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THERAPY WITH PARTNERS OF DETERIORATED MARRIAGES

BY

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CHAPTER I

INTRODUCTION

In this report I would like to present a practicum in the area of marital counselling. I propose an interventive program that would include the following elements: The use of conjoint and group techniques; Planned Short Term Therapy; Task Centered Therapy; Communication Skill Development; and the use of selected testing procedures. Schematically, it could be represented as follows:

First Session	Second, Third, Fourth Sessions	Fifth-Eighth Sessions	Ninth-Tenth Sessions	Third Month After
Intake	Task-Centered Therapy	Communication Skills	Termination Phase	
(Conjoint)	(Conjoint)	(Group)	(Conjoint	
Adjustment Scale		Pre-Post Communication Questionnaire	Adjustment Scale	Adjustment Scale

The purpose is to alleviate an immediate and specific problem and to enhance the ability of the couple to generalize their acquired skills to other areas in their life. This last consideration is crucial for it is the intent to afford them the opportunity of becoming more independent. A fundamental value undergirding this approach is that the concept of "living

happily ever after" is an inaccurate belief and unrealistically utopian. Consequently, the interventive thrust would be in the direction of heightening skills that would aid the couple in tracking the ever changing landscape of their relationship.

There will be five couples in each sequence and it is planned that each couple would go through the adjustment scale three times--once at the beginning; once during the tenth session and once three months later. In addition to the Dyadic Adjustment Scale, other measuring devices will be used. These are: A communication pre-workshop questionnaire and a communication post-workshop questionnaire. There will be at least two and possibly three sequences. As noted above, each sequence will be followed up by a three month measure.

CHAPTER II

METHODOLOGY

As noted, I propose to conduct a practicum that incorporates the following elements: Conjoint and Group techniques; Planned Short Term Therapy; Task Centered Therapy; and Communication Skills Development.

A. Conjoint Marital Therapy

Intervention in the practicum will be structured within the mode of conjoint marital therapy and group processes. Later in the presentation we will discuss the use of groups.

When Peter Martin[1] takes up his discussion on Conjoint Marital Therapy he uses Jackson's definition of the approach:

> "...a therapeutic method in which both marital partners are seen together by the same therapist or co-therapists, one male and one female, and in which the signaling symptom or condition is viewed by the therapist as a comment on the dysfunction of their interactional system (Jackson and Weakland, 1961)." (2)

The same author cites a number of advantages that accrue from this method. Among them he includes the fact that the therapist is afforded an opportunity to observe marital behaviour; that it encourages a dialogue between the mates and it is efficient, economical and convenient. Finally, it does present at least the possibility of providing a

co-therapist.(3) Other writers have also enumerated the benefits of conjoint material therapy. O'Leary and Turkewitz(4), for instance, feel that it provides a forum for "directed practice on new skills", that both spouses will have some control over possible changes and, as a corollary, are more likely to support the changes that they agree to.(5) It is important to note that there are conditions which would contrindicate the use of this approach. For Martin such conditions are: "When one spouse has a severe psychosis necessitating separation and hospitalization"; "excessive narcisstic attitude of one mate whose problems demand individual therapy" or "an unexposable secret in one mate".(6)

Conjoint marital counselling is seen to be an effective method. Evidence for this comes, in part, from an article published in 1976 by J. Richard Cookerly.(7) In the article Cookerly evaluates various approaches to marriage counselling and concludes that "Conjoint interview marriage counselling was shown to produce the best allover results in all four studies, although it has weaknesses for those who become divorced."(8) O'Leary and Turkewitz (1978) whom we have already referred to, make a supporting comment when they cite an unpublished review by Gurman and Kniskern in which these authors conclude that conjoint therapy is "clearly more effective."(9)

My own previous experience with conjoint marital counselling has been largely positive and leads me to subscribe to

the points made in its favour. I would add that it tends to concretize the notion that the relationship problems have to be embraced by both partners. Finally, it is, in my experience, an efficient avenue of conveying the message that we are not here to "fix" anyone.

B. Planned Short Term Therapy

Short Term Therapy is mentioned in numerous places throughout the literature. Elizabeth Kerns(10) talks about "planned short-term therapy" in which the worker and client develop a mutual agreement to work toward a goal. This agreement is expressed in the form of a contract. Once the contract has been worked on, client and worker can evaluate and either terminate or renegotiate. Shaw, Blumenfeld and Senf(11) see it as highly goal focused concentrating on the client's immediate problem. There is a time limitation and this time limitation "mobilized anxiety", promotes active client participation, stimulates the worker toward an early diagnosis and decreases dependence. Another source, Blanca Rosenberg(12) talks about a specific goal within a specific time frame. She sees it as providing an impetus to worker and client to grapple with the issues. One of the points that Rosenberg makes is that the worker must carry a high profile in this type of therapy. There is, then, an active participation by the worker requiring a more directive style. She also touches on the fact that short term therapy decreases dependency.

Finally, termination is seen as an issue that is dealt with both at the very beginning of the work and throughout the process.

Planned short-term therapy is, therefore, a modality that is characterized by a specific time frame (5-10 sessions); a clearly focused goal; a contract; a high level of worker participation; and concentration on the client's immediate problem.

The effectiveness of the approach has been attested to by a number of authors. One, already referred to, explored the effectiveness of short term therapy after suffering a heart attack which placed severe limitations on his work. He tested the approach emphasizing such things as the counsellor's facilitating role, action oriented counselling and two hour sessions. He concluded saying:

> "As already indicated, the writer has himself been convinced by experiments that his new approaches are more effective than the one which they replaced. Looking back over some 35 years of professional marriage counselling, he is aware that he wasted a great deal of time (his own and that of his clients) working doggedly on situations which offered little room for improvement and by allowing clients to go on talking while they avoided action. He believes that the counselling he has done under the severe limitations imposed on him during the past three years has, because of his adoption of more streamlined approaches, actually been more effective than previous efforts." (13)

Other authors over the years in various settings have delineated the effectiveness of short term therapy. Blumenfeld, Shaw and Senf spoke to the issue of effectiveness in their study on the use of the method in a child guidance clinic.

> "The results of this program demonstrate that with proper case selection short treatment is an efficacious type of intervention that produces durable benefits. The program was characterised by a high degree of patient and worker satisfaction. Termination produced no special difficulties." (14)

Kerns in 1970 reported on the use of this method with adolescents and reported that it produced several positive effects. The short term therapy with its time limits muted the adolescent's fear of being abnormal which a referral to an agency suggests. The energy that would ordinarily be directed toward dealing with this fear can now be channelled into working on his problem. Kerns also notes that it forces the worker to use their diagnostic and planning skills with more intensity. Finally, she describes the fact that the approach "defines more realistically" the kind of help that the worker can give.(15) In 1973 Oxley relates the use of short term therapy with student couples. She argues for the approach on the basis that a) it fits in with the type of service provided by her agency, b) that research has substantiated its usefullness, and c) that she herself had had

positive experiences with the approach.(16) She concludes her report by informing us that she had "substantial gains" and refers to it as an "economical method" which offers help "when couples are strongly motivated to change".(17) Earlier in our presentation we had touched on Rosenberg's 1975 article. She summarizes by saying that the approach can be utilized with "individuals", "couples" and "families" who are undergoing developmental crises.(18) In an article published in 1976, Olson and Sprenkle talk about emerging trends in treating relationships. They state:

> "Therapists are employing short term contracts rather than open-ended treatment. Stimulated by the behavioural approaches and educational training programs, spurred by the desire for economy, and motivated by a sincere questioning of the excessive length of much treatment, more therapists are relying on fixed time contracts." (19)

A year earlier Beck published the findings of a survey done on research findings within the area of outcomes of marriage counselling. One of her conclusions is that:

> "...the details of the findings appear to favour the newer modalities that utilize more structure and simultaneously involve both husband and wife in direct communications exercises." (20)

Finally, in 1978 Lemon and Goldstein are making the point that there is a demand for short term therapy. This demand is based on financial savings, the need for accountability and the

tendency of clients to work on that which gives immediate relief.(21)

There is one final point to be made. From time to time in the various references that we have cited, the concept has emerged that this approach can only be used with a certain type of couple. We have seen that the couple should be well motivated; that the couple should be reasonably intelligent and that there should be an absence of psychopathology. In the light of these caveats the intent was to be selective in recruiting couples for the practicum. Accordingly, the couple will have to want to do something about their problem(s); they will have to be willing to engage in this kind of program, they will have to want to work hard and there will have to be no underlying pathology.

C. Task Centered Therapy

It is my proposal to operationalize the concept of short term therapy by utilizing a task centered approach to practice. The model was introduced in the early 1970's by Reid and Epstein(22) and has been recently revised.(23) The exposition of the model and its use in various settings including marital counselling is based on these two sources.

From the outset four important points are made about this system. First, it is a model of brief time limited casework. Second, there is an underlying practice theory. Third, there is a set of value premises. These value premises are two--that the client makes the decision as to what he wants to

work on; and that research knowledge is more important than knowledge acquired from other sources. Fourth, there is a body of empirical data supporting the theory and the model. This empirical data comes from studies made of short and long term casework which enable the authors to make the following generalizations: That recipients of short term treatment show as much improvement as recipients of long term treatment; that most improvement associated with long term treatment occurs shortly after treatment begins; and that most treatment turns out to be short term in any case.

The effort has been to make a system of practice as suited as possible to the typical demands of practice. Reid sees these demands as including the following: A recognition that a central function of social work is the alleviation of problems; a recognition that there is a growing demand for accountability; and a realization that social work often encounters persons who are poor, have low verbal skills, may not be motivated, and who are in need of a variety of skills. Reid stresses that there is a need today for demonstrably effective methods in social work; that there should be some way of saying that this particular intervention made a difference in this person's life.

When social workers deal with a situation they face a dilemma. That dilemma is this: Out of the multiplicity of theoretical perspectives from which they could view the problem, which one will be chosen? It is Reid's point that this dilemma is intensified by the fact that there is little

knowledge as to how or why they function. Or, indeed, if they function. Thus, he argues that there should be a close link between theory and "empirical events". The concept here is that theory should be capable of being tested against the realities of practice. To illustrate his point he uses the notion of "ego defenses" and the situation where a person may be in a crisis state but neither the observer nor the person himself can identify it. The point is that if the condition cannot be measured, how can the theory be tested? Thus, many of our theoretical concepts are educated guesses and should be viewed with caution. The task centered system then is an effort to provide practitioners with a framework that meets the demands of practice and is testable.

The theoretical base upon which the task centered system is constructed has been enlarged by a formulation about the nature and dynamics of psychosocial problems and the role of human action in their alleviation. Reid and his colleague Laura Epstein see a psychosocial problem as occuring in the following manner: a temporary breakdown in problem coping which sets in motion forces for change; these forces encourage a rapid reduction of the problem to tolerance levels at which time the possibility for change is lessened; this, in turn, makes it possible to say that short term treatment would be at least as efficacious as long term treatment. The essential function of task centered treatment is to help clients move forward with solutions to psychosocial problems that they define and hope to solve. The primary change agent then in the resolution of a

psychosocial problem which is defined as a difficulty involving distress over interpersonal or situational concerns in the client. The social worker in this system is seen more from the point of view of collaboration than from the point of view of treatment.

The problems that are articulated by the client are seen as something he wants but doesn't have. The task then is to take action to get it. This action that the client might take is influenced by a sophisticated set of beliefs about himself and his world. This action involves others and is shaped by his evaluation of the response of others. Attention is focused on factors that client/worker can act to change. There are obstacles to this desired change (dysfunctional patterns of action and belief; deficient or uncooperative social systems) which can be modified by the collaboration of client and worker. In this whole system man is seen as having a mind and will of his own that are reactive but not subordinate to internal and external influences.

The Task Centered System deals with the psychosocial problem(s) of the client. The nature of this psychosocial problem is as follows:

The problem must be <u>acknowledged</u>: That is to say, the person must say that it is his problem and he must be explicit in this statement. There should be explicit agreement on what the problem is between client and worker before remedial action takes place. In many situations a problem is <u>attributed</u> when

someone else says that the client has this or that problem.

The client must be able to obtain relief from the problem through independent action. Thus the client should be able to do something about the problem through action taken outside of the treatment session.

The problem must be specific. Thus the problem should be explicitly defined and delimited (at a low level of abstraction). There must also be clear limits to the range of the problem (a particular problem area).

Important to the notion of problem in this system is the concept of want. Thus an unsatisfied want is a necessary condition for the problem; in addition the problem condition must be undesireable to the client. Wants occupy a client's attention a great deal of the time and occur with enough intensity to provoke the person to ask for help. Along with this intensity there is emotional distress. So the problem becomes a set of conditions that the client wants changed.

The Task Centered approach has set up a paradigm for problem classification.

1. Interpersonal Conflict

This is seen in the interaction of specific individuals (marital, etc.) that are bound together in a relationship that is difficult to withdraw from. Each are behaving in a way seen as objectionable by the other. This is strengthened through vicious circles.

2. Dissatisfaction In Social Relations

The person is unhappy with some aspect of his relations

with others or a particular person. The difficulty is located in the person himself and may or may not include conflict.

3. Problems With Formal Organizations

There is a conflict between an organization and the client which the client acknowledges.

4. Difficulty in Role Performance

This occurs when a client is concerned about his or her ability to carry out a social role (student, parent, etc.). The worker has to pin down the exact behaviour that is occuring and that behaviour which is desired.

5. Decision Problems

The difficulties here arise out of the inability to come to various decisions. This sometimes involves a change in role or social situation.

6. Reactive Emotional Distress

The client is concerned with his/her feelings about an event.

7. Inadequate Resources

In this situation the client lacks tangible or specific resources such as money, transportation and so on.

8. Psychological Or Behavioural Problems Not Elsewhere Classified

Examples of problems places in this category are phobic behaviour, addictive behaviour and so forth. Problems placed here cannot be placed elsewhere and should meet the criteria.

While Reid feels that the problem classification system requires continuing refinement, he sees it as being helpful to

the practitioner in the following ways:

- helps to identify those cases where this model would be useful;
- good for classifying cases for instructional and research purposes;
- helps practitioners to clarify complex problem situations;
- helps practitioners locate specific problems;
- helps to define problems in such a way as to suggest possible courses of action

Problem Formulation and Resolution

In the consideration of a problem it is important to understand the forces that facilitate or impede problem resolution. Reid cites Fischer in explaining the dichotomy between "causal knowledge" and "intervention knowledge". Often we can become tied up in searching for a cause to a problem. However, causal knowledge may not be necessary if the definition of the problem suggests an effective solution. Causal knowledge becomes important when it helps to choose and shape courses of remedial action. Reid points out that these two types of knowledge are best brought together when one sees the cause of a problem as that which is preventing its solution. In this system the factors that may impair or facilitate problem resolution are those that either the client or worker can modify. He proposes that these factors are found in the client's current wants, beliefs, emotions, actions and social system.

Wants

This is the issue of motivation which for this system arises from the unsatisfied want. Reid argues that motivation has two aspects: direction, i.e. what I want; and strength, i.e., how much I want it. These are seen in relation to each other; for while I may want something with great intensity, I still may not be able to achieve it. In addition, it is important to realize that there are other wants that may impede or facilitate this want. Further, some wants may conflict with other wants (e.g. alcohol--want to stop but keep drinking). This explains why many problems remain unresolved. If they are to be resolved Reid feels that they can be resolved through the person's belief system.

