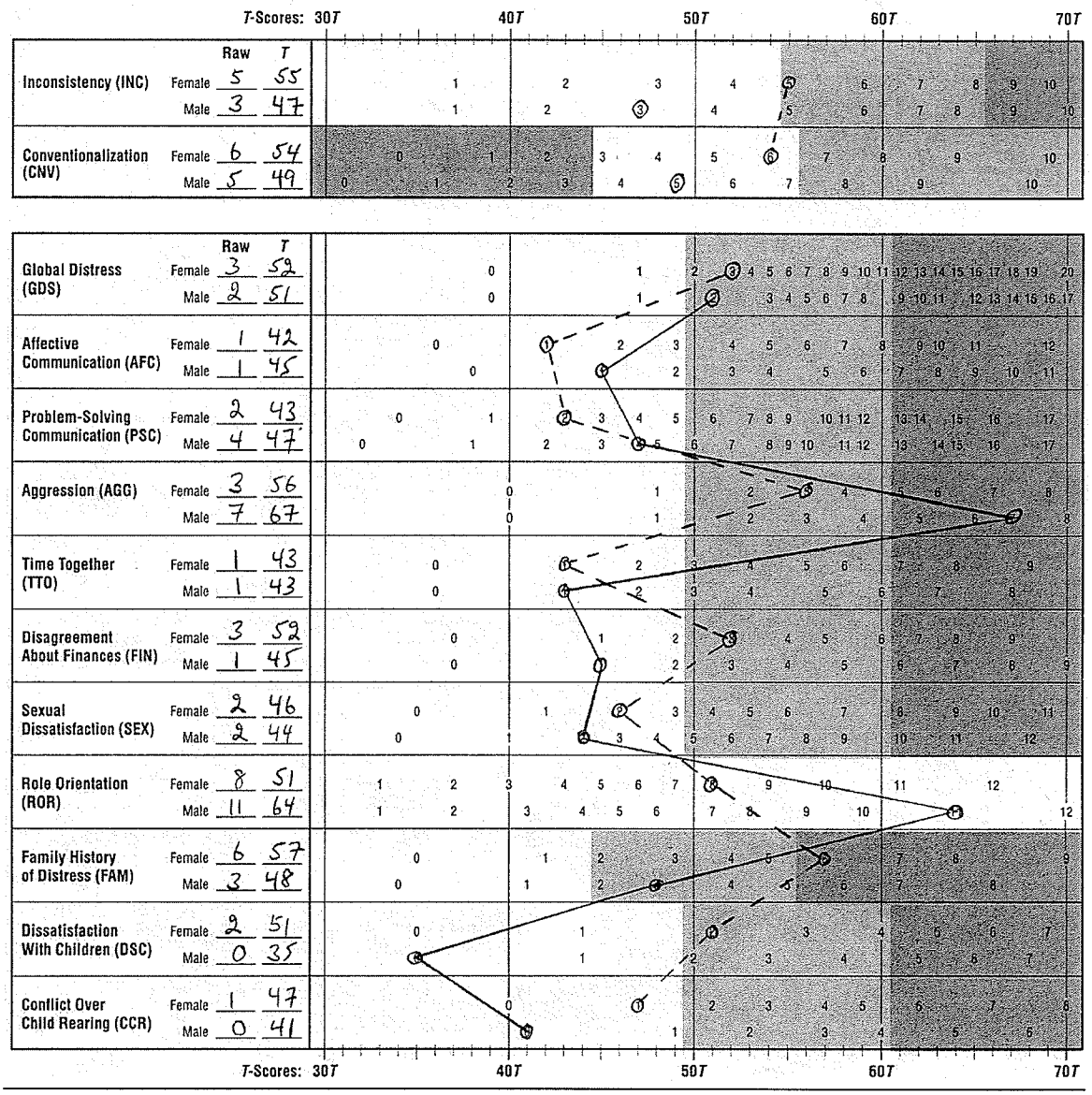
Reggie and Gail each completed the Marital Satisfaction Inventory – Revised (MSI-R) as a pre-test at intake and again at termination (though this last occurred approximately three months after therapy had ceased). Therefore it is possible to compare the couple's answers with each other and to look for change over time. This is

tempered by the timing of the second administration, which also measures how much change the couple retained after a three-month absence. Of note, when the couple returned for the termination session, they stated that they were ready to return to couple counselling. It is possible that they were experiencing heightened conflict at that time, which may be reflected in the results of the second administration of the measure.

On the pre-test (see Figure 2), Reggie scored low on the Inconsistency scale (47*T*), indicating that his answers were not based on random answering. Gail scored somewhat higher (55*T*), which suggests that in her answers she displayed some mixed feelings. Both Reggie and Gail scored in the middle range of the Conventionalization scale (49*T* and 54*T* respectively). Snyder (1997) states that a moderate scores on this scale often reflect "a level of idealistic distortion" (i.e., that the examinee is either purposely or accidentally underplaying the amount of dissatisfaction he/she is experiencing). Since Reggie and Gail felt somewhat forced by the court to attend therapy, I believe that they may have tried to respond in an overly positive fashion to the measure in an effort to enhance the likelihood of winning the custody case. On the Global Distress scale, both Reggie and Gail scored just into the moderate range (51*T* and 52*T* respectively). This corresponds with a history of unresolved conflict and ongoing relationship difficulties, but not overly severe in nature. This fits with the couple's presentation, though seems out of step with some of the information that came to light during therapy, such as Reggie's repeated threats to leave Gail. Possible explanations could be that the couple was trying to present well, downplaying their distress or possibly that acts such as Reggie's threats were just that, threats, and not indicative of real distress.

Figure 2

Marital Satisfaction Inventory – Pre-Test



Good | Possible Problem | Problem

Wife

Husband

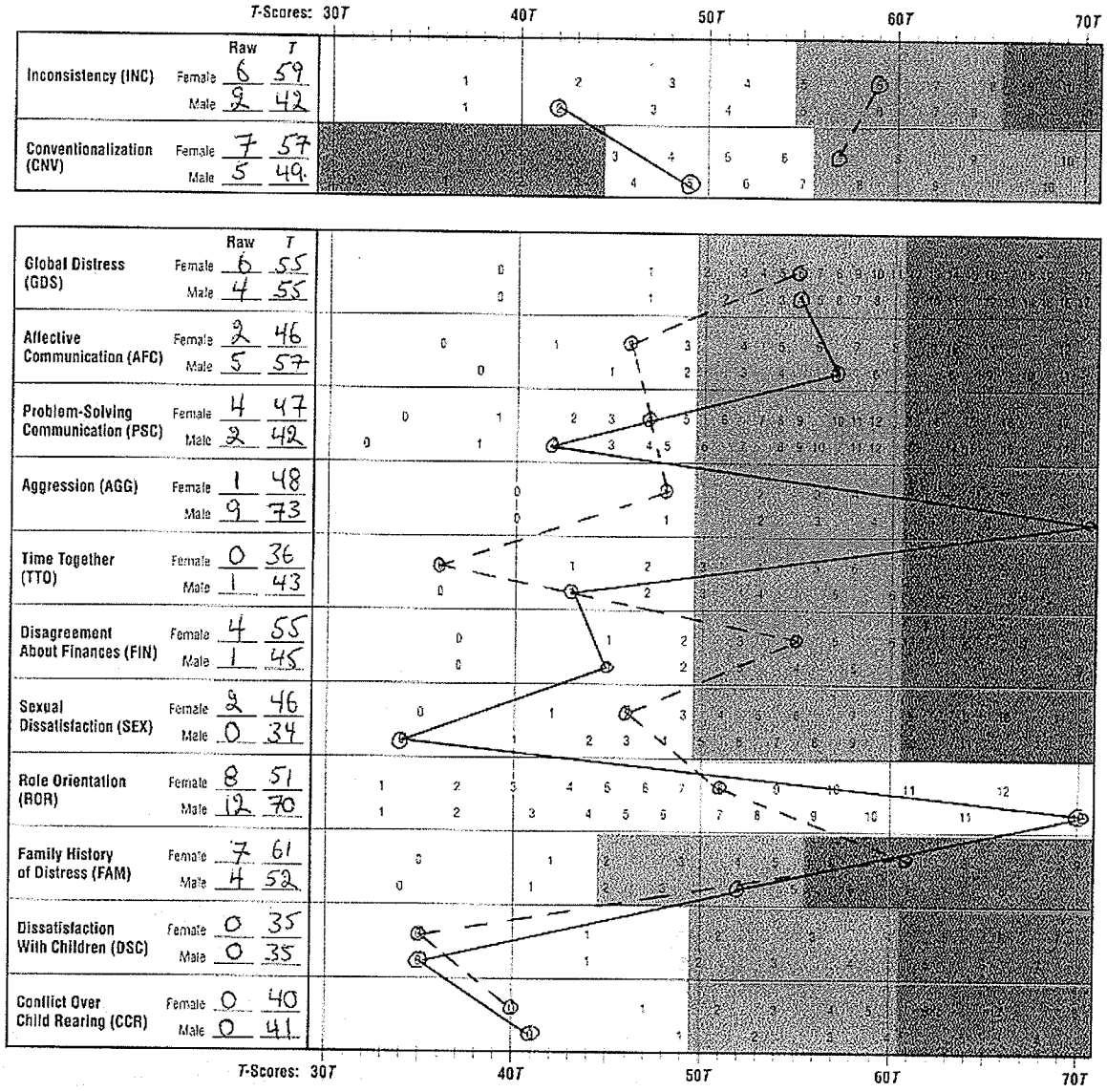
Both Reggie and Gail scored low on the Affective Communication and Problem-Solving scales, implying that both were satisfied with each other's level of affection and attention, and with their ability to work out problems together. This is an interesting finding, since it seems contradictory with the couple's self-report and with some of their interactions in therapy sessions. For example, Gail complained that Reggie often ignored her when she felt she needed him. This contradiction may lend credence to the notion that the couple was trying to answer in an overly positive fashion. On the Aggression scale, Gail scored in the moderate range (56*T*). When her individual answers are checked, she has responded "false" to the statements "My partner has never pushed me or grabbed me in anger" and "My partner has never injured me physically." This seems to suggest that the information that the couple provided in their intake session, in which they both stated that Reggie had never been violent with Gail, was not entirely accurate. Reggie scored in the problem range on this scale (67*T*) which is consistent with the couple's description of Gail's tendency to become physically violent. This was by far the highest score that Reggie received and is consistent with his stated concerns about Gail's impulsive outbursts. In fact, this is the only category in which Reggie scored in the problem range, and he only scored in the moderate range on two others (Global Distress and Family History of Distress). Again, this seems inconsistent with a man who regularly threatened to leave his partner. Both Reggie and Gail scored in the low range for Time Together, illustrating satisfaction with both the amount of time they spent together and a reasonable convergence of interests. On the Disagreement About Finances scale Reggie was again in the low range (45*T*), while Gail scored in the moderate range (52*T*). As is the case with scores on other scales, this does not entirely fit with information the couple shared

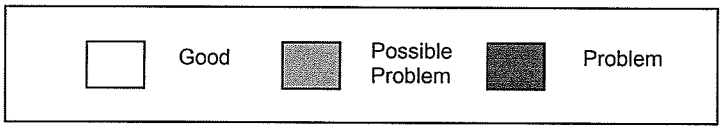
during sessions, such as Reggie's suggestion that they keep their money entirely separate due to his stated concerns about how Gail spent money while grocery shopping. Both Reggie and Gail scored low on the Sexual Dissatisfaction scale (44*T* and 46*T* respectively). On the Role Orientation scale, Gail scored significantly lower than Reggie, indicating that she held more a traditional view about appropriate roles for men and women in a marital relationship. Reggie's score did seem to be generally congruent with the couple's lifestyle wherein (a) neither worked (i.e., Reggie was not a traditional male "bread winner"), (b) Gail went to school, and (c) Reggie spent daytime hours with the children either at the school or at home, once Cathy was returned to their care. On the Family History of Distress scale Reggie scored in the moderate range (48*T*), reflecting some disruption in his family of origin, while Gail scored in the problem range (57*T*) which speaks to some of the problems that she encountered as a child. This is consistent with Gail having attended extensive individual therapy in an attempt to resolve issues stemming from her childhood. Under these circumstances, it is not surprising that Reggie and Gail would experience some level of difficulty in their partner and parental roles. That being said, Reggie responded to each of the Dissatisfaction With Children statements in the positive direction (35*T*). He did the same with every statement on the Conflict Over Child Rearing scale (41*T*). Once again this suggests that Reggie was trying to present as the "perfect" father, leading up to his court case for his daughter's guardianship. Gails also responded overwhelming positively regarding Conflict Over Child Rearing (47*T*). She did, however, score in the moderate range of the Dissatisfaction With Children scale.

