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**A COUPLES INTIMACY GROUP: INTEGRATING FEMINIST AND
SYSTEMIC PRINCIPLES WITHIN A STRUCTURED COGNITIVE-
BEHAVIORAL FORMAT**

BY

Myrna M. Friedenber

A Practicum Report
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

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Myrna M. Friedenberg

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

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Abstract

The practicum was designed to integrate feminism within a framework that was both systemic and behavioral; the result was a program of couples group therapy that focused on the clinical issue(s) of intimacy.

The treatment premise of the eight-session couples group was that the blend of affective therapy in a structured, cognitive-behavioral format would be an effective approach for treating issues of relationship intimacy. A model of individual personality and interaction (cognition, behavior, affect) was extended to include the concept of developmental relationship tasks (relationship identity, relationship cooperation, relationship intimacy). The group process was utilized to merge the individual dimensions and the relationship tasks -cognitive/identity, behavior/cooperation, affect/intimacy- with balance. Throughout the treatment process, couples were encouraged to depersonalize their relationship problems or issues in order to work together at a cooperative level. While the feminist challenge was to foster egalitarian relationships, other skills were also critical: a positive evaluation of women, social analysis, the encouragement of total development, behavior feed-back and self-disclosure.

The outcome was primarily evaluated using the Waring Intimacy Questionnaire (WIQ) in a pre and posttest format. When group participants

were evaluated in their couple systems, four of the five couples were shown to experience an improvement as indicated by a higher posttest Total Intimacy score. The fifth couple maintained the same pre-posttest Total Intimacy score. These results suggest that the couples group was an effective treatment intervention.

The group emphasis was feminist and systemic, and issues of couple sexuality were frequently explored. All of the ten participants reported that the group had been a positive experience and that they would definitely recommend it to a couple who was struggling with intimacy-related issues.

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The practicum project could not have been completed without the love and support of my husband, Oskar, and our two children, Kristen and Stephen.

The work of the project could not have been completed without the contribution of others. I would like to thank Professors Ranjan Roy and Diane Hiebert-Murphy for their role on the Committee, and in particular Professor Roy for his continuous guidance and support. I would also like to thank Russ Chambers for his role on the Committee and especially for his on-going support and feed-back.

The completion of the practicum component could not have taken place without the five couples and I am grateful for their willing participation.

Finally, a very special thanks to my mom, Gladys Smith, who is truly the inspiration of my life!!

Chapter 1 - The Introduction

INTRODUCTION

The following practicum report gradually evolved out an experience of academic study and research that was a continual source of challenge and excitement. The entire process was significantly influenced by the following learning goals and events:

- (a) the initial decision to focus learning on an identified area of interest and relevant clinical skill enhancement, (i.e., the treatment of sexual issues as a specific dimension within marital therapy),
- (b) the desire to incorporate a systemic perspective **and** feminist theory/practice into the more traditional model(s) of sex therapy,
- (c) the initial attempt to carry out a practicum experience that required couples to participate in a program of sex and marital therapy, and
- (d) the successful completion of an eight-session program of couples group therapy focusing on issues of intimacy.

The practicum proposal that was submitted in the summer and fall of 1997 was readily approved by the Committee members. The difficulties began at the recruitment stage. Even though a large variety of strategies were employed, all aimed at accessing different segments of the overall population of Winnipeg,

only three couples responded and set up an initial screening interview (*none* of whom showed up at the designated times). By the end of October it became apparent that the necessary number of couples would not be forthcoming and the practicum design would need to be re-worked.

The decision was made to temporarily postpone the practicum experience until the fall of 1998.

The Committee agreed that the objectives of the first design remained both valid and worthwhile; the quantity and quality of research also remained valid. Thus, the second practicum proposal sought to **add** a new dimension to the issues, concepts, theories and models already studied as a part of the overall learning requirement for the academic endeavor.

LEARNING OBJECTIVES

The practicum experience was organized around two core objectives. The first was to enhance the existing clinical skill of the student. The second was to find a practical and meaningful way to incorporate the research and learning that was initially done into an effective model of clinical application.

As a practicing marital and family therapist, the student had become aware of a gap in her knowledge and skill base. When working with sexual and/or

intimacy-related issues, she questioned the efficacy of the traditional sex therapy approaches. At the same time, strictly systemic principles of intervention also seemed to be insufficient. Over time, the result had become a combination of the two paradigms. While these interventions appeared to be effective some of the time, the student recognized the need to *consistently* orchestrate effective intervention strategies within this dimension of marital therapy (i.e., the treatment of sexual and/or intimacy-related issues).

At a both a personal and professional level, the student was further influenced by a heightened awareness of the inherent value of a feminist practice orientation. In working with couples who request marital therapy it had frequently become evident that social mores and values had influenced their gender-specific expressions of sexuality. Men learn that they need to be strong and controlled; their primary tasks are to be instrumental. Women learn that they need to be emotional and caring; their primary tasks are to be affective. This is as restrictive for men as it is for women, and it can truly inhibit the potential for growth and human connectedness. At yet another macro-societal level, the sociocultural traditions of patriarchy and male privilege/power often surface as issues within marital therapy. The past three decades have evidenced dramatic changes in the organization and structure of the Canadian family. Most

married women now expect to be employed as income earners outside of the home. This lessens their overall tolerance for a double-standard when it comes to household chores, maintenance and childcare. For their part, men express confusion over the virtual lack of role modelling for their current types of family organization. When the situation becomes ambiguous or stressful, they simply resort back to patriarchal standards of male privilege and behavior. As a feminist practitioner, the student acknowledged the need to become increasingly skilled at integrating such realities into all clinically relevant intervention strategies and techniques. The contextual layers of human experience, especially as they are represented by the interplay between the individuals of a dyadic unit, are the backbone of any truly systemic/feminist assessment and intervention.

Chapter II - The Review of the Literature (Primary)

INTRODUCTION

The goal of the primary literature review will be to address the following questions:

What is sex therapy?

What are the feminist issues?

What are the potential alternatives for a feminist sex therapy?

What is systemic theory and therapy?

Is it possible to connect systemic practice to the treatment of the sexual component? Is it possible to connect a feminist perspective to systemic marital and sex therapy?

SEX THERAPY - AN OVERVIEW

To begin, it will be useful to provide a brief historical overview of the development of sex therapy. Prior to the groundbreaking work of William Masters and Virginia Johnson (1970) the mainstream psychiatric and psychological community held a view that was essentially psychodynamic and psychoanalytic. Their approach to the treatment of sexual dysfunction assumed that the major etiological factor was the childhood failure to accomplish

necessary developmental tasks associated with a resolution of the oedipal complex. The goal became reenacting the oedipal situation in the transference relationship with the therapist, and thus finishing in a healthy way the developmental tasks that were left unfinished in childhood. There is currently empirical evidence to verify that such a strictly analytic focus is ineffective in the treatment of sexual dysfunction (Heiman, Gladue, Roberts, LoPiccolo, 1986). In 1970, Masters and Johnson completed their research and published their book, *Human Sexual Inadequacy*. The clinical and theoretical traditions began a process of change. In hindsight, it becomes apparent that the existing sociocultural climate was highly amenable to the direction of a normative model of sexual functioning; the work of Masters and Johnson became rapidly acclaimed and popularized. In the same way, specific members within the professional community must have also been eager to incorporate a more effective way of conceptualizing the etiology and treatment of sexual dysfunction.

Soon after, Helen Kaplan (1974) made another pivotal contribution to the field of sex therapy by integrating psychodynamic concepts into the framework of Masters and Johnson's cognitive-behavioral approach. Kaplan describes her treatment model to be ". . . multi-causal and eclectic in that we believe that

sexual dysfunctions are the product of multiple etiologic factors, and our treatment comprises an amalgam of experiential, behavioral and dynamically oriented modalities" (p.xv). Kaplan is also credited with outlining the most clinically relevant classification system of the sexual dysfunctions.

While there have been a variety of behavioral paradigms, sex therapy, as it has generally been practiced, refers to a type of therapy in which the therapist actively and directly educates the client about sexual physiology and technique. The therapist employs implicit counterconditioning and cognitive-behavioral strategies in an attempt to reduce issues of performance anxiety while also restructuring maladaptive behavioral patterns and cognitions regarding sexuality. Finally, the therapist who utilizes this type of therapy consciously chooses to focus on the development of a more functional level of sexual communication.

The practice of sex therapy continues to be a valid treatment modality. The Masters and Johnson sensate-focus exercises are commonly assigned as a part of the therapeutic process, and many therapists continue to rely on the triphasic classification system that Kaplan organized. However, there is a growing concern that the many social, cultural and familial changes that have occurred in the past two decades have been inadequately addressed by current sex therapy research and literature.

THE FEMINIST ISSUES

There are a significant number of highly skilled and competent feminist academicians and researchers, many of whom specialize in the field of sex therapy. It is important to clearly state that a literature review of this specialization (feminist sex therapy) is not characterized by a wealth of empirical data. Rather, it is typified by a great sense of personal experience, perception and theoretical understanding.

As a renowned activist and sexologist, Leonore Tiefer (1995) has spent many years espousing the issues of a feminist orientation. Most recently, she has published an abridged collection of her essays, speeches and publications. In the second chapter, Tiefer explores the concept of social constructionism as being pivotal to the future study of sexuality, and also as being an indication of the current status of sex scholarship. Social constructionism may be defined as an emphasis on each individual's active role, guided by his or her culture, in structuring the reality that affects his or her own values and behavior. According to such a conceptualization, there is no essential human quality, including sexuality, that is available to be repressed during one period of history, and liberated in another (in reference to the 1880's in England and the 1950's in America). Tiefer quotes feminist anthropologist Rubin (1987) who speculates

that we are in the midst of a historical period during which time sexuality becomes more sharply contested and overtly politicalized. "In such periods, the domain of erotic life is, in effect, renegotiated" (p. 70). She then expresses concern that these changes have not been seriously acknowledged within sexuality research due to the dominant, medicalized perspective of psychologists. It is Tiefer's recommendation that the psychology of sexuality become organized around the understanding that every individual has an active role to play in the structuring of her/his own values and behaviors.

Another of Tiefer's writings is highly relevant to the topic of a feminist sex therapy. In a very interesting critique, Tiefer (1986) explores the degree to which the current nomenclature describing sexual problems serves the interests of women. The American Psychiatric Association's (APA) manual lists three official categories of sexual disorders. The second of these, *Psychosexual Dysfunctions*, is directly derived from Masters and Johnson's physiological research which clearly defined a human sexual response cycle that was thought to be identical for both women and men. Tiefer contends that the cycle is based on a normative model of human sexuality, and is therefore a standard that legitimizes the perspective that functional sexuality is the performance of mechanical and heterosexual intercourse. This is especially dangerous because

of the fact that norms have the historic tradition of social control. While it is possible for a normative model to be feminist, the origin of its norms must be in the experience of women and in women-generated goals. Tiefer conducted a literature search to access research that was based on women-defined sexual problems, but she was only able to locate two such studies. Researchers continually assume the validity of the sexual response cycle model without asking women for their specific difficulties. The first contrast to this trend is the work of Shere Hite (1976), who is frequently cited throughout the feminist literature, and whose research is very important to the argument that Tiefer expostulates. Hite began her survey of women's sexual practices and preferences by rejecting the normative standards for human sexuality, and by asking the women themselves to describe, in open-ended answers, their practices, experiences, preferences and dissatisfactions. What she heard women talk about was a variety of dissatisfactions that would not fit anywhere in the official nosology. Their complaints were essentially invisible because they were not a part of the culturally dominant, normatively-based model. As Tiefer suggests, a system of classification based on Hite's data would look significantly different from the DSM-III categorizations. Tiefer then presents the second contrast to the general research trend, the findings of a 1978 study that supports the

research that Hite completed, and that clearly indicates a correlation between emotional factors and the sexual satisfaction of women that is quite distinct from their performance of the sexual response cycle (Frank, Anderson, & Rubinstein, 1978). Tiefer (1986) does not believe that the DSM-III sexuality nomenclature adequately reflects the real problems that women are having with sex, and although she does not have a large body of empirical evidence to support her opinions, she does bring over twenty years of clinical, educational and academic experience to bear. In her own words:

“ . . . many of women’s concerns about intimacy, negotiation, spontaneity, communication, remembering preferences, etc. *are* addressed in formal sex therapy and may even take up the bulk of the therapy time and work. But these complaints are usually addressed only because it seems that they need to be in order for the couple to regain their ability to perform the normal intercourse-oriented sexual response cycle” (p. 5).

The final issue that Tiefer raises is the inherent danger of a medicalized model of sexuality. She refers to Reissman's (1983) insights into the negative consequences of medicalization for women. The first is that through a process of mystification people become too reliant on the professionals to advise them of the nature of reality. This gives more weight to the experts' interests than the women's (few officially sanctioned experts will have an economically disinterested, women-centered view). The second is that an illusory element of

moral neutrality is introduced, leading to the assumption that there is a 'natural' objective reality that defines the conduct of sexuality, and culminating in the agreement that sex is no longer a human arena for negotiation. The third is that the medicalization of a phenomenon inevitably obscures and ignores the social construction of sexuality. The social origins of sexuality problems (rigid sex roles, unrelenting standards of performance, relationships of unequal power, histories of sexual violence, etc.) are never acknowledged or treated.

As a feminist therapist and sex researcher, Wendy Stock (1988) provides a very intriguing critique of sex therapy and research. She begins by describing, in detail, a two year research project that she participated in as a scientist and project coordinator. The research goal was to develop a cost-effective means of distinguishing organic from psychogenic determinants of erectile dysfunction. At the time of writing the article, the author's intent was to illuminate her own forage into the dimensions of a phallogentric model of sexuality. Stock makes the point that the symbolic meaning of erections goes far beyond that associated with self-esteem or confirmation of masculine identity, and concerns erections as a symbol of male power. She then argues that the sex therapy and research establishment has refused to analyse its own contribution to the maintenance of such a model. Stock cites the research of Hite (1981) that examines how males

feel about erections and intercourse, to further support her argument. The excerpts that she refers to repeatedly indicate that some men perceive themselves as needing to be dominant and powerful when "having" or "conquering" the woman. Stock then refers to a small study done by Hollerorth (1987) that asks married men about their use for and/or need of sexual expression. Nearly half of the interviewed men openly acknowledged using sexual intercourse to dominate or have control over their partners. If these examples represent a significant aspect of the male sexual identity, then the deprivation of the man's penis means the deprivation of his male status. And such an overarching attitude frames the cultural objectification of women at the same time as it paves the way for the mass production and consumption of pornographic materials. Stock suggests that pornography is the mainstay of the phallocracy because it ideologically defends the equation of the male erection with masculinity and power. She then outlines a theory of sexual intelligence that would bring to the study of human sexuality an awareness of the phallocentric function of erections and intercourse.

As a competent private practitioner, Gina Ogden (1988) has begun to write feminist articles that explore the ways in which sex research and therapy has traditionally set limits on the expression of women's sexuality. The essential

point that Ogden presents is the idea that the sexual expression of women includes emotional, intellectual and spiritual connection as well as physical contact. She states that the widely accepted literature on sexuality repeatedly ignores the experiences and concerns of women. Based on a comprehensive review of the literature, Ogden makes the following three assertions. First, most sex researchers are men whose traditions subordinate rather than empower women. Second, most of the research about women's sexual function and satisfaction is either based on pathology or pre-existing research, rather than on what sexually functional women themselves say about their sexual expression and/or satisfaction. Third, in considering only what they can quantitatively measure, mainstream researchers leave out the emotional and spiritual dimensions of sexuality so critical to women. The result is a literature that is steeped in the assumption that women's sexual responses are like men's sexual responses, and therefore should meet men's definitions. For women engaged in sex therapy, the secondary result is that the presupposed goals of therapy are the desire and ability to come to orgasm by either coitus or another form of direct genital stimulation (Ogden cites the formative works of Masters & Johnson, 1970 and Kaplan, 1974 and 1981). Ultimately, this discounts much of the female experience and forces the sexual behavior of women into male-defined,

quantitative molds. To counter the biases of the sex research literature, Ogden conducted her own study. With a perspective on health rather than pathology, she interviewed 50 self-assessed orgasmic women, and listened to them as they talked about their sexual experiences and satisfactions. Ogden summarizes the following, ". . . these women reported a range of sexual function and satisfaction far more extensive than the normality standards set by the literature . . . they reported not only orgasm, but a holistic continuum that included pleasure, orgasm and ecstasy" (p. 46). She then outlines a model of sexuality that is based on women-centered principles and that makes the logical recommendation that responsible therapists need to quit acting out the male medical bias in the sexuality literature. Research that is based on what self-assessed functional women say *themselves* suggests the possibility of a new method of therapy that is centered on health rather than on pathology. It also suggests a feminist, holistic method that is respectful and based on the whole-person concept of human expression.