Beliefs

As noted above, wants initiate action. How this action is carried out depends to a great extent on how a person views himself and his world. For Reid this view is best explained through the concept of the belief system (Goldman; Murray and Jacobson; Bem). A person's beliefs are his collection of perceptions, knowledge, expectations, hopes and opinions. Reid sees other concepts related to this notion of belief. For example, the concept of image elucidated by Galanter, Miller and Pribam (1960), which describes an "accumulated organized knowledge that the organism has about itself and its world." It relates to everything it has learned through values and facts. The concept of belief is also close to Jerome Frank's

notion of "assumptive world". The idea here is that we impose an order and regularity on our experience. The person develops a set of assumptions about himself and his world based on experience. These assumptions help to predict the behaviour of others and the outcome of our own action. Reid states that beliefs can be "factual beliefs" based on what one perceives as facts and that can be tested by data gathering; and they can be "evaluative beliefs" that are value judgments about what is good or bad. While this can be tested they are not capable of empirical verification. Access to a person's beliefs can be achieved through their personal statements or through responses to prepared statements.

As Reid points out, there is a mutual influence between beliefs and wants. Thus what we want from others is determined by our belief about what they can and should do for us. What underlies our efforts to motivate people to change is the principle that a change in beliefs can produce a change in wants. Thus there is an attempt at changing or creating the belief structure of the person. A person may not accept someone telling him that he should or should not want this or that, but they may accept a redefinition of what we think is true.

If wants can be modified through the belief system, how then can we modify the belief system itself? Reid points out that this modification can be achieved through the utilization of points of leverage in the belief system through communication processes.

1. Accuracy

The first point of leverage is accuracy. The idea here is the fit between the person's belief and reality. It applies to factual beliefs although evaluative beliefs can be supported by distorted perceptions of reality. Accuracy thus speaks to the point that existing beliefs can be supported, questioned or refuted by evidence. Distortions between belief and reality can be produced through:

a) arbitrary inference - drawing a conclusion when there is no evidence (or contrary evidence) to support it

b) overgeneralization - the idea of making too much out of a single incident

c) magnification - the idea of exaggerating the importance of a single incident

Obviously erroneous beliefs can misguide problem solving action. They can also help to create and maintain problems.

2. Scope

The notion here is that a belief that may be necessary to solving a problem is not there or is not there when needed. Hence a concept of belief deficits that contribute to problems:

a) absence of accurate beliefs - relates to the realities of a person's circumstances or behaviour;

b) deficits in belief about future events - relates to the idea of adjusting our actions in relation to probable consequences.

The notion of missing belief--belief does not occur when it could influence action.

3. Consistency

A leverage for change can be obtained by noting the inconsistencies among beliefs and bringing them to the awareness of the client. A more functional belief can be put alongside a less functional belief and efforts can be made to make the more functional belief attractive. This process can lead to a new belief that is a synthesis of two beliefs previously held in opposition.

Emotions

For Reid emotions are the product of the interaction between beliefs and wants. The emotion is an expression of how the want is evaluated. All psychosocial problems have emotional aspects. Effects produce states in the person that are perceived as desireable or undesireable and whether they are functional or dysfunctional depends on the amount and character of the emotion and relevant beliefs. Obviously then we have a number of interconnected processes between emotion, beliefs and wants. Emotions are revealed through the belief system just as wants are and the comments on the formulations relating to this process that we discussed under beliefs would obtain here as well.

Action

Reid begins his discussion of action by defining it.

He defines it as "what a person does to achieve a desired effect": Thus an agent with a purpose or intent. This, of course, implies that the practitioner will have to make a judgment about the person's intent. The concept of action draws our attention to the processes within the person that contributed to bringing about the events. In discussing this concept he makes a comparison between the concept of action and the concept of behaviour. As noted above, the concept of action includes the notion that it is something that a person does to achieve a desired effect. Behaviour, on the other hand, is an event which can be analysed objectively and precisely. The distinguishing feature is that action speaks to the issue of intent. Action is important to the practitioner because he must be concerned about what the client wants to do or intends to do about his situation. The concept of action forces us to deal with these things in an organized manner.

The concept of action also lends itself to a consideration of what a client might do about difficulties that have a largely cognitive solution. Additionally, action can be viewed at different levels of abstraction. It can describe one act or a whole range of acts in a summary manner. Finally, the concept of action fits into the task centered system very well since the system is interested in helping people do what they want. The person's cooperation and consent is necessary if he is to be helped in planning and executing problem solving actions.

Wants and beliefs create intentions which control actions.

Intentions are essentially plans which in their turn are descriptions of intentions. Plans are required so as to determine what is to be done and in what order. In order to utilize plans one must take advantage of rationality and foresight.

The results of our actions provide feedback. Our evaluation of this feedback will alter or maintain our responses. This has implications for treatment. Changes, therefore, will depend on how we evaluate the consequences of our actions. Experiential learning also has definite impact on the belief system. For Reid then, behaviour is controlled by the assessment of its consequences. Action takes place if the actor feels that he can get what he wants by that action.

A problem often occurs at the end of a series of actions. Reid makes the point that by changing one of the actions prior in the sequence, the problem itself will be modified.

Problem solving action may not be carried out because the person does not have the skill. Skill in this context refers to an appropriate response under the specific circumstances. Hence a skill deficit is determined by what is required by a preferable mode of response. Reid indicates that he is particularly interested in those skills that the worker can help the client to learn (assertiveness, decision making, conflict negotiation, etc.).

The desired actions may be achieved by proceeding through a hierarchy of incremental actions. This is most likely to work when: there is a series of discrete steps; there are no large gaps in the ladder of difficulty; and when there is some want satisfaction at each level of the action.

The Social System

While belonging to individuals psychosocial problems are the product of complex social interactions--the person, other persons and organizations. It is these others that often control the resources needed to solve the problem(s).

A social system, according to Reid, is defined as "a set of individuals and organizations that are considered relevant to the maintenance or resolution of target problems". It is this social system focus that brings attention to the influences between the person, others and organizations in problem formation and resolution.

The person's belief system is a product of the person's interactions with the social system. In this interaction there are a number of modes of influence:

1. To tell the client what to believe:

This is the content of the communication from others to the client. They convey a picture of himself and his world. This is most effective when the client values the opinion of the other and the information is "specific, accurate, and discriminating". This information may be expressed in words or action.

2. Modeling:

The client imitates the actions that he sees as satisfying the wants of others.

3. Response of the system to the client's actions:

This response will influence the course of future actions as the person evaluates the results against how far he has gone

toward achieving what he wants.

In considering the response of the system to the client's action, Reid wishes to use what he refers to as the "operant paradigm". He would like to utilize the concepts of "positive reinforcement"; "punishment"; "response cost"; and "extinguished". He wants to take advantage of the fact that this paradigm links up with a "vast research base and technology". In addition, however, he argues that it has not developed "motivational and cognitive concepts" and hence he wishes to extend the framework in his own manner.

As noted above, action has a role in problem formation and change. When action involves the social system the action becomes interactive (mutually influential). These interactive cycles can be understood through feedback processes. They can also be viewed as a "temporary system". The point of origin may not be so important as much as locating points in the sequences that are susceptible to change. Problems involving others then are best analyzed in interactive terms.

Organizations are a major part of most client's lives. This interaction is a critical point in psychosocial problems. Organizations can often contribute to the person's problem.

An important distinction in this context is the difference between individuals and collectivities. Individuals act in organizational roles; collectivities are defined by "particular functions, policies, rules and roles". In this system we are interested in those organizational influences that can be modified by the worker or the client. There are various

areas that can be worked on, however. These are areas that create problems or block their resolution as client and organization meet.

1. Areas of labels or collective beliefs:

The categorization of people as clients, inmates, etc. implies an inability on the part of this person to handle their own affairs. This may well be true in the short term but on a prolonged basis it can be damaging and may militate against a person in his belief in his own self sufficiency. Further risks are involved when stereotypical notions are used and expectancies established. These labels are often described in language that is "imprecise and metaphorical".

2. Breakdowns and shortcomings in Service Delivery:

The provision of effective service in an efficient manner may not be accomplished, hence adding to the client's distress. The problem that often arises is that organizational operations sometimes are more aligned to staff needs than they are to client needs.

3. Multiorganizational Involvements:

Clients may have a number of organizations involved in their lives. The coordination of these activities has not always been effective.

The practitioner can modify these problems and influences in the following manner:

a) modify the impact of labelling by emphasizing specific actions;

b) guide client through complex bureaucracies;

c) steer client toward the most effective organization;

d) coordinate when various organizations are involved.

Intervention Strategy

In this model strategy has two purposes: First, to help the client alleviate problems that concern him. Second, to provide him with a problem solving experience that will enhance his willingness to get help in the future and that will strengthen his own problem solving capacities.

The practitioner in this model performs the following functions:

1. Identifies specific problems arising from unrealized wants; specific conditions to be changed;
2. Provides structure within the context of a contract that explicitly states the problems, goals, nature and duration of treatment;
3. Isolates the types of action needed for resolution.

Thus the worker plans implementation; establishes motivation; rehearses and practices the tasks; analyzes obstacles; reviews and provides feedback. Change is effected through those actions and tasks undertaken outside the interview and that are designed to realize the wants.

The central and distinctive strategy of this model is the reliance upon tasks as a means of problem resolution (construction-implementation-review of tasks). Inasmuch as there is success in the completion of tasks to that extent is there benefit from

the application of the model. Tasks are seen as an attempt to build on the human capacity to take action when faced with difficulties. While this capacity may be dormant, it is there nonetheless and the practitioner has the responsibility to unlock this capacity. It follows, then, that the social worker's role may be limited when the client is clear as to the problem and the action required. What is decisive is that the client performs helping actions in his own way and on his own behalf. If these actions are successful the client will likely incorporate the model into his own life and apply it to other problems.

Reid sees this process as better suited to lower-class clients. The reason for this is as follows: evidence suggests that lower-class clients can better utilize more structured, more directive counselling--one that places the emphasis on action. Moreover, this approach is in tune with the realities of their life (requiring needed resources) and educational limitations.

The task centered practitioner is expected to make direct suggestions in task selection and performance. However, the model can also be adapted for use with the more introspective type of client.

The strategy of this approach that we have been discussing flows from the task structure. However, there are two other elements that are important in this process: First, the relationship between client and worker. The worker has to ensure that the atmosphere in the helping situation reflects his

understanding, acceptance and understanding of the client. At the same time, it is necessary to stay on track with task completion. Both of these values have to be balanced. Second, the social agency. The interventive strategy of a model reflects an agency's purpose. The agency does not merely provide office space. In this approach Reid makes the point that the agency provides first, the resources and second, provides or confers an "authority of office" which gives him an aura of authority and competence.

The major purpose of this model is to enable the client to plan and execute problem solving action. This benefits clients in two ways: First, they can begin to see helpers in a positive way and may even wish to return to a helping person at some future time; second, it enhances the client's ability to problem solve on his own.

Assessment and Planning

In this phase of treatment it is necessary to obtain data on the client's personal/situational characteristics and to identify target problems. "What can be done to alleviate the client's difficulties?" Three aspects are objects of concentration here: 1. Action requirements--that is, what actions are required to obtain what the client wants; 2. obstacles--what barriers are in the way; we have to be sure that these barriers can be altered by client action; 3. constraints--unmodifiable factors in the client's capacity or social situation.

While assessment and planning provide direction on how to proceed in a particular case, they are also used throughout the time that client and worker are together. A problem can be redefined as you identify obstacles and concentrate on them. Problems can also be redefined as you outline the constraints which make the problem as originally presented or perceived unresolvable. In this connection it is important to have an awareness of the difference between obstacles and constraints: Obstacles are modifiable and constraints are not. However, what may seem to be a constraint can become an obstacle as modifiable elements are revealed.

The Range of Application

The question here is--In what type of case would this approach be the strategy of choice? Reid states that "...if one can define with a client a specific, acknowledge, psychosocial problem that he can alleviate through independent action, then task centered methods are appropriate." (p.96) The approach can also be used as a discrete part of an overall treatment approach in a case. Reid sees it as an approach that can be used in a "majority" of cases handled by clinical social workers. He also makes the added comment that some case should be long term but only after using short term approaches. Reid also outlines situations where task centered methods are not appropriate: cases where existential issues are paramount; where the client has primarily expressive needs; where there is resistance to structured treatment; where there is a lack of stable problem

focus; where there is a purely protective situation; or where conditions are not responsive to client action.

Task-Centered Treatment and Behavioural Treatment

Reid points out that in developing the approach they began to break down larger tasks into more manageable tasks. With the increasing specificity Reid argues that the model began to get closer to behavioural type approaches. However, behavioural methods do not always apply to all situations where task centered methods are used (e.g. the problem is lack of resources). Nor do behavioural methods always get at the cognitive factors. However, what is important for Reid is the use of methods that are scientifically testable.

Activities of the Model

Problem Specification and the Service Contract

These are basic activities during the initial phase of contact--especially during the first to fourth interview. By the end of the first session it is desireable to have reached agreement on one problem and establish a contract. Of course, this is not always possible. Nonetheless, Reid recommends that the problem specification period should be kept as short as possible since time is not used well until the problems have been specified. It is not necessary to slow down simply to develop a relationship--much can be accomplished by getting at what is troubling the client and getting at what can be done.

It is essential that there be agreement on the problem between the client and the worker before you begin problem solving efforts.

Problem Specification

The purpose of problem specification is to enable the worker and client to get an idea of the problem in such a way as to identify tasks and to analyze obstacles. It is important to remember that the problem is probably not completely specified at the outset. Problem specification has a set of sub-activities: The person presents a general problem area out of which will emerge several target problems. The worker works with the person who comes seeking help (the applicant in Reid's terms) as a clarifier of issues so that what the client wants and is not getting is pinpointed with some accuracy. The client's definition is accepted unless there are grounds to challenge it. Reid emphasizes that when there is disagreement on the problem it is the worker's responsibility to prove that he/she is right. Reid also speaks of the client who is sent to a social worker--the respondent. Here problem specification begins with the worker exploring the reasons for the referral with the emphasis placed on what is troubling the client. In this situation a problem is attributed to the client. In this process the practitioner appeals to the client's self-interest and tries to outline the consequences if the client either does or does not modify his/her behaviour.

Exploration

Once the problem area is marked out, it is checked out in detail. This sets out target problems; it begins to identify obstacles and perhaps identifies ways in which change can be effected. Historical events are elicited in an effort to get at the present belief system. (How can the problem be defined? What is preventing resolution?) You trace the development of the problem and the consequences of the problem are discussed. The idea is to explore for precise details. From this you proceed to discover what the client has done to alleviate the problem. This helps in the selection of tasks.

Problem Definition and Explication

This is a general statement of the difficulty and conditions to be changed. Both client and worker go over this definition until it is acceptable to both. An effort should be made to obtain baseline data about the problem in the time preceeding the interview. This information will aid precision and helps to monitor changes once treatment begins. Having done this you can move on to the determination of desired change. That is to say, what change has to occur in order for the client to feel that his want is satisfied?

Once the therapist gets an idea on the nature of the problem, it is desireable to get an idea of what is happening in the rest of the person's life. This serves two functions: To identify factors that may elaborate on the problem; and to identify factors that may be pertinent to these problems.