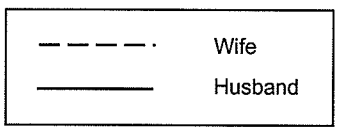
On the second administration of the measure (see Figure 3) a few changes are noticeable. Once again Reggie scored low on the Inconsistency scale (42*T*) and moderate on the Conventionalization scale (49*T*). The results suggest that his answers were not generated randomly and were not unduly influenced in a socially desirable direction. For Gail, however, her scores on these two scales increased slightly (59*T* up from 55*T* on the Inconsistency scale, and 57*T* up from 54*T* on the Conventionalization scale), the implication being that she was less consistent with her answers, perhaps reflecting an increase in mixed feelings, though still unrealistically positive. Both scored higher on the Global Distress scale (each scored 55*T*). Since there is reason to wonder if the first measure was influenced by the pending court case for legal guardianship of Reggie's daughter, this change may more accurately reflect the couple's true level of distress. Another interesting change is that Reggie's score on the Affective Communication scale increased from 45*T* to 57*T* from the pre-test to the post-test. While this is not the direction of change that clients and therapists hope for, one explanation may be that Gail was less driven to attend to Reggie, after working through how she would survive if Reggie left. Gail, too, scored higher on this scale (46*T* up from 42*T*), though this is still in the low range. There was little change in the couple's scores on the Problem-Solving scale, though their relative positions had reversed, with Gail expressing slightly less satisfaction (47*T*) than Reggie (42*T*). On the Aggression scale, Reggie scored slightly higher than he did on the first administration (73*T*). Gail scored much lower than she did at first (down to 48*T* from 67*T*). This is noteworthy, and a little concerning because as it was pointed out earlier in this paper, most of the statements on the Aggression scale are not designed to track improvement over time (i.e., if the answer to the statement "My

Figure 3

Marital Satisfaction Inventory – Post-Test







partner has slapped me" is ever "true", it cannot be expected to change to "false" in the future). When individual responses were investigated, Gail changed three responses from the first administration. Her response to the statement "My partner sometimes screams or yells at me when he or she is angry" was changed from "true" to "false. This is indeed possible and, in fact, desirable. However, her responses to the statements "My partner has never pushed or grabbed me in anger" and "My partner has never injured me physically" were both changed from "false" to "true". If this had been flagged as part of ongoing therapy (rather than after termination) it would have warranted further exploration, since this change is not possible and may reflect inaccurate responding or purposeful misdirection. The couple's scores on the Time Together and Disagreement About Finances scales remained virtually unchanged. On the Sexual Dissatisfaction scale, however, Reggie scored very low (34*T* reflecting his answering all statements in the positive direction). The final point of interest is that on this administration of the measure, is that Reggie once again responded positively to all statements on the Dissatisfaction With Children and Conflict Over Child Rearing scales. This time Gail did the same, lowering her score on the Dissatisfaction With Children scale from (51*T*) on the first administration to (35*T*) on the second. The "glass is half full" view is that she was truly more satisfied with her children. Again, this would warrant further exploration, if therapy were continuing.

Summary

Prior to therapy, Reggie and Gail Brown presented as a couple with numerous issues. They were experiencing predictable stress related to transitions in the family life

cycle. They had moved from being unattached adults to being a married couple with young kids, without a chance to adjust to just being a married couple. There were also blended family issues, with Reggie unsure of his role with the children that Gail brought to the relationship. The boundary between the couple was rigid, impeding their ability to communicate and empathize with each other. The boundary around the couple, however, was diffuse, allowing young children to participate in the executive functions of the family. There was a clear power imbalance in this couple, with Reggie wielding significantly more power than Gail, most notably through his use of threats to leave the relationship. The couple experienced trouble communicating, with Reggie disregarding Gail's opinions and concerns. The couple also struggled in their attempts at collaborative problem-solving. After experiencing an emotionally distant relationship, punctuated by conflict, little joy or passion remained.

After attending therapy, there were several noted improvements. The boundary between the couple was less rigid, with Reggie more able to sense when Gail experienced stress. By reducing the strength of Reggie's threats to leave the relationship, the power imbalance between the partners was significantly reduced, with Gail feeling less dependent. After exploring and practicing communication skills, Reggie demonstrated an increased ability to participate in dialogue, rather than monologue. The improved communication also illustrates the improved clarity in the boundary between the couple. The couple had taken successful steps to try to revitalize their relationship, though it was unclear by the end of therapy whether they would continue to attend to this aspect of their relationship. Though the blended family issues had been discussed in therapy, this continued to be an area requiring growth.

The use of Structural Family Therapy was beneficial in this case. Exploring how the couple interacted with each other within the couple subsystem and considering how the couple subsystem interacted with other subsystems (e.g., the children subsystem) helped to map out important elements of this couple and set a course of action for therapy. Sensitivity to the boundaries similarly provided information about interventions that would be helpful. An example of this is the work that was done to strengthen the boundary around the parental subsystem and block the couple from drawing the young children into their adult conflicts. When the power imbalance was noted between Reggie and Gail at the outset of therapy, steps were taken to rebalance the family system to empower Gail and elevate her to a more equal footing with Reggie. Overall, Structural Family Therapy was useful both as a diagnostic tool and as a model of intervention in this case.

The Smith Family

Background

This couple participated in the second portion of the practicum. The focus was on working with couples who had experienced conflict in their relationship, though not necessarily violence, and utilized a single therapist model.

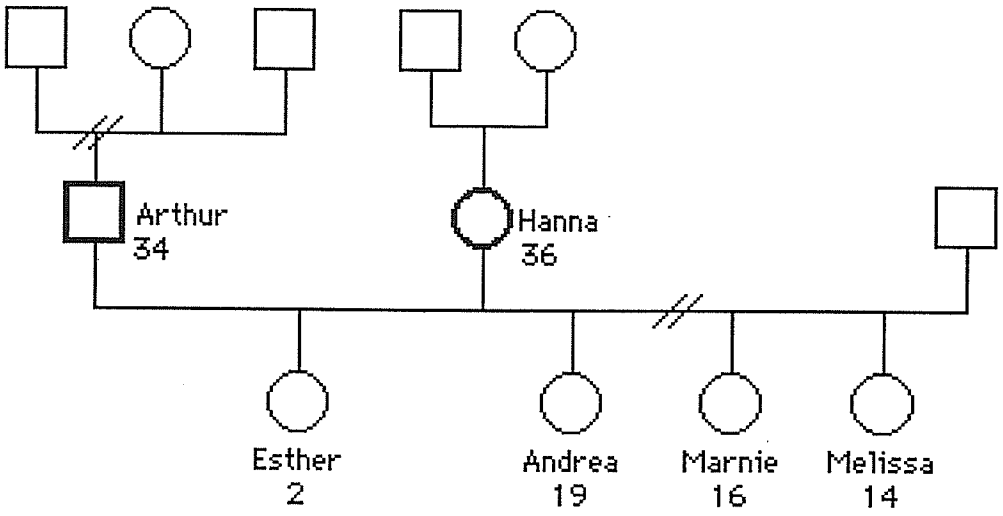
Arthur and Hanna Smith (see Figure 4) are a Caucasian couple. Neither has extended family in Winnipeg. They had been together for approximately five years, of which they had been married for three. Hanna had initiated the couple's request for therapy, describing significant conflict between herself and Arthur, but no physical violence.

When the couple arrived for their intake session they seemed to be in good spirits. After an introduction to the Centre, including signing releases for videotaping, a conjoint session was held. During this session, the couple was asked to identify what brought them to seek therapy at that time. The couple identified numerous problems that they had been experiencing. This included:

- Parenting;
- Conflict between the couple, and between Arthur and the teenage daughters;
- Communication between the couple;
- Periods of what the couple considered "depression" for Arthur;
- Sexual issues; and
- Disagreements over finances.

Figure 4

Genogram



The second session began with the couple filling out the Marital Satisfaction Inventory, followed by having the couple describe how they met, and some of the highlights (and lowlights) of their relationship. In the next two sessions, Arthur and Hanna were seen individually. Over the course of these sessions, the couple were asked to provide a brief history of their relationship and to provide more detail regarding the concerns they had initially raised.

Prior to meeting Arthur, Hanna had been in a marriage, from which she has three daughters, Andera, Marnie, and Melissa. Hanna and Arthur have one child together, Esther, who was two years old at the time they were seen in therapy. The couple agreed on many of the details of their history, but could not agree on the order in which they occurred. They described Arthur's initial hesitation to commit to marriage, because he wasn't sure he wanted to take on the responsibility of parenting Hanna's three daughters. He even terminated the relationship over this issue, but when his father became seriously ill and Hanna was very supportive, he changed his mind. Shortly after they were married, Arthur accepted a job in another country. This was supposed to be an extended stay and a good opportunity, but it turned out very negatively. Arthur did not get along with his supervisor and his new job was not what he had hoped for. The couple spent much of their savings on their move and setting up a new home, only to decide to move back to Canada, where they arrived stressed and financially troubled. Arthur is quite concerned with finances, so this situation exacerbated the problems that the couple experienced. Further, Hanna's ex-husband refused to pay any child support heightening Arthur's resentment towards Hanna's daughters. The family's stress was compounded by the having to live in a house that they considered too small for their needs, particularly with

three teenage daughters. Arthur's resentment boiled over to become overt anger towards the daughters, particularly the eldest, Andrea. The troubles experienced by the couple worsened when Arthur returned to University on a part time basis, in an attempt to prepare for a better job that would bring more financial stability. Arthur spent a great deal of time in the basement studying. By the time the couple came to EHCC, they were considering ending their marriage, but had decided to try therapy as a last resort. Their relationship had become very fragmented, which was illustrated by their separate finances, activities, and parenting duties. Their interactions were often heated and hurtful, followed by days or weeks of tense silence. Both felt that Arthur was the source of much of their problems. He experienced very negative moods that the couple described as "depression" (note: Arthur had not been formally diagnosed as suffering from clinical depression, though the couple stated that his father had been formally diagnosed as "manic-depressive" and that his mother experienced "depression"). Arthur's negative moods were most pronounced at Christmas time and more generally during the winter months. During these times, Arthur would withdraw from the family, spending more time at work or in the basement study. Arthur openly acknowledged that he had become increasingly more unpleasant towards the other members of the family and noted that no one in the family hated him more than he did himself.

The couple also mentioned that they were having trouble with their sexual relations. Arthur stated that he wanted to have sexual intercourse more frequently. Hanna acknowledged this, but stated that the combination of their constant fighting and being generally tired contributed to her being less interested in sex. She felt that Arthur made her feel like a "piece of meat", by ignoring her need for affection then just wanting

sex.

Arthur and Hanna stated that their relationship had deteriorated to the point where they were considering separation. However, despite noting the extent of the problems they had been experiencing, both Arthur and Hanna expressed a sincere commitment to improving their relationship.

In the next session, the couple was presented with an evaluation and a recommendation for conjoint couple therapy. The couple accepted the evaluation, and agreed to attend five more sessions, to work on the following issues:

- Improving communication,
- Reducing the frequency and severity of arguments,
- Arthur's periods of "depression",
- Parenting,
- Shared decision-making,
- Re-building the resilience of the relationship (ability to tolerate problems),
- Re-building closeness and fun in the relationship, and
- Improving their sexual relationship.

We contracted to review what progress had been made after these five sessions, at which point we would decide about further sessions or termination.

Intervention Highlights

From the outset, it should be noted that this is a motivated, resourceful couple. They took many of the ideas and concepts that were discussed in therapy and re-worked them to make them their own or to fit other situations. Karpel (1994) points to the

feelings of the therapist as a reflection of what is occurring for the couple. He feels that when the therapist experiences positive feelings about a couple during therapy, this can be an indicator of resources within the couple's relationship. This idea certainly fits for my experience with this couple.