As yet another experienced private practitioner and educator, Marianne Keystone (1994) presents a feminist approach to sex therapy that specifically refers to the appropriateness of defining and treating vaginismus as a sexual dysfunction. Keystone argues that defining the experience of vaginismus as

dysfunctional pathologizes and disempowers women. While stating that her analysis is constrained by the limited amount of literature on sex therapy from a feminist perspective, Keystone goes on to explore the following question: should sexual dysfunctions be a part of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder* (DSM IV)? The very word "dysfunction" implies that there exists a "normal" standard of behavior, and that nonconformity to the standard is pathological. In focusing on the issue of vaginismus, Keystone attempts to show that the focus of the DSM IV's definitions of the sexual dysfunctions is still on intercourse. This is in spite of the fact that feminist practitioners, scholars and researchers have been struggling to reduce the focus of sex therapy from genital functioning to an emphasis on the emotional and intimate issues in the relationship (Keystone & Kaffko, 1992). The author comments that, ". . . vaginismus should not be labelled as the problem or the dysfunction *per se*. Instead, the lack of intimacy or equality in the relationship should be labelled the dysfunction" (p. 322). This would enable the therapist to remain focused on the emotional and sexual connections that do not necessarily involve intercourse. Based on the information that she receives from the work that she does clinically, Keystone notes that a significant number of women are indicating that they are unsure whether or not

they want, or even need, intercourse. Given this context, it is easier to understand that sometimes a woman's vagina simply says "no" to intercourse, and that to pathologize the physiological response is absurd and disempowering. The term "dysfunction" implies that it is the individual (or the couple) who has the sexual problem. This effectively ignores the theory of social constructionism and the realities of the wider social environment .

The final work to be included in this section of the literature review, an article written by Handy, Valentich, Cammaert, and Gripton (1985) brings a feminist perspective to bear on the gender relations issues that underlie the four phases of the behaviorally-oriented treatment of sexual performance problems: assessment, goal-setting and contracting; intervention; and evaluation of the effectiveness of therapy. The authors heighten the awareness of sex therapists to the existence of sexist biases that reduce the effectiveness of treatment. "If therapists are unaware of the power struggles between men and women which underpin gender role issues, their efforts to improve either sexual or non-sexual aspects of the relationship are likely to be frustrated" (p. 70). During the first phase of treatment, it is very important that the assessment give equal recognition to female interests, both in its process and in the instruments that are employed. During the second phase of treatment, the challenge becomes

realizing the feminist goal of an egalitarian couple relationship while yet affirming the particular values of both partners. The treatment goals and contracting need to reflect what the client desires and what the therapist views as appropriate to the sex therapy. During the third phase of treatment, the propensity for a sexist interventive bias lies in some of the assumptions inherent in the therapeutic process of sex therapy. Therapists may ignore the reality of power imbalances and assume that both partners have the ability to share equally in the resolution of their problems, that both partners have equal access to the range of resources within the relationship, or that both partners have the ability to collaborate on homework assignments. Throughout the intervention process, therapists need to be cognizant of the fact that men typically respond more readily to the problem-solving approach than do women. They also need to recognize that women may not feel comfortable with a continued emphasis on orgasmic functioning or performance. During the fourth and final stage, it is important that the evaluation consider the content and the process of the therapy as well as the goals attained. The evaluation criteria that are chosen must be free of gender bias and must reflect the fact that the therapy has been equally attentive to the concerns and hopes of each partner when establishing the goals for treatment. Qualitative as well as quantitative dimensions should be included,

and performance objectives should be balanced by objectives that are related to emotional satisfaction and the quality of the couple relationship.

SUPPORTING EMPIRICAL EVIDENCE

Although the relevant feminist literature tends not to be characterized by a vast amount of empirical data, it is important to note that there *is* a supporting body of available research data.

During the past two decades, sexologists have studied the physiology of the human sexual response cycle and experience. Some of their findings are congruent with the feminist perspectives that have herewith been explored. In so acknowledging, it is imperative to state that the research itself would not necessarily qualify as a women-centered or women-generated resource.

Various researchers have studied the role of orgasm in female sexual satisfaction and have concluded that orgasm is not a prerequisite to such satisfaction (Darling & Davidson, 1986; Davidson & Moore, 1994; Heiman et al., 1986; Hurlbert, 1991; Hurlbert, Apt & Rabehl, 1993; Rosen, Taylor, Leiblum & Bachmann, 1993; Taublieb & Lick, 1986; Waterman & Chiazzi, 1982).

Other researchers have studied the female versus the male sexual experience

and have found there to be distinct, qualitative differences (Cotton-Hustor & Wheeler, 1983; Hsu, Kling, Kessler, Knappe, Diefenbacht & Elias, 1994; Purvine, 1994; Stuart, 1986; Swartz, 1994).

There is enough research to provide empirical evidence in support of the general tenets of social constructionist theory (Hurlbert & Apt, 1993; Jobes, 1986; Lavee, 1991).

And finally, researchers have continued to study the issue of a female ejaculate (G-Spot) with an enduring sense of insufficient understanding and/or interest (Alzate & Hoch, 1986).

The significance of the sexological research that has been cited relates to its alignment with essential feminist values. A normative model of human expression denies the experience of many women and minimizes the inherent gender differences between women and men. An understanding of the social origin of sexual problems is critical to ongoing growth and change. Ultimately, the lack of combined research effort into singularly female issues reflects the differential access of power and the overarching politicalization of sexuality.

ALTERNATIVES FOR A FEMINIST SEX THERAPY

Having completed an extrapolation of the essential feminist issues, it

becomes imperative to analyse alternatives for the future of both sex therapy and sex research. The authors, researchers, academicians and therapists that have herewith been examined under the umbrella of feminist issues, all make unique contributions to the questions of change and improvement. The continued challenge becomes finding reasonable and pragmatic methods of evoking change in areas that seem so controlled by the sociocultural traditions of patriarchy and male-domination.

As has already been discussed, Tiefer (1986, 1995) recommends the encouragement of a new theoretical perspective, social constructionism, that allows for the realization that social mores and values dictate the gender-specific expression of sexuality in this culture. Tiefer acts as a commendable role model due to both the strength of her convictions and the energy that she expends making presentations of atypical theoretical values and/or ideologies. This is one method that feminists have always relied upon; the ability to speak well publically and present ideas in a clear and interesting manner.

Along the same line, Stock (1988) makes the choice to be more discerning in the research projects that she chooses while also becoming vocal about the biases that she perceives, thus refusing to continue the tradition of remaining quiet to covertly support the phallogentric model of sexuality.

Ogden (1988) is working to improve the sex research and therapy tradition by designing and implementing her own research studies that are women-centered and women-driven. This may not be an available option for most of the feminist community, but it certainly is an ideal method to prepare and allow for an alternative future history.

A very articulate writer, Keystone (1994) uses both experience and intellect to challenge deeply entrenched value-systems around the issues of sexual nomenclature and the official DSM-IV nosology. Not everyone has a genuine talent with the written word, but many feminist sex therapists and researchers are competent writers. It is certainly an available and inexpensive method to communicate opinions and concerns. It is also a well recognized tool within the context of academic settings and research organizations. And finally, Handy et al. (1985) focus their collective energies on the task of critically evaluating the specific technique and format of sex therapy. Their goal has an educational orientation in that they seek to heighten their colleagues' awareness of the sexist biases that negatively affect the outcome of treatment. While it seems logical to assume that researchers share their work with their professional associates, it may not be the consistent reality, and it is another method of effecting change for an alternate, feminist sex therapy.

Aside from the above possibilities, a pragmatic approach would continue to connect the theories and the techniques of a traditional model of sex therapy (based on the pioneering works of Masters, Johnson and Kaplan) with the values and expectations of a feminist model of sex therapy. It would then take the work one step further by connecting the dual modalities with a third dimension or focus, ideally, a set of theoretical principles that were well-established, mainstream and amenable to a feminist interpretation.

FAMILY SYSTEMS THEORY AND THERAPY - AN OVERVIEW

At this juncture, it will be useful to provide a brief historical overview of the development of systems theory. During the 1950's an innovative therapeutic paradigm emerged amidst a matrix of fields concerning the study of human behavior. Its intent was to move beyond the reductionistic and mechanistic scientific tradition that focused on linear cause and effect. Often described as a conceptual framework, systems theory framed explanations in the general principle of wholeness, organization and relationship while simultaneously tracking the significance of interacting variables. Mental health practitioners had become aware of the critical importance of the past and the present family to the individual's psychological symptoms and problems, and over time became

convinced that the family should be the integral unit of treatment or intervention. Although it has a distinct historical lineage, family systems therapy is essentially an offshoot of this paradigmatic shift.

The pioneering family system therapists adopted ideas borrowed from systems theory and cybernetics to assert that problems were not located within the individual, but within the family context. The function of such problems was to maintain the family equilibrium or homeostasis (Breunlin, Rampage, & Eovaldi, 1995). Three core concepts were incorporated as basic tenets to apply to all living systems. The first was the concept of organization referring to the important organizational characteristic of families as systems. The second was the concept of morphostasis referring to the fundamental characteristic that all living systems function as steady states maintaining a remarkable consistency over time. The third was the concept of morphogenesis referring to the characteristic ways in which family systems change over time (family life cycle) and the energy sources that fuel this increase in organizational complexity.

This view of family interaction and psychopathology is essentially a set of theoretical postulates, and as such, it has generated a variety of systemic family models. Some of the more popular of these include structural family therapy, the various strategic family therapy models, the Bowen model and the Milan

systemic model. Obviously, each model has its own variation and focus on the essential systemic principles, consequently, each views the sexual problem or issue in a more or less different way.

CONNECTING SYSTEMIC PRACTICE TO THE TREATMENT OF THE SEXUAL COMPONENT

There are a vast number of extremely skilled and effective family therapists who regularly operate within the couple dyad, and who just as regularly find themselves confronted with the demands of sex-related problems, concerns or dissatisfactions. These practitioners have frequently relied on a variety of systems-based intervention strategies. However, when necessary, they have also fallen back on the traditional, cognitive-behavioral intervention strategies of sex therapy (Rosen & Leiblum, 1995). This becomes a very interesting realization when understood in the context of the different historical traditions, (a systemic versus a cognitive-behavioral paradigm). Glick, Clarkin & Kessler (1987) have written on the relationship between sex therapy and marital therapy, and have concluded that there are instances where the couple suffers from specific sexual difficulties that may lead to secondary marital consequences, but that are appropriately treated with sex therapy. They go on to suggest that there are instances where specific sex therapy cannot be carried out until the relationship

between the two partners has improved; a resolution of the marital problems may automatically lead to a resolution of the sexual problems. Of course, it may not always be easy to disentangle marital from sexual problems, and the priorities for therapy may not always be clear.

Gerald Weeks and Larry Hof (1987) have both edited and contributed to a book that explores the integration of sex and marital therapy. They conclude that the formative works of Masters and Johnson have led to a gradual shift. Instead of being considered an individual problem, sex has begun to be seen as a couple problem and even a family problem. This changing emphasis brings the treatment of sexual dysfunctions into the arena of couple and marital therapy. The marital relationship impacts on the sexual problem, and in turn, the sexual problem impacts on the marital relationship. The authors recognize that sex therapy is not a discipline by itself but is based on contributions from a wide variety of scientific arenas. Further, the changes of recent decades demand that theoretical and practice integration become increasingly focused and deliberate. Weeks and Hof have set out to build on the practice of sex therapy by adding a systems perspective. In their words, ". . . such an integration could revitalize the field of sex therapy by expanding the types of problems treated, by providing new perspectives for understanding problems, and by creating the opportunity

for therapists to develop treatment programs for specific problems"(p. xiii). This would ultimately broaden the skill level of both sex therapists and marital therapists while changing the way that sexual problems are understood (from an individual to a systemic focus). It would also create a new breed of sex therapists trained in individual, sex, marital and family therapy.

Hof (1987) writes a chapter that elaborates on the necessity of a contextual evaluation of the marital relationship of clients who present with sexual issues or complaints. Since they do not occur in a vacuum, sexual dysfunctions must be understood within the context of the interactional dynamics of the client's various subsystems(most notably marital,extended family, individual, biological and social). Such a comprehensive and multidimensional approach enables the therapist to assess marital factors that either facilitate or inhibit the process of treatment. It forewarns the therapist of potential problem areas in therapy while assisting in the decision about whether or not sex therapy is the most appropriate intervention strategy. And, in cases where sex therapy *is* contraindicated, then the approach allows the therapist to devise an intervention plan that would pave the way for *future* treatment of the sexual issues.

Lorne Hartman (1983) conducted a relevant outcome study to evaluate the effects of both sex and marital therapy on sexual interaction and marital

happiness. Couples complaining of sexual difficulties were treated with sex therapy in a balanced cross-over design. The results revealed a complex pattern of treatment by sex effects. For women, sex therapy produced greater improvement on their average level of sexual enjoyment, and a greater acceptance of such enjoyment. Men, however, showed a trend favoring change in response to marital versus sex therapy in both the measures of sexual enjoyment, and the acceptance of such enjoyment. Sex therapy demonstrated a greater impact on mate acceptance of sexual enjoyment for men, while in this regard, women responded more favorably with marital therapy. Finally, in terms of overall marital happiness, the couples showed a very strong initial response to both forms of treatment regardless of whether it was sex or marital therapy. The intent of the study was to obtain evidence, in a controlled investigation of treatment outcome, that would eventually allow for systematic decision making in clinical practice. Hartman concludes:

" . . . that there is little doubt sex therapy is the treatment of choice for sexually dysfunctional couples. When sexual and marital treatments are combined, there are inconsistent findings to allow for informed decision making with respect to the order of interventions. Most significantly, couples improved in overall relationship satisfaction regardless of whether treatment focused on the sexual or the marital realm" (p.149).

While the study may not clarify clinical decision making concerning the application of sex versus marital therapy, it does validate the very real experience of clinicians. Perhaps it is a beginning step to the development of a consistent set of intervention guidelines. At the very least, it is a statement of support for the provision of therapeutic services irrespective of the *initial* modality or style of intervention.

In their article, Ellen Berman and Larry Hof (1986) express the belief that family therapy and theory has much to offer in the treatment of sexual issues and dysfunctions, while at the same time, sex therapy has much to offer in the theory and treatment of family therapy. The authors go on to argue that sexuality is best understood within the context of family systems theory, in particular, those theories involved with family structure, three-generation loyalty transmission, dyadic power issues, intimacy and sex role learning. To operationalize the therapeutic integration of sexuality into family therapy, Berman and Hof present a very practical technique. This specific method, the sexual genogram, explores an individual's three-generation sexual history. It can be utilized in the treatment of a wide variety of sexual dysfunctions and potentially enables a deeper clinical understanding of the full spectrum of the couple's issues. It may be used in conjunction with a variety of other therapeutic strategies, however, it represents

a distinct addition to the usual sex and family therapy armamentarium.

Collier Cole (1983) explores the treatment of sexual disorders within the field of family therapy and states that, ". . . the family therapist is in an excellent position to deal with sexual problems having already worked with the family unit on some other difficulties and having established rapport" (p. 60). This position is supported by a study that Stone Fish, Busby & Killian (1994) conducted on a structural therapy approach to the treatment of inhibited sexual desire (ISD). The researchers conceptualized ISD as a relational phenomenon that may most effectively be treated within the couple context. They then applied a model of structural family therapy to a clinical sample of couples presenting with ISD, and utilized two measurement scales to evaluate outcome. The results indicate that a structural family therapy approach is effective in both reducing the symptoms of this specific sexual disorder and in increasing overall couple satisfaction. In their article, Stone Fish et al. suggest that the conceptualization of ISD in interactional terms has been a major development within sex therapy during the last decade. They argue that the literature reveals a bleak prognosis for treatment of ISD when it is perceived to be an exclusively individual symptom. Family therapists who utilize an interactional, couple perspective have repeatedly been more successful, and this efficacy is validated by the above

study.

Although clinicians and researchers have written about the desirability of a systemic model of sex therapy, Toni Zimmerman and Ellen Darden (1991) studied the scope of a such a perspective. They conducted a decade review (1980-1990) of three marriage and family therapy journals, and found a mere six articles that employed a systems orientations toward sex therapy. Zimmerman and Darden suggest several possibilities for the lack of articles. First, when treating sexual dysfunction, many systemic therapists may be abandoning their primary orientation in favor of the more behavioral approach of the traditional sex therapy literature. Second, many systemic therapists may be referring their sexually dysfunctional couples to traditional sex therapists. Third, it may be the case that systemic sexual treatment exists but is not being written about, studied or published. In any event, the limited number of articles indicates that this is an area in need of attention. Therapists *must* be able to design their intervention strategies based upon available and applicable systemic models that are themselves based upon current research data and information.