Forming the Contract

The contract sets down clearly agreements as to what will happen and how. It specifies at least one problem to be worked on and it sets down the goals of treatment with specificity and precision. It provides the necessary shift in focus from what is wrong to what is needed. The contracting process, of course, is ongoing and is open to revision as treatment continues. Efforts should be made to help the client understand what is expected of him--that treatment will consist of his working on tasks that he devises with the help of the therapist. The contract also deals with the length and duration of service and can be either written or oral.

Task Planning and Implementation

In this model interventive strategy consists of helping the client plan and execute problem solving actions. Thus: To determine what he should do--how and why he should do it; rehearse and practice actions; analyze obstacles and review accomplishments.

Tasks are problem solving actions of the client and must be: Agreed upon with the practitioner; and capable of being worked on by the client between sessions.

Tasks can also be viewed from various levels of abstraction. There is the general task which is a direction for action without the actual steps being spelled out. The operational tasks are specific activities.

Tasks involve action either mental or physical. Tasks may be unique or complex; they may be individual (done by one);

reciprocal (related tasks worked on by different individuals) or shared (a single task worked on by two or more persons).

The distinction between a plan and a task lies in the fact that a plan includes all the tasks that have been decided on and the means of implementation. A task states what is to be done.

Planning Process

The planning process includes the following actions: Generating alternative actions; agreeing on one or more actions to be done; developing strategies for implementation; to summarize the task plan and a client recording of task progress.

In generating alternative actions the practitioner and client freely suggest alternatives as they come to mind. While working on a particular alternative something else may come up. Reid suggests that you encourage client experimentation in problem solving as this increases investment. Thus tasks are not assigned by the worker but are suggested so that they can be owned by the client. Reid points out that task committment is a good predictor of success.

When we speak of task agreement we usually mean the agreement that is reached at the end of the planning process so that everyone knows what is involved.

When implementing the chosen task the recommendation is that the task should be broken down into a sequence of operations that may be required to carry it out. There may be a general task but there must also be an operational task that can be

begun prior to the next session. It is important that it calls for actions that the client can carry out.

Toward the end of the interview the worker goes over what is to be done so that everyone is clear about what has to be done. It is important to ask the client to present the plan as he sees it.

It may be helpful to a client to keep a task record. In this way the client can keep an eye on his progress. It also helps to award credit for success and helps in identifying obstacles.

Task Strategies

In working on a task it is well to be aware of various strategies that can be used in their successful accomplishment.

Thus one can use what is referred to as incremental strategies. In this way successful accomplishment is rewarded. Smaller units of gradation are used; place an upper limit on the task; modify some point in the sequence that the client has control over; and the use of tasks that "cut two ways" (exploiting paradoxical elements). It is also a useful idea to search the treatment literature for treatment plans.

Another important tool in task strategy is the use of incentives and rationale. The incentive aspect includes the idea that the gain that is expected will occur. The rationale relates to the fact that the gain is adequate justification for completing the task; a consequence of doing or not doing the task.

It is also suggested that the client be helped to practice whatever it is he/she has agreed to do. Thus the client learns by doing and demonstrates his knowledge of the task. This can be done through role play or through guided practice.

In identifying obstacles and analyzing them it is pointed out that some obstacles originate in the belief system. The belief system is then looked at from the point of view of scope, accuracy and consistency through a series of challenging and searching questions. Changes in the belief system can be obtained through in-session analysis or through the development of tasks that deal with problems in the belief system.

As each interview begins the first order of business is to review what has been done since the last session. While the practitioner's techniques are useful, it is more important to examine what has been done or accomplished through joint efforts.

Ending

The time when treatment will terminate has, of course, been set up well in advance as part of the contract. When it comes to conclude, then, the activities of this phase include: To review and assess accomplishments; to plan directions for the client to follow; and to help the client to see that problem solving methods can be extended to most problems in living.

In assessing (during the problem review) the client and practitioner consider the status of the target problem; there is a review of the other problems and a discussion of the

client's own assessment of problem change. This gives an idea as to what has been accomplished and is a basis for judging effectiveness.

Task Centered Treatment
and Marital Counselling

The system of task-centered counselling was originally designed for work with one to one relationships. However, as Reid points out, it has now been extended to conjoint treatment of marital couples.

In this situation the target is the marital interaction resolving difficulties in how marital partners get along with one another. The unit of attention is the two person system.

Reid points out that many of the problems that arise out of the marital interaction proceed from a system of rules that characterize the interaction. For Reid rules mean regularities in the interaction. These rules could be descriptive (actual), that is, rules that characterize the interaction in the past or present; rules can also be prescriptive, referring to the way in which interaction ought to be. The prescriptive rule expresses a requirement whereas the descriptive rule is a description. The former expresses a relationship that one or both would like; while the latter expresses the relationship as it exists now. These rules can be dysfunctional or functional depending on the point of view. Partners in the relationship evaluate the rules on the level of their satisfaction whereas the practitioner must evaluate rules on the disagreement

and the ramifications of those disagreements. On the part of the client, negative evaluation is usually voiced as a complaint as to the partner's behaviour. The nucleus of a rule of interaction is the combination of a patterned action and response.

These rules of interaction are influenced by "metarules" which is seen as a principle for forming or interpreting rules. The interactive rules of most couples are guided by the principle of conformity to social norms concerning married life. These rules originate in the client's belief system. It is Reid's point that couples are placing a high value on metarules that generally guide relationships among equals. Two rules, then, seem to be especially important in this regard: The rule of mutual devotion and caring and the norm of reciprocity (quid pro quo exchanges). Problems begin to arise when one partner feels that he/she is being cheated when the other is not living up to expectations. This, in turn, institutes a vicious circle.

It is the central goal of task-centered treatment of marital conflict to help couples resolve acknowledge problems in their interaction. The activities in this process are outlined in this way: The descriptive rules and metarules contributing to the difficulty are clarified; prescriptive rules suggesting desired behaviour are worked out; tasks for partners are designed to put these new rules into operation; and there is a reliance on reciprocity.

Problem Specification and Analysis

In this type of counselling problem formulation is difficult and it is difficult to focus on any one. Usually, partners see problems in terms of the other while the practitioner sees them as part of their interactions. The first step is to get each person to elucidate their unsatisfied wants in respect to the other's behaviour. Then it is necessary to lead them to a view that the problem is a common one rather than just a problem with the other. This also defines the target for intervention--the conflict between them. It is also suggested that the partners list the problems that they see with each other. They then work on these problems at the same time, thus beginning to establish reciprocity (quid pro quo). For Reid, to understand marital problems it is essential that one understand the rules of interaction that product them; how these rules work against positive reciprocity; the details of problem sequences (who does what to whom and when); and the practitioner needs to be aware of the beliefs of the partners.

Task Implementation

Before tasks are finalized, incentives and rationales must be established. The usual incentive is that there will be a change in the partners' behaviour. Yet work on the tasks must be perceived by the partners as being balanced. Thus it is crucial that both be satisfied with the tasks. In addition the practitioner must be sure that the connection between the task and what is trying to be achieved is clear.

Considerable stress is laid on in-session work on problem solving and communication tasks and this is done through simulation and guided practice. The practitioner's role in this effort is as follows: observe the partners' performance; praise actions that further the task; structure communications; pinpoint difficulties; provide feedback and model desireable responses. Reid sees that tape recordings of the couple's conversation could be of use. It gives a couple a vivid picture of what they have just done and it helps the practitioner to point out specific problems. Thus the proceedure to follow is to set up the task, the couple work on it for a few moments and the practitioner interrups where appropriate. The criticisms of the interaction must be balanced between the two partners. All of this usually constitutes practices for work between sessions. In considering obstacles the practitioner should be concerned with the beliefs they have of each other and their interactions.

Experience with the Model

Reid and Epstein reported on experiences with the model in a work entitled Task Centered Practice published in 1977.(24) In this work edited by these two authors, professionals were given an opportunity to discuss their experiences with the model in various settings. In all, the work reports on seventeen efforts to use the model. These experiences range from a child guidance setting to working with young adults in Israel. For my purposes, two reports are of special interest. In the

the first, Frances Wise discusses her experience which took place at the Cincinnati Family Services.(25) She claims that she found a link between task accomplishment by the couples and the state of their marriage. The couples, then, who were able to work on getting the tasks completed, seemed to reflect a committment, or as Wise phrases it "marriage bond".(26) She delineates limitations in the model in terms of its usefulness for certain types of clients. For example, in the client "whose defense structures are rigid may be unable to agree on problem areas";(27) or it may be difficult to utilize in those cases where "one or both partners have been too emotionally traumatized to be able to develop a relationship with one another";(28) finally, the possibility of task activities triggering off unplanned behaviour could lead to problems.(29) Despite these limitations, however, Wise says that it can be effective and summarizes by stating:

> "Task-centered methods proved particularly useful in certain circumstances and with certain kinds of couples. In some instances, the approach served to cut through a client's ambivalence and encourage decision making. Thus, nonperformance can be motivation for change. Faced with the challenge of performance a client may have to face his own ambivalence, thus forcing a decision he has been avoiding. For example, a decision to separate may be reached after a client realizes he cannot carry out tasks necessary to resolve problems in the marriage." (30)

In another article, Tolson reports on the use of task-centered methods in treating marital communication problems. She sees it as a successful approach.(31) She warns about symptom substitution and the fact that one must be alert for

possible side effects in one area while trying to effect change in another, and concludes,

> "...task-centered methods appear to have promise as a means of bringing about positive change in specific marital communication problems." (32)

Carvel Taylor employed it in an industrial setting and in summarizing his own experiences echoes the findings of others:

> "When Task-Centered methods are applied to specific, agreed-upon problems, a very high proportion of the problem situations so treated will show at least some degree of alleviation." (33)

Finally, we cite the work of Cameron MacDougall who in reporting on a small scale study conducted in the Antigonish Branch of Family Services of Eastern Nova Scotia, finds that interventions focused on "target problems and viewed as time limited and task-structured" produce better outcomes.(34)

D. Communication Skills Development

It is my conviction that there exists a strong linkage between marital maladjustment and dysfunctional communication patterns. It would be inappropriate to see disturbed communication as the single causal factor to a complex reality. However, it is a critical element in the process. In an article published in 1970 Bienvenu maintains that there is growing evidence that problems in communication prevail in the majority of troubled marriages and that these difficulties tend to moderate as marital adjustment improves.(35) Another writer makes the point that communication is so important that it is

likely to be the vehicle through which the relationship can be studied.(36) If there is then this essential connection between marital maladjustment and disturbed communication patterns, it is logical to address this linkage in the practicum.

As stated earlier in this presentation, it is my intention to shift from a conjoint approach to a group approach at the fourth session. The group is to be made up of the five couples already in therapy. There are a number of ways in which group methods will be useful in this context: First, the fact that they are all in therapy at the time and with the same practitioner will give them a commonality that they would not ordinarily have. Second, the group can provide a built-in encouragement and monitoring system. Third, the group will give the couples a chance to learn from each other and thus lessen any dependence on the therapist. Finally, in the group setting the couples will have an opportunity to practice and watch other couples so that feedback and modelling will occur. It is also, I believe, important to recall that much of our time is spent in some sort of group. In using a group in this way I feel that it is reasonable to expect that participant will intensify their awareness of group norms, roles, and decision processes. This greater awareness will aid their personal and social effectiveness. In addition, research would seem to support the usefulness of the conjoint and group methods. Cookerly, for instance, discusses the effectiveness of various approaches to marriage counselling and concludes that the

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conjoint and group approach tend to be the most successful.(37) Thus by using both, one would appear to be maximizing one's chances for success.

In this part of the practicum the effort will be toward developing specific communication skills within four group sessions which occur on a weekly basis. My basic source for these group sessions is Garland's Couples Communication and Negotiation Skills,(38) which is part of the Workshop Models For Family Life Education Skills. This particular workshop suggests four sessions and presents different skills in each one of the sessions. In the first session the objective is to "teach the knowledge that communication may occur in a number of channels, that a person cannot not communicate and that perceptions of the same experience may be quite different".(39) The second session's objective is to "teach the listening skills of attending, observing, paraphrasing, and reaching for information".(40) The third session is used to "teach negotiation skills of pinpointing the question, staying with the pinpointed issue, defining the question, labelling behaviour, and determining whether the question is one of fact or opinion".(41) In the final session the objective is to "explore the difficulties in agreeing on matters of fact and negotiating matters of opinion in marital discussions".(42)

In order to get at these objectives, a number of techniques are suggested. One of them is role play. I have some misgivings about this type of intervention, for in my experience people are reluctant to participate in role play

privately, much less within a group. I have serious questions as to exactly what it demonstrates. However, this is not to say that role play will not be tried. It will depend very much on the group just how extensive its use will be. In addition to role play, other strategies will be applied: These include communication exercises, lecturettes, behavioural observation forms, a true-false quiz, pre- and postworkshop questionnaires and ongoing review. After the last workshop and after feedback has been received, the couples will then return to their conjoint sessions and enter the termination phase of their treatment.

The brief nature of the communication development skills component of the practicum is consistent with my emphasis on short term therapy. Furthermore, the literature seems to point to success in this type of intervention in communication training. Norman Epstein and Elizabeth Jackson reported on this subject in 1978. They conclude by stating:

> "...a short term structured intervention involving both partners can have a measurable impact on both overt interactions and spouses' experiences of each other's communication." (43)

The success of training for interpersonal communication skills within a structured environment is also discussed by Pierce.(44) In the study that he reports on, they took five couples and arranged sessions once a week for a two-hour period. They met together for a total of twenty-five hours. He brings out a number of implications that flow from the study. First in interest to me is that "systematic training programs can

significantly raise the level of interpersonal skill between spouses of deteriorated marriage in a relatively brief time".(45) Secondly, he points out that the training group communicated at higher levels with their spouses than did the treatment group and gives a number of reasons for this: First, "training is a model that combines both modelling and didactic sources of learning" and that when "people are both told what to do and shown how to do it learning increases"; and second, there are "multiple helpers available".(46) Rather than being used in isolation, Pierce sees it as being used in combination with other strategies.

CHAPTER III

MEASUREMENTS

The basic goal of this practicum is to afford the writer the opportunity to gain experience in the use of Task Centered Therapy in conjunction with the use of a communication group type of intervention. To this point we have discussed how this would be done: The use of conjoint therapy, planned short term therapy, task centered therapy and communication skills development (training). It would be appropriate at this juncture to discuss the measures to be used.

The basic measuring device in the practicum that I am proposing is the Dyadic Adjustment Scale reported on in 1976.[47] The intention is to apply this scale at the first interview; at termination; and three months after termination. This last test is to monitor the persistence of any change that has taken place in the earlier tests. (See Appendix 2 for sample)

The Dyadic Adjustment Scale was developed after a long series of procedures which included the following:

- identification of all items ever used in any scale measuring marital adjustment resulting in a pool of three hundred;
- any items that were duplicated were eliminated;
- outside judges screened these items for "content validity" and this reduced the items to two hundred;

- questionnaires were administered to 218 married persons, resulting in 94 that could be used;
- frequency distributions were analyzed; response variation was assessed; t-test for significance between means of the married and divorced samples were analyzed;
- items were factor analyzed and factors loadings applied resulting in the thirty two items.

What we have then is a scale that has been rigorously constructed, is uncomplicated and easy to use (cf. Appendix I for sample).

Task Centered Therapy also has a number of measuring devices developed for the model. The intent is to use them as much as possible. In this way the problem to be worked on will be delineated clearly, tasks will be set down in writing, results achieved will be recorded, and the overall satisfaction of the couples with the service will be reported on by the client.