It is also worth mentioning that in Arthur's place of employment, hierarchy is very defined and obedience is strictly enforced. Arthur was comfortable in that environment, which fit with many of his personal beliefs and values. Arthur's predilection for hierarchy and his belief in the importance of obedience carried over into the family's home life. However, this did not work well with his three teenage daughters, who from a developmental perspective needed to move toward independence and autonomy. Also affecting the family was the long distance between their current home in Winnipeg and the province in which they had spent most of their lives, which was still the home of their extended families. While they did have friendships in Winnipeg, the ability to call upon the rest of their support network was lessened by the distance. Further, the family had experienced several moves, which were stressful.

At the time that the couple first attended therapy, there was a significant emotional gulf between Arthur and Hanna. In structural terms, the couple had a disengaged transactional style. Arthur went to work, attended University, and when at home went down to his basement study. Hanna worked in the garden, kept house, worked at two part time jobs, and parented the children. From time to time, when she wanted a break from childcare, Hanna would enter Arthur's basement world and put Esther on his lap with instructions to play with her for a while. The couple's finances were kept entirely separate, because Arthur did not trust Hanna's spending.

Disagreements were either pushed out of sight, to fester and build, or exploded into heated arguments. There was little or no healing after these arguments with the combatants retreating into their separate lives. If one partner experienced stress in his/her life (e.g., related to employment), the rigidity of the boundary between them limited the ability of the other partner to notice and respond in a supportive manner. This is consistent with Minuchin's assertion that "...stresses in one family member do not cross over its inappropriately rigid boundaries. Only a high level of individual stress can reverberate strongly enough to activate the family's supportive systems." (1974, p. 55).

Two interventions occurred during the initial, information gathering sessions that began immediately to bridge that emotional gap. When Arthur and Hanna were asked to describe how they met and what first attracted them to each other, the mood in the room altered noticeably. As they shared positive memories, and even as they disagreed over details or recounted some early struggles, there were smiles, teasing, and warmth. When asked for their impressions at the end of the session, both expressed surprise at the feelings this evoked. The act of retelling the old stories clearly brought forth a positive emotional response, and reminded the couple why they chose to come to therapy.

The other thing that prompted an immediate response during the information gathering sessions was the creation of a timeline for the couple's relationship. A timeline is a visual representation of some of the most notable points in a selected time span. This exercise facilitated the couple telling their story and also created a visual account of some of the stressors that they had experienced since meeting. There were several stressors that the family had endured, often overlapping with life cycle transitions.

To look at this family from the perspective of the family life cycle (Karpel & Strauss, 1983), they were clearly experiencing several stages simultaneously. The Smiths were:

- A family with young children (Esther was two years old),
- A family with adolescents (the daughters from Hanna's first marriage were all in their teens), and
- A family launching children (Andrea had recently moved away to live with her birth father, and while not marking total adult independence, it did require a significant change in the family structure and functioning).

Exacerbating the difficulties of negotiating family life cycle transitions were the adjustments required to successfully integrate a new parent into an existing single parent family. Arthur had no appreciable experience as a parent and more trepidation than desire to become the father of three adolescent girls. For Arthur, transition to this stage overlapped the transition to married life, and predated the transition to life as a family with young children. For Hanna, she was at least able to negotiate married life, life with young children, and life with adolescents prior to marrying Arthur, though she, too, was caught trying to manage several transitions at once. This assessment is consistent with some of the desires espoused by the couple (i.e., Arthur desired more time alone as a couple, while Hanna wanted more time with the family).

For Arthur and Hanna, struggles with lifecycle transitions overlapped with their move to another country, a move that was to have been a golden opportunity but instead brought dashed hopes, stress, and financial hardship. As the timeline unfolded highlighting these struggles, the couple began to remark on all the pressures that they had

endured. This accomplished several things. First, it normalized some of their struggles. It no longer seemed that personal failings were the root of their problems. Secondly, this process offered me an opportunity to congratulate the couple on the strength they had shown to manage as well as they had during that time. By reframing their struggles to highlight the strength and resilience the couple had shown helped them to see themselves in a different and decidedly more positive light. The other thing that emerged from the timeline task was that both Hanna and Arthur felt like they were coming out from under a cloud. With that hardship behind them and with their financial situation returning to normal, the task of improving their relationship seemed less daunting and more likely to succeed.

Building from these first steps, one of the subsequent interventions focussed on assisting the couple to inject more "fun" into their relationship (something that they felt was missing). This is consistent with the ideas of Liberman, Wheeler, deVisser, Kuehnel, and Kuehnel (1980) who point to the benefit of beginning therapy by working through an issue that is not too emotionally loaded. Accordingly, the couple was asked to decide on a leisure activity that could include the whole family, but would have a high chance of being successful. Hanna mentioned that Marnie was to go to the beach on Saturday to spend time with her friend and that if she was to go, she needed a ride. However, Hanna stopped short of suggesting that Arthur come along. When prompted to finish her thought, she stated that Arthur wouldn't really want to come and that if he did, he'd ruin the day for the whole family. This statement was rather like throwing down the gauntlet, and functioned as a paradoxical strategy (Haley, 1978; Karpel, 1994). By asserting that Arthur was incapable of spending a day with the family without ruining the time for

everyone, Hanna had laid down a challenge for him. Arthur quickly responded to this challenge by affirming that not only did he want to go with the family, but also gave assurances that he would work hard to stay positive. Hanna was slow to accept this response, but with encouragement from myself, agreed to the plan. When the couple came to the next session the following week, they were very pleased to recount their fine day at the beach. Arthur, true to his word, had steadfastly remained upbeat. Hanna, while initially uneasy, made the effort not to undermine Arthur by scripting him into the role of spoiler. While this was a small step, it demonstrated to the couple that they had the ability to enjoyably spend leisure time together and the level of commitment required to follow through with plans, despite initial misgivings. At future points in therapy, if the couple slipped into a negative dialogue about "always" having problems or family outings "never" working out, this successful outing was a useful exception that could dispel these universal statements and help the couple more forward.

At a workshop given by Yvonne Dolan (Oct. 1998), she discussed the benefits of couples taking up an activity that was new to both. She pointed to the benefits of learning together, as well as ensuring that the activity was not as likely to meet one partner's needs, while ignoring the need of the other. I saw this as an intervention that could help re-build some of the joy that had gone out of the couple's relationship. As well, it would have the effect of bringing the couple together and relaxing the rigid boundary between them. Since this fit well with my work with the Smiths, I was eager to introduce this at the next session. However, when the Smiths arrived for their next session, they were anxious to tell me that they had signed up to curl together in a mixed curling league. Neither had curled before. While this effectively preempted the idea I

was planning to borrow from Ms Dolan, it was far more important that the couple had been the initiators.

While attention was paid to the couple's patterns of communication, this was seen to be a lesser problem. When they were not arguing or shutting each other out, both Arthur and Hanna were quite able to express themselves and were generally able to listen and understand the other.

The couple's ability to solve problems and make decisions collaboratively was limited. The couple had compartmentalized many elements of their lives, so that most decisions were made by one of the partners, not by both working collaboratively. This compartmentalization can be seen as an attempt to find a solution that helped avoid arguments, however it was not successful. The couple was still at odds over decisions and continued to argue. Further, their attempt to ignore problems resulted in additional stress. In Minuchin's terms the Smith's struggles with decision-making illustrates that they had too narrow a range of behaviours and that they rigidly adhered to these behaviours, even when they did not resolve problems.

This point is illustrated particularly clearly through the issue of finances. As mentioned, the couple kept their finances entirely separate. While this is possible in theory, in reality it is difficult to achieve. When either partner made a major money decision without the other, this precipitated a heated argument. For example, during the previous income tax season Arthur unilaterally invested a large portion of their income tax return in a Registered Retirement Savings Plan. Hanna's response was to complain that the family was forced to scrimp and save to get by. Conversely, when Hanna bought an expensive watch, Arthur became very angry, despite the fact that Hanna made the

purchase out of "her" money. The attempted solution of having separate finances led to an increase in the severity of their arguments. Money was in many respects a metaphor of the couple's relationship. It showed their separateness, their differing needs and wants, and the methods through which they vied for control. With this in mind, I asked the couple to discuss in front of me how they should spend their next year's income tax return. With little help, they worked out a plan that was acceptable to each. What was important was not the solution itself, rather it was the process of working together to create a mutually acceptable solution. It seems clear that one reason for this achievement was that my presence in the room changed the routinized pattern of their interaction. Neither Hanna nor Arthur was comfortable taking a polarized stance, under those circumstances. This is consistent with Haley's (1978) view that the therapist forms a triad with the couple, thereby altering the couple's (dyadic) interaction pattern. Although they still maintained separate bank accounts by the time that therapy was terminated, the couple did continue to work towards more collaborative problem-solving (e.g., day to day scheduling, investing, holiday arrangements).

Symbolic of his disengagement from the rest of the family, Arthur spent a great deal of time away from the other family members, either at work, at school, or in the basement studying. Not only did this occur on a daily basis, but also for longer blocks of time (e.g., Arthur decided to take a week of vacation and spend it in his study). This pattern helped to create and maintain the distance between Arthur and the rest of the family, and can be seen as an attempted solution to cope with the stress and conflict in the home. However this solution exacerbated the underlying problem of disengagement and helped to trap the couple into a pattern of withdrawal and subjugated feelings, followed

by explosive conflict, which in turn precipitated further withdrawal. Hanna was locked into a similar loop, in which she was beginning to build a life for herself and her children that did not include Arthur in any meaningful way.

Building on the successful process of resolving their income tax refund, the couple was asked to take as homework the task of reconsidering their use of time. They agreed to begin by discussing Arthur's studying schedule, which had a significant impact on the functioning of the family. The following week the Smiths presented a revised studying schedule. This plan included Arthur taking fewer courses at a time, pushing back his projected graduation date. They also presented a weekly schedule that identified times that Arthur could legitimately use for studying and other times that were set aside for family and/or couple time. They had also discussed how rigid or flexible this schedule would have to be, cognizant of the varying demands of Arthur's school program. They had drawn up the schedule and posted it on their refrigerator. Weeks later, when I asked for an update about how the new plan was working, both were pleased with the results. To the best of my knowledge, the couple continued to use this schedule throughout the time they attended EHCC. This intervention achieved two goals at once. By changing the interaction pattern, the couple was able to move away from their previous strategy that had been unsuccessful. Also, at the level of process, they had again worked together to come up with a solution that was mutually acceptable. Solving problems together set the stage for other collaborative solutions in the future by altering the transactional style of the couple and helping to make the boundary between the couple less rigid.

One of the concerns that was raised by the couple was Arthur's periods of "depression", which Arthur also described as a "blue funk". In consultation with my Clinical Supervisor, Mr. David Charabin, we decided to address this problem through support and self-care, and through facilitating changes in the couple system. These interventions were then monitored. If Arthur's negative moods did not improve or became worse, referral for a mental health assessment could be considered. Accordingly, time was spent with the couple exploring what solutions they had tried. Hanna stated that for years she had tried to be supportive to Arthur when he was in a "blue funk", but that this had not seemed to help. Rather, Arthur became more irritable and reactive. As a consequence, she had started withdrawing instead, just waiting until his mood improved. This was also not helpful, but was seen by Hanna as less unsuccessful. A two step intervention was used in this situation. First, I asked Arthur what he already did that made him feel better. He stated that he felt better when he was exercising regularly. From the session, Arthur took as homework the task of designing a realistic exercise plan. The following week, he stated that he had started going to the gym with a friend several times per week and started to play hockey again (an activity he had previously discontinued). This had not only lifted his mood, but by including another person in the equation, he increased the likelihood of maintaining his new exercise routine. At subsequent sessions, when I checked with Arthur about his exercise routine, he stated that he was continuing and that he felt it had a positive effect on the frequency and duration of his "blue funks". The second element of this intervention was to have Arthur describe to Hanna how it felt to be in his depressed mood and have her withdraw. While Arthur understood why she withdrew, and acknowledged that his behaviour had driven her away

at the times when he most needed support, he was able to express that her withdrawal made him feel even worse. The couple then discussed ways in which Hanna could offer support in non-intrusive ways. Arthur also admitted that he had been giving himself permission to treat those around him shabbily during his down times. He committed to trying harder to accepting Hanna's efforts more positively. Although these plans did not entirely eliminate Arthur's "blue funks", they were alleviated sufficiently that the couple decided not to pursue other intervention at that time. Minuchin (1974) wrote "stresses in one family member do not cross over [the] rigid boundary" (p. 55) in a disengaged relation. As the boundary between the couple became less rigid, Arthur's symptom ("blue funk") was no longer needed to elicit support from other parts of the system.