Two other researchers have proposed a succinct model for the integration of sex therapy and marital therapy because they believe that their historical separation is both unnecessary and impractical. Although they are unable to

provide empirical data in support of their model of therapy, Joan Atwood and Susan Dershowitz (1992) use social constructionist principles as an alternative to the traditional models of sex therapy. The result is a framework that incorporates a constructionist therapeutic stance while utilizing the notions of sexual meaning systems and sexual scripts. Atwood and Dershowitz establish the basic premises of the approach, outline the relevant theoretical concepts and delineate a clear set of intervention guidelines. Given the organization of their model, it is easy to understand why they feel that it is possible for family therapists to incorporate sex therapy into the marital therapy that they regularly practice. The model itself is definitely a promising alternative form of clinical intervention.

CONNECTING A FEMINIST PERSPECTIVE TO SYSTEMIC MARITAL AND SEX THERAPY

While a review of the literature indicates a minimal amount of research done on the connection between systemic therapy and issues of sexual dysfunction, it also indicates a minimal amount of research done to make the connection between the three different areas of focus (sex therapy, systemic marital therapy and a feminist perspective). Towards such an end, it becomes necessary to

attempt an encapsulation of the different ideological frameworks into an inclusive treatment perspective.

CREATING AN INCLUSIVE TREATMENT PERSPECTIVE

Laurie McKinnon and Dusty Miller (1984-85) review the family therapy literature that relates to the sexual component of family relationships and critically examine the ways in which family therapists appear to assess and treat such problems. In applying a feminist lens, McKinnon and Miller assert that to be truly contextual, family therapists must acknowledge and deal with women's lack of social, economic and political power relative to men. While frequently less sexist and blaming than other paradigms, the authors still highlight several deficiencies in the theory and practice of family therapy. For example, an interactional approach conceptualizes the circular pattern of interactions that maintain the problem, and such a purely interactional description runs the risk of obliterating the females's unique experience by treating both partners as if they were interchangeable. Other approaches to family therapy focus on the apparent function of the sexual problem for the individual, or, its benefit to the system as a whole. Very little attention is given to gender issues, and to illustrate this reality, the authors draw on Regas and Sprenkle's (1984) case example of the

treatment of inhibited sexual desire (ISD) within a couple's relationship. The therapeutic goal is to determine the function of the ISD in creating either distance or closeness within the relationship, and then to alter the system so that different behaviors can serve the same function. The function that ISD serves for women and for men, given different socialization to gender roles would presumably be different, however, such a distinction is ignored. The result is that traditional gender roles are validated. When the therapist takes a position of neutrality towards a couple's balance of power, she/he will be seen by the couple as endorsing the status quo. McKinnon and Miller acknowledge that both the works of Haley (1984) and Madanes (1984) address the issue of unequal power in marital relationships. However, their assessment and intervention strategies do not examine issues in terms of gender. From their writings, one could assume that either the female or the male has the equal chance of being one up or one down. This fails to recognize the larger social context in which women have less power than men. McKinnon and Miller describe some attempts in the current family therapy literature to address gender issues in working with sex and marital problems, but in general, they pronounce that the failing of most family therapy models is the fact that systems theory describes persons without reference to gender. This negates the social, financial and

emotional experience of women. The authors specifically mention mobility restrictions, differences in interpersonal styles and the continuing role of women as the primary care-givers of children, as factors that inhibit the change options available to women. They then conclude with the insight that family therapy has the opportunity to be of considerable benefit to women who have been trapped in traditional gender roles. Whether or not this occurs depends on the values of those who practice and the ideology that underlies the practice models they choose to employ.

Virginia Goldner (1991) also evaluates family therapy from a feminist perspective. She begins by looking at the developments in systemic practice through the lens of developments in feminist theory, reflecting that as the older tradition, feminism might have some knowledge to impart. She then asserts that the systemic movement appears to be burdened with contradictions similar to those experienced by the young American Women's Movement of the early 1970's. First, the stance of the particular, meaning the reluctance to use or create ideas and theories larger than those that describe the most immediate. Second, the reluctance to claim any therapeutic hierarchy, meaning the utilization of any leadership aspects of the therapeutic relationship. Third, the implicit, negative attitude towards the therapists's unique wishes and desires such that only

empathic facilitation of the existing context is acceptable. In Goldner's opinion, systemic practitioners would benefit from the understanding that the strong use of therapeutic role and position is both clinically relevant and necessary.

As a feminist therapist whose work has already been examined within the scope of this review, Keystone (1985) writes an interesting piece about the connections between intimacy, sexuality and gender differences. She states that sex and marital therapists must be cognizant of the fact that when couples present with sexual problems in therapy sexual functioning may in fact be symptomatic of deeper intimacy issues within their relationship. She goes on to discuss the importance of an integration of both sex therapy and marital therapy because of the unique resulting opportunity for therapists to assume a dual role. Clients can be educated and instructed about sexual attitudes and techniques, as well as helped to become aware of the significant impact that intimacy issues have upon their interactional patterns (both sexually and throughout their relationship). The final point that Keystone stresses is the fact that responsible clinical practice must always incorporate and address gender issues.

The final article to be explored is written by Barbara Rothberg and Vivian Ubell (1985), two marital and family therapists who explore the co-existence of systems theory, systemic practice and feminism. After reviewing the literature,

the authors conclude that there has been little exchange between the practitioners of family systems therapy and feminist therapy. They suggest that this is due to key differences within the two orientations. The first such difference is the fact that feminist therapy is based upon a linear cause and effect model while systemic therapy views problems as circular. The second is the use of insight; feminist therapists foster demystification and sharing of power while systemic therapists explicitly use the power of expert knowledge to push for change. Many systemic or family therapists are women, and since the underpinnings of both methods are essentially compatible, Rothberg and Ubell recommend that feminists enter the field of family therapy with the intent of meeting the challenge of change. In their opinion, such a predisposition increases the likelihood of a positive and working interrelationship between the two theories and styles of intervention.

CONCLUSION

Although there has not been a great volume of published materials on the connection between sex therapy, systemic marital therapy and a feminist perspective, the possibility of an inclusive treatment perspective remains. The paucity of published materials/resources *cannot* be the yardstick to measure the

value of an academic pursuit.

To summarize, a brief overview of sex therapy was presented before proceeding with an exploration of the feminist issues including supporting empirical evidence and alternatives for a feminist sex therapy. This was followed by a brief overview of family systems theory. Then, an evaluation of the literature connecting systems theory to the treatment of the sexual component within a couple's relationship was presented. Finally, the existing literature was utilized to apply a feminist perspective to systemic sex and marital therapy. The goal of creating an inclusive treatment perspective had come full circle; the three specific areas had been integrated in a layered manner to reflect the inherent possibilities.

All of the material included within the scope of this review implies (implicitly or explicitly) the need for an expanded clinical awareness, an elevated educational focus and an increased research effort. The sexual component of an individual's life is integral to her/his continuing sense of self-dignity and worth. As academicians and clinicians, we have to strive for more effective theoretical tools and foundations. The intervention methods that we employ must reflect the patriarchal realities vis-a-vis women, for as always, "the personal is political", and the power of social constructionism cannot be minimized. At the very same

time, our practice must reflect an on-going appreciation for the enduring, contextual dimension of all human behavior.

To conclude, it should ultimately be stated that the literature supports the position that it is *possible* to apply systemic, feminist values towards the clinical treatment of a couple's sexual issues, concerns and dissatisfactions.

Chapter II - The Review of the Literature (Secondary)

INTRODUCTION

When it became necessary to re-design the original practicum proposal, it seemed possible that a couples group model might provide an alternative way to access the relevant client population, and ultimately, to accomplish the learning objectives. The following is a brief summary of the literature review that was done to evaluate the research on couples group therapy (as pertaining to sex therapy, marital therapy, systems theory/therapy, feminist theory/therapy *and* as a general intervention modality).

COUPLES GROUP THERAPY - AN OVERVIEW

The search for academic sources was exhaustive. While a lot of research has been published in the area of couples group therapy, it tends to focus on models of either marital therapy *or* sex therapy. Indeed, only one journal article was found that outlined a model of simultaneous marital and sex treatment within a format of couples group therapy.

Metz and Weiss (1992) developed the model of couples group therapy that provided the framework for the practicum. The model itself was modified. In its original format, the Metz and Weiss model was a therapeutic couples group

developed by a university-affiliated human sexuality clinic for the simultaneous treatment of marital and sexual dysfunctions. The approach was essentially cognitive-behavioral, although there was clear indication of theoretical values that were both feminist and systemic. The authors ascertained that even though the interaction between marital and sexual dysfunctions had been described clinically and empirically, both marital and sex therapists continue to treat sexual dysfunctions as a part of conjoint sex therapy. They suggest that such a division is unnecessary, and at times, ineffective. Their group format was specifically designed to offer a combined treatment for both marital and sexual dysfunctions. While the authors do not provide evaluative research to support either the short or the long-term effectiveness of the model, they do provide anecdotal case histories to illustrate specific instances where difficult couples were able to successfully progress. Formal acknowledgment of feminist theory is not a part of the Metz and Weiss model. However, the structure of the couples group is based upon an obvious assimilation of core feminist principles/values.

“Inasmuch as there may be gender specificity to relationship problem symptoms, men may cognitively identify their marital distress through the sexual paradigm, while women may cite non-sexual emotional or relationship symptoms. From a systemic perspective, then, a balanced and gender equitable approach to treatment requires that both aspects gain concomitant therapeutic attention . . . by briefly presenting the

overview of the group's structure during the first session, partners learn that both sex and marital issues will be addressed, and this serves to neutralize the tug-of-war about which aspect of the relationship distress to address" (p. 187).

The above quotation highlights an understanding and an integration of both feminist and systemic principles. As has been noted, a critique of the Metz and Weiss model will be presented in chapter four of this report.

Zilbergeld (1980) explores both individual and group therapy as alternatives to marital counselling for sex problems. Although the article is interesting, it fails to provide a specific model for the conceptualization of group therapy.

Tovey (1979) makes the recommendation that group models be utilized to work with couples. He further outlines a structure that combines traditional psychotherapy with systemic theory (very minimal attention is given to issues of sexuality, intimacy or feminism).

Zimmerman, Prest & Wetzel (1997) critique the validity of a model of solution-focused therapy in use with couples groups, and Feld (1997) provides an interesting overview of an object relations perspective on couples group therapy. While informative, each model has only general applicability to the context of this literature review (very minimal attention is given to issues of sexuality, intimacy or feminism).

Kaslow and Lieberman (1981) suggest that couples group therapy is employed much more frequently than the literature would indicate. Concepts related to the rationale, dynamics and process of such therapy is provided; a specific model or therapy format is not provided.

COUPLES GROUP THERAPY - DYNAMICS

There are several key intervention dynamics to consider when employing group therapy as an intervention modality.

To successfully achieve its goals, Shulman (1984) emphasizes the need for emergent norms to develop and guide the progression of the group. A variety of roles may emerge throughout this process (i.e., internal leader, scapegoat, deviant member, gatekeeper, defensive member, quiet member, verbal member). Shulman stresses the fact that group norms and roles may have either a positive or a negative function.

The beginning phase (particularly the first session) is the time during which the therapist addresses critical issues and objectives. As outlined by Shulman, activities within the group become governed by a group culture that emerges out of the following developmental tasks:

- initial clarification of mutual obligations and expectations,

- meeting of the needs of individual participants,
- issues of relationship vis-a-vis the therapist (authority theme),
- issues of relationship between the participants (intimacy theme),
- working culture/structure,
- formal and informal communication patterns.

Shulman states that it is important that the therapist enable participant interaction throughout every phase of the group's development. This intersects with Klein's (1972) writing on the concept of groups as systems of mutual aid in which the therapist helps individuals to help themselves. According to Klein, the process of mutual aid within a group setting occurs through the sharing of information, the on-going dialectic of discussion and challenge, the validation of learning that someone else has been where you are, the receiving of support, the demand to provide support and role playing/rehearsing.

And finally, the group therapist needs to understand the often subtle connections between individual/couple issues and the general work of the group. Shulman (1984) and Gitterman (1971) both discuss the necessity for the therapeutic role to evolve and remain flexible. During the beginning stage, the therapist is highly supportive helping the group to clarify tasks and understand the importance of process. During later stages, the therapist may become more

directive acting as the expert/professional, or, she/he may become more transparent (sharing personal experiences and limitations, sharing personal vulnerability/fallibility etc.). At all stages of the group development it is the therapist's role to foster spontaneous communication, support, confrontation and validation.

FEMINIST GROUP THERAPY - ISSUES

At this point it becomes relevant to extrapolate several feminist issues as they pertain to the dynamics of couples group therapy.

McCarrick, Manderscheid and Silbergeld (1981) studied gender differences in competition and dominance during couples group therapy. Their findings highlight a general feminist concern about the implication of power differentials between men and women. Female group members were overwhelmingly more submissive toward their spouses than they were toward other men. This suggests that, in a group setting, women may be unable to speak openly due to the implication of power imbalances within the relationship.

Lazerson (1992) explores the potential for feminist theory to help increase understanding of the way that gender issues interact within groups. She goes on to express the common feminist concern that traditional mixed-gender therapy

groups neglect the analysis of social roles, particularly stereotypic responses by women and men and between women and men, thereby reinforcing social role stereotyping. To counter this potential Lazerson recommends that interactional patterns be continually monitored and addressed within the group, (i.e., women acting submissively toward men, men assuming leadership roles, women acting dependently toward therapist, women looking for intrapsychic explanations for their difficulties rather than social, political and economic interpretations, etc.). She also suggests that feminist goals be clearly stipulated prior to any group work:

“ . . .feminist goals for therapy in groups should focus on re-socializing women and men to (1)value the support women get from other women, (2)distinguish the personal from the political by understanding how economic and social conditions affect their lives, (3)empower women by developing their self-worth through mastery skills and problem-solving, and (4)develop leadership skills be influencing the format and course of the groups” (p.531).

It is evident that the analysis of power and gender must be a part of any feminist therapeutic intervention. In a group setting this translates into the need for the therapist to consistently and repeatedly maintain a focus that is empowering and women-centered.

Chapter III - The Intervention

The intervention was based upon a model of couples therapy that was adapted from the work of Metz and Weiss (1992). The model was chosen because of its theoretical and clinical ‘fit’ with the research that had been done and with the learning objectives of the overall practicum experience.

THE MODEL

The couples group model that Metz and Weiss (1992) describe is a brief, fifteen- session format developed to simultaneously treat marital and sexual dysfunction(s). While group formats are used to treat individuals with sexual dysfunction(s), couples with sexual dysfunction(s) and couples with marital dysfunction(s), they tend not to be used to treat the simultaneous issues of marital and sexual dysfunction(s). Metz and Weiss ascertain that a specific, conjoint group treatment program is advantageous and effective. In their words:

“ . . . because marital issues frequently contribute to sexual dysfunction, and sexual dysfunction can have a detrimental impact upon the marital relationship, we regularly choose to treat both, often without great concern for understanding chronologic or linear causality . . . to be successful, the therapy must treat each dimension - whether cause, effect, or independent feature - simultaneously” (p. 174).

The Metz and Weiss model essentially combines social learning theory and

the directive techniques of a cognitive-behavioral approach with the strong affective focus typical of classical group therapy. The two-hour sessions are facilitated by a female and male co-therapy team and include an initial 'check-in' time followed by a ten-to-twenty minute informal mini-lecture by the therapists to provide specific knowledge or skill-building. While the presentation is typically positive and growth oriented, it may also challenge, or gently confront clients in areas such as anger management, negative belief-systems or resistance to homework assignments. The challenge is always balanced by an affective affirmation (commonly arising out of the group process of mutual alliance and support). While the fifteen-session format addresses relationship and sexuality aspects throughout, it is designed to emphasize relationship themes and/or issues during the first eight sessions. Then, following a two-day Sexual Attitude Assessment Workshop, the remaining seven sessions are designed to emphasize sexual themes and/or issues.

For the purposes of this practicum, the decision was made to divide the Metz and Weiss model into two distinct stages of work (following the natural division occurring between sessions eight and nine). The reasons for this were pragmatic. Without the resource of a male co-therapist, it was felt that the entire fifteen-session program would be a less than optimal intervention strategy.

Activities like the same-sex discussions would be impossible. In keeping the group focused on the broader dimensions of marital therapy, (*including* issues of sex and intimacy but not *focusing* on them), the opportunity for successful recruitment was likely to be increased. And, it was believed that a modified eight-session group format would most effectively meet the learning objectives of the practicum experience. The group model, as developed by Metz and Weiss (1992), contains powerful techniques and interventions that blend the practice of marital and sex therapy in a way that would undoubtedly increase the clinical skill of the student at the same time as it would incorporate the entire process into an effective model of clinical applicability (see Appendix A - Outline of the Revised Metz & Weiss Model).

TREATMENT PRINCIPLES

The Metz & Weiss model blends traditional group process, educational mini-lectures and cognitive-behavioral tasks or homework assignments. Their overarching treatment premise is that the blend of affective therapy in a structured, cognitive-behavioral format is an effective approach to treating often difficult and complicated relationship and sexual dysfunctions.

In treatment, the chronologic or linear causality of the problem issue (marital

issues contributing to sexual dysfunction or sexual dysfunction having a detrimental impact on marital issues) is seen to be unimportant. The authors contend that, to be successful, the therapy must treat each dimension simultaneously.