The Communication Skills Workshop will have a number of measuring devices. There will be a pre-workshop and post-workshop questionnaire; participants will rate one another through behavioural evaluation forms and there will be, of course, the various exercise that participants will experience (cf. Appendix II for sample).

In conclusion, then, it is noted that the practicum proposal has made provision for testing at various stages of the treatment providing both overall data and information as to what is happening at each stage.

CASE RECORD - 1

J. and A. were seen for a total of nine sessions. They were respectively 42 and 41 years of age and had been married for nineteen years. There were four children, ranging in age from 13 to 18. They both worked.

They both expressed a dissatisfaction with their relationship but also expressed a desire to have it "work". A. seemed to be the most dissatisfied and seemed to have a great deal of pent-up hostility going back a number of years as she rehearsed old hurts and feelings of non-support. There had been a previous separation and an extra-marital affair on A.'s part. She was also in poor health at the time they were being seen. J., for his part, expressed a desire to see things work out and felt that his shift work was a major problem for the family. There were also conflicts between children and parents with A. expressing a sense of apartness from the rest of the family. This seemed to be heightened for her by the separation and a perception on her part that she was, as it were, on probation.

During the second session they both completed the Dyadic Adjustment Scale. Their responses are summarized in Table 1 and Appendix 3, page 1.

TABLE: 1

CASE RECORD: 1

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	9
1	15
2	6
3	2
4	0
5	0

As can be seen, the responses of the couple reveal both shared disagreement and disagreement in perception on a majority of items. In a large number of issues this disagreement is substantial. Where this is most notable is the areas of finances, affection, sexual relations, how to deal with in-laws and aims and goals believed important. It would also seem that A.'s level of disagreement and discontent is more pronounced than her husband's. Finally, it would seem that A.'s commitment to the relationship is substantially less than her husband's.

In the first session the practitioner invited the couple to begin to state the problem or problems according to their perception. A. articulated a sense that "things always seem to go wrong" and that there is "never quite enough". She saw J. as being non-supportive in the past although she was prepared to acknowledge that there had been some change. Nonetheless, she saw him as a "fault finder" and expressed the belief that they "never worked as a team". She concluded her statements by saying that she felt "loneliness" and was "alone". J., in his turn, felt that "many things" got in the way of being tender. He felt that it was "hard to be honest". He felt that he was seen by her as an "attacker". He wanted to "communicate" with A. and wanted to know if he was hindering or helping.

These were their opening statements. My interventions at this point were confined to affording them an opportunity to articulate some of their feelings so that they could begin to formulate the problem they most wanted to work on. In

addition, I spent a good deal of time rephrasing, paraphrasing and reflecting so that the clients could begin to refine what it was that they really wanted to work on.

As the session unfolded, A. revealed that J.'s drinking "scared her". In fact, this seemed to be the most immediate problem. J., on the other hand, also began to get more specific and stated that he wanted her to be "more happy" which he felt would be specified by a heavier investment in the home. Using this as a springboard, I then invited the couple to choose actions they might perform to resolve their problems. After some further discussion they agreed that between sessions the following tasks would be completed: First, J. would restrict his alcoholic intake to three bottles of beer at a time; second, A. would begin to do more things at home along the lines of baking, tending plants and so on.

We began the next session by reviewing the tasks from the previous session. They both appeared satisfied with the fact that the tasks were carried out. In the second session we began again by inviting the couple to discuss the problems of their relationship. Once again, the session was occupied with tabling how they felt about various issues. Eventually, J. indicated to A. that he wanted her to tell him how she felt. A. expressed a desire that J. not "control" her. Finally, they came up with a shared task: J. was to avoid always asking the question "Do you love me?" while A. was to involve herself with J. in more physical contact. They left the session feeling satisfied with these tasks.

During the next session (the third) they began to discuss their four children. From this discussion it became clear that A. saw the family as forming two groups or camps: One, comprised of mother and daughter, and the other, comprised of father and the boys. After discussing this matter, they agreed that they would sit down with the whole family to discuss their problems. One of the goals of the discussion was to determine whether or not I would be invited in to consult with the family.

It was apparent from their interviews and the scale that the communication patterns of this couple were dysfunctional. At the beginning of our time together they were offered the opportunity to participate in four group sessions with other couples. While they professed some concern, they eventually felt that they would find it useful and requested to be included. Accordingly, they were invited to the first meeting of the group. These group sessions were to be part of their therapy and were to begin with what would have been their fourth session. However, as it subsequently turned out, it was at this time that the couple began to be erratic in keeping appointments. They did not show up for the first group session. When contacted, they assured me that they would be at the second group session. However, they did not show up for that session either and this pattern of missed appointments became firmly established. At the same time, things were apparently deteriorating and came to a head on Christmas Eve when I was called by the daughter to come to the home and speak to her

parents. This was done and the immediate crisis was defused. (J. had been drinking heavily and A. and J. had been quarrelling.) Future appointments were set up for the earliest possible time but were not kept.

The whole situation presented this practitioner with a dilemma. It seemed that this couple needed further input. However, they invariably missed appointments despite their assurances. Finally, after appropriate consultations I made the decision to terminate the contact. As a postscript, I might mention that J. contacted me some time after this indicating that A. had left the home and requesting an appointment to see me. This was set up but again the appointment was never kept.

The effect of therapy in this case seems impossible to judge. The original assessment indicates a very poor prognosis for the life of the relationship. There was substantial disagreement between A. and J. across numerous issues. There were significant issues where their individual perceptions were not shared and certainly A.'s committment to the relationship was questionable. A whole range of behaviour seemed to underline their reluctance to deal in an effective way with the serious problems affecting their relationship and family. It seems that at this time they have chosen to resolve these difficulties in their own way.

CASE RECORD - 2

A. and L. were seen for 10 sessions, four of which were as part of a married couples group dealing with communication. At the time of therapy, they had been married for twenty-four years and had eight children. A. worked for the provincial government and L. combined her housekeeping duties with efforts to upgrade her education. L. acknowledged that she had had an extra-marital affair while visiting in England and there seemed to be continuing attachment to that relationship at the time of therapy. L. also indicated that their's was "a mixed marriage" inasmuch as she was a Roman Catholic and A. was not. Of the two, L. came across as the more vocal with A. tending to be more deliberate and slow to speak.

Following the model, the first session was used to invite the couple to discuss the problems as they saw them. L. began first and spoke of a sense of "restriction". There was some "urgency" to this feeling she explained. She also admitted that she felt "guilt" and having a sense of being ungrateful. She felt that their communication had broken down and seemed to feel that A. gave her a sense of security. A. also used the term "restricted" to partially explain his feelings. He indicated that his employment called for him to be away often and sensed that he was not getting the attention he needed. He stated that he very much respected L. and in fact tended to

put her "on a pedestal". He feels "wrong a lot" and expressed a strong feeling against being manipulated.

Both members of the couple thus agreed that there were problems in the relationship. It was almost at a point of being "stuck" as to what to do. At times a separation seemed most logical and yet neither one appeared to be prepared to make the definitive move. A. particularly felt that things could not continue to go on as they had; he felt a sense of not knowing where he stood. In terms of the model, therefore, it would appear that this couple's problems could be classified as problems of interpersonal conflict, difficulty in role performance and decision problems.

In this initial session the couple completed the Dyadic Adjustment Scale (the results are presented in Table 2 and Appendix 3, page 2). There seem to be substantial areas of disagreement with A. being much more pessimistic than his wife. A. appears to feel significant disagreement between he and his wife in the areas of sex relations, affection, and aims and goals. They also have different perceptions as to how often they exchange ideas, laugh together, calmly discuss something and work together. Again the husband seems to be more pessimistic. A. feels that things are going well between he and his wife only rarely, while L. is more optimistic. They both reflect a shared perception in areas dealing with their sexual life. Both declare a high level of unhappiness. A. appears to be more committed to the relationship, while L. expresses her feelings through a question mark.

TABLE: 2

CASE RECORD: 2

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	8
1	13
2	5
3	2
4	1
5	0

Missing: 3

As they began to work in the next session, L. expressed a sense that she felt that A. did not know what she wanted. As an illustration of this point, she explained that when she was feeling depressed A. did not try to make contact but withdrew. On the other hand, A. was feeling a sense of isolation. This feeling of isolation was exemplified by the fact that he did not get what he considered to be sufficient attention. For example, coming in from a long, cold road trip, sitting down to dinner and being "ignored". As the session went on, the practitioner's efforts were primarily directed at helping them to speak to each other. As has been the practice with other couples, A. and L. were encouraged to listen, to paraphrase and to concentrate on stating the problems as specifically and behaviourally as possible. Accordingly, by the end of this session they had agreed on a task--they wished to continue to discuss the issues already presented and it was further agreed that A. would continue to seek out L.'s feelings even as she tried to withdraw in "depression". This would be done by staying with her and talking to her. They were to work on this shared task until the next session.

It was at this time that in the estimation of the writer an error was made. A. had explained that he would be away at the time of the next session on a business trip. L. asked for an individual session and after checking with A. the practitioner agreed to it. This individual session was used to gather background information on L. and her perception of the relationship. However, at the beginning of the next session (their third as

a couple) it appeared to the practitioner that A. was annoyed and after "checking it out" with A. this was verified. As noted in the initial session, A. has an aversion to "being manipulated" and it seemed to him that some sort of a manoeuver was underway between L. and the practitioner. Accordingly, the remainder of the session was devoted to dealing with this issue. It was finally resolved to everyone's apparent satisfaction but it did cause the loss of valuable time.

The sessions four through to seven were group sessions. The practitioner had suggested that A. and L. participate in this couples group and work on their communication skills. In this manner they would be better equipped to deal with their concerns without being sidetracked. They took some time to consider this and agreed to accept the opportunity.

Both A. and L. completed a pre- and postworkshop questionnaire. The following is a discussion of their answers to these questionnaires:

As explained elsewhere in this presentation, the couples were involved in a four session workshop based on the work of Diana Garland. The purpose of the workshop was to help the couples begin to develop communication skills to help them in their relationships. Each session included didactic material, exercises and discussion. The basic model of the practicum was also utilized in the workshop as problems were identified in communication and tasks developed to be worked on between sessions.

The first communication questionnaire was completed prior

to the first group session (see Tables 3 and 4 for amount and frequency of difference; see Appendix 4, page 1 for raw scores). In the first application L. seems to show significantly higher levels of satisfaction than does her husband. This corresponds with the results of the Dyadic Adjustment Scale but not with her original statements. This trend is perhaps most dramatically shown on the item dealing with whether or not they see things alike. There are various areas where their satisfaction is only moderate and probably would benefit from exposure to a communication skills program. There do not appear to be any areas where they are identifying present communication patterns as presently dissatisfactory.

It is difficult to compare the second test taken two months after treatment, inasmuch as parts were not responded to by one participant. However, from the data that we do have at hand I do not see any substantial change. They are, however, closer on the issue of seeing things the same way. Moreover, A. seems to score himself less severely in the negative types of communication behaviour while L. scores herself more severely. They also seem to be perceiving more avoiding behaviour, particularly L., and finally, they seem to be arguing about the same issues less.

As can be seen, there have been both gains and losses since they participated in the workshop and the therapy. However, it can also be said that the gains appear to be greater than the losses. The couple was asked to assess the workshop. L. felt that the workshop was useful because she felt that she was "made aware of specific ways in which we were communicating

TABLE: 3

CASE RECORD: 2

Differences between spouses' scores on Communication Questionnaire, Frequency

First Questionnaire

DIFFERENCE OF ...	NUMBER OF ITEMS
1 - 20	15
21 - 40	9
41 - 60	3
61 - 80	0
81 - 100	0

TABLE: 4

CASE RECORD: 2

Differences between spouses' scores on Communication Questionnaire, Frequency

Second Questionnaire

DIFFERENCE OF ...	NUMBER OF ITEMS
1 - 20	10
21 - 40	7
41 - 60	3
61 - 80	1
81 - 100	0

Missing: 6

poorly". In response to a question as to how much that she learned she had been able to put to use, L. explained that she utilized what she had learned "to a degree--we can talk about our problems better now; drawback--my reservations about committing myself totally to our relationship". A. thought the workshop as being useful because it was "someone new to talk to". A. expressed the notion that he "certainly appreciated you and your wife's participation in the group sessions". In responding to the question as to how much he had been able to put to use, A. stated: "Yes but not as much as I would like to, the rules of the game keep changing."

After the workshop on communication was completed, the couple returned to conjoint therapy sessions. In the final three meetings it was becoming more obvious that A. was becoming less and less comfortable with the state of their relationship and began to drive toward a solution. It certainly was inferred by the workshop that L. was much more optimistic about the level of communication than was A. A. seemed to be very pessimistic and tired of the continuing state of ambivalence. Using the principles of the model and the workshop, efforts were made to help the couple work toward a decision. This was done using the usual tactics: Providing structure, interpretation, clarification, confrontation, guided practice, tasks, systematic/responsive communication patterns and elucidation of the couple's belief system.

The couple was also asked to respond to the Dyadic Adjustment Scale approximately two months after completion of

therapy. The same areas as before seem to remain a problem, as can be seen in Table 5 and Appendix 3, page 2. There have been areas of movement but generally in a negative direction or in such a way that perceptions are less shared. A. continues to be less optimistic than L. and reports that he is thinking more of separation or divorce. He also reports a lessening commitment to the relationship. In a follow-up contact three months after treatment, they were still together and indicated that they were still working on their difficulties.

TABLE: 5

CASE RECORD: 2

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	12
1	8
2	8
3	1
4	1
5	0

Missing: 2

CASE RECORD - 3

G. and M. were seen for nine sessions including four group sessions. G., 27, was a university student with a heavy involvement in various student organizations. M., 22, worked full time as a medical receptionist. They had been living together for a little over a year.

In the first session together the couple was invited to express the problem(s) as they perceived it (them). G. spoke first and felt that the biggest problem was the fact that they "fight without resolution". He felt that in their fights their voice levels and his drinking added to the problem. G. also felt that they tended to prefer different social spheres. He was, as noted above, very much involved in university life, whereas M. was not and, in fact, as far as G. was concerned, disliked various aspects of it. He also felt that they had "sexual problems". M. for her part, expressed the perception that "arguing" was a real problem in their relationship. She also felt that they, as a couple, do more of the things that he wants. Finally, a real problem for her was that G. had no future plans and lacked a goal.

Having completed this part of the session, the couple was asked to complete the Dyadic Adjustment Scale. The results from this are delineated in Table 6 and Appendix 3, page 3.

TABLE: 6

CASE RECORD: 3

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	11
1	18
2	3
3	0
4	0
5	

The results of this test infer that there is substantial disagreement in the relationship. This relates both to shared and unshared perceptions. While the two persons in the relationship see areas of concern, it is more the case that they share different perceptions. As to what they disagree about, G. sees more problems and disagreement than does his mate M. and he had less commitment to the relationship. Areas of sharpest concern are the issues of recreation, religion, sex relations, household tasks, philosophy of life, leisure time activities, fighting and the number of shared outside interests. It is interesting to note that while they state that fighting is a major problem in their relationship, they both report that they quarrel only "occasionally".