Early in therapy, Arthur stated that the frequency of the couple's sexual relations had decreased to the point that he found it problematic. The couple did not describe any symptomatology that suggested physiological sexual dysfunction. The decision was made not to expend great effort addressing this issue directly. The primary approach taken was to check in with the couple from time to time as other aspects of their relationship changed, though in deference to the couple's concern in this area, one session was used to discuss the situation directly.

Although the couple reported that the quality of their sexual relations was satisfactory to both, Arthur desired increased frequency, while Hanna did not. I asked Hanna if Arthur had ever behaved in a way that made her feel more like having sex more frequently. She was able to say that she felt more interested when Arthur made her feel "special", but ended the statement with the qualifier "isn't that awful?" She was able to go on and list things that Arthur could do to show his affection (e.g., cooking dinner,

looking after the children, unprompted hugs and kisses, and a focus on her needs). Though Arthur balked at the prospect of cooking dinner, he stated that he would try to be more accommodating to Hanna's needs. By the end of therapy, the couple reported an improvement in their sexual relations, but that this was still an area that they felt could be improved. The couple were encouraged to be patient, as the healing within their relationship was continuing to progress. Further, if this continued to be an area of concern, they were encouraged to consider seeking help specifically in this area.

It is worth noting Hanna's comment "isn't that awful?" which illustrated Hanna's perception of her role within the family, looking after the needs of others and feeling guilty when she had needs, too. This statement provided an opening for exploring what could bring more balance into the couple's life.

The intensity and frequency of arguments was seen as problematic both by the couple and by myself. As the emotional gulf between Hanna and Arthur had increased, their ability to discuss emotionally charged topics had decreased. Both bottled up their feelings, at times letting them loose on each other in explosive and hurtful quarrels. Although the couple maintained that there had never been any physical violence in their relationship, they openly admitted that the verbal jousting that occurred on these occasions was abusive. The couple's interaction pattern was drawn out on a flip chart, to assist them to understand the pattern and to identify points at which they could intervene in the pattern. For example, when Hanna was upset, rather than holding it in, she could find a calm time in which to raise the issue or when something occurred that angered Arthur, he was to give himself a "time out", instead of yelling. Since a change in one part of the system necessarily changed the whole interaction, the couple was able to come

up with numerous possibilities. As the couple's relationship improved and as Hanna, in her own words began to "let Arthur back into her life", she felt more willing to share her concerns with him. Every time Hanna brought up a concern and Arthur did not explode, she was encouraged to keep trying. By the end of therapy, the couple reported that the frequency and severity of their arguments had decreased significantly.

There was one session that was particularly fiery. As the couple entered the therapy room, it was obvious that they had experienced some conflict. Hanna began by stating they had had a "relapse". Arthur angrily complained that Hanna had been sick and disagreeable for two weeks, then had purchased an expensive watch without regard for the family. He stated that he had been working hard to change, but that there really was no hope and that the couple should just separate. Hanna acknowledged that she had been sick and also had a wisdom tooth removed, but that she had tried to carry on anyway. She admitted the watch was an extravagance, but pointed out that she had spent her own money, therefore it should be all right (based on the couple's own rules for finances). My response was to compliment the couple. Despite the troubles they had incurred during the week, they had come to therapy and they were willing to talk out their differences. I used the metaphor of addiction recovery, in which a relapse (or near miss) is normal and anticipated. I also prompted discussion of their accomplishments over the previous months. By the end of the session, the couple appeared more settled and calmer, but still on edge. When they arrived for their next session, they were in high spirits. They reported that the day after the previous session one of Hanna's daycare clients had called to suddenly remove her child. Upset, Hanna called Arthur at work to discuss the situation. This had prompted a discussion about their recent troubles. Both reported that

they had been able to keep their discussion at a moderate level and felt proud of this. As well, they had kept their commitment to go curling together, which had also softened their antagonism. The couple was complimented on their achievements. This demonstrated the greater clarity of the boundary between Hanna and Arthur (less rigid), and also the boundary between the couple and the rest of the world (e.g., the Day Care mother). This experience reinforced for the couple that they were becoming better able to support and rely on each other.

As Christmas approached, the couple saw this as an important "test". Year after year Christmas had been a most difficult time for the family. At a time when they were inundated by media images of happy families, their experience was one of discontent, fighting, and negativity. Historically, one of the main points of stress came on Christmas day. In the past, Arthur had been furious when the girls had not purchased gifts for their mother, interpreting this as a sign of their greed and self-serving nature. He also disliked and returned every gift that he was given. Since this was the pattern of Christmas ever since Arthur joined the family, it was approached with trepidation. Gaining strength from the positive steps that they had made, the Smiths prepared for another Christmas season, however unlike previous years, the Smiths entered the season with improved trust and resiliency. A session was used for the couple to become more proactive, planning out how they would change their Christmas experience. In the weeks leading up to the event, both Hanna and Arthur spoke with the girls about setting aside time to shop for gifts. The couple also made plans to spend Christmas dinner with another family. On Christmas day, their preparatory work paid enormous dividends. In the morning, the girls presented their mother with appropriate gifts and an affectionate poem they had written.

Arthur was presented with a gift from Hanna and the girls with which he could not find fault (new golf clubs). He was genuinely touched. The evening, too, was a success. In the first therapy session after Christmas, Arthur and Hanna stated that the presence of the other couple had worked as a buffer, helping to keep spirits uplifted. They both stated that they felt the success of this Christmas would be present with them the following year. They had begun to re-write their family story of Christmas. The couple received praise for identifying potential problems (based on past patterns), possible changes, and also for following through with their new plans.

Termination

After the Smiths success at Christmas time, I introduced the idea of terminating therapy. We had already rolled the sessions back to once every three weeks, and had gone five weeks between sessions at one point, when the couple had to cancel a session. Hanna expressed that she would have felt uncomfortable had we planned to wait five weeks, but that when it occurred naturally, she was encouraged by their ability to manage well without coming to EHCC. We then set a date for a final session.

The final session began with the couple completing the Marital Satisfaction Inventory, then proceeded with our reviewing the original goals of therapy and reviewing the couple's accomplishments. The final portion of this session was to elicit from the couple some feedback regarding their experience in therapy. Compliments were turned back to the couple, pointing out that their successes were attributable to their hard work and courage. When asked if there were any points over the course of therapy that had been particularly important, the couple mentioned the session in which we had created

the timeline and also the session following their "relapse". The couple was encouraged to re-contact the Centre if they felt the need, but this did not occur.

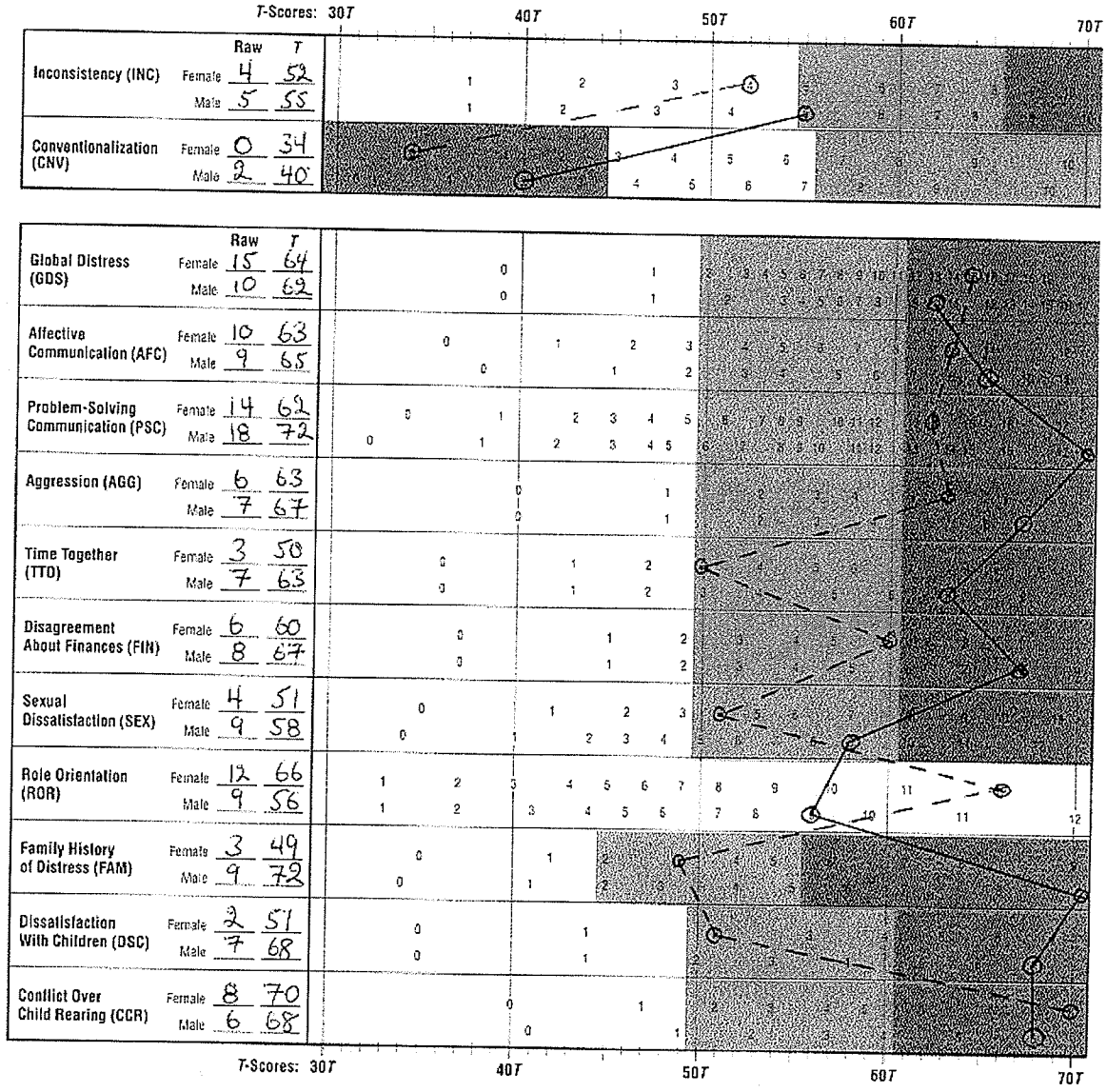
Marital Satisfaction Inventory

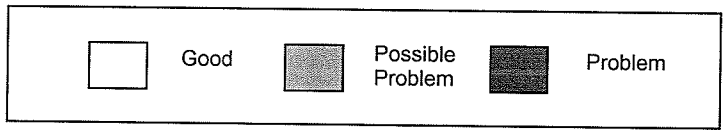
Arthur and Hanna completed the Marital Satisfaction Inventory at intake and again at termination allowing for comparison over time. There were no problems with the administration of the measure.