The authors draw upon a social learning and cognitive-behavioral model of individual personality and interaction that posits three facets of personality: cognition, behavior and affect (see figure 1). The treatment theory is that change occurs as these individual components are focused upon, and as group participants are trained to think (cognition), act (behavior), and feel (affect) more confidently, constructively and affirmatively, thereby improving the quality of their relationship. A combination of didactic teaching, the group process, and experiential training via homework tasks is utilized to focus on the individual components of each participant's personality structure. Throughout the group sessions, the social learning and cognitive-behavioral model is extended to describe the relationship system. The relationship system is characterized by themes or on-going developmental tasks: relationship identity, relationship cooperation and relationship intimacy. Consistent with cognitive therapy the three themes are presented in the group as on-going developmental tasks that are central to relationship satisfaction and health. The group process is used to

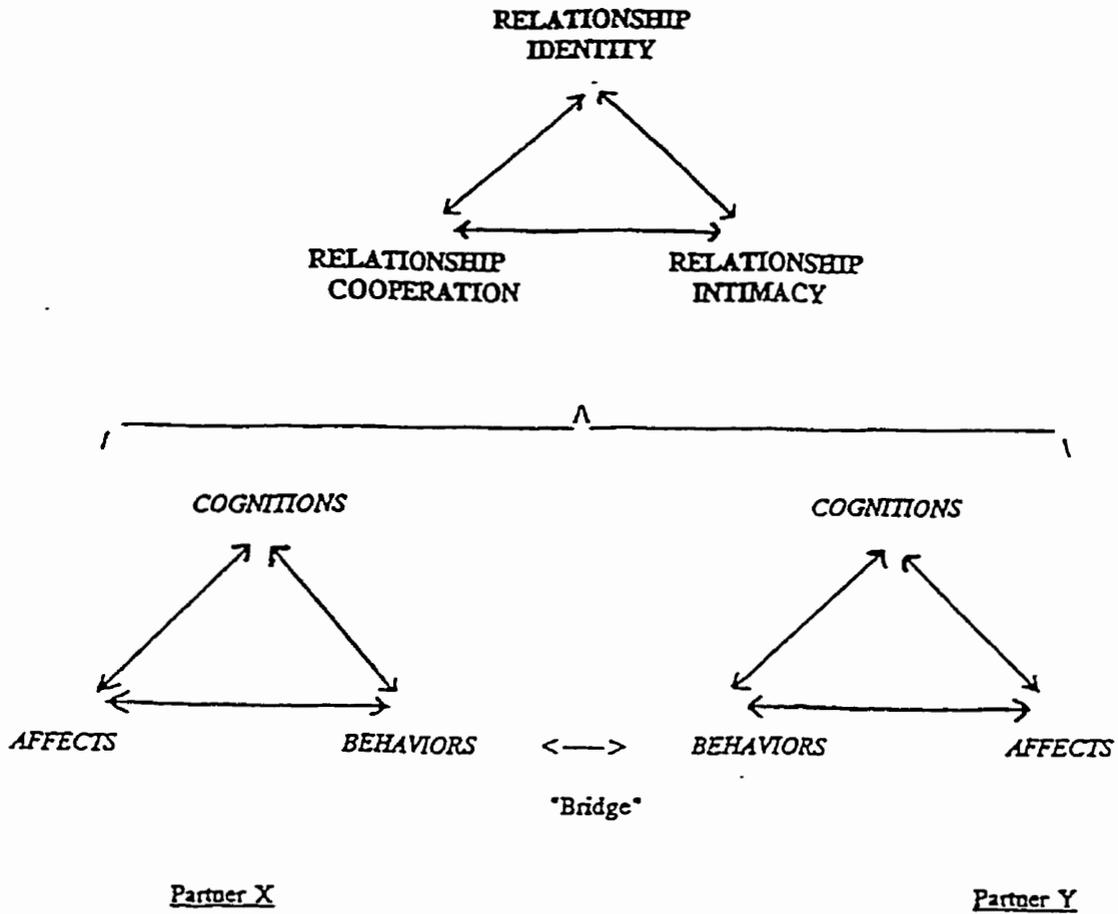


Figure 1: The Identity/Cooperation/Intimacy Model of Relationship Interaction

address and integrate the individual and relationship dimensions (cognitive/identity, behavior/cooperation, and affect/intimacy) with balance.

The treatment premise is that change occurs as couples are encouraged to depersonalize their relationship problems or issues in order to work together cooperatively. This justifies the work without partner blame or self-recrimination.

Relationship identity refers to the cognitive life of the relationship including the expectations that each partner brings into the relationship, the personal history that each partner brings into the relationship, and, the meaning that commitment has for each partner.

Relationship cooperation refers to the couple's behavioral interactions including their ability to communicate effectively, to work together in a balanced way and to mutually engage in problem-solving activities. Their behavior serves as the bridge that joins them together; on-going power struggles, severe conflicts and unresolved angers are all indices of serious cooperation dysfunction.

Relationship intimacy refers to the relationship's climate or level of emotional bondedness. Intimacy, as it is used in this model, describes the emotional, friendship and sexual aspects of the relationship. These include feelings of

affection, commitment and closeness. How the couple spends time together, how satisfied they feel, and the ability to share mutual playfulness are some indicators of intimacy.

THE FEMINIST ISSUES

The Metz and Weiss model (1992) does not explicitly acknowledge an integration of feminist theory and practice, however, it is the student's opinion that its essential principles are parsimonious with the feminist perspective. Thus, it is *possible* to integrate essential feminist principles and guidelines into the framework provided by the work of Metz and Weiss. Towards that end, the following guidelines are critical.

The feminist goal, throughout the process of therapy, must always be the development of an egalitarian relationship. This may not be a straightforward endeavor. The couple may themselves be in fundamental conflict about the gender role expectations they have for themselves and their relationship; there can be no presumption that either member of the couple wants such equality.

The feminist challenge, throughout the process of therapy, must be to foster an egalitarian relationship while yet affirming the particular values of both partners. Neither partner should be made to feel sole blame or responsibility for

the difficulties; neither partner should seek change solely for the other's benefit.

There are a variety of skills critical to a feminist style of intervention. They include a positive evaluation of women, on-going social analysis, the encouragement of total development, behavior feed-back and self-disclosure. The therapist must strive to explore the macro-level implications of patriarchal sex-role assignment as well as the micro-level implications of gender role change and conflict. This includes promoting the woman's right to determine her own personal style of expression aside from ascribed or prescribed societal expectations. The therapist must also remain cognizant of the fact that both members of the couple may not have equal access to the range of resources within the relationship, equal contribution to decision-making, and equal rights to the benefits of the relationship. With regards to the Metz and Weiss model, when homework tasks are assigned and interpreted, it has to be with a full awareness of the couples unique power configuration and history.

RECRUITMENT PROCESS

The process of recruitment was time-consuming and arduous. The student diligently circulated written information and posters to fourteen different Agencies or Centres throughout the city limits (personally visiting five of them).

She ran a variety of advertisements in six different newspaper publications during an eight-week time frame and she posted signs on several community centre bulletin boards. As well, she repeatedly perused the Intake waiting lists at both The Family Centre of Winnipeg and the Psychological Services Centre.

By the end of September, forty-six inquiries had been made about the group. The first screening interview was scheduled for September 24, 1998, and the final such interview was scheduled for October 8, 1998. In total, ten couples were interviewed; six were offered the opportunity to participate in the group. Of those six, two were clients of The Family Centre of Winnipeg, one was on the waiting list at the Psychological Services Centre, one had read an advertisement posted at the University of Manitoba Counselling Centre, one had read an advertisement placed in a Community newspaper, and one had read an advertisement placed in The Winnipeg Sun newspaper.

The process of screening consisted of a sixty-to-ninety minute interview. Both partners needed to attend and participate in the couple assessment. A brief amount of time (fifteen-to-twenty minutes) was spent interviewing each individual privately. The criteria for group admission were as follows:

- both partners had to be motivated to work in the group format agreeing to attend all sessions,

- both partners had to be free from a current or recent history of violence,
- both partners had to be able to control the tendency towards severe animosity or verbal assault, and
- both partners had to agree that there was not a recent marital 'secret', or history of infidelity.

As recommended by Metz and Weiss (1992), couples who were at extreme risk of divorce, unable to discipline themselves to follow homework assignments, or, unable to cooperate together on simple non-controversial tasks were excluded from the group.

THE SETTING

The practicum was completed at the Psychological Services Centre (P.S.C.) located on the Fort Garry campus of the University of Manitoba. It is probable that the University setting added immediate credibility to the experience for potential participants. The P.S.C., an established clinical training facility, offered group rooms that were fully equipped with audio-visual recording systems and two-way mirrors. The fall schedule provided for the Centre to be open two evenings a week making it convenient to organize the couples group in an evening time slot.

GROUP PARTICIPANTS

As has been noted, six couples were chosen to participate in the couples group. All six attended the first session. Between sessions one and two, one of the couples dropped out because the female partner had obtained an evening job. The remainder of the group sessions proceeded with five couples. To protect confidentiality, the couples' names will not be used.

MR. & MS. A. Ms.A., a reserved twenty-two year old woman is currently in the midst of completing a University education. She grew up in an upper-middle class family and continues to reside at the family home (although she spends the majority of her time at Mr.A.'s residence). Mr.A., a likable twenty-four year old man is nearing the completion of his post-graduate University education. He also grew up in an affluent family and currently resides in an apartment near the campus. Both work part-time. They describe themselves to be very committed to the relationship, planning to be together long-term. They have been together three years.

MR. & MRS. B. Mrs.B., an out-going twenty-seven year old woman is currently providing for the full-time care of their two-year old daughter (and often of Mr.B.'s five-year old son from a previous relationship). Mr.B., a

socially reticent thirty-year old man is completing an upgrading course and working as a building caretaker. They have been together four years, and during that time, they have both been active in addressing their personal issues. Both were abused as children; Mrs.B. is an incest survivor. Their level of commitment to one another is obvious and intense.

MR. & MRS. C. Mrs.C., a verbal and articulate twenty-seven year old woman is self-employed as an artist. As an incest survivor and recovered alcoholic, she struggles to cope with a lack of friendship and family supports (both having been sources of disruption in her life). Mr.C., a well-spoken and sociable thirty-nine year old man is employed as a skilled labourer in a stressful business environment. His family of origin experiences were positive although he has been hurt in a series of adult relationships. Both are struggling to work through their trust-related issues to the point of being able to define their sense of a couple identity. They share a high level of emotional connectedness.

MR. & MRS. D. Mrs.D., an energetic twenty-nine year old woman recently made the difficult decision to stay home instead of returning to her former place of employment. Their first child is almost one year of age. Mr.D., a self-absorbed thirty-one year old man is employed as a professional in the business industry. They have been together for eight years, and during that time they

have experienced many occasions of severe conflict and break-down. They were both raised in large families. Mr.D. was parented by a very controlling and punitive father while Mrs.D. had a more balanced experience and childhood. In spite of their difficult relationship history, both have remained very committed to one another. It is obvious that they share great joy in the addition of their son.

MR. & MRS. E. Mrs.E., a bright and effervescent thirty-four year old woman works at home to care for their two children, aged seven and four years. Mr.E., a quiet and likable thirty-three year old man manages a busy commercial business. Two years ago, Mr. & Mrs.E. separated for a period of nine months and now that they have reconciled they are determined to protect their relationship from ever again sliding so far into despair. They express open love and respect for one another and are committed to work as hard as it takes to succeed as a couple, and as a family.

The group composition was relatively homogeneous. The women were aged twenty-two to thirty-four years. The men were aged twenty-four to thirty-nine years. Of the five men in the group, three were employed as the full-time family income providers, and two were engaged in full-time academic pursuits. Of the five women in the group, four were working in the home (unpaid labour), and one was engaged in full-time academic studies. It should also be noted that two

of the couples had two children, two of the couples had no children and one of the couples had one child. In terms of family income, one of the couples was struggling at the level of poverty and the rest were living at a middle income level range.

DESCRIPTION OF GROUP SESSIONS

Session One

Tasks: The session tasks included the following: establish group norms and rules, introduce the couples to one another, mini-lecture on the topic of the relationship model, begin to discuss current and goal metaphors and assign homework (journalling, creating metaphors and individual relaxation).

Couple A: Mr. & Ms. A listened attentively, offering very little feed-back or discussion.

Couple B: Mr. & Mrs. B. participated at different levels. Mrs. B. tentatively offered an option for a more comfortable set-up for the room. Although the suggestion was not agreed upon, it opened the topic to further discussion. Mr. B. spoke only when asked a direct question and he presented as being somewhat agitated or uncomfortable.

Couple C: Mr. & Mrs. C. arrived late and both appeared flustered. They

listened and spoke appropriately. Mrs. C. was the most vocal of the participants sharing that their first couple identity struggles surrounded issues of free-time and friendship groups.

Couple: D: Mr. & Mrs. D. listened attentively appearing to be only mildly anxious. Mr. D. offered a personal example of relationship identity, indicating that he understood the concept. Mrs. D. also shared her own personal illustration of the concept.

Couple E: Mr. & Mrs. E. listened well and actively, (asking for clarification when needed). Mrs. E. shared a story from their lives to illustrate the concept of relationship identity. Mr. E. added onto her example.

Group Dynamics: The student (alternately referred to as the therapist) set the context for the development of group norms and rules. The commitment of time was emphasized for both attendance and the completion of assigned tasks. The issues of respect and safety were also emphasized included specific rules about what participants were to do when strong feelings surfaced during the session (speak up immediately rather than waiting to ‘confront’ their partner after the session). If hurt or angry feelings surfaced after the session participants were instructed to either express themselves constructively or hold the matter until the next group session (particularly important if the group’s support and control was

needed to prevent an unhealthy interaction). The therapist informed all participants that they could contact her during the week if they felt unable to control/contain a destructive process. Participants were also informed that they could not intimidate one another during the week by threatening to bring something personal or private into the group setting. And finally, all group participants were told that they had a responsibility to be direct, honest and confrontative with one another, giving and receiving feed-back throughout the session time.

Midway through the session Mrs. C. emerged in the role of group leader. This appeared to relieve the other participants.

Feminist Component of the Intervention: The therapist became aware that none of the participants had moved beyond their initial feelings of discomfort. The proscribed material (re: the Metz and Weiss model) had been presented and a full hour of time remained. The decision was made to abandon the model and focus on 'connecting' with the participants. In keeping with a feminist perspective, the therapist proceeded to offer her own personal history (self-disclosure) as a technique to reach out to each participant. She drew diagrams depicting both her own and her partner's extended families and utilized them, together with concrete examples, to elaborate the concept of relationship

identity. This opened up a group discussion that lasted until the session time was over. The overall tone/atmosphere had become positive.

Summary: The first session was the most difficult for a variety of reasons (room over-booking, high anxiety levels, weakness of the model to focus on connection issues, lack of established group norms and roles). Two homework tasks were assigned and participants were requested to begin the practice of journaling.

Session Two:

Tasks: The session tasks included the following: mini-lecture on the topic of communication skills, discuss the significance of active listening and assign homework (the 'relationship time-line' and the audio-taped paraphrasing exercise).

Couple A: Mr. & Ms. A. could relate to the importance of listening in their relationship and also in their parents' relationships. Mr. A. shared that he frequently tuned Ms. A. out in the same way that he knew his dad tuned his mom out. They agreed that it was an ineffective way to resolve issues. Both Mr. & Ms. A. participated well throughout the session.

Couple B: Mr. & Mrs. B. appeared somewhat withdrawn although they both responded appropriately during the session. Mrs. B. expressed the opinion that

over time most couples tend to decrease the amount of attention and energy invested into the area of communication.

Couple C: Absent.

Couple D: Mr. & Mrs. D. offered input frequently during the session. Mr. D shared that he had an inflexible listening style, although it was obvious that he was unaware of the controlling nature of his statements and/or actions. It was equally obvious that his listening style reflected a distinct power imbalance between them as a couple.

Couple E: Mr. & Mrs. E. offered continuous discussion through the session. At one point, Mrs. E. became emotional as she explained that she had never been listened to as a child. They both agreed that active listening skills were very important.

Group Dynamics: The second session was more relaxed. Mrs. C.'s absence did not appear to affect the development of a group norm for active verbal participation. Group participants spoke repeatedly and the session time passed quickly. In an animated discussion, a variety of reasons were offered to explain why it was difficult to practice active listening skills during regular interaction with one another (fear, frustration, anxiety, hurt, disappointment, insecurity, personal difference, the tendency to take the other for granted).

Mr. D. appeared to be assuming the role of either the deviant or the scapegoat member repeatedly making comments that cast his behavior in a highly traditional, sexist manner (appearing oblivious to the group's negative reactions to his comments). Mrs. E. appeared to be assuming the role of the internal group leader. At the same time, the therapist was clearly perceived to be the group leader.