At this point in the first session the practitioner laid out the type of therapy that he was prepared to offer them. He explained the central importance of tasks and their inclusion in a group. He also pointed out that ten sessions would be made available to them. In conclusion, he gave a brief description of himself and his background. The couple accepted what was offered and contracted to participate in the therapy for ten sessions. To bring this first session to a close, the couple agreed to use the week before our next meeting to carry on the discussion of their perceptions of the problem(s) begun in this session. In terms of the problem classification of the model, it would appear that the problem is one of interpersonal conflict as each is behaving in a way seen as objectionable by the other.

In the second session they reported that they had talked about the material that came up in the first session. They had focused on G.'s drinking patterns. It seems that G. does enough drinking to disturb M. and she articulated in this session and to G. on previous occasions that "that much drinking is not necessary". In response to this, G. pointed out that he was "afraid of control" and felt that he should be able to monitor his own drinking without being told how much is enough. M., on the other hand, was able to point out that she wants "to have love" and that in her mind G.'s drinking gets in the way of this. The interventions of the practitioner in this session were aimed at keeping the couple on track and to keep pushing them for specifics. These specifics would relate to the behaviours in their mate that created problems. As time went on, the practitioner also began to steer them to some sort of action plan. Eventually they agreed upon two tasks. First, they planned to go to a bar on the way home. It was agreed that they would each have one drink and then go home. Second, they agreed that during the week they would discuss with each other what they wanted out of the relationship.

At the beginning of the third session they reported that they had accomplished both tasks. They reported that they had begun to look at what they wanted to do for the future. M. related that she was looking for some stability. She wanted to start planning for a stable life together. She wanted to be married, have children, and work together for various things in life. G., for his part, had strong reservations about the

necessity of being married officially and being married in the church. He also expressed strong misgivings about having children baptized. He expressed a desire to leave the city and retire into the wilderness away from what he considered to be the harmful influence of the city. While M. was not opposed to leaving the city, she came back to her insistence on getting married and settling down. At this point the practitioner began to set up interventions that would afford the couple an opportunity to negotiate these difficulties. Perhaps it would be more accurate to say to explore the real extent of these differences; what these differences really are. They began to work on this and arrived at an action plan--a task. They argued that they would try to negotiate the differences expressed in this session and discover exactly what it was that they differed about. The next four sessions were to be with the group.

In their first group session, G. and M. completed the pre-workshop questionnaire. M. felt that the biggest problem in her communication with G. was "not understanding what each other is saying to the other". She indicated that her goal for the workshop was to gain "understanding in the relationship". G. did not indicate what he considered to be the biggest problem but he did articulate three goals: First, "Learn to communicate better and when arguing hopefully learn to resolve differences in some positive way."; second, "I hope to determine whether our relationship is going in a direction that satisfied both our needs."; and, third, "If not, how do we split without hurting and remain friends.".

As can be noted from reading the summary of their scores (see Table 7, Appendix 4, page 2) G. and M. tend to have different perceptions of how well they communicate with M. being the more optimistic than G. In terms of avoidance by refusing to argue or leaving the room and so forth, this same trend holds true. G. sees his performance less optimistically than M. who tends to be optimistic for both of them. When they responded to items related to their arguments, they shared a perception of their ability to state one another's position. It wasn't happening all the time but it was occurring frequently. In addition, they both felt that their spouse could state their position more often than not. They share the perception that only sometimes do they get agreement after arguing. M. feels that she and G. both know what they argue about, While G. feels he does but M. only realizes this occasionally. They also agree that they argue over things argued about before. They also express the idea that they argue about who is right or wrong and not about a matter of opinion, with G. seeing this happening more often. They also bring up past problems and, again, G. sees himself doing this more frequently than M. G. also feels that he uses derogatory names more often than M. and she tends to agree with this although not to the same extent. M. feels that G. tries to read her mind more than vice versa. They agree that they see things the same way sometimes and M. feels that they communicate in ways other than talking more frequently than G.

Their perceptions of their communication patterns is

TABLE: 7

CASE RECORD: 3

Differences between spouses' scores on Communication Questionnaire, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
1 - 20	12
21 - 40	11
41 - 60	3
61 - 80	1
81 - 100	0

that there are problems with G. tending to be more pessimistic about the extent and viewing himself as the worst offender. This couple did not return the questionnaire sent out to them and, as a result, comparative figures of pre- and post workshop are unavailable.

After going through the four group sessions, they then returned to conjoint therapy for two sessions. These sessions were spent reviewing the group sessions and providing them with an opportunity to explore the various issues in their relationship utilizing some of the techniques covered in the workshop. The practitioner's involvement in this process was as a clarifier and interpreter. He also provided guided practice and tried to keep them focused on the real issues. This was done as they tended to become shrill in their argumentation and attempted to sidetrack the dialogue. The final session was used for terminating the therapy and summarizing where they had been.

An attempt was made to contact the couple one month after therapy was completed. At that time I was informed that they had terminated their relationship. Hence it was not possible to obtain feedback on their reaction to the process that they had just completed.

D. and E. were seen for eight sessions. They are in their mid-forties and have two children. The oldest (20), a daughter, was in Europe at the time of therapy and the youngest (16), a son, was living at home and attending secondary school. D. and E. both have well established careers in communications and education.

In the first two sessions they were invited to express their individual perceptions of what the problems were.

D. saw himself running into "a brick wall" and he made it very clear that the "major" problem that was causing him the greatest distress was his career. He felt that his career had been disastorously affected by a decision not to accept a different position in another city. As he continued to discuss this issue, it became increasingly clear that he was highly dissatisfied with the way in which the decision was made and saw the "wall" solidifying at that point. He felt that the children had had a disproportionate input into the decision so that he perceives that the decision had been made for him by other's needs in the family--"wife's career" and "the children". Another problem for D. was the issue of the children's education. Again, this problem seems to relate to the issue of family decision which, in this respect, he sees very much as a "me against them" situation. Finally,

D. saw their relationship with friends as a problem. He felt that, as a couple, they had few friends and felt that over the years the family had been over "introverted". Thus, they (the couple) did not become independent from the family as the children had done, being locked into their parenting and career roles.

E. expressed her main concern as the serious sense of "hurt" that she was experiencing. She perceived D. as shattering their plans and hopes for a future simply out of concern for a "job". She articulated a sense of "confusion" about D.'s "intentions". She felt that he had forgotten his role as father and could not understand his attitude toward "us". Finally, E. expressed the belief that as a couple she and D. were poor communicators and that this reality was at the root of their dysfunctioning.

At this first level of problem expression it would appear that their concerns fall within the problem typology of the model. The couple was in conflict. This point was made as they discussed their frequent arguments in the past and even alluded to actual physical contact on one occasion. Thus they expressed concerns about problems in interpersonal conflict, dissatisfaction with social relationships, decision making, reactive emotional distress and difficulty in role performance.

In attempting to identify the factors that impair and facilitate problem resolution, it soon became apparent that some sort of stability was necessary in order to proceed with

their tasks. E. in expressing her sense of hurt, was very much on the offensive and it was difficult to keep her on track (i.e. to delineate the problems as she saw them) rather than spend the time reciting D.'s wrongs. The communication seemed to be characterized by point-counter-point argumentation rather than a discovery type dialogue. At this point the therapist became very much of a consultant as an effort was made to enhance in the couple an awareness of what they were doing. This was done by confronting them with their behaviour and its impact. By the end of the second session we were able to get a consensus that they would accept the task of avoiding engaging in "hurting" behaviour; that D. would try to be more "civil", i.e. do things around the house; keep E. informed as to his comings and goings; that E. would try to express her feelings without using a detailed history of past injuries. By the end of the second session, then, problems had been identified, classified and action begun on their resolution. The interventions of the worker had been in listening, interpreting, rephrasing, consulting and confronting. A task had been developed and initial efforts put in train to identify and remove obstacles to problem resolution. A problem here was that the tasks that were agreed to came originally from the practitioner and that is not in accord with the model. Of course, the crucial test is the kind and degree of agreement given to the task by the couple.

During the third session the couple had brought out another problem. They both agreed that they spent a good

deal of time arguing about money. Apparently, they had made a deal as to how money would be spent and who would pay what bills. This agreement had soon broken down so that bills were not being paid and were going into arrears. The task then was for the couple to take this problem with them and see if they couldn't come up with some sort of consensus as to how money in their home and under present circumstances should be spent. In reporting on the task they indicated that they had quickly come to an agreement. The agreement seemed to centre on the money but both seemed to feel that there were "loose ends". The task met the model's criteria of feasibility and desireability and there was an experience of problem solving. However, the practitioner developed a sense that this experience was not viewed as very significant by the couple and that little was learned by it. They felt that there were more urgent issues to be dealt with. At this juncture they fell back into the previously noted behaviour pattern of discussing matters in a point making manner. In this effort they tended to use the therapist as a referee. They were confronted on this issue by the therapist and asked to speak to each other rather than to the therapist. Eventually D. commented on how his relationship with E. had been affected by his relationship with the children. He expanded on this by voicing his feeling that his wife had become identified with the children against him and that she did not "back him up" in crucial areas of family life. This "me against them" perception led to a polarization that enhanced an atmosphere of conflict on a

broad range of issues. At first, E. did not deal with D.'s expressed feelings in this area and responded by going back into past history. This led to another round of communication that was characterized by blaming overriding contributions and an inability to share perceptions. The therapist at this point confronted them again with their behaviour, using humour to make the point. This led to their discussion of how D. relates to the daughter and the intervention of the therapist was by way of reflecting on the tragedy of solidifying positions taken on the basis of pride without efforts to bridge the gap. In addition, the therapist engaged in advice, giving around the inadviseability of casting situations into a win or lose context. E. then began to articulate her belief that she had given loyalty to D.--at least that was her intention. She stated that she had never intended to align herself with the children against D. and that she was deeply sorry about the rift between father and daughter. Out of this discussion D. volunteered to undertake the task of writing his daughter a letter and in this way reopen communication. The task appeared to be appropriate: It was something that the client wanted; it was something that the client could do, and it was something that the client felt should be done. At the same time, the couple agreed to enter into a discussion of their mutual needs between now and the next session. In this connection, it can be stated that there is an ongoing clarification process in task delineation as they go from the first level of problem expression to a more specific and real level wherein the

potential target problems begin to emerge.

During the next session D. revealed that he had not actually done the task of writing his daughter but said that he had "written it in his mind". He also announced that he had accepted a job offer in another city and this, of course, altered to a great extent the course of therapy. E. felt happy about this new job of D.'s, expressing the belief that it was his career that had caused a lot of the problems in the first place. She also felt that the new position would give him direction and will tend to make him more appreciative of the family. At this point I asked them to dialogue for a period about their views of their careers. E.'s contribution seemed to be more of a defense of herself rather than a sharing of how she sees career. D. revealed that for him a career was intimately connected to his sense of self worth and accomplishment and that he hadn't realized how crucial this was until he left the past position. The interventions here were attempts to summarize their positions and to interpret what they were saying and the possible meaning of the various events in their life. D. articulated that he "desperately" missed the children and the old feeling of togetherness and that perhaps he was "grieving" for this period. Again intervention was centered on interpretation. Summarizing the various crises that the family had to face and the toll that this had on the family. E. seemed to continue to make self-serving statements but also began to suggest that they search for each other's view of basic concepts such as happiness, values and so on.

Toward the end of the session D. began to bring out one or two things about E. that he did not like. In this effort, however, much labelling went on and he was vague about what it was precisely that bothered him and what he wanted to see in its stead. E. made efforts to accept this although continued to be defensive. The efforts of the therapist was to help them pinpoint the objectionable behaviour and to elucidate the desired behaviour. In this regard, some confrontation was necessary. Task selection at this point became a problem inasmuch as D. expected to leave for his new job within the month. The question for the therapist then became how to work within these new parameters. Three more sessions were held with this couple and much of the time was taken up with the issue of D.'s imminent departure and its implications for future work on the relationship. Finally, termination occurred at the end of the eighth session.

In dealing with this couple an effort was made to follow the model of task-centered therapy. They were asked to state the problems that they thought were paramount and giving them the most difficulty. They did this, although at least two sessions were utilized for ventilation purposes by the couple. In this process there was an ongoing tendency to make statements and responses using the therapist as a referee. Their problems were classified using the problem typology of the model as being concerned with interpersonal conflict, dissatisfaction with social relationships, decision making, reactive emotional distress and difficulty in role performance.

Attempts were then made to get at the factors that were facilitating or impairing problem resolution. These attempts include efforts by the therapist to help them share their belief systems so that they could get some conception of the other's wants. This was done through interventions that included setting up dialogues in which the couple were asked to listen actively and rephrase what the other had said; interpretation; summarizing; confronting and reflection. The couple also were asked to perform a number of tasks, some of which were suggested by the therapist and some of which were developed by the couple themselves. The model declares that communication on the part of the therapist should be both responsive and systematic. Working with this couple the therapist found that a high level of systematic communication was necessary. The aim was to keep the couple focused on the identified problem areas and the task at hand. It was also necessary to be even handed in using systematic or responsive communication since to do otherwise would be to run the risk of encouraging client/therapist alliances.

Outcome was measured in two ways: The self report of the client and the completion of the Dyadic Adjustment Scale. D. reported at the end of the final session that he felt that there was less argumentation between he and E. He also felt that the relationship hadn't moved that much and that he was feeling "wounded", "drained" and "tired". D. also expressed a fear of loneliness. This last point came up as he was preparing for his move. E. felt that at the end of the eighth

session that she was catching irritations earlier. She explained that her awareness level was higher and that she was optimistic about the relationship.

The Dyadic Adjustment Scale was administered both at the beginning and the end of therapy. The responses to the first application indicated serious and pervasive disagreement. The perception of this disagreement was shared but was most strongly expressed by E. although she articulated a higher level of commitment to the relationship. By the time the second set of responses were submitted E. was seeing improvement along most dimensions.

Instead of being "fairly unhappy" with the relationship, she was "a little unhappy". She wants to see the relationship succeed and will do all she can to see that it does. D., on the other hand, was much less optimistic. He does see improvement in many areas--notably in the area of major decisions; and that there is more agreement on the aims and goals and things considered important. However, there is no sexual activity; there are only mild expressions of affection and they go their separate ways for leisure. He "wishes" it could be the same and sees it as being nice if the relationship succeeded. However, he realizes that more than "wishes" are needed. (Their responses are delineated in Tables 8 and 9 and Appendix 3, page 4.)

It can be stated that the intervention using this particular model was modestly successful. Discomfort in problem areas was reduced. Thus, for example, there is less destructive argumentation. Some effort has been made by D. to reopen

communication with his daughter by writing her a letter. D. has now been able to get his career back on the line (as he sees it) and this has given him more direction. E. is more aware of D.'s agenda and is less confused as to D.'s behaviour than when they started therapy. Recommendations were made to the couple for the future which included: That they establish a definite time frame to come to some decision about their relationship; that they both see a counsellor on an individual basis to examine their needs and life goals; and that they establish a time to come together to discuss these needs and goals with each other and make a decision as to the future of their relationship.

TABLE: 8

CASE RECORD: 4

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	8
1	16
2	6
3	1
4	1
5	0

TABLE: 9

ASE RECORD: 4

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	10
1	13
2	6
3	3
4	0
5	0

TABLE: 10

CASE RECORD: 5

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	11
1	11
2	7
3	2
4	1
5	0

CASE RECORD - 5

A. and C. were seen for six sessions. They are in their mid-twenties and have two children. They have been married for seven years and have been separated for the past six months. A. works in the computer field and C. is a teacher. They came for the first four sessions on a regular basis (once a week) but then became less regular. This reflected the fact that A. was away a lot on business trips and went on a vacation for three weeks to Europe without C. The arrangement was that they would call when he got back but this contact was never made.