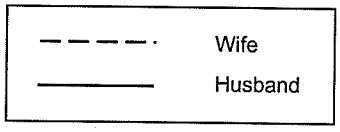
On the first administration of the measure (see Figure 5), Arthur scored just into the moderate range on Inconsistency scale (55*T*) perhaps reflecting ambivalent feelings towards the marriage. This possibility is supported by Arthur's answer ("true") to the statement "At times I have very much wanted to leave my partner." Hanna's *T* score on this scale (52*T*) was slightly lower than Arthur's but falls in the low range, suggesting slightly less ambivalence. On the Conventionalization scale, Arthur and Hanna's scores were both low enough to fall well into the problem range (40*T* and 34*T* respectively). This implies that the couple was very focussed on the negative aspects of their relationship, which is common at the outset of therapy, according to Snyder (1997). On the Global Distress scale both Arthur and Hanna scored in the problem range (62*T* and 64*T* respectively). This speaks to the overall level of dissatisfaction that the couple was experiencing. Again, this is not uncommon for couples at the outset of therapy. Since the Smiths were prompted to seek help due to the worsening problems that they had been experiencing, these scores are not unexpected. Affective Communication scores and Problem-Solving scores were also in the problem range for both (65*T* and 72*T* for Arthur and (63*T* and 62*T* for Hanna). This supports the initial goals of therapy that included

Figure 5

Martial Satisfaction Inventory – Pre-Test







work on communication, shared problem-solving, closeness, and sexual relations. On the Aggression scale, both again scored in the problem range (Arthur 67*T* and Hanna 63*T*). Hanna's responses to specific statements on this scale show that the anger and aggression in this relationship had been high, but that the couple stopped short of physical violence. This was true for the most part of Arthur's answers as well, with the exception of his "true" response to the statement "My partner has slapped me." Despite the couple's position that they had never experienced physical violence, there were certainly grounds to cover safety plans for both. The results from the Time Together scale were interesting, in that Arthur scored higher than Hanna (63*T* and 50*T* respectively). This is congruent with information that the couple shared during therapy sessions, in which Arthur expressed the desire to spend more time together as a couple, while Hanna was less concerned about couple time, balancing it with personal and family time. Arthur's score on the Disagreement About Finances scale was in the problem range (67*T*), which fits with the concerns he expressed about Hanna's spending habits and his overall heightened concern for all things financial (i.e., income, Hanna's employment, taxes, expenditures, child support, etc.). Hanna scored lower (60*T*) likely reflecting less intense concerns about finances, though still illustrating dissatisfaction with the amount of discord that discussions of finances stirred up. This is noteworthy, as the couple had already worked out a "solution" to their finances by keeping them as separate as possible. The results from the Disagreement About Finances scale suggest that this was not working. Both Arthur and Hanna scored in the moderate range on the Sexual Dissatisfaction scale (58*T* and 51*T* respectively) with the difference coming from their responses to the statements about frequency of sexual intercourse. On the Role

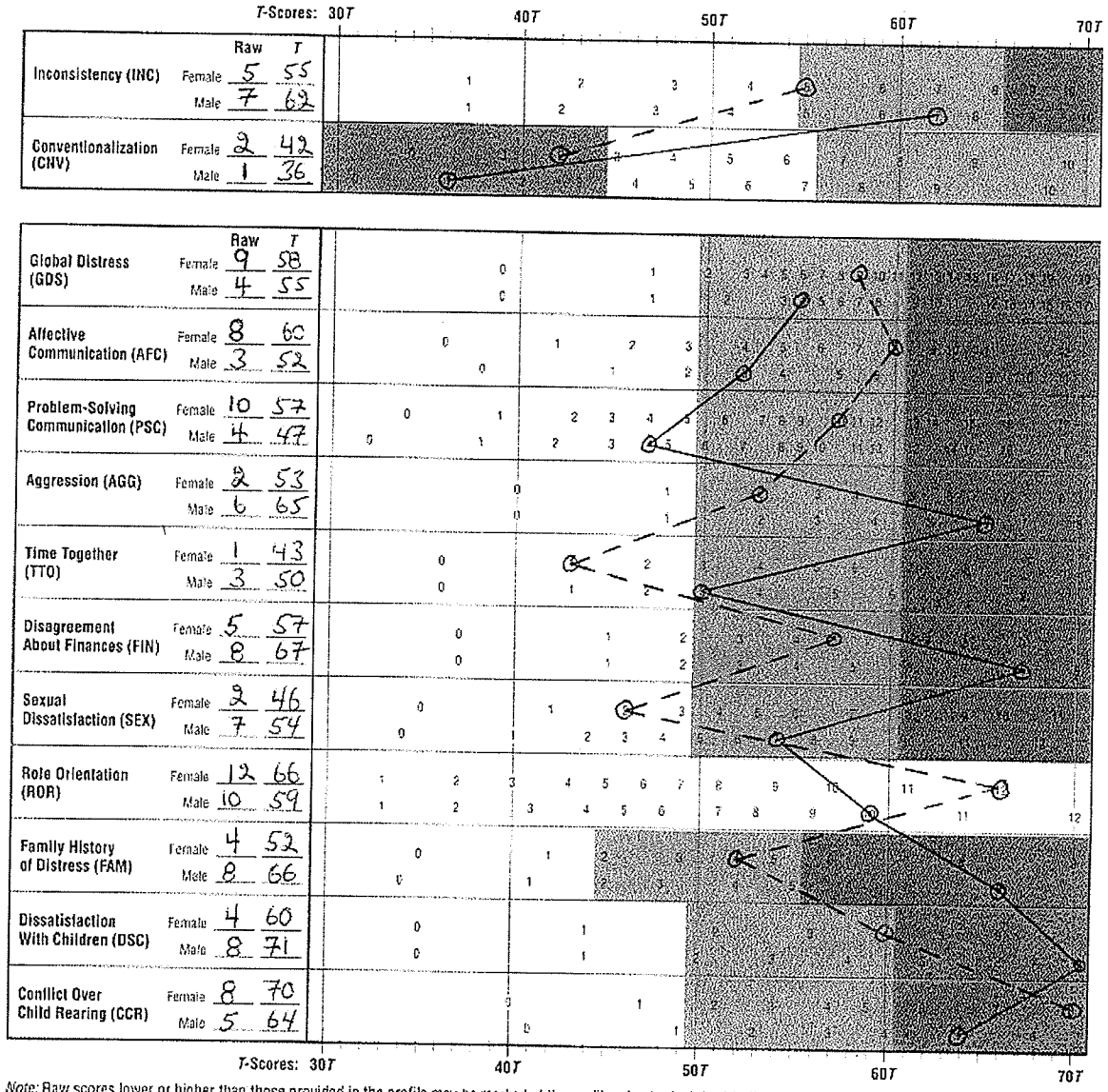
Orientation scale, Hanna scored higher (66*T*) than did Arthur (56*T*). This may be reflective of Hanna's independence, stemming from her time as a single parent. It is an interesting result, since it was Arthur who consistently encouraged Hanna to work out of the house more, while she preferred to stay home and work in a more traditional role (i.e., homemaking, home Day Care, etc.). Further, Arthur's profession does not have a reputation of being supportive of non-traditional roles. Perhaps this shows some "moxy" on Hanna's part or some change in the culture of Arthur's work. Although there are differences in their scores, the difference is not wide, implying that the couple's problems were not likely greatly influenced by competing views in this area. Arthur scored very high on the Family History of Distress scale (72*T*). This speaks to the likely contribution of his early childhood learning to the problems that the couple were experiencing, both in their relationship and as parents. Hanna scored in the moderate range on this scale (49*T*), but significantly lower than Arthur. The information garnered from the couple's responses to the two scales on child rearing was very much congruent with the information that they shared during intake. While Arthur scored very high on the Dissatisfaction With Children scale (68*T*), Hanna scored much lower (51*T*). However, both scored high on the Conflict Over Child Rearing scale (Arthur scored 68*T*, while Hanna scored 70*T*). The implication is that while both experienced dissatisfaction with the children, Arthur experienced this as much more troubling. This likely contributed to arguments over child rearing that in turn fits with their scores. This lends credence to the idea that Hanna's role as the birth mother for the elder girls and her extensive time caring for children has better equipped her for dealing with the frustrations of child rearing than Arthur, whose sum total of parenting experience has been the three years since their

marriage. One of the useful aspects of the Marital Satisfaction Inventory is that the couple can be plotted together on the same profile chart, which facilitates looking for areas of discrepancy between the partners. For Arthur and Hanna, this is the case on the Time Together, Family History of Distress, and Dissatisfaction With Children scales.

On the second administration of the Marital Satisfaction Inventory (see Figure 6), Arthur scored higher on the Inconsistency scale (62*T*) identifying a potential lack of reflection in his answers or increased ambivalence. Hanna's score was slightly higher, as well (55*T*), though both were in the moderate range. On the Conventionalization scale Arthur remained in the problem range (36*T*) suggesting that he continued to view the relationship in an overly negative light. Hanna's score (42*T*), while still in the problem range, had risen somewhat. This can be interpreted as still having an unrealistically negative perceptual distortion, but less so than before. On the Global Distress scale both scored in the moderate range (55*T* for Arthur and 55*T* for Hanna), showing some improvement for the couple, since their earlier scores were both in the problem range. This result suggests that the couple benefited from their time in therapy. For the Affective Communication and the Problem-Solving Communication scales, a similar result is evident. In both cases the couple scored well into the problem range on the first administration, but the scores were lower on the second administration. Arthur scored 51*T* on the Affective Communication scale and 47*T* on the Problem-Solving Communication scale (which is in the low range). Hanna scored 60*T* on the Affective Communication scale and 57*T* on the Problem-Solving Communication scale. Since working to improve their problem-solving skills, and increasing affection and understanding between the partners were initial goals of therapy, these scores are

Figure 6

Marital Satisfaction Inventory – Post-Test



Note: Raw scores lower or higher than those provided in the profile may be marked at the profile edge to the left of 30T or to the right of 70T.

Good | Possible Problem | Problem

Wife

Husband

encouraging signs. There was change noted on the Aggression scale as well, though as has been mentioned earlier in this paper, the language use in the Aggression related statements does not support tracking positive change. Nonetheless, when individual responses are explored Hanna had changed her answer to statements such as "I have never worried that my partner might become angry enough to hurt me." While the use of the word "never" when interpreted literally precludes changing to a positive response over time, it is still possible that the anger and aggression in the relationship has cooled sufficiently that she re-interpreted past events and feelings. On the Time Together scale, both partners scored lower than on the first administration (Arthur down to 50*T* from 63*T* and Hanna down to 43*T* from 50*T*). This is congruent with the couple's efforts to start and maintain more leisure activities and to include Arthur in family outings. Scores on the Disagreement About Finances scale were virtually unchanged from the first scores (67*T* for Arthur and 57*T* for Hanna). In my opinion, this reflects Arthur's exaggerated concern over finances. While over time the couple felt better able to solve problems together, it seems clear that this did not extend to their financial disagreements. On the Sexual Dissatisfaction scale, both Arthur and Hanna scored slightly better (lower) than they did the first time (54*T* and 46*T* respectively). While Arthur's score was still in the moderate range, Hanna was now in the low range. During therapy, the couple's sexual dissatisfaction was addressed primarily through attempting to improve the overall relationship, especially the affection that they showed to each other. It is hoped that the couple will continue to build that affection with a corresponding improvement in their sexual relationship. The results for the Role Orientation scale were mostly unchanged, with Arthur moving slightly towards the non-traditional end of the scale (Arthur scored

59*T* while Hanna once again scored 66*T*). Little change was noted on the Family History of Distress scale, with Arthur's score dropping slightly (66*T*) and Hanna's rising (52*T*). As previously noted, this scale (and the concept upon which it is based) should not be expected to highlight positive change over time. Both Arthur and Hanna scored higher on the Dissatisfaction With Children scale (71*T* and 60*T* respectively) than on the first administration. This may have reflected an actual change in the couple's struggles with their children. For example, the first administration occurred not long after the eldest daughter moved away to live with her birth father, thereby reducing the pressure on the family (small house, limited finances, etc.). It was also administered at the end of June, when the school-aged children had completed their work for the summer. The second administration was in April, when the couple was experiencing increased difficulty and concern regarding their second eldest daughter and her schoolwork. On the Conflict Over Child Rearing scale Arthur scored lower than on the first administration, though still in the problem range (64*T*). Hanna's score remained constant (70*T*) at the highest end of the scale. This suggests that while the couple relationship was functioning better, Arthur and Hanna were still struggling as a parental subsystem. This has implications for further therapeutic intervention, if the couple so desired, specifically consideration of family therapy, rather than further couple therapy.

Overall, if the elevated scores on the Inconsistency scale do not negate the apparent gains, the scores on this measure show substantial positive change for the couple. On the first administration, Arthur scored in the problem range on the global affective scale (Global Distress) and on eight additional scales. On the second administration, his Global Distress score was in the moderate range and he scored in the

problem range on five additional scales. For Hanna the results were similar. On the first administration she, too, scored in the problem range on the Global Distress scale and on four additional scales. On the second administration, she scored in the moderate range for the Global Distress scale and in the problem range on only one additional scale.