Feminist Component of the Intervention: The therapist was very cautious to avoid gender stereotyping as she discussed the individual need to feel understood (a human need versus a gender-specific human need). The role of socialization in the interpretation of these needs was analysed. The therapist was also very sensitive to a potential group conflict when Mr. D. made some very controlling, rigid statements about his listening style. Mrs. E. correctly interpreted his statements to be based on the presumption of male dominance and patriarchy. Maintaining a feminist perspective, the therapist affirmed and validated Mrs. E.'s interpretation. She then positively supported Mr. D.'s ability to share honestly, inviting both him and Mrs. D. to make any further comments (both declined).

Summary: The second session was primarily spent allowing participants to become comfortable with the process of a group experience. There was

insufficient time to cover the material as suggested by the Metz and Weiss model and to discuss the assigned session one tasks. Two homework tasks were assigned.

Session Three: The session tasks included the following: mini-lecture on the continued topic of communication skills, share couple histories and metaphors, process paraphrasing experiences and assign homework (the ‘marital beliefs check-list’ and couple relaxation).

Couple A: Mr. & Ms.A. had completed the paraphrasing exercise (twice) and they both felt comfortable with their skills in this area. Ms. A. stated that she planned to keep the audio-tape as a memory of this stage in their couple history. They both shared their current and goal metaphors and relationship time-line. Although they spoke less frequently than other participants, Mr. & Ms. A. were actively involved in the session.

Couple B: Mr. & Mrs. B. had also completed the paraphrasing exercise. Mrs. B. stated that because she was at home caring for young children all day, she had different needs to talk and feel heard. Mr. B. agreed that he had not understood the significance of his skill as a listener. The communication exercise helped them both to work on this important issue/skill. Mr. & Mrs. B. had not completed their relationship time line. Although they were both involved during the

session, Mr. B. appeared to be emotionally withdrawn.

Couple C: Mr. & Mrs. C. immediately offered to share their current and goal metaphors. They had each spent many hours on the task; their metaphors were full of meaning and insight. They had not completed the other two tasks due to their absence during the second session. Both Mr. & Mrs. C. participated actively and enthusiastically throughout the session.

Couple D: Mr. & Mrs. D. attempted the paraphrasing task several times and Mr. D. admitted that it was a struggle for him. They each shared their current and goal metaphors as well as their relationship time-line reporting that both had been meaningful activities. In regards to their time-line, Mr. D. commented that many awful things had happened during their relationship. Mrs. D. immediately countered that there were also many positive occurrences. Their participation level was high and interactive.

Couple E: Mr. & Mrs. E. began to discuss their paraphrasing experience by sharing a week-long conflict that centered around the difficulty of listening. They added that they recognized the need to regularly schedule time to talk and listen to one another. Having spent the drive to the University finishing their relationship time-line, Mr. & Mrs. E. agreed how surprising it was to actually see (as represented on the line) the litany of moves and upheavals they had gone

through together; how validating it was to acknowledge that they had endured a huge amount of physical change and instability. They also shared their current and goal metaphors. Both Mr. & Mrs. E. were actively involved throughout the session.

Group Dynamics: The third session was purposeful and dynamic. All of the five couples interacted and there was a beginning sense of group cohesion. Mrs. C. repeatedly attempted to exert herself as the internal leader, however, the group norm of equal verbal participation persisted. Most of the participants were eager to have their opportunity to share the work that they had done during the previous two weeks (assigned tasks) and the combined discussions around metaphorical concepts and relationship histories allowed for the couples to begin joining with one another. Ms. A. could clearly be seen as the quiet member. This had a distinct effect on Mr. A. who appeared to struggle with the desire to support his partner while yet participating actively. Mrs. B. emerged as somewhat of a gatekeeper (functioning to cut Mrs. C. off whenever the discussion became too focused on sexual abuse issues). Mr. & Mrs. E. took turns leading the discussion into particular areas during the session.

Feminist Component of the Intervention: The therapist worked to monitor the amount of time that each participant was given during any discussion, thus

intending to moderate existing power differentials (particularly between the C.'s and the D.'s). When Mr. & Mrs. B. disagreed over who should share their relationship time-line, and Mr. B. overrode Mrs. B., the therapist encouraged Mrs. B.'s interjections (thus supporting a process of co-involvement and mutual decision-making power).

Summary: The third session was spent with the five couples sharing their histories and their issues. The levels of participation were meaningful and interactive. Two homework tasks were assigned.

Session Four

Tasks: The session tasks included the following: mini-lecture on the concept of relationship identity, review common beliefs as represented by 'the marital beliefs check-list' and assign homework ('the powergram exercise').

Couple A: Absent.

Couple B: Mr. & Mrs. B. talked about a workshop that they had attended as having been key to their working through beginning relationship identity issues (while also helping them at individual levels). They also shared how the birth of their daughter had strengthened their love and deepened their overall commitment. Both Mr. & Mrs. B. participated actively in the discussion generated by 'the marital beliefs check-list' and the resulting interactions made

it apparent that Mr. B. had finally engaged in the group process (he was the last participant to do so).

Couple C: Mr. & Mrs. C. shared their relationship time line, and as they spoke it became apparent that there was a degree of tension between them. Although Mr. C. encouraged her to be brief, Mrs. C. went into great detail, explaining her history as an incest survivor as central to many of their struggles as a couple. Both agreed that they were currently grappling with relationship identity issues. With respect to ‘the marital beliefs checklist’, they admitted that several of the potentially dangerous belief systems were operant in their daily altercations. Their participation was appropriate and intense.

Couple D: Mrs. D. began the session by sharing that they were communicating much more effectively. Although a significant disagreement had occurred between them, she felt pleased with how each of them had responded. Mr. D. agreed that it felt good to resolve an issue together. Both Mr. & Mrs. D. related to several of the faulty beliefs (re: ‘the marital beliefs exercise’), participating actively in the discussion.

Couple E: Absent.

Group Dynamics: The fourth session was the first during which there was an obvious sense of group cohesion. The participants made supportive comments

to one another and the atmosphere was congenial. It was a pivotal session for Mr. B. as it became apparent that he had overcome his social reticence to become invested in the group process. Mrs. B. continued to act in the role of the gatekeeper ensuring that the emotional level within the group remained at a tolerable level. Mrs. D. assumed the role of the verbal member throughout the session allowing her to share exciting changes that were occurring in their relationship.

Feminist Component of the Intervention: The therapist offered a feminist interpretation of Mrs. D.'s decision to stay at home for another year with their young son following Mrs. D.'s explanation of the value she places on her mothering role. The critical piece was that Mrs. D. had felt empowered to make her own choice (both Mr. & Mrs. D. indicated this to be the case).

The therapist repeatedly offered a positive evaluation of women and an on-going social analysis as 'the marital beliefs checklist' was scrutinized. For example, during the discussion centered around one such belief ("If you loved me, you would always know what I think, feel and want.") the therapist balanced the group's tendency to stereotype this kind of thinking as only feminine by offering an alternate example (the story of a relationship where the man struggled with insecurities because his female partner rarely knew what he was

thinking or feeling). The therapist also offered a social commentary on the faulty belief as heavily related to the socialization standards of our culture; the tendency for the training/teaching of young girls to emphasize compassion, empathy and emotional care-taking.

Summary: The fourth session was characterized by even and constant discussion and/or interactive debate. The couples appeared relaxed; there was a distinct sense of group unity and shared concern. One homework task was assigned.

Session Five

Tasks: The session tasks included the following: mini-lecture on the topic of relationship cooperation, focus on the techniques of individual and couple relaxation and assign homework (the written part of 'the caring days' exercise and the final part of 'the powergram' exercise).

Couple A: Absent.

Couple B: Mr. & Mrs. B. expressed relief and excitement due to an impending opportunity to change residences (feeling that much of their daily stress would be reduced). This set the tone for their level of openness during the session. Mrs. B. shared that she was a sexual abuse survivor and that she was going through a time of very limited sexual desire. Both Mr. & Mrs. B. went on to

candidly discuss their relationship. Several of the participants empathically related to their issue(s) and the changes of parenthood were discussed.

Couple C: Absent.

Couple D: Mr. & Mrs. D. both talked about the changes that had occurred in their sexual relationship over time and especially during the year since their son had been born. Mr. D. emerged as a relaxation ‘expert’ modelling his technique and sharing that it had become an uplifting and empowering part of his work-out routine. They both stated that they had continued to communicate more effectively at home.

Couple E: Mr. & Mrs. E. were very helpful throughout the session, both having learned first-hand the effectiveness of cooperating with one another on a day-to-day basis. Following reconciliation they had both prioritized the need to work as team players. Mrs. E. stated that functioning as a cooperative unit even helped to re-build the trust. Without calling it couple relaxation, Mr. E. shared his technique for helping both of them relax and fall asleep (a soothing combination of massage and creative visualization). Mrs. E. agreed that it was a special time of closeness between them.

Group Dynamics: The fifth session was intense. Mrs. B. emerged as the deviant group member (re: the norm that discussion did not revolve around the

theme of childhood sexual abuse) by sharing her personal experiences as an incest survivor. The other group participants were empathic and respectful during her disclosure. However, as soon as possible afterward Mrs. D. assumed the gatekeeper role (previously maintained by Mrs. B.) by guiding the discussion into the arena of sexual issues versus sexual abuse. Mr. D. emerged as the expert providing the group with a 'lesson' on his relaxation technique(s). Mr. & Mrs. E. took turns sharing their previous struggles to act cooperatively highlighting the difference in their current style of interacting with one another. The group members appeared to rotate in the role of session leader (with the exception of Mrs.B.).

Feminist Component of the Intervention: The therapist emphasized the value of an egalitarian relationship while also validating the participant's examples of different levels of cooperative behaviors (highlighting reciprocity and mutuality). The therapist was careful to state that while both partners are equally responsible for the work necessary to successfully achieve the task of relationship cooperation, neither partner can be held responsible for the other partner's choices.

The therapist repeatedly offered behavior feed-back as appropriate during the session. For example, Mrs. B. expressed wistfulness at the idea that she could

enjoy shoulder massaging because it would represent safe, caring, non-sexual closeness. The therapist asked Mr. B. how he felt about her comment. He replied that he had tried to massage her in such a way, but that it invariably turned into a sexual encounter. The therapist suggested that he work to offer his partner a non-sexual experience of intimacy (offering him the feedback that his behavior could be changed to facilitate their closeness).

Summary: The fifth session was the first time that issues of sexual intimacy were explored and discussed. The concept of relationship cooperation was well received, as was the emphasis on relaxation as a means of moderating routine relationship stress. Two homework tasks were assigned.

Session Six:

Tasks: The session tasks included the following: mini-lecture on the issues of decision-making and power as related to relationship cooperation, discuss 'the powergram' exercise, evaluate the role of unresolved anger(s) and assign homework (the importance of 'the caring days' exercise was reinforced and couples were encouraged to continue practicing effective communication skills and relaxation techniques). A new homework assignment was not given.

Couple A: Mr & Ms. A. had not completed 'the powergram' exercise. Ms. A. explained that she felt their situation was different from the others; they were not

yet at the point of having to negotiate a household together. Mr. A. spoke up indicating that he felt that they *were* struggling with power-related issues. He explained that his parents' marriage had been essentially egalitarian, although when it came down to it his mom would emerge as the leader. In Ms. A.'s family of origin, her mom was always the leader and the one who wielded the most decision-making power. Mr. A. continued by agreeing with a previous group discussion saying that he felt especially powerless vis-a-vis their relationship when Ms. A. would refuse to interact with him. The group was supportive of his observations and feelings. Ms. A. appeared to withdraw from the discussion (her position being that they resolved conflicts without difficulty).

Couple B: Absent.

Couple C: Mr. & Mrs. C. had attempted 'the powergram' exercise finding it to be difficult and frustrating. Both agreed that they lack cooperative skill as a couple, sharing how emotionally draining it was to be so 'stuck'. Mr. C. stated that he felt Mrs. C. exerted unfair power-related behavior when she refused to talk to him. Mrs. C. agreed. They both shared that they have a similar tendency to carry around angry feelings for days, or even weeks, at a time.

Couple D: Mr. & Mrs. D. again shared how much better they were getting along with one another. The issue of power hit a nerve for both of them. Mrs.

D. described their battle over finances stating that since she no longer brings income into the family she no longer makes any of the monetary decisions. They both rationalized this to be fair. At the same time, they both indicated that it was a source of tension. When group participants remarked on the evident sexism, Mrs. D. became defensive, commenting on the high value she places on being able to stay home with their very young child. Later in the session, Mrs. D. shared that she tended to 'nurture' her anger, watching it grow and grow. Mr. D. shared that he tended to become very angry, very quickly, but that he rarely continued to be angry for more than a short period of time.

Couple E: Mr. & Mrs. E. had had a positive experience completing 'the powergram' exercise; they agreed that it affirmed how much growth had taken place between them. They had full agreement between them (re: the division of decision-making authority). Mrs. E. later commented that she tended to carry around unresolved angers and that she was pursuing individual therapy to find less draining alternatives.

Group Dynamics: The sixth session was spent exploring the volatile issues of relationship power and decision-making. The group members interpreted Mr. D.'s attitude towards financial decision-making to be highly sexist. Mrs. D. responded by assuming the defensive member role (stating that the situation felt

fair and reasonable because of the trade-off that it represented for her - the opportunity to be a full-time mom). Mr. A. assumed the role of the verbal member appearing to relish the opportunity to have his experience in their relationship validated (Ms. A. in the position of the powerful partner). Ms. A. assumed the role of the quiet member (appearing to disagree with her partner but declining the opportunity to respond). Both Mr. & Mrs. C. were angry throughout the entire session indicating that the topic pinpointed the area of their relationship 'stuckness'. Having already worked through the issues of relationship cooperation and power, Mr. & Mrs. E. emerged as the experts. They offered a variety of insightful comments.

Feminist Component of the Intervention: The therapist began by emphasizing the inherent merit of egalitarian principles. She then moved into the arena of relationship power. Although the feminist challenge is to foster egalitarian relationships, the therapist remained aware that some of the couples would not want such equality. She also remained aware that macro-level realities impacted the specific power-related issues. For example, Mr. & Mrs. D. both seemed to agree that Mrs. D. no longer had any right to monetary decision-making power. The basis of their reasoning was prior history (when Mr. D. was unemployed she had assumed all of the monetary decision-making

power). The therapist challenged them suggesting that the weight of the entire culture (patriarchy) makes Mrs. D.'s current powerlessness a more profound experience than what Mr. D. would have gone through. When Mr. D. felt that his partner had the relationship power he could still experience the male-dominant position culturally afforded him via his gender (i.e., at every extended family dinner he was able to sit around and eat without *ever* being expected to help prepare, cook or clean-up). As well, Mr. D. did not have to experience the double-bind situation of a young mother choosing between the full-time needs of her child and the ability to earn an income (his unemployment was due to indecisiveness and lack of desirable opportunities). After offering the feedback, the therapist immediately respected Mrs. D.'s defensiveness as an indication of her need to define the relationship within the parameters of her own time-frame. The discussion was concluded with an overarching positive evaluation of the role of women inside and outside of the family unit.

Summary: The sixth session was spent evaluating the significance of power-related issues between couples. The topic and relevance of anger was also discussed. All eight participants verbally agreed with the tenets of egalitarianism, however, it became obvious that two of the couples were not functioning according to such value principles (Mr. & Mrs. C., Mr. & Mrs. D.).

A new homework task was not assigned.

Session Seven:

Tasks: The session tasks included the following: mini-lecture on the topic of relationship intimacy as both a current skill and a developmental process, evaluate work done on ‘the caring days’ exercise and assign homework (couples were asked to reflect and journal about their beginning and goal metaphors in preparation for the final session). A new homework assignment was not given.

Couple A: Absent.

Couple B: Absent.

Couple C: Mr. & Mrs. C. immediately shared that their week had been full of arguments and tensions. They agreed that it was difficult to be cooperative with one another; they fought about most things including roles and allocation of chores. Mrs. C. talked about on-going struggles with her own sexuality. She stated that she felt an inner pressure to erect a wall whenever she was feeling especially close and intimate with Mr. C. (he shared how much it hurt when the wall went up). Mr. & Mrs. C. understood the distinction between relationship intimacy and sex. They also understood the importance of a close sexual relationship.

Couple D: For the first time, Mr. D. offered a personal story of a crisis that he

had gone through during the week (indicating that he felt less aloofness from others in the room). Mrs. D. shared that their fight pattern continued to be different; that there were very significant changes in their relationship. When intimacy issues were being discussed, Mr. & Mrs. D. both agreed that their sex life had dramatically changed since they became parents. Mr. D. went on to share that during the first year of their marriage his trust had been violated. Since that time he had found it difficult to allow himself to become emotionally intimate with his partner, fearing that she might leave. Mrs. D. shared that her trust had also been violated during the intensely conflicted first months of their marriage. They quietly agreed that they were still not intimately connected to one another (becoming evasive when asked if they desired to change the degree of connectedness between them).