In the first session the couple was requested to complete the Dyadic Adjustment Scale. The results as seen in Table 10 and Appendix 3, page 5, reveal that they perceive their level of agreement quite differently over a variety of issues; e.g. finances, recreation, sex relations, conventionality, philosophy of life, parents and in-laws, time spent together, and degree of happiness. In addition, they also reported a shared perception of disagreement around such areas as affection, friends, and leisure time. However they both seemed to have a high commitment to the relationship.

Early in our time together the couple was invited to make a statement as to the main problem(s) in their relationship. C. spoke first and indicated that she had two problems:

One to resolve the reservations that she had about the marriage and, second, to deal with the "hang-up" she had regarding physical contact with A. This was in agreement with the results of the scale. There was a great deal of discussion until these statements were made and I found it difficult to get the client to state these problems as concretely as possible. When A. responded to the invitation to state the problem as he saw it, he felt that he too had a physical block and expressed it as not wanting "to kiss my wife". This led him to believe then that there was something "basically" wrong with the marriage. Moreover, for A., this lack of physical contact with C. had been compensated for in another relationship.

As we went on, efforts were made to help the couple begin to discuss their differing perception and disagreements. A task was developed whereby they would dialogue about their concepts of love. This was a general task. A more operational task was that they would endeavour to be able to express each other's point of view to the other's satisfaction. This was begun in the therapy session using the technique of guided practice. The therapist entered into a dialogue with each person using such interventions as clarifying, reflecting and paraphrasing so that this would serve as a model.

However, by and large, outcome in this case was dissatisfactory. One of the problems was the fact that there were so many missed and cancelled appointments. This was caused by the fact that A. had to be away for business reasons and, at the end, for a vacation. This resulted in a sense that whatever

meetings we did have were more like individual sessions starting from the beginning in each one. Therapeutic direction and intensity were also lost because of this irregularity. Another problem that I experienced in this case was the fact that much of the discussion tended to be cerebral leading to philosophizing and rationalization rather than action. This lack of action is, of course, a serious consideration in the use of this model. This, in turn, led me to lay down tasks and then get agreement on them instead of having the couple generate their own tasks. Such an approach reflected my impatience with the way in which the sessions were going. This may also reflect the fact that task-centered treatment was not the approach of choice in this case. It is possible that the couple required an approach that met their expressive needs.

In summation then, I can say that it is not possible to estimate what gains or losses occurred as the result of this intervention.

CASE RECORD - 6

W. and R. were seen for seven sessions. They had been having weekly sessions with another therapist using a Rogerian orientation for the previous four months. W. was 37 years of age, suffers the effects of a childhood attack of polio, and is a teacher by profession. R. worked in the home and was also 37 years of age. They had three children, ranging in age from three years to seven years. The two oldest children are adopted. (See Table 11 and Appendix 3, page 6)

As we began to explore the problems, R. explained that she felt that she was "lacking something". She clarified this by talking about a desire for "closeness", "affection" and intimacy" with W. She felt that she wasn't getting this now and did not feel an"openness" toward him. In terms of the model, it would appear that R. has a problem in the areas of interpersonal conflict and dissatisfaction with social relations. W., in his turn, saw the problem as being one of a lack of mutual understanding; problems in their sexual relations; and problems in their communication patterns. In terms of the problem classification of the model, it seems that W.'s problems fall in the same category as his wife's. In fact, one could even suggest that his delineation was a specification of R.'s more general statement. During the first session they both completed the Dyadic Adjustment Scale. In this first

TABLE: 11

CASE RECORD: 6

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	14
1	9
2	5
3	2
4	1
5	0

Missing: 1

test substantial disagreement showed up in many areas. Some of this sense of disagreement was shared by the couple. However, much of it was not and R. seemed to see more and deeper disagreement than her husband. The most serious problem areas seemed to be around the issues of a philosophy of life, things shared together, affection, leisure time activities, and household tasks.

In the beginning session R. expressed herself and demonstrated a high level of anger. This came to light in her discussion with W. as she threw out challenges to him--to "teach" her to be a "good woman"; that he was "afraid" of her; and for him to be a more aggressive lover. In all of this there was dysfunctional communication as evidenced by mind reading, labelling, interrupting and a difference of perception. This last item came to light as R. was saying that she wanted him but received no response. W., on the other hand, wanted her but got no response. As this session unfolded it became increasingly clear that the couple should work on their communication. The session, then, was used for the sake of getting the couple to demonstrate their communication styles and as the problems emerged, develop tasks. The session ended with the couple agreeing to undertake a shared conversation task to talk face to face about the way they talk.

The next three sessions were used to deal with communication exercises. These exercises were done during the sessions and tasks were agreed to and designed to put into practice the

skills discussed during the sessions. These skills were communication skills--paraphrasing, reaching for information, attending, staying with the issue, labelling, reaching for feelings, and methods of sidetracking. As we indicated, the couple agreed to work on the various contentious issues in their relationship (leadership; mutual expectations; intimacy) between sessions using skills developed in the sessions. This development took place through role playing (involving the couple and practitioner), simulation and guided practice. During the fifth session we began with a review of a task set up in the previous meeting. The task that they agreed to was to discuss their expectations of each other prior to marriage. The review showed that they had trouble with this. In order to help them with this task, the practitioner asked them to prepare a list of their expectations. This exercise took approximately fifteen minutes. They were then invited to use this list as a basis to begin their interaction. I found this intervention helpful for the purposes of assessment, encouraging the couple to begin talking and providing a structure within which they could articulate their expectations. During the ensuing dialogue between R. and W., a number of issues were touched on. W. expressed the opinion that R. did not like him as he was and wanted to change him into her ideal. He felt that her expectations of him as a husband had changed. This led to the expression of R.'s feelings that his commitment to change was not there; that he was afraid of her and had retreated from her sexually. She also expressed a desire for him to be

more initiating in their life together and specifically in their love making. Throughout this dialogue the practitioner made several interventions. These included stopping the dialogue and providing interpretation, seeking clarification, modelling a piece of the dialogue now with one partner then with the other, and some general advice giving. In addition to this, the whole session had been structured in such a way as to provide an opportunity for guided practice. As the session drew to a close, they agreed on a task--to talk about how they talk using their sexual relations as an example.

In the next session they began by making statements that seem to indicate that they both have a sense of inferiority. For R. her inadequacy comes to the surface in the face of what she calls a clever use of the language by W. (seen in puns). W., conversely, feels this inadequacy when she begins to suggest that it would be better if she left. However, he acknowledges that it is easier to talk about such issues now than it used to be. As if to confirm this, W. reacts to R.'s statement that, at one time, she had thought of leaving. In dredging up past conversations, W. brings up a past comment of R.'s on their honeymoon. His perception of this type of statement is that she really means it, although he gets the message that it is said more in anger than from conviction. In any case, W. became visibly upset (stutter; tears; shaking). His feelings and strong memory of what she said concerning her disappointment with the honeymoon seem to indicate a frail sense of worth and poor concept of his ability to perform in his husband role

which may be accentuated by his limp. After letting the interaction run on, the practitioner attempted to slow it down. An invitation was extended to W. to explain his perception and its impact. We, in this way, asked him to share his belief system about his marriage and about he and R. The session came to a conclusion as we invited them to dialogue about their individual sense of being inadequate which engendered feelings of rejection and anger.

The remainder of the sessions were spent in trying to generalize what they had done during the previous sessions. We also used the technique of diagramming the sequence of an argument. The purpose was to lead them to articulate what they were really fighting about.

In presenting feedback to the practitioner they felt that there had been some progress. They felt that the therapist was direct and that "evasion was not easy". Finally, they suggested that the tasks should be written out.

Three months after their last session this couple completed a second Dyadic Adjustment Scale. In looking at the second set of scores, we note that movement occurred in twenty six of the items. Twenty of these movements we describe as positive. Positive, inasmuch as the couple's perceptions are closer and more optimistic. Substantial positive movement occurred around the areas of the philosophy of life, household tasks, and leisure time activities. Things are seen as going well more often; they are calmly discussing things more frequently; and they are working together on a project more often;

finally, not showing love is not longer seen as a problem. There were six items that reflected negative movement. Negative in the sense that perceptions are drifting apart and there is less optimism. This is particularly true of R.'s commitment to her husband. (See Table 12 and Appendix 3, page 6)

In summation, then, these instruments seemed to infer that there was a definite improvement over a variety of issues between the first and second test. It also seemed to indicate that the wife's perceptions seemed to change on more items and in a larger order. The husband, on the other hand, tended to be more constant in his responses although he too reported perception change. For both man and woman their reported changes seemed to be in a positive direction.

TABLE: 12

ASE RECORD: 6

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	10
1	17
2	4
3	0
4	1
5	0

CASE REPORT - 7

C. and I. were seen for six sessions. C., 27, was born in South Africa, having left there at age 16 and come to Canada. He was a graduate student at the university. I., 34, was born in England and came to Canada at age 22. She was a part time student at the university and also worked part time as a receptionist position. They had been living together for two years and now were experiencing difficulties. (See Table 13 and Appendix 3, page 7)

In the first session the practitioner gave a brief description of his own background and outlined the kind of therapy that he was able to offer. This included a brief description of the model used in the practicum. They agreed to carry on and at this time completed the Dyadic Adjustment Scale.

The responses elicited by this scale indicated that they shared a common perception on the majority of items. It also showed that in the majority of cases there was a high level of agreement in these areas. Except in one or two instances this characteristic of shared perception obtained.

On the basis of the scale we find areas of disagreement on the issues of demonstrations of affection, friends, and conventionality. They have different perceptions of the frequency of quarrelling, getting on each other's nerves, how well things are going, frequency of laughing, degrees of

happiness and amount of time spent together on a project. It is interesting that they both show varying degrees of pessimism. One of the lowest scores relates to correct or proper behaviour and they both express that they have thought of separation or divorce a great deal.

In the first session after completing the scale the couple were invited to express what they saw as the major problem or problems. C. saw the main problem as his "inappropriate behaviour". He felt that he lied a great deal to I. particularly when it came to his continuing attachment to a prior relationship. He described this as one lie leading to another and hence "spinning a web". He also expressed the feeling that he was in a great fog with his mind "misted over" by problems. I. in her turn, saw that there were three problems: her lack of trust in the relationship; the previous relationship to which C. seemed to have a continuing attachment; and her own growing use of "hostility" and "nastiness" triggered by her perceptions of C.'s behaviour. These statements seem to amplify the responses to the questions of the scale. This is especially true in the area of conventionality or correct behaviour; in the area of quarrelling and in the area of general happiness. In terms of the problem classification of the model, it would appear that the couple have difficulties in the area of interpersonal conflict. They are involved in a relationship from which it is difficult to extract themselves and each is behaving in a way seen as objectionable to the other. During this first interview our time was devoted to presenting each partner with an

TABLE: 13

CASE RECORD: 7

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	22
1	8
2	1
3	0
4	0
5	0

Missing: 1

opportunity to express their view of the problem(s). This was something of a slow process as the couple proved to be deliberate in speech and somewhat reticent. The practitioner therefore intervened various times in reaching for more information and clarifying. As the session drew to a close, the couple's attention was drawn to the need to design a task to be done between sessions. Gradually, as they worked on this they agreed that they wanted to discuss the problem as they see it for a longer period. This was then set up and the session ended.

The second session began with a review of the task. I. said that as a result of their discussions during the week she felt that the problem was the overriding thing and she wanted to "get it behind us". Refining the problem further, I saw it basically as C.'s apparent inability to shake off the previous relationship. C. felt that the problem was there. He felt that her perception of the problem was causing problems for them. During the session C. admitted to a difficulty in facing things and found it hard to say to her that "I have been lying.". I. expressed anger and disgust at C. for his behaviour and was insulted by his willingness to "modify" promises. During these interactions the practitioner allowed the exchange to carry on directing them to speak to each other as they began to use him as a referee. The practitioner also attempted to help the couple to crystallize their thinking and help them to state what it was that they wanted to modify. This resulted in I. making the declaration "I want to be the only one!" As we

once again focused on a task, they agreed that they would begin to discuss ways of dealing with C.'s attachment to his previous relationship. By this point it was becoming clear that they were experiencing some problems with their communication problems. When this was checked out, they confirmed this perception and accepted the idea that a future session include work on the way they talked to each other. In view of the fact that a group would not be available, they were offered this exposure within the context of a conjoint session.

As usual the next session (the third) began with a review of the task that they had agreed to at the end of the last session. They indicated that they did not complete this task. Consequently, we agreed that this present session would be devoted to a working out of this task with the practitioner monitoring communication and to interrupt where he felt it was appropriate. The goal was to reach a decision on a specific action step. My intent during this session was to help them to come to an understanding of the concepts of paraphrasing and labelling. Interventions then were made at specific points in their dialogue in order to point out to them where they were getting caught up in point making statements as opposed to seeking understanding statement. They said that they found this helpful and work continued until they came up with an action task. C. was to speak to the partner of the previous relationship to explain to her that he could no longer see her. This was to be done by the next session. It was agreed between C. and I. that I. would be present as a support to C. in what

was for him a difficult task.

In the fourth session we began by reviewing what had been happening during the previous week as far as the action plan was concerned. To this point C. had not accomplished the agreed upon task. The work of the session, then, was to discuss this situation and to review the task. During this dialogue the practitioner was again involved in helping them with their communication patterns: Once again stressing paraphrasing and the avoidance of labelling. It was clear that I. was putting a lot of pressure on C. to act on this task and equally as clear that C. was feeling very reluctant about it. This reluctance was expressed, for instance, in his statement that he felt that she needed someone just now and to tell her that he was going to have to sever their relationship entirely was a bit difficult. He explained that he wanted to disengage "gradually" and felt that progress had been made in this direction. I., on the other hand, was finding it difficult to see why it was taking so long and suggested quite strongly that C. represented more than moral support for this other person. The session was occupied entirely with this dialogue. Toward the end they agreed once again on the same task as last week. C. was to speak to the partner of his previous relationship and explain to her that he could no longer see her; I. was again to offer support. Prior to leaving the office they both agreed that they were satisfied with their task.

When they came in for the fifth session C. began by speaking to the task. He stated that he had told S. that he

could no longer see her. It appeared that C. was feeling somewhat uncomfortable with this and after checking this out this was confirmed. He and I discussed this for the remainder of the session. The practitioner used this dialogue to make interventions around listening skills specifically reaching for information. The point was to help I. listen to the difficulty of C. at this time in his life and to help C. gain understanding of I.'s impatience. As we have said, this was done through direct application within the dialogue and also done within the context of guided practice. In this last was included the idea of slowing down the whole exchange and offer them the opportunity of searching out a clear notion as to what was being said. As the session came to a close it was agreed by the couple that they would continue with this kind of exercise. As they left, the practitioner was not really sure that the decision C. had made was fully integrated.

After this fifth meeting the couple was not seen for a month. Part of this was pressure from academic work. However, as the practitioner tried to make contact with the couple in order to arrange another meeting, it was becoming clear that some deterioration was taking place. Finally, we were able to set up a sixth session. As this session began the practitioner asked about their last task. I. began by pointing out that C. had telephoned S. and had "lied about it". I. expressed a great deal of anger over this. C. himself did not really say too much in this session although he did feel "bad" about contacting "S." in this way. After some further discussion

the couple came to an agreement on a task: They were going to talk about whether or not they wished their relationship to continue or not. They were then to call the practitioner within a week to arrange another appointment if they felt that they wanted one. They did not contact the practitioner again and despite efforts on his part to arrange another session, this was not accomplished.