Summary

Prior to therapy, the Arthur and Hanna Smith's relationship had become emotionally disengaged. The boundary between the couple was extremely rigid, illustrated by their separate finances and struggles with collaborative decision making. Arthur was isolated from the family, with Hanna and the daughters forming a coalition against him. The couple struggled with being a blended family, exacerbated by Arthur's disinterest in parenting Andrea, Marnie, and Melissa. There was predictable stress stemming from the family's unresolved struggles to accommodate several family life cycle transition simultaneously (i.e., becoming a married couple, becoming a couple with a young child, and preparing to launch the eldest adolescents). This was compounded by unpredictable stress from various sources (e.g., their financial hardship stemming from their unsuccessful placement in England). The chronic conflict that the couple had experienced virtually since they met had taken a toll on the vitality of the relationship. The couple expressed dissatisfaction with their sexual relationship. Arthur felt that he suffered from depression.

By the end of therapy, the boundary between Hanna and Arthur was less rigid, though Hanna still struggled with allowing Arthur into the parental subsystem. For his part, Arthur was putting greater effort into becoming a parent, but he was clearly still

ambivalent and success in this area was limited. Improvement in the couple boundary was noted in other ways, with significant gains in problem-solving and collaborative decision-making. The couple worked hard to regain some of the energy and vitality that had ebbed from their relationship. They participated in a number of positive activities as a couple. Collaborative decision-making and a clearer boundary around the couple subsystem was also illustrated in their preparation and follow-through with Christmas plans. Arthur's "blue funks" seemed no longer to be an issue due to positive changes such as increased physical activity and decreased isolation. As Arthur became less absent in his role within the couple relationship and the family, the need for the "blue funks" (symptom) as a means of receiving attention was not as necessary. The couple's focus on meeting Arthur's needs had partially shifted to one of balance, though both Arthur and Hanna struggled with attending to and meeting her needs. The Smiths were a couple who, despite stating that they were committed to each other and their relationship, were teetering on the brink of separation when they requested therapy. By the end of therapy, there was reason to hope that they had salvaged their relationship and would continue to strengthen it over time.

Working with this couple provided a very positive learning experience. Arthur and Hanna are a resilient, resourceful, charming couple, yet when they entered therapy their relationship was very negative. The couple had tried to work through problems on their own, but wound up locked in cyclical patterns of behaviour that were not helpful. The use of Structural Family Therapy was effective in exploring the structure of the family, and deciding upon appropriate interventions. Minuchin (1974) contends that most families have a greater repertoire of behaviours than they use when they are in

crisis. That position is consistent with this case. With some guidance and support, Hanna and Arthur were able to tap into alternative behaviours that proved more successful in resolving many of their differences. Throughout the course of therapy, there was an undercurrent of affection between Hanna and Arthur. In my opinion, this affection was instrumental in carrying the couple through times when they were in conflict.

Chapter 6

Themes

Over the course of this practicum a number of themes emerged. Due to the changing nature of the practicum there is also an opportunity to comment on similarities and differences across client groups (i.e., those who had experienced violence in their relationships versus those who had not). The following is a summary of some of these similarities and differences. This information is admittedly anecdotal in nature and since the total population of this practicum is relatively small (a total of ten couples were seen for varying lengths of time) these observations cannot be generalized to all couples seeking marital therapy. Rather they are offered as "food for thought" and as a means of explicating some of the learning that occurred through the practicum.

1) Multiple Relationships

Five of the eight couples who had children were part of blended families (i.e., one or both of the partners had a child or children from a previous relationship living with them). This represents 62.5 percent of the couples with children who participated in this practicum. There are no statistics available regarding the proportion of blended families in Winnipeg, against which these numbers can be compared. However, this is likely higher than the percentage of blended families in the general population. A blended family presents added complexities for the parents in particular. Balancing the needs of all children, forming new attachments without damaging existing attachments, exercising appropriate parental authority without years of building a strong relationship, and

potentially having to manage several family life cycle transitions simultaneously can make the role of parent in a blended family more difficult. In most cases, the couples in the blended families in this practicum experienced difficulties with parenting. In most cases, the children were the birth children of the woman. In several cases, the man had no previous parenting experience. This may have contributed to the level of dissatisfaction that the men experienced with the children. This, in turn, contributed to difficulties between the parents.

2) Alcohol and Drug Use

Although alcohol and drug abuse was not prevalent to the point of precluding couple therapy, it likely played a role for several of the couples. With one couple I was (and remain) suspicious that alcohol use was more problematic than the couple admitted, although ample opportunity was provided for the couple to share this information. In another couple, the woman had a previous history of alcoholism. The man felt that he had "saved" her from this fate, therefore (in his opinion) she owed him a debt of gratitude, though this did not stop him from using street drugs on a daily basis. The man from another couple, when asked how he would conduct himself after the couple had experienced an intense argument, stated that his intention was to go home and drink. Yet another couple had attended alcohol treatment prior to attending couple therapy (though the man had dropped out of the alcohol treatment). Finally, in one case the man not only struggled with his own alcohol use, but also may have experienced cognitive impairment due to his mother's drinking when he was in her womb. Relationships and child rearing can be difficult enough without these added obstacles. Since the couples who received

therapy through this practicum had all experienced conflict in their relationship, and since the literature on family violence shows that there is a correlation between alcohol abuse and wife abuse perpetration (Hindman, 1979; Karpel, 1994) this was a situation that required careful monitoring. For the couples who had experienced violence in their relationship, this situation highlighted the need for safety plans.

4) Setting the Stage

During the termination sessions, I asked each couple what they had found most helpful. Several couples mentioned things that had occurred at the outset of the therapy. The two mentioned most frequently were being asked to recount "what attracted you to each other" and developing timelines. The attraction question seemed to have the desired effect of reminding the partners of each other's best qualities and the days during which their passion for each other was an overriding force. This helped move the couple away from their initial presenting attitude, which was often distant or antagonistic, and provided a basis for shifting to a more positive attitude. Developing timelines was very helpful for couples who had experienced a series of difficult events. Once they could "see" what they had endured it became easier for them to understand why they had struggled and how strong they were to have survived. Another benefit of these interventions is that they facilitated the gathering of information.

5) Extra Marital Involvements

For couples who had experienced "extra marital involvements" (a term coined by Karpel, 1994), re-building trust in the relationship was paramount. The lack of trust and

the need to rebuild it was demonstrated in both large and small ways. Large, in that believing that the partner would (now) remain faithful was a lynch pin for the future success or failure of the relationship. Small, in that these couples tended not to rely on their partners for support and tended to be more cautious about sharing information with them. Also, despite declarations of trust, some were quick to assume that their partners would have further extra marital involvements (e.g., Reggie's response when Gail didn't come home on time).

Previous extra marital involvements tended to colour all aspects of therapy. The goals of therapy needed to include a focus on rebuilding trust. The ability of the partners to share information was hampered. Anger and hurt were often very close to the surface, creating a simmering undercurrent. The non-involved partner had a tendency to use the involvement against the involved partner. At the termination of therapy, there remained a sense that no matter what positive steps the couple had taken towards resolving their feelings regarding the extra marital involvement, only time would heal the wound.

6) Personal Characteristics

For two of the couples, personal characteristics played notable role in their functioning. Genevieve Jones was quite intellectual, liked to deal in the abstract and the philosophical. She was also emotional and tense much of the time. Her partner, Oscar, was generally much more relaxed, earthy, and visceral. Genevieve's style of handling problems was to focus on and prepare for the worst. Oscar was more prone to expecting that all things would work out in the long run. These personal characteristics contributed to misunderstandings between the two, such as Genevieve's assumption that Oscar's

tendency to float away from her at social events was a sign that he did not care about her feelings. Oscar's interpretation of this occurrence was that they were at a party so he "partied". Similar differences were stressful for the Brown family, as well. In that couple, Reggie prided himself on his logic and debating skills, and often tried to manipulate situations to his benefit. Gail was much more straightforward. Another tendency was for Reggie to work hard to be in control. Gail's tendency was for the most part to let Reggie be in control, except that she began to chafe at her powerlessness, contributing to her violent outbursts.

7) Rebuilding "Joy"

Consistently, the couples that attended therapy in this practicum had lost much of the joy and vitality that characterized their beginnings as couples. The couples that successfully rebuilt some of this joy seemed to benefit immensely. Tasks such as "find a new activity that both can enjoy, but that neither has participated in before" or "take turns choosing what activity to participate in together and do it once a week" were common homework assignments in this practicum. Despite the simplicity of this task, several couples did not follow through. These couples, by and large, continued to seem discontented with their relationships. This begs the question, did the task contribute to the couples' joy or did more joyful couples find it easier to accomplish the task. In either case, minimally this exercise contributes to the therapist's knowledge of the couple relationship.

8) Family of Origin

Several of the participants in this practicum were very connected with their families, particularly their mothers. Often these connections seemed to be a detriment to the couple's ability to function as a unit. Parents were routinely brought into the fray, either literally or figuratively and sided their sons or daughters to form alliances against the partner. Whether or not the parents actually felt or acted as they were portrayed, was perhaps secondary. The impact was felt even when the parent was located in another province or had died. In a few cases, one of the partners described a positive relationship with a parent, however in most of these instances the other partner described this relationship as too close (e.g., "his mother still babies him"). Although some therapeutic models, such as Solution Focus Brief Therapy, suggest that it is best to remain rooted in the here and now, understanding the dynamics of the client's family of origin can provide valuable illumination for the therapist.

9) Men, Women, and Feedback

For all couples who did not drop out of therapy, a termination session was held in which the couple was asked to recall what was more helpful and what was less helpful. Invariably the women remembered specific sessions and interventions much clearer than did their partners. At first, most men tended to look sheepish, as if they were feeling guilty. Once conversation ensued, the men were more likely to begin recalling specifics. One explanation for this apparent gender-based difference may be that the women placed importance on actively working to retain what they learned in therapy. Another possibility may relate to how men and women learn. Either of these explanations would

have implications for how therapy is provided. Perhaps at the outset of therapy, men should be issued log books in which to track their impressions of therapy. The women could be excused from this task.

10) Multiple Stressors

Of the couples that participated in this practicum long enough for information to be gathered, all had experienced multiple stressors. These included deaths in the family, addictions, financial hardships, emotional abuse, physical abuse, sexual abuse, medical problems, divorces, separations, extra marital involvements, mental health problems, suicide threats, employment problems, housing problems, and involvement with the justice system. Many couples had experienced an assault of stressors in such rapid succession that they had had little opportunity to grow as a couple or even catch their breath for the next blow. This was often both a strength and a weakness. A strength in that often the couple had shown enormous resilience and resources, which could be utilized in therapy to find positive exceptions and to encourage the couple to continue to work even when it was hard. A weakness since initiating therapy did not necessarily stem the flow of stressors and the couple had to manage not only their therapeutic goals, but also the stresses of their day to day lives.

11) It is the Couple's Opinion that Counts

Despite the potential risks of working conjointly with couples as identified in the literature, conjoint therapy proponents note that many high-risk couples remain together. The couple of Martin Davis and Penny Green is a case in point. During therapy the

couple experienced an episode of violence, there were threats of suicide, and Penny expressed ambivalence about remaining in the relationship. On the strength of this, and Penny's decision to initiate a separation, the focus of therapy was to help the couple to separate safely. Not only did the separation only partially occur (i.e., even when Martin was officially not living with Penny, he was with her most of the time) but a year after termination of therapy, the couple was still together. In fairness, a negotiated separation is not intended to be a "written in stone" ending to the relationship, however, this case is a reminder that it is the couple's opinion of what should happen that counts in the long run.

Chapter 7

Conclusion

Structural Family Therapy Model and Social Work

The structural family therapy model is a useful framework for providing therapy for couples. Being sensitive to the transactional patterns of the couples helped to provide a comprehensive understanding of the issues the couples were facing, and also to structure interventions to assist the couples to achieve positive change.

Social work encompasses a wide range of roles and tasks in today's society. In my experience, structural family therapy is not limited to strictly "therapeutic" settings. Rather, the application of structural theoretical concepts helps to further the understanding of the dynamics of a variety of groups (e.g., work teams, committees, individual meetings, etc.) in non-therapeutic settings. This is equally true with large or small numbers of people, with supervisors and staff, with colleagues and with the public. Knowledge of structural family therapy is also useful for understanding whether a system is flexible enough to adapt to external change, and where to intervene, if there is not sufficient flexibility.

Learning Objectives Revisited

1) To increase my understanding of the theories and clinical treatment of marital conflict.