Couple E: Mr. & Mrs. E. began by offering their own insight about how change had occurred in their relationship, saying that prior to the separation they had fought bitterly about all cooperative level functioning, (especially time spent caring for the children). Mr. E. poignantly shared how the eight months alone had opened his eyes allowing him to see how uncooperative and uninvolved he had become in his family's lives. Mrs. E. agreed that she too worked on her issues during the separation, (especially anger and fear). At a later point in the

discussion they talked about the degree of emotional intimacy or connectedness between them. While both agreed that becoming parents had changed their sexual relationship, they also agreed that they were currently feeling a level of connectedness that was not defined by the volume of their sexual activity.

Group Dynamics: The seventh session focused in on the topic of intimacy. Mrs. C. immediately began discussing her personal struggle(s) to participate in a healthy sexual relationship. Mr. C. added his experience with respect to her incest survivor history (both honoring the group norm by not prolonging the discussion). For the first time, Mr. D. admitted a personal vulnerability (indicating his desire to be a part of the continued group cohesion). Mr. & Mrs. E. again assumed the role of group leaders and experts offering insight and advice to the other couples (an on-going message of support and hope - working past cooperative struggles to a place of emotional intimacy).

Feminist Component of the Intervention: The therapist spent time focusing on individual development as a prerequisite of healthy relationship development. The dynamics of interdependency were explained and illustrated. The participants were encouraged to take responsibility for their own sense of well-being and worth, and the importance of time spent apart was emphasized.

The therapist defined relationship intimacy to include both emotional and

physical connectedness. In this way she validated the woman's position and the man's position; acknowledging that healthy adult relationships are defined by a unique configuration of emotional *and* physical connectedness is respectful and empowering to both genders

Summary: The seventh session was spent focusing on the emotional facets of relationship intimacy. The participants understood the distinction between physical and emotional intimacy, and the resulting discussion was powerful. Two of the couples (Mr. & Mrs. D., Mr. & Mrs. E.) seemed to internalize the concepts. The remaining couple (Mr. & Mrs. C.) seemed to experience less impact.

Session Eight

Tasks: The session tasks included the following: mini-lecture on the issues of physical intimacy (including sex) as they relate to the issues of emotional intimacy, discuss and process goal metaphors, evaluate 'the caring days' exercise, complete the posttest and feedback survey and assign homework ('the special date' and an encouragement to maintain relationship change).

Couple A: Absent.

Couple B: Absent.

Couple C: Mr. & Mrs. C. were much calmer during the session. Mr. C.

expressed the continuous rejection he felt whenever he approached Mrs. C. at a sexual level. Even though he had an intellectual understanding of her abuse issues, he admitted that it hurt. Mrs. C. affirmed that he was very patient, adding that his gentle behaviors as a lover had helped her tremendously. She went on to share that prior to meeting Mr. C., every consensual sexual encounter she had ever had occurred while she was inebriated. Now that the alcohol had been removed as a crutch, she found it difficult to express herself sexually. They both agreed that their emotional commitment to one another made it possible for them to continue working at the sexual issues.

In discussing their goal metaphors, they both expressed relief to have found out that they were not alone in their struggles. Mr. C. stated that he had achieved some of his goal metaphor and that he was more hopeful than he had been prior to the start of the group. Mrs. C. also stated that she had partially achieved her goal metaphor and that participating in the group had increased her awareness of the work ahead of them.

Couple D: Mr. & Mrs. D. stated that changing priorities, with the arrival of their son, meant that their sex lives took somewhat of a backseat. Mr. D. attributed their comfort (re: the changes) to an understanding that there were other ways that they could express love to one another (Mrs. D. became teary-

eyed following his comment). When discussing the gender myth that men can always have sex irrespective of emotional involvement, Mr. D. commented that his emotional feelings were critical to his ability to entertain feelings of sexual arousal.

In discussing their goal metaphors, Mr. & Mrs. D. both agreed that the group had allowed them to make many positive changes in their relationship. Mr. D. felt that he had accomplished his goal metaphor. Mrs. D. also felt that she had accomplished her goal metaphor, although she added that learning how much Mr. D. cared about their relationship stood out as the highlight of her learning experiences. Both found it helpful to hear the struggles and concerns of other couples and to learn to practice active listening skills.

Couple E: Mr. & Mrs. E. talked openly about the importance of their sex lives. Mr. E. shared that there were many things that contributed to his wanting to make love to his partner and that it often started hours before they crawled into bed. Mrs. E. remarked that her favorite foreplay was brushing up against her partner whenever he helped with the after-supper clean-up. She added that it takes effort, creativity and initiative to keep the sexual part of their relationship fun and interesting.

In discussing their goal metaphors, Mr. & Mrs. E. reported that their

participation in the group had allowed them to accomplish their individual goals as well as highlighting the many positive changes that they had already worked into their relationship. Both shared that the group had helped them tremendously because it had validated both their experiences and their struggles.

Group Dynamics: The eighth session was divided between a focus on issues of sexual intimacy and issues of group closure. The group norm around equal verbal participation continued and all who attended were actively involved. Mr. & Mrs. C. evaluated their emotional and physical intimacy issues recognizing the need to continue work at the relationship issues. Mr. & Mrs. D. both emerged in the expert role explaining (with evident agreement and clarity) their understanding of the changes in their sexual relationship that naturally accompany parenthood. Mr. E. emerged in the role of the highly verbal group member sharing his insight/experience into the realities of a long-term relationship (articulately illustrating the integration of emotional and physical intimacy).

Feminist Component of the Intervention: The therapist was very careful not to reinforce stereotypical standards of narrowly defined sex (i.e., intercourse). Instead, she repeatedly articulated a definition of sex that was inclusive and flexible. The therapist also validated the healthiness of a relationship system that

modifies its definition of sex in response to its place in the family life cycle (i.e., accepting the decrease in frequency of intercourse as normal and natural in the months after the birth of a child, and then re-defining sex to include a range of activities beyond coitus).

The therapist ended the final session by offering brief statements about each of the group participants; by focusing on their unique strengths and signs of growth she allowed for the intervention to end on a note of positive evaluation for both the women and the men.

Summary: The eighth session was productive and emotional. The topic of sexual intimacy was explored and ‘the special date’ exercise was assigned (presented as an opportunity to maintain excitement and romance). Specific goal metaphors were evaluated and participants were given the opportunity to share their thoughts about the group experience. The posttest instrument had been completed, along with the feedback survey, when it became obvious that participants were having an emotional reaction to the termination process. As a cohesive therapeutic system, it seems reasonable that the ending of the group would not only represent optimism and hope, but also sadness.

Chapter IV - The Critique of the Model

The Metz and Weiss model, as critiqued by the student, will herewith be examined.

STRENGTHS OF THE MODEL

The student/therapist experienced various of the strengths inherent in the application of the Metz and Weiss model and generally felt that the model was a moderately effective tool.

The therapist appreciated the session by session organization of the model, and even though it became impossible to re-enact the group according to the original design, the specificity was itself experienced as positive.

The presentation of 'the relationship model' as a normative tool to empower group participants in their work as couples, was thought to be a distinct strength of the model. As linked to personality theory, 'the relationship model' was basic and easy to understand; the participants of the group responded readily to its conceptualizations.

The assignment of homework tasks was felt to be a major strength of the model. It became obvious during the screening interviews that potential participants were *very* receptive to the expectation and this carried through to the

actual group process. Even when they had missed a session the participants kept up with the assigned tasks. By the end of the final group session, four of the five couples had completed every homework task that they had been given, often spending more than the suggested hours per week.

It was the therapist's opinion that some of the recommended homework tasks were definite strengths of the model. Three stood out as powerful interventions: the marital time line(re-named the relationship time line); the paraphrasing exercise; and the caring days technique. The relationship time line enabled couples to spend time discussing and plotting their history together as a couple. The feedback was extremely positive. The paraphrasing exercise compelled couples to implement active listening skills. When they filled out the client feedback form, at least one person in every couple mentioned this exercise as helpful. 'The caring days' technique provided a practical, achievable way to enable couples to begin the practice of caring for one another, thus beginning the process of cooperative functioning. Although the response was varied, the exercise had an obvious impact for each participant.

The two-session focus on communication skill-building was a positive, albeit time-consuming, component of the model. This aspect of the work was rated very highly on the client feedback forms and during the final session wrap-up.

As a final strength of the model, the therapist was particularly impressed by the implementation of metaphorical concepts vis-a-vis goal-setting. Asking couples to think and journal about a beginning and a goal metaphor was both insightful and exciting. In all cases, the participants put a significant amount of time and thought into the task. The concepts seemed to empower the participants, providing them with safe, creative languaging as a means to express difficult feelings and/or experiences. The use of metaphors also allowed for a concrete measurement of an abstract dimension (relationship quality). During the final session it was especially gratifying to hear each participant indicate a sense of movement (partial to complete) from the beginning to the goal metaphor.

WEAKNESSES OF THE MODEL

The student/therapist experienced many weaknesses evident in the application of the Metz and Weiss model.

The first major weakness became evident early into the initial group session. The Metz & Weis model does not take into account the time needed to create a therapeutic context. According to the model, the therapist should have been able to address the couple's presenting concerns within the initial session. This

is an impossible supposition. Fortunately, the therapist was able to rely on her skill as an experienced clinician to improvise during the session and begin the process of 'joining' with individual participants.

The next weakness is related to the first point. By the time that session one had concluded, the group was lagging behind the Metz and Weiss outline. This remained a weekly constant. By session three the therapist began to streamline the quantity of homework tasks to be assigned. Even with the revision, it typically took three-to-four sessions to discuss a task that was assigned. For example, although individual relaxation was assigned during session one, it was session five before it was processed (re: the experience, any difficulties, feedback).

An overarching weakness of the model was the fact that too much content was designated for each weekly session. To have accurately followed the original outline the therapist would have been required to eliminate all processing time. The group would then have been educational, not therapeutic.

The resource materials needed for the homework tasks were outdated and difficult to access. This is another weakness of the model. In some cases, the therapist re-typed the sources to improve their applicability. At other times, she distributed the original source. For example, the original 'marital beliefs

checklist' was a section within a chapter of a book, and some of its language was outdated. For another example, the therapist expended time and money to access the original source for an exercise entitled 'the awareness wheel'. When the source arrived it turned out to be an entire twenty-two page chapter on the exercise (never succinctly organized or presented). The decision was made to omit the exercise. A statement similar to the above two examples could be made for each of the original homework assignments contained within the Metz and Weiss model. For these reasons, preparing for group sessions was often a time-consuming experience. A final weakness of the model was its lack of clarity pertaining to clinical intervention skills. Although the focus was often cognitive-behavioral, it was not consistently maintained. While it was stated that the affective component of traditional group therapy was intended to achieve many of the goals of the treatment, the model failed to identify the specific skills required vis-a-vis the therapist. This flaw or omission made the process of student supervision critical.

GENERAL COMMENTS

The student/therapist experienced both the strengths and the weaknesses that were inherent in the clinical application of the Metz and Weiss model. Even

though there were many identifiable weaknesses, it can generally be stated that the therapist found the model to be a moderately effective tool or resource. That is, the strengths outweighed the weaknesses. This became the case once the student/therapist had received the supervisory wisdom to regard the model as a 'roadmap'; that is, to regard the model as a broad *guideline* organizing group structure and process.

It should be stated that the therapist would absolutely run another couples intimacy group utilizing the Metz and Weiss model. Over time and replication it is believed that the model could be applied with a *very* high level of effectiveness.

It should also be acknowledged that the act of integrating a feminist perspective within the Metz and Weiss model represents a distinct alteration of the original framework. Indeed, the variation may even be identified as a new treatment model. The primary strength of the integration was its ability to attend to the realities of patriarchy and power within dyadic relationships. The only limitation was the student/therapists' struggle to maintain a professional neutrality towards her own essential experience of gender without the balance of a male co-therapist (i.e., establishing and maintaining a non-judgemental therapeutic connection with the women *and* the men). The overarching

challenge of the integration was the weekly process of preparing for each session (working to define and focus on the relevant feminist issues).

There are some considerations around whether or not the Metz and Weiss model allowed for the student to accomplish the specified practicum learning goals. These will be addressed elsewhere (see chapter v - the evaluation).

Chapter V - The Evaluation

OVERALL EVALUATION

The practicum was evaluated at both a process and an outcome level. The process was primarily evaluated through the interaction between the student and the Chairperson of the Practicum Committee, Professor Ranjan Roy. The supervision involved on-going weekly discussions and reviews in combination with direct viewing of taped group sessions. As well, following each group session, the student utilized process logs (to track thoughts and perceptions as the practicum proceeded through its various stages) and very detailed recording practices.

The outcome was primarily evaluated using the Waring Intimacy Questionnaire (WIQ) in both a pre and posttest format (Waring & Reddon, 1983). As well, the student constructed a seven question voluntary feedback form for the group participants to complete at the end of the eighth group session (following the completion of the WIQ). Of the total seven questions, six were open-ended, and one was based upon a simple five-point Likert scale.

The WIQ is a 90 - item true or false questionnaire specifically designed to measure the quality and quantity of marital intimacy. It was developed from the theory that interpersonal dyadic relationships can be defined by three

dimensions: boundary, power and intimacy. Waring and his colleagues collaborated to eventually delineate an operational definition of intimacy as a multi-dimensional concept comprised of: Conflict Resolution (CR), the ease with which differences of opinion are resolved; Affection (Aff), the degree to which feelings of emotional closeness are expressed by the couple; Cohesiveness (Coh), the degree of commitment to the marriage; Sexuality (Sex), a spouse's level of satisfaction with the couple's sexual activity; Identity (Id), each individual's level of confidence and self-esteem; Compatibility (Comp), the degree to which the couple is able to work and play together comfortably; Expressiveness (Exp), the degree to which thoughts, beliefs, attitudes and feelings are openly communicated within the marriage; and Autonomy (Aut), the ability of the couple to exist, as an entity, independantly from their families of origin and their offspring. The WIQ provides subscale scores on the above 8 facets of marital intimacy. In addition, the WIQ includes a measure of Social Desirability (Des), or the extent to which people respond desirably regardless of item content (Waring & Reddon, 1983; Waring et al. 1994).

The test construct strategy employed in the development of the WIQ was a sequential strategy designed to foster the construct validity of the inventory. The emphasis was on the importance of psychological theory, the necessity of

suppressing response style variance, convergent and discriminant item selection procedures and validation, and scale homogeneity and generalizability (Waring & Reddon, 1983). The choice of constructs was guided by mutual exclusiveness and theoretical import. Items were written and edited for conformity to the scale to which they belonged, and, for brevity and clarity. They were also edited for discriminating power and the balancing of positive and negative exemplar to minimize acquiescence. Finally, the items were edited to assure neither desirability nor sexual bias (Waring et al., 1994).

Since its construction, the WIQ has been used in a variety of evaluations of social work practice. It has proven high reliability and validity properties and the 90 questions are brief and succinct. A summary Total Intimacy score is available by summing the 40 most efficient items and subtracting the desirability subscale score. Test-retest and internal consistency (KR20) are high, especially since there are only 10 items per scale (Patton & Waring, 1991). Scoring protocols are straightforward, and overall intimacy scores are easy to compute and score.

The WIQ is a Canadian measure that has been used repeatedly throughout the years since its publication. When it is employed in a pre-posttest format, the WIQ provides a succinct outcome measure of the effectiveness of couple's

group therapy (i.e., comparing the Total Intimacy scores prior to therapy with the Total Intimacy scores following therapy). A higher Total Intimacy score indicates a higher level of intimacy between the individuals in the couple. The practicum participants were required to complete the WIQ prior to therapy, and then again immediately following termination. In this way, the outcome of the practicum intervention was evaluated. The criteria for a positive evaluation was an improved overall Total Intimacy score.

The WIQ was chosen for three specific reasons. First, it was developed from a theory that fits well within the systemic and feminist perspectives. Second, Waring's operational definition of intimacy contains 8 dimensions, one of which is sexuality. This will allow for the sexuality subscale to be evaluated separately from the Total Intimacy scores (enriching the evaluation process). Third, it was felt that a measure of intimacy would be highly congruent with the feminist goals of the group process. In viewing the interactional and contextual dynamics of human relationships, the practicum intervention(s) considers the entire quality of the couple relationship; a measure of intimacy most accurately reflects the entire quality of the couple relationship.

In researching the WIQ, the student was impressed with its psychometric properties, its ease of administration and scoring, and its history of

comprehensively evaluating the practice of clinical social work.

PROCESS EVALUATION

As has been noted, the primary evaluation of process occurred via weekly supervisory sessions between the student and Prof. Roy. During these meetings, the group sessions were explored in depth with particular focus guided by the student's concerns and/or issues. Taped group sessions were randomly watched and evaluated, and therapeutic plans for upcoming sessions were discussed. The supervisory meetings proved to be a critical dimension to the process evaluation of the group as well as to the level at which the student was able to embrace the learning experience.