In assessing what was achieved in these sessions with this couple, one has to admit to a sense of frustration. No true termination took place although it is possible that the couple thought that it had. Certainly they were given an opportunity to work on their problem and had found the emphasis on communication and tasks "helpful". They also seemed to come to grips with the main issue of their relationship although one has to wonder how successfully. In any case, the couple has broken contact and no further sessions were arranged.

CASE RECORD - 8

L. and D. were seen for eight sessions. L. was 35 years of age and was divorced from his first wife. He had two children from that marriage, both of whom were living with their mother outside the province. D. was 24 years of age and this was also her second marriage. Both work in the social services field. They have one infant child from this marriage. This infant was brought to each session by L. and D.

In the first session, as is the custom with our model, time was set aside for problem identification and specification. It was elicited that they were having a difficult time with unresolved arguing and specifically they could not resolve a situation around L.'s children from his first marriage. L. very much wanted to have his son come and stay with them for a holiday in the summer. D. was having trouble with this because of previous negative experiences with the child. D.'s hesitancy seemed to be perceived by L. as outright opposition to the idea, whereas D. seemed to be making the statement that the kids should come as long as clear cut rules were set up and L. backed her up on their enforcement. As time went on, it became apparent that this couple's problems could be categorized in terms of our model in the following manner: First, there was a problem with role performance with regard to L.: He seemed to be having difficulties in his role as separated

parent and was feeling some sense of failure and even guilt about leaving his children in the care of his previous wife who he looks upon as something less than a perfect mother. Second, there seemed to be a problem of interpersonal conflict between D. and L. This was reflected in their arguments around issues that were never resolved. This seemed to be exacerbated by their faulty communication patterns. Third, there seems to be a problem around decision making, particularly around whether or not L.'s children should come for a vacation. Other potential problems were surfaced by the Dyadic Adjustment Scale that were not enunciated by the couple.

Following the usual plan this couple was requested to complete the Dyadic Adjustment Scale. The results of this activity are seen in Table 14 and Appendix 3, page 8.

On the basis of the test results they seem to share perceptions on a majority of the items. The test also reflects that they view most things with a high level of agreement. However, it must be pointed out that D. is somewhat less optimistic than her husband and more guarded in her answers. For instance, D. sees that being too tired for sex has been a problem while L. does not. Again D. sees that the issue of correct behaviour is a source of frequent disagreement.

In this second session after the scale was completed by the couple, discussion took up where it left off at the end of the first session. They reiterated the problem of the children from L.'s first marriage. There were two children--a boy and a girl. They both seemed to agree that the girl would not likely

TABLE: 14

CASE RECORD: 8

Differences between spouses' scores on Dyadic Adjustment Scale, Frequency

DIFFERENCE OF ...	NUMBER OF ITEMS
0	16
1	14
2	2
3	0
4	0
5	0

want to come and stay with them. However, they felt that the boy would. It was around this issue that much of their fighting took place. They were seeing this fighting as being destructive and failing to resolve the problem. D. also brought up the fact that she was somewhat concerned about the boy's behaviour. Apparently, he had stayed with them on a previous occasion and had created a number of problems in the home. Accordingly, she explained that she felt that clear rules should be set down if L.'s son was to come to stay with them. In addition, she expressed the belief that if these rules are to be effective, L. would have to be ready to enforce them. As the session grew to a close, they worked out a task--to try to work out an agreement under which L.'s son could come and visit them.

After the end of the previous session I felt that there might be a chance that D. felt manoeuvered into a position that she was not sure about. There was almost a feeling that the children were coming and there was nothing further to discuss. Therefore I began the third session by checking this out with D. When she indicated that she did feel a bit like that, L. became angry and accused her of "game playing". As they began to work on this, it became clear that their perceptions as to what rules were agreed to for L.'s son's visit were different. Also different was their concept of this child's role in their home. D. was insisting on some sort of behaviour code, while L. was pushing for the need to be flexible with the child. Finally, they also began to speak of these children's role in their lives together. At this

point L. was being aggressive, perhaps reflecting a certain guilt (for having "abandoned" them) and fear (of losing them). This exchange surfaced part of their individual belief systems; i.e., D.;s rules and L.'s flexibility. Out of this belief system proceed wants. The problem then is for them to agree as to the conditions under which L.'s children (or child) will make their visit. The practitioner's intervention at this point was to interpret what was going on in the communication patterns. A summary was presented to them as to what they seemed to be saying to each other. Finally, attempts were made to isolate the required action, trying to help them understand the obstacles and to interpret what one was saying to the other. After these initial attempts to identify target problems, they returned to their dialogue. Again problems in the way they talked to each other began to surface. L. indulged in a great deal of mind reading and labelling (telling her that she is "not honest"). D., on her part, also began to label and told L. that "You're feeling sorry for yourself." D. tried to make a deal: I'll be honest with you if you are more understanding with me. When he asked for clarification, D. suggested that he stop "dumping shit" on her. Intervention at this point consisted in confronting the couple with their communication behaviour. Instead of speaking with each other, they are arguing with each other and concentrating on making points. They also tend to take extreme positions. Thus when L. says that he just wants to "forget the kids" everyone knows that this is not what he really wants. In making this point, the practitioner was able to utilize the leverage of inaccuracy in attempting to change

his belief system. The session came to a close and they agreed to work on the following task: To discuss the rules for the children's visit and to write them down.

In the fourth session they mentioned that they had discussed their task during the period between sessions. Then they described an experience which for them seemed to be an effective way to parent. They were asked to look after a young child during the week and the experience proved to be helpful. D. especially was excited about it and explained that they had worked together and "backed each other up". D. then said to L. that she felt the experience was positive because of a number of factors: L. backed her up; she felt like an "equal" in dealing with the child; she was not being "second-guessed"; and all of this resulted in a more tolerant attitude on her part because she was secure in L.'s support. At this point the practitioner provided them with some air time to discuss this event and to help them make the connections with their problem around L.'s children coming to visit them. During this session D. brought up L.'s previous marriage and his previous relationship with his first wife. He met this by saying that it was not relevant. As this dialogue continued and showed signs of becoming circular, the practitioner intervened and entered into a dialogue with D. This effort was an attempt at guided practice in which the objective is to help the couple state each other's position so that understanding rather than attack is encouraged. The idea was to slow their exchange down and to help them define their problems with more

specificity. At this point L. made the statement that he gets "locked into" a form of communication which he felt was inappropriate. From the very start the practitioner had felt that while L. had come to therapy he was not in therapy. Using this observation as a starting point, L. and the practitioner entered into a dialogue. In this dialogue we covered the issue that perhaps L. feels himself to be a failure as a person and a professional. After all, it would be difficult for a professional in the field of child welfare to admit that he had a problem with his own children. The dialogue with L. was for the purpose of illustrating to him and to D. the concept of pushing for understanding in discussion rather than in ensuring that one makes his points. By using personal material from his own life, the practitioner attempted to establish linkages with L. in this area. The couple still had not come to a conclusion as to whether or not the children were coming in the summer. Accordingly, as they worked they agreed to work on the issue again between sessions. They agreed that they would work on coming to a decision on this matter utilizing some of the communication principles illustrated during this session.

The fifth session with this couple was not productive. As they were both feeling quite low it was difficult for them to interact. L. expressed serious concerns about his work and felt that perhaps he should just forget the children. At this point he became emotionally upset and the balance of this shortened session was employed in helping L. deal with his depression.

The sixth session with L. and D. (as well as the remaining sessions) took place in their home. In every session up to now they had brought their infant daughter. On several occasions she proved to be a real distraction but they had to bring her since they had no one that could provide a baby-sitting service. Home visits were then suggested and accepted by the couple. This session began with the practitioner summarizing what had happened in the earlier sessions. The predominant feature of this meeting with L. and D. was L.'s attitude. Throughout the session he demonstrated a resigned attitude. He was saying that he would never get the "kids" and while that wasn't good, he didn't feel that he could do anything else about it. He also felt that he was too "disorganized" and too "spontaneous" and was receiving this message from D. and the people at work. He summed up this whole frame of mind by saying that he didn't "want to fight anymore". D. reacted to this presentation by saying that it really didn't reflect how L. felt inside. She felt that he was trying to assume a "martyrdom" stance. Such was their disposition during this meeting that I asked the couple if they still felt that couple counselling were appropriate or whether in fact they felt that they could do better with another practitioner. They both felt that they should continue to meet. In saying this, D. also mentioned that there have been times when she felt like leaving and L.'s reaction to this was strong. It was the one time throughout the time together that he showed a willingness to enter into the session. D., and later L., expressed a desire

to work on communication, pointing out that she felt that they could deal with their problems if they could learn to communicate. The session closed after a dialogue with L. entered into by the practitioner to model for D. how to reach for feeling.

In the seventh session the couple appeared to be in a much elevated mood. D. had had her hair done and was smiling. L., for his part, was much more involved in the process and was willing to participate. He expressed an awareness of his non-involvement at times and his desire to argue with D. just for fightings sake. Earlier in the week there had been a call from his children and they both felt that they had handled it well. They felt this not only in terms of the actual call but in terms of how they related to each other after the call. While they admitted to feeling much better at this time, they also knew that there would be other down periods. A lot of conversation centered on L. and D.'s reaction to him (his moods, his fighting and so forth). During this session we used some of the material from the communication workshop to present principles of communication and specific listening skills. They were presented with a task to use these listening skills during the week between sessions. They agreed to this and the session was adjourned.

During the final session their mood was less elevated but still positive. We spent some time on negotiation skills, presenting them and using them in guided practice. In their exchanges it was apparent that L.'s feelings around his children was still a problem. They also seemed to have some problem

trusting each other with L. feeling that she has a "hidden agenda" and D. feeling that he "doesn't believe me". L. displayed a lot of emotion around the topic of the children.

In this final session they were invited to make any comments as to how they felt they were with their problems as opposed to where they were when they started out. D. stated that she now feels "less desperate". While the communication material was basically a reminder, it was helpful. L. felt that I was less directive than himself and this caused some problem for him. He would have preferred it if I was more directive. L. felt that he saw movement in D. and D. herself felt that the issue of the children had been settled or at least dealt with satisfactorily.

While this couple was sent out a second Dyadic Adjustment Scale to complete, it was never returned. I spoke with D. approximately three months after the last session and she informed me that the children had come out to their home for a visit during the summer.

THE GROUP EXPERIENCE

The original design of the practicum called for five couples to go through a sequence of ten sessions. At the fourth session these five couples would begin a group experience in which the focus would be on developing communication skills. As noted above, the basic material for these sessions would be Garland's Couples Communication And Negotiation Skills. In her forward to this work, Ruth Middleton points out that what is being offered to social workers is a mechanism whereby they might offer "short-term task-focused programs to couples interested in enhancing their marriages".(48) Garland herself makes the point that the workshop is "not therapy--it is skills training" which is concerned with "one aspect of the marital system--verbal interaction as it occurs in communication and negotiating conflict..."(49)

In the process of matching the proposal with the realities of practice, we encountered various problems that eventually altered the design. The crucial importance of intake for any proposal became apparent almost immediately. Our only group did, in fact, begin as planned; i.e., at the fourth session. However, while we had anticipated using five couples there were only three couples in therapy at the time. This fact was to present its own problems as the group evolved. It must be pointed out that even if other couples had started

the sequence, they would not have been invited to join the group since it was felt that it was important that each couple be roughly at the same point in the therapeutic sequence when they entered the group. The problem thus became twofold: To ensure that there were enough couples for the group and that they begin treatment at roughly the same time. We could not control for this and, as a result, we were only able to establish one group and that one group was not large enough.

During the introductory session of the sequence the couples had been informed that part of the counselling process to which they were committing themselves was a group experience. They were briefed as to what would happen during the sessions; who would make up the group; the length of the sessions; the location; and the times. After all of this the three couples indicated that they would attend the group. This was followed up by telephone reminders a day prior to each session.

One couple missed the first session. This was something of a problem since it left only four people (two couples) and the leader as part of the group. Despite this we went through the first session. When contacted, the missing couple indicated that they still wanted to attend. Again, prior to the second session, each couple was contacted and reminded of time and place and again each couple indicated that they would attend. However, the same couple missed the second session. Again, we went ahead with the second session with the people present. At the end of the second session the

participating couples felt that the third couple should not attend the third session. They felt that in a four session workshop they would have missed too much already. It was at this time that they suggested that I bring my wife into the sessions. After further discussion, I agreed to ask my wife to participate. She agreed and the last two sessions were conducted with three couples present.

The fact that the therapist was present with his wife is, I believe, something of an innovation. It is particularly so inasmuch as she has no professional degree and has had no previous exposure to any kind of group session. It would seem to have been a successful intervention for the following reasons:

- Her presence in the group was requested by the members of the group and hence was not imposed. This fact fostered the perception that this was their therapy and allowed them some control in its direction;
- The group reacted positively to her presence both during the sessions and in their comments after;
- The presence of the partner of the therapist gave some reality to this professional--he is married; he is likely to know our problems and has problems of his own;
- Areas of real disagreement between the therapist and his partner (not likely to be as immediate in the usual male/female co-therapy situation) were discussed. This encouraged a perception that therapist was not a member of a "perfect" relationship and helped to normalize disagreement.

- The presence of the therapist and his partner dealing with areas of real disagreement seemed to work toward minimizing the distance between therapist and client. It also seemed to ameliorate the sense of being "one-down" that the term "client" can imply.
- The modelling done in the exercise by the therapist and his partner helped to illustrate some of the points under discussion.
- The discussions entered into by the therapist and his partner over mutual disagreements demonstrated that difficulties do not arise from problems but from how they are handled.

In order to teach the various skills of communication and negotiating conflict, various techniques were used. These included the use of tapes, exercises, role playing and modelling. Preparation for the groups was essential. At the same time, while it was important to have something ready, it was equally important to have the flexibility to go in the direction chosen by the group.

Whether or not the group was effective in achieving the goals of the couples remains largely a question mark. To begin with, of the three original couples, only one responded to the post-workshop questionnaire. As we have mentioned, one couple never actually attended a group session. The second couple terminated their relationship after therapy so that no feedback was available. The couple that did respond felt that the workshop was useful. They saw it as providing "someone new to talk to" and "being made aware of specific ways in which we

were communicating poorly". This couple also felt that they have been able to use what they learned, although in the husband's case "not as much as I would like to". The wife felt that she had been able to use what she had learned "to a degree--we can talk about our problems better now". Both of the couples who participated in the group sessions were in agreement that the group would be more effective with four or five couples.

The couples seen in the second sequence did not participate in a group. It was discussed with all of them but for various reasons a group could not be developed. There were various reasons for this: Couples came into the sequence at various times; one couple had to complete their sessions quickly as the husband was leaving the city; one couple was very sporadic in their appointments as the husband was away for long periods of time on business trips; and, finally, two couples did not come into therapy until well into the sequence.

Based on my experience with this one group, I have a stronger conviction that this type of group technique must be utilized as a regular feature by those involved in couple counselling. Communication problems seem so fundamental and pervasive that dealing with them in this way is appropriate. However, in my estimation is it imperative that the group be composed of not less than four couples. I also feel that it would be effective to make greater use of audio and video equipment. The advantages to this would be to provide objective feedback on their manner of relating and to provide a method of

practising new skills. It is also necessary to be well prepared for the session so that the attention of the leader can be primarily on process rather than structure. Finally, the use of the therapist's partner is a technique that has shown great potential and will be followed up in my future work.