Reviewing the literature, preparing to work with clients, discussing the practicum with my advisor, and penning the proposal and practicum report have all contributed to

my theoretical knowledge base regarding marital conflict. The changing nature of the practicum, reduced the emphasis on working with couples who had experienced violence, though this was counter-balanced by increased learning in other areas. Also, there is a great deal of similarity between the two populations. The couples tended to be locked into patterns of interaction that were not helpful. Boundaries within and around the families were likely to be excessively rigid or diffuse. Roles within the family were often confused, with children elevated to positions of power beyond their developmental age. Many of the families had formed coalitions against one parent (e.g., Hanna Smith and her daughters versus Arthur). Levels of conflict were high for each of the couples in this practicum, regardless of reported physical abuse. This meant that much of what I learned in preparation for working with violent couples was useful for working with non-violent couples. When considering the nature and level of conflict that couples experience, it is useful to think of marital conflict as a continuum, from mild/occasional through extreme/chronic. Since one of the most important tenets of using a conjoint therapy model with couples is an accurate assessment of the safety in that relationship, it is helpful to envision where the couple would be located on this continuum. Practice assessing couples for safety is as important for working with couples professing non-violence as it is working with couples who have disclosed violence.

2) To enhance my clinical skills in a variety of therapeutic modes:

   a) individual, conjoint, and family therapy (when indicated)

Over the course of this practicum, both individual and conjoint sessions were held, though no family therapy sessions were provided. The individual sessions afforded

clients the opportunity to speak without reprisal from their partners, though in my experience there was little shared in the individual sessions that the clients were not willing (and in some cases anxious) to discuss in front of their partners. The individual sessions were in some ways simpler to manage, in that information flowed from one source and it was not necessary to observe the interactions between the couple. On the other hand, observing those interactions first hand, rather than through a client's self-report, provided a valuable source of information. When both partners were present, it was easier to work on process and content levels simultaneously. For example, if the couple was having trouble solving a problem, they could be asked to work on a solution in therapy. When successful, not only did the couple have a new solution to try, but they also had the opportunity to practice collaborative problem-solving.

Provided the couple does not collude to mislead the therapist, it is likely that the therapist receives more complete and balanced information about the couple in conjoint sessions. This is due to the ability to tap into two sets of memories, from two separate perspectives. Also, there is a certain amount of reality checking that occurs when one partner monitors how the other portrays a situation. There are times, however, when couples in this practicum appeared to be filtering or withholding information. For example, I was left with the suspicion that one of the men in the practicum was a heavy drinker and that this affected the course of treatment. When asked about drinking, both the couple stated that the man's drinking was not that heavy and was not a problem. It is possible that I was mistaken and the couple was entirely honest when denying a drinking problem. But it is also possible that to avoid the stigma of the man being labeled as having a drinking problem they had developed a pattern of working together to keep his

drinking hidden, and that during therapy they didn't feel safe enough to disclose this information.

b) working alone and as part of a co-therapy team

Originally, this practicum was to incorporate a balance between individual and co-therapy, depending upon the needs of the clients. However, after my co-therapist changed the focus of her practicum, all therapy session with subsequent families utilized a single-therapist model. The result was that only one couple (the Browns) received any extensive co-therapy. Nonetheless, sufficient sessions were held to allow some comment on the contrast between the two models.

Working with a co-therapist provided the opportunity to sit back and watch interactions unfold, without necessarily having responsibility for guiding the session. There is time to observe and reflect, since the flow of the session is sometimes in the hands of the co-therapist. This is also an advantage when the situation is reversed (i.e., when one's partner is sitting and observing) in that he/she is more likely to note things that are missed by the therapist handling the session. Other advantages include being able to draw from the other therapist's thoughts and ideas, before, during, and after sessions. Since my co-therapist and I differ in many ways (work experience, education, therapeutic orientation, gender, life experience, child-rearing, etc.) there was a cross-pollination that occurred on the cases that we shared. Co-therapy also allows for efficiencies in information gathering or intervention, since individual sessions could be held simultaneously. Another advantage, as noted in the literature review, is the reduced likelihood that the couple will perceive the therapist as siding with the same gender client. As is the case with most successful partnerships, there is a coming together that

occurs over time as the two learn more about how each other thinks and works. Unfortunately, due to the limited time that my co-therapist and I worked together, this did not really occur to any great extent.

Working as a sole therapist also had advantages and disadvantages. First and foremost, there was greater clarity, since the direction of the session did not rely on two minds moving as one. While there were times that I understood the direction in which my partner was moving, there were other times when I felt that I had been guiding the session one way only to have my partner step in and move in a different direction. I know from our discussions that my co-therapist felt the same way. Perhaps an apt analogy is the difference between a town and a city. A town offers fewer opportunities, but the opportunities that do exist can be explored with less distraction. A city, on the other hand, has more opportunities but there are more distractions. Had there been the opportunity to hone our partnership, I believe that some of the pitfalls would have become less problematic. As a single therapist, I needed to work to ensure that the couples felt that their points of view were understood and respected equally. There are also fewer moments in which to gather one's thoughts, since this must either be done on the fly or by stopping the session.

3) To practice using clinical measures to aid in therapy and to evaluate the effectiveness of interventions.

The initial plan was to use two separate measures, the Marital Satisfaction Inventory – Revised (Snyder, 1998) and the Partner Abuse Scale (Hudson, 1992). As described earlier, the Partner Abuse Scale was not used extensively. The Marital

Satisfaction Inventory, however, was administered as a pre-test for all of the couples seen in this practicum. It was also administered as a post-test for almost all of the couples. As mentioned previously, the primary use of the measure was to assess changes that occurred over the course of therapy.

The Marital Satisfaction Inventory provided a good overall picture of the level of satisfaction reported by the couple. Since the scoring is set up so that the couple's scores are placed together on a single chart, this aids in comparing and contrasting the couple's scores. This element was particularly informative for instances in which the partners' reported satisfaction level differed. The inclusion of the two validity scales is another important feature of the scale. Without the validity scales, scores on the other scales could easily have been misinterpreted. The information generated through the administration of this measure was useful for corroborating or calling into question my own assessment of the couple.

Since the Marital Satisfaction Inventory was designed for working with couples, it was a very good fit for this practicum. The inclusion of the "Global Distress Scale", as an overall measure, combined with the nine other scales, provided both a general measure of the overall level of satisfaction of the couple, and more specific information. The sub-scales were very appropriate for the population of this practicum. In fact, for some of the couples, the sub-scales anticipated each of the areas in which the couples were struggling. This speaks to the work that went into designing a measure that addressed many of the difficulties commonly experienced by couples. The aggression scale was helpful for assessing safety for all couples, regardless of reported violence. The one drawback that I noted about the measure was that the Aggression scale was not designed to be sensitive to

change over time (note: the Family History of Distress scale was also not sensitive to change over time, but since this is an historical measure, this was less problematic). In fairness, the aggression scale was designed as a screening tool, not a measure of change. If in the future I provide therapy for couples, my experience with the Marital Satisfaction Inventory certainly encouraged me to use the measure again. As mentioned previously, due to a time lag in obtaining the self-scoring version of the MSI-R some administrations of the measure were not scored right away. Learning from this experience, when using measures in the future I will take steps to ensure that I am able to score the measure immediately upon completion.

4) To work in partnership with other systems involved in servicing domestic violence.

Due in part to the truncated nature of the portion of this practicum in which the client population was couples who had experienced violence, there was limited opportunity "to work in partnership with other systems involved in servicing domestic violence". When preparing to begin the practicum, my co-therapist and I met with Brian Van Wellingham and Elaine Bergen of the Family Centre of Winnipeg who provide group therapy for couples who had experienced violence. Their groups were seen as follow-up to individual and conjoint couple therapy. We hoped that this might develop into a productive relationship, by providing us with a service to which couples could be referred if we assessed that they were ready for this form of treatment. Conversely, if the number of couples who had experienced violence and contacted the Family Centre requesting service were too great for that agency to manage, we were hopeful that they would be referred to the Elizabeth Hill Centre. Unfortunately, finding a sufficient

population of clients for our practicum proved difficult, which in turn meant that there were no referrals to forward and we did not receive any referrals from the Family Centre.

While this was the only contact with individuals working specifically on the problem of domestic violence, there were opportunities to work with collateral agencies that provided a range of non violence specific services to couples who had experienced violence. This included: Martin Davis' psychiatrist; numerous staff from the Child and Family Services agency involved with the Davis-Greens; staff at Martin Davis' addiction treatment programs; the Brown's Family Reunification worker; members of the Family Reunion team involved with one of the clients I shared with another therapist; and contact with the Smiths' referring therapist.

5) To integrate this learning into other spheres, such as my current work with children and youth.

Learning more about the dynamics of domestic violence has definitely been useful in my work initially as Program Coordinator of a Treatment Foster Care program and subsequently in charge of foster care for the province. A significant number of foster children come from families in which violence is a problem. The prevalence of the mothers of these children becoming involved in serial relationships with abusive men is high. Increased knowledge of this issue, enhanced my ability to understand some of the characteristics and actions of the families, as well as those of the foster children themselves.

In a similar vein learning about and practicing the elements of structural family therapy has provided a clear, non-judgmental framework through which to explore couple

and family functioning. Aspects such as being sensitive to the role of the therapist are not limited to therapy sessions alone. Rather, the tools of the structural family therapist are very applicable to other types of therapeutic and non-therapeutic situations. The enhanced ability to consider a family's progression through the different stages of the family life cycle, while remaining open to the wide range of "normal" variation has also been beneficial.

Many of the children, youth, and families that I have worked with since the beginning of this practicum have provided excellent opportunities to recognize and address issues with interactional patterns, boundaries, hierarchy, power imbalance, coalitions, and alliances. As I noted above, much of my professional work during this practicum was with foster families and with a staff team supporting these families, the foster children in their care, and their families of origin. The dynamics of these situations can be very complex, considering the number of people involved. Similarly, the dynamics of the groups of foster parents, treatment teams, staff and management teams, etc. can been seen through their structure and interactional patterns. Once the system is better understood, that increases the likelihood of intervening in an appropriate and effective fashion.

Final Remarks

I have learned much during this practicum. Some of the learning was academic and closely related to the chosen topic. Some of the learning was practical, with application in many other aspects of life. Some of what I learned is more related to overcoming obstacles.

I have had my patience, flexibility, and resilience tested as my practicum changed course, then changed again. I think, however, that it is useful and positive to relate this to the process of therapy, itself. No matter how prepared and polished the therapist is for a session, the content and process of the session can require the therapist to move quickly and fluidly to another tack. The ability to evaluate and re-evaluate, to move with the couple or alter the direction, to accept that which is not in one's control and work on that which is, and to move in and out of a system, is tested when working with couples. I have certainly learned that it is not only the clients who must stay open to change.

REFERENCES

Bedrosian, R. (1982). Clinical approaches to family violence VIII: Using cognitive and systems intervention in the treatment of marital violence. Family Therapy Collections, 3, 117-138.

Blau, G. (1993). The assessment and treatment of violent families. In R. Hampton, T. Gullotta, G. Adams, E. Potter III, R. Weissberg (Eds.), Family violence: Prevention and treatment (pp. 198-229). Newbury Park, CA: Sage Publications.

Bograd, M. (1992) Values in conflict: Challenges to family therapists' thinking. Journal of Marital and Family Therapy, 18 (3), 245-256.

Bruenlin, D. C., Schwartz, R. C., & Kune-Karrer, B. M. (1992). Metaframeworks: Transcending the models of family therapy. San Francisco, CA: Jossey-Bass Inc.

Burris, C. A., & Jaffe, P. (1984). Wife battering: A well-kept secret. Canadian Journal of Criminology, 26 (2), 171-177.

Cappell, C., & Heiner, R. (1990). The intergenerational transmission of family aggression. Journal of Family Violence, 5 (2), 135-152.

Carden, A. (1994). Wife abuse and the wife abuser: Review and recommendations. The Counseling Psychologist, 22 (4), 539-582.

Cook, D., & Frantz-Cook, A. (1984). A systemic treatment approach to wife battering. Journal of Marital and Family Therapy, 10 (1), 83-93.

Davis, L. (1987). Battered women: The transformation of a social problem. Social Work, Jul-Aug, 306-311.

DeMaris, A., & Swinford, S. (1996). Female victims of spousal violence: Factors influencing their level of fearfulness. Family Relations, 45, 98-106.

Eisikovits, Z., & Edleson, J. (1989) Intervening with men who batter: A critical review of the literature. Social Service Review, 63 (1), 384-414.