The evaluation continued at other process levels including the student's own viewing of weekly taped sessions, the student's detailed recording practices, and the student's routine process log. It could be estimated that the student spent a minimum of four hours following each group session reviewing the taped sessions. This included note-taking. It could also be estimated that the student spent a minimum of eight hours following each group session accomplishing the task of adequate recording. This two-tired activity involved maintaining the recording standards of the filing system at the P.S.C., as well as accomplishing

the student's individual and academic need for accurate recall and process information. The student began to maintain a process log at the initial stage of recruitment making it impossible to even estimate the amount of time devoted to the activity. The log became a useful summary, detailing the student's feelings and emotional experiences as additional sources of information enriching the process evaluation of the practicum experience.

OUTCOME EVALUATION

As it has been stated, the outcome was primarily evaluated using the Waring Intimacy Questionnaire (WIQ) in a pre and posttest format. The pretest instrument was administered to each participant following the screening interview. The posttest instrument was administered to each participant following the termination of the group. The scoring was completed once the intervention was over and the pre and posttest instruments had been accumulated. All the research was gathered, scored and analysed by the student/therapist. Every reasonable attention was given to issues of confidentiality. The raw data were identified by a coded number system, the key to which was stored in a separate, locked cabinet.

WIQ RESULTS

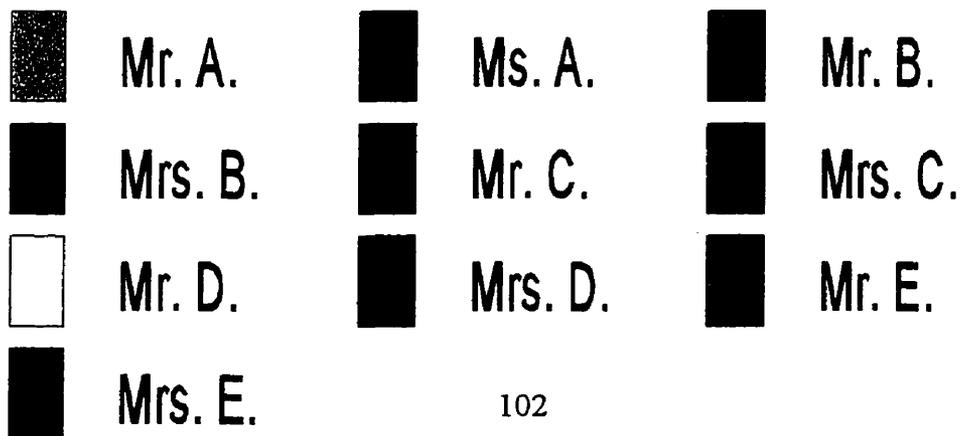
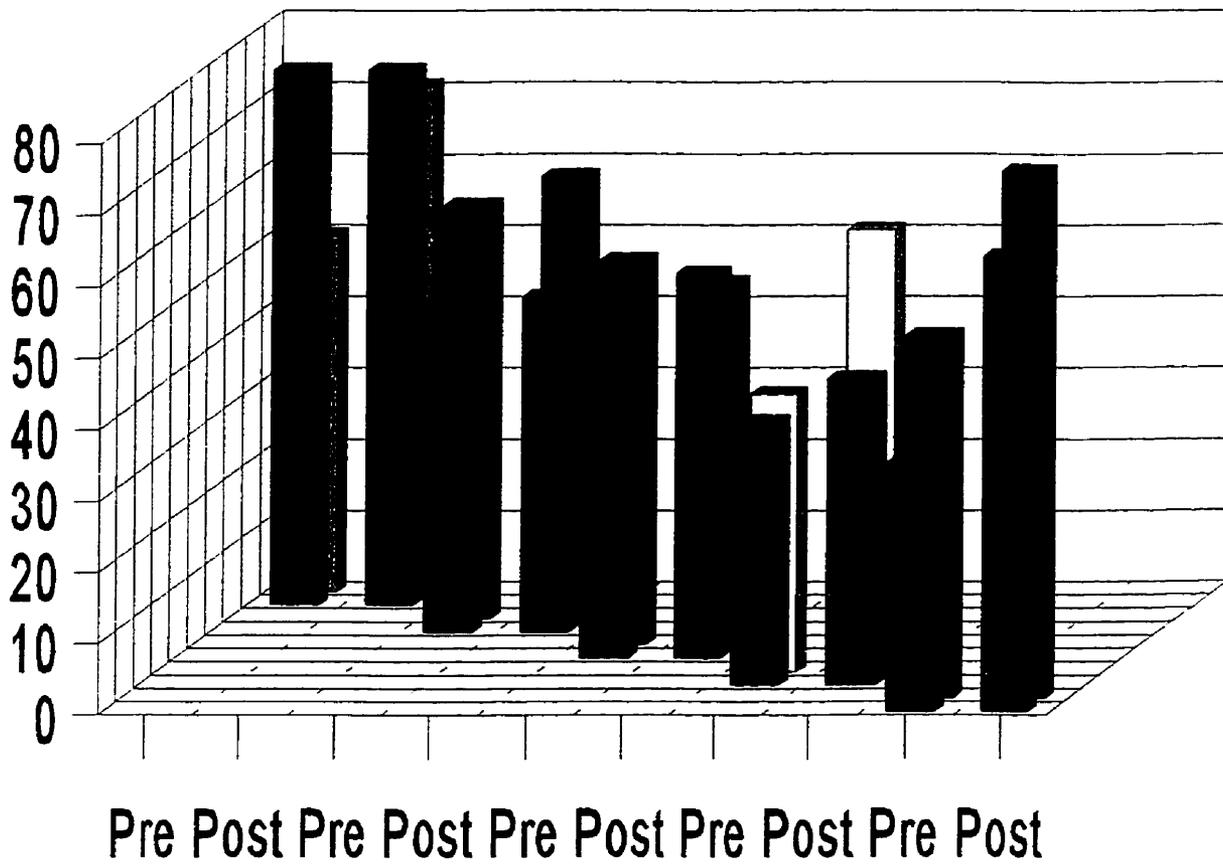
The student was able to evaluate WIQ pre-posttest scores for all ten of the group participants (see figure 2). The scoring protocols were straightforward and easy to compute. When evaluated within their couple systems, four of the five couples experienced an improvement as indicated by a higher posttest Total Intimacy score. The fifth couple (Mr. & Mrs.C.) maintained the same pre-posttest Total Intimacy Score. The interpretation of these results suggests that the couples intimacy group was an effective treatment strategy.

MR. & MS. A. The WIQ's Total Intimacy scores indicate that the A.'s experienced an improvement in their overall level of intimate connectedness. Mr.A.'s pretest score of 50 increased to 71, for a total positive difference of 21. Ms.A.'s pretest score of 75 remained at 75. This analysis matches the student's perception that Mr.& Ms.A. differed in their level of involvement in the group sessions and activities. It can be argued that as a dyadic system the improvement of Mr.A.'s Total Intimacy score would necessarily improve the overall degree of their relationship intimacy (see Table 1).

Mr. & Mrs. B. The WIQ's Total Intimacy scores indicate that the B.'s experienced an improvement in their overall level of intimate connectedness. Mr.B.'s pretest score of 58 increased to 62, for a positive difference of 4.

Figure 2:

WIIQ SCORES



Mrs.B.'s pretest score of 44 increased to 47, for a positive difference of 3. This analysis fits with the student's expectation that, although the scores indicate positive growth and change, the group represents only a beginning of the therapeutic work that needs to occur between the partners in this couple (see Table 2).

Mr. & Mrs. C. The WIQ's Total Intimacy scores indicate that the C.'s did not experience an improvement in their overall level of intimate connectedness. Mr.C.'s pretest score of 54 decreased to 51, for a negative difference of 3. Mrs.C.'s pretest score of 51 increased to 54, for a positive increase of 3. Taken together, it would appear as though this couple failed to benefit from the experience of the treatment intervention. This would not fit with the student's perception. Mr.C. appears to be the only group participant whose Total Intimacy score was lower at the posttest evaluation. At the same time, when evaluated at a process level, Mr.C.'s interactions were consistently seen to be meaningful and growth-oriented. Throughout the progression of the group, Mr. & Mrs. C. became increasingly open to sharing their high level of on-going identity and cooperative tension. Thus, it was the student's perception that, as a couple, the C.'s were being forced to acknowledge some hard truths about

WIQ SCORES

Table 1: Couple A

<i>Subscales</i>	PRETEST		POSTTEST	
	<i>Mr. A</i>	<i>Ms. A</i>	<i>Mr. A</i>	<i>Ms. A</i>
<i>Conflict Res.</i>	9	9	9	10
<i>Affection</i>	5	8	7	8
<i>Cohesion</i>	3	7	5	8
<i>Sexuality</i>	4	4	7	7
<i>Identity</i>	9	9	8	6
<i>Comp.</i>	6	9	8	9
<i>Autonomy</i>	8	9	10	9
<i>Expr.</i>	4	10	10	9
Total Intimacy	50	75	71	75

Table 2: Couple B

<i>Subscales</i>	PRETEST		POSTTEST	
	<i>Mr. B</i>	<i>Mrs. B</i>	<i>Mr. B</i>	<i>Mrs. B</i>
<i>Conflict Res.</i>	8	4	8	5
<i>Affection</i>	7	5	7	5
<i>Cohesion</i>	8	8	9	8
<i>Sexuality</i>	5	4	7	5
<i>Identity</i>	9	3	8	4
<i>Comp.</i>	8	6	8	6
<i>Autonomy</i>	4	6	5	4
<i>Expr.</i>	8	7	9	8
Total Intimacy	58	44	62	47

their relationship (see Table 3).

Mr. & Mrs. D. The WIQ's Total Intimacy scores indicate that the D.'s experienced a definite improvement in their overall level of intimate connectedness. Mr.D.'s pretest score of 39 increased to 62, for a positive difference of 23. Mrs.D.'s pretest score of 37 increased to 43, for a positive difference of 6. This analysis corresponds with the student's assessment. The D.'s were very invested in the group process and it was consistently obvious that they were connecting at both an individual and a dyadic level. Their positive growth and change was the most readily observable of all the five couples (see Table 4).

Mr. & Mrs. E. The WIQ's Total Intimacy scores indicate that the E.'s experienced a distinct improvement in their overall level of intimate connectedness. Mr.E.'s pretest score of 51 increased to 74, for a positive difference of 23. Mrs.E.'s pretest score of 35 increased to 64, for a positive difference of 29. These results correspond with the student's assessment. The E.'s were extremely involved and engaged in the group process. As the sessions progressed it became apparent that they were gaining insight into a significant amount of change that had already occurred between them. The group validated and cemented their relational struggles and successes (see Table 5).

WIQ SCORES

Table 3: Couple C

<i>Subscales</i>	PRETEST		POSTTEST	
	<i>Mr. C</i>	<i>Mrs. C</i>	<i>Mr. C</i>	<i>Mrs. C</i>
<i>Conflict Res.</i>	4	6	4	6
<i>Affection</i>	6	7	6	6
<i>Cohesion</i>	6	2	6	3
<i>Sexuality</i>	5	6	5	4
<i>Identity</i>	9	10	9	10
<i>Comp.</i>	6	4	6	5
<i>Autonomy</i>	8	5	8	9
<i>Expr.</i>	9	7	9	9
Total Intimacy	54	51	51	54

Table 4: Couple D

<i>Subscales</i>	PRETEST		POSTTEST	
	<i>Mr. D</i>	<i>Mrs. D</i>	<i>Mr. D</i>	<i>Mrs. D</i>
<i>Conflict Res.</i>	3	1	5	4
<i>Affection</i>	4	2	8	5
<i>Cohesion</i>	7	7	9	7
<i>Sexuality</i>	5	5	5	5
<i>Identity</i>	2	9	8	8
<i>Comp.</i>	2	1	7	2
<i>Autonomy</i>	8	5	7	4
<i>Expr.</i>	5	6	7	7
Total Intimacy	39	37	62	43

WIQ SCORES

Table 5: Couple E

<i>Subscales</i>	PRETEST		POSTTEST	
	<i>Mr. E.</i>	<i>Mrs. E.</i>	<i>Mr. E.</i>	<i>Mrs. E.</i>
<i>Conflict Res.</i>	2	1	10	8
<i>Affection</i>	8	7	9	8
<i>Cohesion</i>	8	4	8	8
<i>Sexuality</i>	9	4	9	6
<i>Identity</i>	10	3	10	4
<i>Comp.</i>	5	6	8	9
<i>Autonomy</i>	7	4	8	6
<i>Expr.</i>	2	5	8	10
Total Intimacy	51	35	74	64

CLIENT FEEDBACK FORM

The voluntary feedback form was utilized to gather an additional source of outcome information. Its design consisted of six open-ended questions and one question that employed a five-point Likert scale. The student, in consultation with Professor Roy, constructed the measurement tool (see Appendix C). The feedback form was distributed to each participant following the termination of the group and the completion of the posttest instrument. The forms were gathered and analysed by the student. Of a total ten possible forms, eight were completed and returned. Of that total, three respondents chose to identify themselves; five chose to remain anonymous. The forms were somewhat more complicated to evaluate due to the nature of open-ended questions.

Question One: Did the group help you to deal with your couple issues more effectively? All eight respondents answered affirmatively. The following is an example of some of the comments (all were positive);

- “. . . the group allowed me to have more insight into how other couples deal with issues, in turn creating more options for my own issues.”,

- “. . . the group helped us conquer some of our inhibitions and develop our communication skills.”, and,

- “. . . to relax, try to talk and listen calmly.”.

Question Two: *Do you feel more 'connected' to your partner than you did before participating in the group?* Seven of the respondents answered affirmatively and one respondent indicated both “yes” and “no”. The following is an example of some of the comments (all had positive components);

- “ . . . during and after some of the sessions we would argue and disagree, but overall it did help our connectedness.”,

- “ . . . feel the same amount of connection to my partner.”, and,

- “ . . . definitely, the communication skills have helped considerably.”.

Question Three: *Would you recommend this group to another couple who was interested in working on issues related to 'intimacy'?* All eight respondents answered affirmatively. The following is an example of some of their comments (all were positive);

- “ . . . I already have, to my best friend.”,

- “I would! I think this group would be very beneficial to a couple with issues related to intimacy.”, and

- “ . . . I would recommend this group for relationship building.”.

Question Four: *How would you rate the overall skill of the group facilitator?*

As can be seen, all responses fell within the ‘good’, the ‘very good’ or the ‘excellent’ category; six respondents rated the therapist’s skill to be ‘very good’.

Question Five: *What did you find the most helpful about the group experience?* All eight respondents listed one or two things that they found to be helpful. The following is a synopsis of their responses;

- the experience of admitting a dysfunctional problem-solving strategy,
- the listening and conflict resolution skills,
- the group discussions and sharing of common couple experiences,
- the weekly topics, and
- the relationship model.

Question Six: *What did you find the least helpful about the group experience?*

Six of the eight respondents responded to this question. The following is a synopsis;

- would have liked more instruction and lecturing,
- session time too short (many made a variation of this comment),
- participants who talked too much, revealed too much, or, rambled on, and
- too little focus on issues of sexual intimacy.

Question Seven: *How many of the sessions did you attend? If you attended less than the full eight, please explain the reason(s). Be sure to indicate any specifics about the group that might have made it easier for you to attend all of the eight sessions.* Two of the respondents had attended all eight sessions

and two of the respondents chose to leave this question blank. The remaining four respondents offered the following comments/suggestions;

- “ . . . time and location were fine, I didn’t account for all the academic pressures.”,

- “ . . . would have been more convenient at a central location.”,

- “ . . . missed because of a sick child and nothing could have changed that.”,
and

- “ . . . nothing to do with the group, probably just my time management skills.”.

Unfortunately, the responses for this final question offer little insight into the reality of the sporadic pattern of participant attendance observed throughout the duration of the group. The entire issue of attendance will be dealt with subsequently.

PARTICIPANT ATTENDANCE

The issue of participant attendance frequently arose during clinical supervision; the pattern was experienced as disconcerting. The student had clearly stipulated, during the screening interview, that full attendance was critical. All five couples agreed, stating that they understood how it was an issue of respect (for fellow group participants) and group process (see Table 6).

ATTENDANCE CHART

Table 6:

	Couple A	Couple B	Couple C	Couple D	Couple E	Total Attendance
Session One	✓	✓	✓	✓	✓	12*
Session Two	✓	✓	X	✓	✓	8
Session Three	✓	✓	✓	✓	✓	10
Session Four	X	X	✓	✓	✓	6
Session Five	X	✓	X	✓	✓	6
Session Six	✓	X	✓	✓	✓	8
Session Seven	X	X	✓	✓	✓	6
Session Eight	X	X	✓	✓	✓	6

Key:

✓ present

X absent

*The total includes the sixth couple who withdrew following session one.

Attended All Eight Sessions: Mr. & Mrs. D. and Mr. & Mrs. E. attended every session.

Attended Six Sessions: Mr. & Mrs. C. missed two sessions, one due to a fight and the other due to a pre-scheduled business trip (a fact they informed the student of prior to the first session).

Attended Four Sessions: Mr. & Ms. A. missed four sessions. As University students, they both seemed to have some difficulty estimating the time needed to meet academic requirements/deadlines. At the same time, it is probable that one or both of them were exhibiting avoidance behaviors. Mr.A. became very involved in the group process, at times sharing more than Ms.A. was comfortable with (as indicated by her body language and facial expression). Ms.A. was always the one to contact the student/therapist with the information that they would be absent. It is the student's opinion that some of the four absences were Ms.A.'s way of avoiding the intensity of the group experience; her way of maintaining the distance between themselves and the other couples in the group. As has been evaluated, Mr.A.'s Total Intimacy score increased significantly from pre to posttesting. Ms.A.'s Total Intimacy score remained exactly the same. Both Mr. & Mrs.A. responded very positively in their feedback form evaluations. It is likely that the A.'s would have both

experienced an increased growth had they attended more than only half of the group sessions. However, it should also be acknowledged that attending group sessions must have been a very stressful experience for both of them and particularly for Ms.A. In spite of the challenges they felt around attending the group sessions, both Mr. & Ms.A. evaluated the couples group to be a positive experience.

Attended Four Sessions: Mr. & Mrs. B. also missed four sessions. It is probable that events that occurred during session five became an obstacle that overwhelmed their couple system. By the conclusion of that session the student/therapist was concerned about the volume of very personal information that they had both shared. Mrs.B. provided details about her history as a sexual abuse survivor and Mr.B. provided information about a period in his life when he was acutely suicidal. Their sharing had been completely voluntary and unsolicited; it appeared to be a cathartic experience for them. The group was respectful and supportive. And yet, the B.'s were absent for the following three group sessions. The student was only successful at establishing contact with them following group termination (they had been difficult to contact due to a residential move). While they completed the posttest instrument, they did not complete the feedback form, nor did they offer an explanation for the absences.

If the student's assessment is presumed to be accurate, Mr. & Mrs. B. became overwhelmed during the days and weeks that followed session five. In an attempt to restore equilibrium to their relationship system, they chose to discontinue group attendance. As has been evaluated, both Mr. & Mrs. B.'s Total Intimacy scores had increased at the stage of posttesting. This suggests that, even though they elected to miss half of the group sessions, the treatment intervention was effective.

Having illuminated the specific issues surrounding group attendance rates, it seems reasonable to presume that qualitatively, the overall intervention *might* have been better had attendance rates been more consistent. It is also reasonable to suggest that the volume of material presented and processed *might* have been higher (utilizing time spent informing couples about information or assignments that they had missed from the previous week).

From a completely different point of view, it might also seem reasonable to speculate that the sporadic attendance pattern was functional to the group process in that it helped to balance a group membership that was too large. The student had known, following session one, that twelve participants (six couples) was an unmanageable size. When the sixth couple had had to withdraw, the student immediately felt more comfortable with the remaining size of ten

participants. But, perhaps the total of ten participants (five couples) was less than optimally functional. In reviewing the taped sessions, it is visually apparent that each of the three most impactful sessions had only three couples in attendance (sessions four, five and seven).

LEARNING OBJECTIVES

The final section of this evaluation is concerned with issues relating to the degree with which the utilization of the Metz and Weiss model enabled the student to accomplish the learning objectives of the practicum experience.

The first core objective was to increase the clinical skill of the student. Throughout the progression of the group, the student encountered struggles that typified a learning curve experience. While some of the work felt natural and comfortable, other parts felt awkward or difficult. The area of the most intense skill-building surrounded the student's struggle to facilitate group interaction, rather than to engage individual participants in a process of couples therapy. Reinforced by supervisory input, the student became very conscious of her role as a couples group facilitator, focusing particular attention on how that role differed from the clinical skills of a marriage and family therapist (the student's employment capacity). By session four the student was beginning to grasp some

of the new skills as a group facilitator, and by the end of session eight, observable skill-building had occurred. The student did not have pre-existing clinical skill in the area of couples group therapy, thus, the objectives of the first core goal were achieved.

The second core objective was to find a meaningful way to incorporate the research and learning that was done into an effective model of clinical application. Throughout the progression of the group the student became acutely aware of both weaknesses and strengths inherent in the clinical application of the Metz and Weiss model. As was done in chapter five of this report, an overarching critique suggests that the therapeutic interventions were effective. At a more subjective level, the opinion has also been stated that the Metz and Weiss model, most particularly in its revised form, is worthy of clinical replication. As a final evaluative statement, it should be emphasized that the research and learning that was undertaken to fulfill the requirements of the primary and secondary literature review made a strong academic and clinical contribution to the positive learning experience that the student was able to achieve vis-a-vis the practicum.

Chapter VI - The Conclusion

The conclusion of this practicum report symbolizes the end of the lengthy process of academic study, research and clinical application that was undertaken by the student. They also serve as commentary on the progress made towards learning goals, and on the general observations of the student.

PROGRESS TOWARD LEARNING GOALS

The student's core learning objectives were evaluated in chapter five. At this time it becomes cogent to reflect on the progress made towards the student's more specific learning goals (as identified in chapter one).

It may be argued that the student was unsuccessful when it came to orienting the treatment intervention around the topic of sexual issue and/or dysfunction. There were several reasons for this:

- the inability to organize a practicum around couples sex and marital therapy due to recruitment difficulties,
- the decision to re-design the practicum so as to minimize recruitment difficulties,
- the strategic decision to substitute 'intimacy' for 'sexual issues and/or dysfunctions' when advertising for potential participants, and then again when

conducting screening interviews, and

- the successful completion of a couples intimacy group.

A central issue is the fact that the pressures of academic success (as recognized by the awarding of the Master of Social Work degree) add an element of risk. That is, financial and career obligations pressure students to complete their degree requirements as expediently as possible. Remaining with a topic area due to interest is often a risk that cannot be chosen. In this case, the student broadened her topic area and lost the opportunity to focus on the treatment of sexual issues and/or dysfunctions within a clinical setting. In exchange, she accessed the opportunity to facilitate a couples intimacy group, learning more about the facets of intimacy and also about the skills of therapeutic facilitation.

It should be acknowledged that the couples intimacy group did explore presenting issues related to sexual performance, sexual difference, sexual pressure and limited sexual libido. The topic of sex and sexual functioning was discussed at various intervals throughout sessions three-to-eight.

It may also be argued that the student was successful when it came to the goal of integrating a systemic perspective within a feminist framework. As has been discussed elsewhere, the Metz and Weiss model was amenable to a high degree of feminist theory and practice. The student was particularly conscious

of issues involving power between couples and whenever possible attempted to lessen the disparities. The student was also particularly careful to remain flexible and responsive in the role of group facilitator. At a systemic level, 'the relationship model' was a particularly useful resource and learning guide (as provided by the Metz and Weiss model). The student frequently relied on concepts that explained issues in terms of family versus individual functioning.

It should lastly be stated that the student satisfactorily completed the proposed clinical intervention; the student satisfactorily facilitated an eight-session couples intimacy group. Of the total ten participants, eight were evaluated to have achieved a higher level of emotional connectedness following completion of the couples therapy group. And, the student's existing clinical skill level was successfully expanded by way of functioning (and receiving guidance and supervision) as a couples group therapist/facilitator.

OBSERVATIONS OF THE STUDENT

At the stage of near completion, the student would make the following brief comments.

The study and research component of the practicum report was at times tedious and labour-intensive; at times exciting and rejuvenating. The process of

composing and orchestrating the couples group was at times stressful and anxiety-provoking; at times uplifting and energizing. The task of organizing, analyzing and writing the pages of the practicum report could also be referred to with a number of adjectives. The only component of this academic endeavor that was without negative ramification was the clinical work. The mandate to gather together five relatively homogeneous couples was powerful. The opportunity to impact and enrich their lives was exhilarating.

The unique challenge of this practicum was the evolutionary nature of the treatment process; recognizing a feminist perspective throughout the treatment and then analysing the different ways that systemic and behavioral techniques became valid and useful. In the student's perception, the entire project was a resounding success.

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APPENDIX A

Couples Group Therapy Format

Focus/Process	Task Assignments
Session 1: <i>Introduction</i> Group Norms/Rules Relationship Model	Journalling - Beginning & Goal Metaphors - Individual Relaxation
Session 2: <i>Communication I</i> Couples Histories and Metaphors Structured Communication Skills	Relationship Time-Line Paraphrasing (audiotaped)
Session 3: <i>Communication II</i> Therapist-Guided Relaxation Training Structured Communication Skills Relationship Histories(Time-Lines)	Marital Beliefs Checklist Couples Relaxation
Session 4: <i>Relationship Identity</i> Relationship Beliefs: Expectations/Hopes/Values Styles of Behavior	The Powergram
Session 5: <i>Relationship Cooperation</i> Issues Related to Gender & Power Unresolved Anger & Power Issues	The Caring Days Technique
Session 6: <i>Relationship Intimacy</i> Feelings, Anger Management Definition of Emotional & Physical Intimacy	Review Communication Skills
Session 7: <i>Relationship Skills/Integration</i> Physical Intimacy Importance of Caring	Journalling - Beginning & Goal Metaphors - Evaluate Change
Session 8: <i>Termination</i> Dynamics of Change Metaphor Stories	Special Date

APPENDIX B

University of Manitoba - Fort Garry Campus - Psychological Services
Centre (P.S.C.) Building

COUPLES GROUP - SCHEDULE

Session One - Wednesday, October 21, 1998

Session Two - Wednesday, October 28, 1998

Session Three - Wednesday, November 4, 1998

No Session - REMEMBRANCE DAY - November 11, 1998

Session Four - November 18, 1998

Session Five - November 25, 1998

Session Six - December 2, 1998

Session Seven - December 9, 1998

Session Eight - December 16, 1998

1) CHECK-IN

**2) SKILL-BUILDING: STRUCTURED COMMUNICATION
ACTIVE LISTENING**

3) COUPLE HISTORIES

**4) TASK ASSIGNMENT - REVIEW OF PREVIOUS ASSIGNMENT
- NEW ASSIGNMENT**

1) CHECK-IN:

2) SKILL-BUILDING: Communication Skills II

3) RELATIONSHIP HISTORIES: Relationship Time-Line

4) TASK ASSIGNMENT: Couple Relaxation

1) CHECK-IN:

2) SKILL-BUILDING: Relationship Identity
- expectations/hopes/dreams

3) INDIVIDUAL & COUPLES RELAXATION:

4) TASK ASSIGNMENT:
- the powergram

5) CHECK-OUT:

1) CHECK-IN:

2) RELAXATION TECHNIQUE: Individual & Couple

**3) SKILL-BUILDING: Relationship Cooperation
- the powergram & decision-making**

4) TASK ASSIGNMENT:

5) CHECK-OUT:

1) CHECK-IN:

- 2) SKILL-BUILDING: The Powergram**
- decision-making
 - issues related to gender & power

3) TASK ASSIGNMENT:

4) CHECK-OUT:

1) CHECK-IN:

- 2) SKILL-BUILDING: Relationship Intimacy**
- the role of feelings
- passion and romance

3) THE CARING DAYS TECHNIQUE

- 4) TASK ASSIGNMENT:**
- re-visit beginning & goal metaphors (journal)

5) CHECK-OUT:

1) CHECK-IN:

2) SKILL-BUILDING: Core Developmental Tasks
- the goal of relationship intimacy

3) METAPHORS

4) FINAL TASK -
-maintenance plan/follow-up plan
-special date

5) CHECK-OUT/CLOSURE

PARAPHRASING

Paraphrasing is when you restate the content and the emotion that you heard in the original message. A good paraphrase includes both the **facts** and the **feelings**.

When we tell someone our telephone number or street address, we usually repeat it to make sure that they have heard the correct message. With other types of messages we tend to assume that the message is heard and understood the way that we intended for it to be heard and understood.

Paraphrasing is one way to make sure that you have understood the intended message. It has several purposes:

- 1) It provides a climate in which the speaker is more likely to feel understood.
- 2) It allows you to check to make sure that you understand the speaker's intent.
- 3) It allows the speaker to correct you if you have misunderstood something, thereby preventing miscommunication.
- 4) It allows the speaker to restate feelings and ideas in a way that more correctly expresses what she/he is trying to communicate.
- 5) It provides you the opportunity to focus on understanding the other person rather than thinking of your own response.
- 6) It conveys to the speaker that you are interested in her or him and in what she/he has to say. This often encourages the person to express themselves openly.

REMEMBER - FACTS AND FEELINGS!!

PARAPHRASING EXERCISE - OCTOBER 28, 1998

Over the past week your partner has seemed withdrawn and aloof and you have wondered if something is bothering him/her. After supper, you leave the dirty dishes stacked by the sink even though it is your turn to clean them up. A short while later your partner asks if you are planning to do the dishes. You say, "Yeah, in a while." He/she pauses and responds

Paraphrase each of the following statements. Remember to include the facts and the **feelings**.

1) ". . . . you know, I don't know if I can handles this anymore. I'm tired at the end of the day, and I don't need to be responsible for everything."

2) ". . . . you never take me seriously."

3) ". . . . everytime I get upset you ignore my feelings."

THE POWERGRAM

The following is a list of sixteen areas in which couples commonly make decisions:

- a. Where the couple lives.
- b. What job the man takes.
- c. How many hours the man works.
- d. Whether the woman works.
- e. What job the woman takes.
- f. How many hours the woman works.
- g. Number of children in the family.
- h. When to praise or punish the children.
- i. How much time to spend with the children.
- j. When to have social contacts with friends.
- k. When to have social contacts with in-laws and relatives.
- l. When to have sex.
- m. How to have sex.
- n. How to spend money.
- o. How and when to pursue personal interests.
- p. Whether to attend church, and if so, which church to attend.

You may cross off any that do not apply, and, you may add additional items, (ie., how to decide where to go on vacations, how to decide to invest money, etc.).

PART ONE:

Rank order the most important areas in your relationship (at the present time). Start with the most important. Do this as a couple.

- 1.
- 2.
- 3.
- 4.
- 5.

PART TWO:

Then, review the list of five areas answering the question - at this time in your relationship, who usually has the responsibility for making decisions in each area? Do this individually.

- a. Almost always the man.
- b. The man, after consulting the woman.
- c. Both share equally.
- d. The woman, after consulting the man.
- e. Almost always the woman.

PART THREE:

Once again, review the list of five areas answering the following question - at this time in your relationship, how do you think decision-making authority should be divided? Do this individually.

- a. Almost always the man.
- b. The man, after consulting the woman.
- c. Both share equally.
- d. The woman, after consulting the man.
- e. Almost always the woman.

THE CARING DAYS TECHNIQUE

Both partners are to make a list answering the following question: Exactly what would you like your partner to do as a means of showing that he or she cares for you? Each list should be a minimum of fifteen items and should follow these guidelines:

1. Each request should be positive.
2. Each request should be specific.
3. Each request should be a 'small' behavior that can be done at least once daily.
4. All requests should not have been the subject of a recent conflict.

When both partners have completed the lists, they should be exchanged and clarified. That is, each request should be discussed, (the partner making the request should state exactly what, when, and how, he or she would like the other to respond).

THE CARING DAYS TECHNIQUE

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.

CONSENT FORM

As you are aware, Myrna Friedenberg will be facilitating a Couples Group as the final component of her Masters of Social Work degree requirements. The group will focus on intimacy issues and will begin on Wednesday, October 21, 1998. Each two-hour session will involve a psycho-education presentation, an opportunity for group interaction and a weekly task or assignment. It is expected that participation in the eight-week program will enable couples to establish a deepened sense of intimate connection with one another.

Participation in the group is completely voluntary; you may choose to withdraw at any time without recrimination. All of the information that you provide, in the context of the group, is confidential. The sessions will be video-taped. The tapes will be used for evaluation purposes **only**, your name will never appear on the actual tapes and the tapes will be completely destroyed by April 30, 1999. Professor R. Roy may attend one or more of the group sessions, at his discretion, and solely for evaluative purposes.

A summary of the results of this practicum will be made available to all interested participants. If you have additional concerns or questions please contact Myrna Friedenberg at 339-8966 or 947-1401.

Date: _____ Signature: _____

Witness: _____

APPENDIX C

COUPLES GROUP - FEEDBACK FORM

1. Did the group help you to deal with your couple issues more effectively?

2. Do you feel more "connected" to your partner than you did before participating in the group? _____

3. Would you recommend this group to another couple who was interested in working on issues related to "intimacy"? _____

4. How would you rate the overall skill of the group facilitator?

Poor	Average	Good	Very Good	Excellent
1	2	3	4	5

5. What did you find the most helpful about the group experience? _____

6. What did you find the least helpful about the group experience? _____

7. How many of the sessions did you attend? _____ If you attended less than the full eight sessions, please explain the reason(s). Be sure to indicate any specifics about the group that might have made it easier for you to attend all of the eight sessions, (ie., the location, the time of day, the issues being explored, etc.). _____