Elbow, M. (1982). Children of violent marriages: The forgotten victims. Social Casework: The Journal of Contemporary Social Work, Oct, 465-471.

Flemmons, D. (1989). An ecosystemic view of family violence. Family Therapy, 16 (1), 1-10.

Foley, V. (1976). Alcoholism: A family system approach. Journal of Family Counseling, 4 (2), 12-18.

Frankel-Howard, D. (1989). Family violence: A review of theoretical and clinical literature. Health & Welfare Canada.

Furniss, T. (1991). The multiprofessional handbook of child sexual abuse. London: Routledge Press.

Ganley, A. (1989). Integrating feminist and social learning analyses of aggression: Creating multiple models for intervention with men who batter. In P. L. Caesar & L. K. Hamberger (Eds.), Treating men who batter: Theory, practice, and programs (pp. 196-235). New York, NY: Springer Publishing Company.

Gardiner, S., & McGrath, F. (1995). Wife assault: A systemic approach that minimizes risk and maximizes responsibility. Journal of Systemic Therapies, 14 (1), 20-32.

Gelles, R., & Maynard, P. (1987). A structural family systems approach to intervention in cases of family violence. Family Relations, 36, 270-275.

Gelles, R., & Straus M. (1979). Determinants of violence in the family: Toward a theoretical integration. In W. Burr, R. Hill, F. I. Nye, & I. L. Reiss (Eds.), Contemporary theories about the family (pp. 549-561). New York, NY: The Free Press.

Goldberg, I., & Goldberg, H. (1991). Family therapy: An overview. Pacific Grove, CA: Brooks/Cole Publishing Company.

Haley, J. (1971). Family therapy: A radical change. In J. Haley (Ed.), Changing Families (pp. 272-284). New York, NY: Grune and Stratton.

Haley, J. (1978). Problem-Solving therapy. San Francisco, CA: Jossey-Bass Publishers.

Harris, J. (1986). Counseling violent couples using Walker's model. Psychotherapy, 23 (4), 613-621.

Hindman, M. (1979). Family therapy in alcoholism. Alcohol, Health and Research World, 1, 2-9.

Jenkins, A. (1993). Invitations to responsibility: The therapeutic engagement of men who are violent and abusive. Australia: Dulwich Centre Publications.

Jung, M. (1984). Structural family therapy: Its application to Chinese families. Family Process, 23 (3), 365-374.

Karpel, M. A. (1994). Evaluating couples. New York, NY: W. W. Norton & Company.

Latham, T. (1986). Violence in the family: An attempt to apply contemporary theories of non-violent action and conflict resolution skills. Journal of Family Therapy, 8, 125-137.

Leeder, E. (1994). Treating abuse in families; A feminist and community approach. New York, NY: Springer Publishing Company.

Liberman, R., Wheeler, E., deVisser, L., Kuehnel, J., & Kuehnel, T. (1980). Handbook of marital therapy : A positive approach to helping troubled relationships. New York, NY: Plenum Press.

Liebman, R., Sargent, J., & Silver, M. (1983). A family systems orientation to the treatment of anorexia nervosa. Journal of the American Academy of Child Psychiatry, 22 (2), 128-133

Lipchik, E. (1991). Spouse abuse: Challenging the party line. New Yorker, May-June, 59-63.

Madanes, C., (1981). Strategic family therapy. San Francisco, CA: Jossey-Bass Publishers.

Madanes, C., Keim J. & Smelser, D. (1995). The violence of men, new techniques for working with abusive families: A therapy of social action. San Francisco, CA: Jossey-Bass Publishers.

McGoldrick, M., & Carter, E. (1982). The family life cycle. In F. Walsh (Ed.), Normal Family Process. New York, NY: Guilford Press.

McGoldrick, M., & Gerson, R. (1985). Genograms in family assessment. New York, NY: W. W. Norton & Company.

McKain, J. (1987). Family violence: A treatment program for couples. Journal of Independent Social Work, 1 (3), 71-83.

Mehlman, S., Baucom, D., & Anderson, D. (1983). Effectiveness of cotherapists versus single therapists and immediate versus delayed treatment in behavioral marital therapy. Journal of Consulting and Clinical Psychology, 51 (2), 258-266.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Minuchin, S. & Nichols, M. (1998). Structural family therapy. In F. Dattilio (Ed.), Case studies in couple and family therapy (pp. 108-131). New York, NY: The Guilford Press.

Nichols, W. (1988). Marital therapy: An integrative approach. New York, NY: The Guilford Press.

Orme, J. (1994). Violent women. In C. Lupton & T. Gillespie (Eds.), Working with violence (pp. 170-189). London: Macmillan Press.

Pardeck, J. (1989). Family therapy as a treatment approach to child abuse. Family Therapy, 16 (2), 113-120.

Preli, R., Protinsky, H., & Cross, L. (1990). Alcoholism and family structure. Family Therapy, 17 (1), 1-8.

Protinsky, H. & Shilts, L. (1990). Adolescent substance use and family cohesion. Family Therapy, 17 (2), 173-175.

Rosenfeld, B. D. (1992) Court-ordered treatment of spouse abuse. Psychology Review, 12, 205-226.

Schechter, S. (1982). Women and male violence: The visions and struggles of the battered women's movement. Boston, MA: South End.

Schulman, W. (1997). A study of domestic violence and the justice system in Manitoba: Report of the Honourable Mr. Justice Perry W. Schulman, Commisioner. Government of Manitoba.

Schuyler, M. (1976). Battered wives: An emerging social problem. Social Work, 21, 488-491.

Sieppert, J., Hudson, J., & Unrau, Y. (2000). Family group conferencing in child welfare: Lessons from a demonstration project. Families in Society: The Journal of Contemporary Human Services, 81 (4), 382-391.

Silvern, L. & Kaersvang, L. (1989). The traumatized children of violent marriages. Child Welfare, 68 (4), 421-436.

Snyder, D., Wills, R., & Keiser, T. (1981). Empirical validation of the Marital Satisfaction Inventory: An actuarial approach. Journal of Consulting and Clinical Psychology, 49 (2), 262-268.

Snyder, D., Lachar, D., & Wills, R. (1988). Computer-based interpretation of the Marital Satisfaction Inventory: Use in treatment planning. Journal of Marital and Family Therapy 14 (4), 397-409.

Snyder, D. (1997). Marital Satisfaction Inventory, Revised – manual. Los Angeles, CA: Western Psychological Services.

Statistics Canada (2001). Family violence: A statistical profile.

Steinfeld, G. (1989). Spouse abuse: An integrative-interactional model. Journal of Family Violence, Vol (1), 1-23.

Straus, M., & Gelles, R. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. Journal of Marriage and the Family, 48 (Aug), 465-479.

Todd, T. (1986). Structural-Strategic marital therapy. In N. Jacobson & A. Gurman (Eds.), Clinical handbook of marital therapy (pp. 71-105). New York, NY: The Guilford Press.

Traicoff, E. (1982). Family interventions from women's shelters. In J. Hansen & L. Barnhill (Eds.), Clinical approach to family violence (pp. 105-115). Rockville, MD: Aspen Publications.

Trute, B. (1998). Going beyond gender-specific treatments in wife battering: Pro-feminist couple and family therapy. Aggression and Violent Behavior, 3 (1), 1-15.

Walker, L. E. (1979). The battered woman. New York, NY: Harper and Row.

Weidman, A. (1986). Family therapy with violent couples. Social Casework, 67 (4), 211-218.

Wheeler, D. (1989). Faulty fathering: Working ideas on the treatment of male incest perpetrators. Journal of Feminist Family Therapy, 1 (2), 27-48.

Willbach, D. (1989). Ethics and family therapy: The case management of family violence. Journal of Marital and Family Therapy, 15 (1), 43-52.

Wylie, M. S. (1996). It's a community affair. Networker, Mar/Apr, 58-65.

Yegidis, B. (1992). Family violence: Contemporary research findings and practice issues. Community Mental Health Journal, 28 (6), 519-530.

Appendix A

Despite a history of violence, many couples chose to stay together.

This program is designed to emphasize safety, while addressing the impact of the violence.

Elizabeth Hill Counselling Centre

Third Floor
321 McDermot Avenue
956-6560 ph. 943-4073 fax.

Couples With A History Of Violence

A Program
At the
Elizabeth Hill Centre

- SAFETY OF THE VICTIM IS OF PRIMARY CONCERN
- HOLD THE PERPETRATOR RESPONSIBLE FOR THE VIOLENCE
- ONGOING ASSESSMENT OF THE RISK OF CONTINUED VIOLENCE
- DEVELOP SKILLS TO IMPROVE THE PARTNER RELATIONSHIP
- TREATMENT MAY INCLUDE INDIVIDUAL OR COUPLE SESSIONS WHEN APPROPRIATE

Where do couples go when they struggle with violence?

The Elizabeth Hill Centre is operated by the University of Manitoba. Clients are accepted through agency or self-referral. There is **no charge** for these counselling services.

This Program Is Appropriate For Couples

- For whom the violence has ceased
- For whom the prepetrator can contract for continued non-violence and the victim can develop a safety plan
- Who are commited to remaining together and working to improve the quality of their relationship

The Co-Therapists

Brian Ridd &
are finishing Master's degrees in Social Work. They have extensive experience working in the Family Services field. Both hold undergraduate degrees and have previous counselling experience.

Clinical Supervision will be provided by David Charabin, Director of the Elizabeth Hill Counselling Centre, and Dr. Diane Hiebert-Murphy, from the Faculty of Social Work.

For more information or to refer call: 956-6560

Appendix B.1

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12031 Wilshire Boulevard
Los Angeles, CA 90025-1251
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March 8, 2002

J. Brian Ridd
Winnipeg, Manitoba
Canada

Dear Mr. Ridd:

Thank you for your letter of February 9, and your follow-up e-mail of March 5, requesting permission to reprint copyrighted test material in your Masters of Social Work practicum report, in satisfaction of your requirements through the University of Manitoba.

Western Psychological Services authorizes you to reprint up to four (4) completed Profile Forms for the *Marital Satisfaction Inventory, Revised (MSI-R)*, solely for the above-described purpose, on the provision that each reprint bear the following required notice in its entirety:

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We appreciate your interest in this instrument as well as your consideration for its copyright. If you have any follow-up questions, please feel free to contact me.

Sincerely yours,

Susan Dunn Weinberg
Assistant to the President
WPS Rights and Permissions
e-mail: weinberg@wpspublish.com

SDW:se

Appendix B.2

Subject:RE: Request for permission to reproduce MSI-R Profile
Date: Thu, 14 Mar 2002 16:53:26 -0800
From: Susan Weinberg <weinberg@wpspublish.com>
To: "J. Brian Ridd"

Dear Mr. Ridd:

I conferred with key senior staff at WPS regarding this aspect of your request. Under the circumstances, and particularly given that your request pertains to completed _profile_ forms and not to the actual test items themselves, this message serves to confirm that we will make an exception to policy in this case, and allow you to reprint the MSI-R Profile Forms in the microfiche version of your report, as well as in the paper-bound copies, on provision that the previously provided copyright notice appear in its entirety on the microfiched reprints as well.

Many thanks for your interest in the MSI-R, and best wishes for a successful completion of your project.

Sincerely yours,

SusanW

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Susan Dunn Weinberg
Assistant to the President
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web: www.wpspublish.com

> -----Original Message-----
> From: mailsvc@wpspublish.com [mailto:mailsvc@wpspublish.com]On Behalf Of J. Brian Ridd
> Sent: Tuesday, March 12, 2002 6:13 PM
> To: Susan Weinberg
> Subject: Re: Request for permission to reproduce MSI-R Profile
>
> Thank you for your response. Unfortunately, when I checked with the Graduate Studies Department at the University of Manitoba, I was informed that all theses and practica reports are copied onto microfiche, which is sent to the National Library of Canada. I know that the letter you provided only gives permission for reproduction of "paper-bound copies". I am disappointed because I value the visual nature of the Profile form of the Marital Satisfaction Inventory.
>
> If permission cannot be granted under my circumstances, I understand and will comply. However, if permission could be granted, I would certainly be grateful. If it makes a difference to your company, this is a practicum report and therefore will not be submitted for publication.
>
> Thank you once again.
>
> J. Brian Ridd