CONCLUSION

This presentation has been concerned with two things. First, I have presented a proposal for social work intervention that involved the utilization of short term therapy, task centered therapy, communication skill development, conjoint and group techniques and selected testing procedures. Second, I have presented my experience with this model. What follows is a discussion of and a reflection upon that experience.

I found short term therapy to be a useful model. It is highly goal focused, it does take advantage of the readiness to change inherent in intolerable situations, it certainly puts pressure on the therapist and his clients to work during the sessions, and it seemed to give the client a sense that this counselling would not go on forever; that there is a beginning and end which enabled us to deal with termination as we went along. This also had the effect of reducing dependency. Nonetheless, I found the structure imposed by this method to be, at times, frustrating. For instance, on a number of occasions the results from the various tests (Dyadic Adjustment Scale, and the communication questionnaires) did not reflect the same concerns verbalized by the couple in earlier sessions. In one situation a communication questionnaire revealed that the female partner was reporting higher levels of satisfaction than her male partner although it was her impetus that brought them to

the clinic. Despite my desire to deal with this anomaly, I felt that I did not have the time. Toward the end of the practicum I experienced a growing conviction of the importance of material from the couple's families of origin. This conviction was strengthened in a recently published article by Arlene S. Fontaine. She makes the point that couples develop their expectations and concepts of marriage from their experiences in their own family. Moreover, this important material is readily accessible and less threatening than a discussion of their own personal pain.(50) Again, time constraints prevented me from acting on this conviction in an effective manner. In working on the material from families of origin the therapist would also be able to present the couples with the opportunity of gaining access to hidden expectations and contracts. Sager has noted that people enter marriage with individual contracts relating to what they expect their obligations and benefits to be. He further states that the partner's awareness of these contracts can be on three levels: A conscious, verbalized level where the partner expresses what they expect to give and receive in the relationship; a conscious but not verbalized level where the partner has the expectations but does not express them, and a level that he calls "beyond awareness" in which the person seeks to satisfy desires or needs of which they are not aware.(51) Yet I found that given the time constraints imposed by the ten session sequence, I did not have the opportunity to attempt to surface these hidden expectations (contracts). In my opinion, such is the importance of material

from families of origin and the hidden contracts that my future work will be designed in such a way as to get at this information. I believe that this might be operationalized by adding at least two sessions. In addition, I intend to use the initial session as a purely administrative and testing session. Thus, we would cover such items as the type of counselling that I am prepared to offer; to obtain a firm commitment to consider this work as a top priority in their lives should they accept this form of counselling; to begin to set up a contract with the couple; have the couple complete the one or two tests; and help the couple generate their first task(s).

As we discussed earlier in the presentation, the type of group that was to have been used during the practicum was not so much a therapeutic group as it was a workshop. The couples were to enter this group not for the purpose of presenting or dealing with the type of material surfaced during the conjoint sessions but for the purpose of acquiring specific communication skills. The issues of small group dynamics were clearly discernible as the workshop evolved. The group went through phases of development that paralleled Parson and Bales stages:(52) In the beginning the couples were introduced to each other and testing behaviour began such as light attempts at humour, seating arrangements and so forth (information and orientation; inclusion). A leader was quickly identified in the person of the therapist who coordinated the group and was to present the material to the group (evaluation and opinion-control). Finally, as the second session came to a close, the

couples began to get closer and establish linkages to the point of sharing time together after the group. This feeling seemed to emerge as they gained experience working with each other (action and positive social-emotional support--affection). The leadership style in the beginning was authoritarian as the form of the workshop was detailed, work set up and tasks assigned. However, as time went on this was less and less the case. In one instance, the therapist went to the blackboard to illustrate a point and one participant asked if that type of lecturing was necessary. This intervention by the group was important for it established the norm that to question the group leader was appropriate and, in addition, helped the leader to steer the leadership style toward a more democratic mode. The success of this particular intervention was illustrated in my judgment by such group action as deciding times to meet, a request to have the wife of the therapist join the group, and the subsequent high level of participation by the therapist. As the leadership issue became more balanced and the group established norms for itself, the climate or atmosphere using the terminology of Bion[53] began to shift from dependency (a traditional mode emphasizing leadership) to one of pairing (emphasizing mutual support). As was anticipated, various members of the group carried out various roles: The leader (therapist) initiated activity, gave information, offered opinions, elaborated, coordinated and summarized. Several members in the group sought information, sought out opinions, and expressed group feeling. All of these being task roles. As time went on and

the level of participation by the group leader became greater, these roles tended to circulate.

In my opinion, one of the more exciting developments in this phase of the practicum was the inclusion of my wife in the group. It must be emphasized that this notion came unsolicited from the group itself and occurred at the halfway point of the group's existence. A second important point is that my wife has no professional degree and had never been involved in any type of group in the past. It is this last point that makes this intervention unusual. At the beginning of the third session my wife and I engaged in role play in order to illustrate the need for listening skills. We used as material for this role play an actual situation that occurred in our home. The intention was to run through the role play once illustrating the common problems that couples have in listening. We would then solicit the group's opinion as to what was done wrong. Finally, we would repeat the role play using the listening skills that had been discussed. In this process we found that the group not only discussed the mistakes in the role play but went on to give ideas as to how we might solve what for us was a problem in our relationship. Thus we became, very quickly, members of the group. Roles became reversed and we found that the therapist was learning from the client. Other developments also took place. As members of the group, the leader and his wife were in a position to influence group process from within rather than from above. The revelation that the therapist has real problems of

his own which he is working on tended to normalize the other couple's problems so that they were not seen as unprecedented and insoluble catastrophes. This, in turn, develops a mutuality between client and therapist which tends to minimize the possibility of stigma attached to a person labelled "client". It seems to redress the situation where the client is "one-down" simply because they are a client. When the client perceives that he/she can actually help a helping person it seemed to me that a reciprocity was set up leading to a balanced relationship. I expect that this will have the effect of modifying the couple's fear of therapy and will enable them to seek out help more readily in the future. This, of course, is one of the primary aims of the task oriented approach.(54) There certainly is need for equilibrium here since the therapist's position gives him a mantle of authority which for Reid is effective(55) in the helping process.

While this particular intervention may be unusual and interesting, it is also one that is accompanied by potential hazards. There is the possibility of losing control of the group. It is also possible that the therapist may monopolize the air time within the group. Part of the rationale for using this intervention was that it was seen as an opportunity to establish mutuality and reciprocity between client and therapist. One might well ask, however, what does this say about your own needs? Why do you wish to be "like your clients"? Furthermore, if you are like your clients, what do you have to offer them when they come to see you as a professional.

A related issue to this point is expressed by a concern around the possible conflict of roles that the therapist is carrying out. There is also danger in exposing your own relationship with your mate to this type of forum. One should also remember that the relationship of the therapist with his/her mate is not necessarily the one true model. More accurately, one must say that it is a relationship that works for these two people. Finally, there may even be legal dangers involved with this type of intervention arising from the issue of confidentiality.

All of these caveats bring to mind issues that must be considered if one is to use this approach. Perhaps the central point here is--What is a therapist? It would appear that there are numerous beliefs connected with this role. Some would see this role as being primarily that of a leader; others would see it as that of a teacher; some see the therapist as a counselor; some as a friend and so on. Therapists assume all or any of these persona from time to time and from setting to setting. What is, in my opinion, a central reality here is the fact that whatever role they assume therapists share a common humanity with their clients personalized by the individuality of their experience. In my judgment, it is this reality that must inform our work and has provided the context for this particular intervention.

Unfortunately most of the conclusions as to the effectiveness of the workshop must remain tentative. The actual group itself was very small and the feedback was even more

restricted. What did come back in verbal and written form was the following: A sense that new skills had been learned on the part of the participants; that other couples had similar problems; that the group was too small; that the presence of the therapist's wife was helpful; and that what was learned was not applied in their everyday lives as much as they would like. For my part, I felt that the workshop was useful in its emphasis on doing as opposed to talking in the actual sessions. I also feel that further work should be done on helping the couples use the skills in everyday life and that further testing should be done using the therapist's wife as co-therapist. From the feedback and measurements then[56] I feel that the workshop was effective, although on a limited scale.

In this next phase of the discussion I would like to deal with the question of what actually happened to the couples who were exposed to this type of intervention. However, before addressing these specifics I would like to take some time to make a few observations about the environment within which the profession is currently working.

It appears to me that there is a growing demand upon human services to demonstrate their effectiveness and to be accountable. This is evident to me in my own professional life and in a brief survey of the literature. In an article written in 1978 Stretch[57] argues that with an ever increasing expenditure in the area of human service delivery by the public sector, it is important for each service organization to "clearly delineate the scope of its charge," and to

"clearly define its mission". In addition, the organization must marshall its resources in the best possible way in order to fulfill its mission. This is echoed for the individual social worker by Haselkorn(58). She points out that there are strong arguments for accountability both within and without the profession and claims that "We have entered an era which demands evidence of effectiveness." It is my belief that Social Work must deal with this issue. If we do not then inappropriate and unrealistic standards will be placed on our performance to the detriment, if not the demise, of the profession. A promising approach is exemplified in the work of Leonard Rutman and his concept of "evaluability".(59) In his writing and work Rutman appears to have been dealing with the large social service programs of the Government of Canada. Nonetheless I feel that many of his comments can be applied to the work of individual practitioners. He makes the point that the process of evaluation is an effort to test "the efficiency and effectiveness of particular programs".(60) He argues that in order to do this the program must be "evaluable". For him a program is evaluable if it meets three preconditions: First, there must be "a clearly articulated program". By this he means that everyone is referring to the same thing when they are talking about the program. This clear definition, then, is something that everyone recognizes and makes measurement that much easier. Second, a program must have "clearly specified goals and/or effects". He makes the point that too often this is neglected so that you have goals that are vague or long

range or you have contradictory goals. Thirdly, the program should have "a rationale linking the program to the goals and/or effects". By this he means that the reasons why the program will reach its goals and/or effects should be stated.

Now when evaluations are made as to efficiency and effectiveness in order to meet the demands of accountability, one must be cognizant of the fact that efficiency and effectiveness mean different things to different people. Politically there may be a decision to discontinue a program or close an agency. Evaluation, then, can become a means to that end. Effectiveness may mean one thing for the client and another for the therapist. Again what may be efficient and effective to government may not appear so to the general community. Rutman refers to Suchman(61) in making a similar point. He notes that there are numerous motivations for conducting evaluations and indicates that Suchman calls such exercises "pseudoevaluations". He gives five examples:

1. "Eye-wash - a deliberate focus on the surface appearance of a program to make it look good";
2. "white-wash - an attempt to cover up program failures during the investigation";
3. "submarine - the political use of research to destroy a program";
4. "posture - evaluation research is a ritual having little substance";
5. "postponment - using evaluation to postpone needed action".

When the profession makes the claim that the terms effectiveness and efficiency are relative, there may be a danger of such a position being construed as fear of critical appraisal. It seems to me that this challenge should be met simply by stating that these terms are in fact relative and that the profession is developing and utilizing its own models of evaluation. I feel that in this way the profession will not be seen as merely reacting defensively but as actively grappling with the issue and initiating solutions.

It is my belief that the interventive program that I have developed for this practicum does indeed grapple with the issue of efficiency and effectiveness. It is a program that makes an effort at being evaluable. Its various elements impose time limits, set goals, require continuous feedback and measure results. The results that are achieved are linked to the basic concept that the client can develop skills in communication and problem solving in order to achieve the goals he/she has set up with the therapist.

It is now opportune to shift our attention to the clients seen during the practicum.

In all, a total of eight couples were seen during the period of the practicum. Of the eight, three couples have now separated; and of these three, one couple did not complete the agreed upon number of sessions. Five of the couples remain together and of these, two did not complete the agreed upon number of sessions. It was our intention to take a measurement of each couple upon completion of their therapy and three

months after therapy. In reality, the three month measurement was the only one used after completion. Obviously, the couples who did not complete the program (three) did not complete the final questionnaire. Of the remaining five, only three completed these measurements. In terms of written feedback then, there is little information to go on. Each of these cases have been discussed earlier in the case records and some notion of progress is conveyed. However, there is too much reliance on the verbal feedback of the couples during the closing session. That is not to say that such information is meaningless but it is hardly adequate. The three month reading that we were able to get from two couples was more interesting, dealing as they did not only with a progress report but some sort of notion of the strength of any gains noted by the last session.

In the case of the first couple, J. and A., they neither completed the agreed upon ten sessions nor the final measure. In fact, this couple separated during this period. The role of our intervention in this separation is impossible to say with any high degree of accuracy. However, one one say that they were followed closely, were visited in their home during a crisis period, and were encouraged strongly within the framework of the therapy to begin working on the problems that brought them to counselling. A. and L. completed their ten sessions, all measures and participated in the communications group. They report that they now have a clearer understanding of the issues dividing them; they also report that their communications are more functional and have a concept of what now

must be done. G. and M. completed the ten sessions, participated in the group but did not complete the final measure. Shortly after their sessions were completed they separated. Again it is difficult to assess the role that this method played in that decision. However, I feel that I can speculate that the individual and group sessions clarified some basic issues (for example, the male partner's goals in life; his intentions vis a vis his studies; etc.) especially for the female and action ensued soon after termination. In the case of D. and E., while they attended all sessions, little follow-up was done on the effect of the method because D. left for another city to pursue his career. It would seem that his departure was in fact a separation even if both were seeing it as a "cooling off period". From individual conversations with both partners after therapy, it would appear that the level of recrimination will remain high. C. and I. did not complete their ten sessions nor did they attend a group and they did not complete a final measure. However, the male partner had completed an agreed upon task during therapy and then had reversed himself. This had been difficult for the female partner to accept and at last report they were seriously contemplating a separation. During therapy I. had pressed strongly for C. to take some sort of action and when he failed to accomplish this it seemed to resolve an issue for her (i.e. his commitment to an exclusive relationship). L. and D. completed ten sessions but did not enter a group nor return the final measure mailed to them. However, at the last session and during a recent telephone

conversation they do report "better" communications and they also reported that one of their goals was achieved--i.e. having L.'s children from a previous marriage come for a visit. This union is still intact. W. and R. completed their ten sessions and their final questionnaire but did not participate in a group. They reported gains across a number of issues and are still together. Finally, A. and C. did not complete their ten sessions, did not attend a group nor did they complete a final measure. Because of his business schedule, appointments were hard to set up. This made for a lack of consistency and prevented us from gaining any momentum within the treatment phase. At last report they were still together but I would feel that very little changed as the result of our sessions together.

In summation, then, I would say that the interventive model was effective in those cases where the couple attended all sessions, completed before and after measures and particularly where they were a part of the group. It seems that when a focus on behaviour change was maintained with consistency and constancy, change did in fact occur. It would appear that in the majority of cases something happened--the couples came up with decisions to separate, change jobs, remain together to work on problems that they surfaced during the sessions. In this sense, I see this method as being effective.

One of the distinctive features of the model used in this practicum is its insistence on tasks. During the sessions tasks were used but often my tendency was to impose tasks rather than allow the couple to generate them themselves. It

seems to me that this was set up by a combination of my awareness of having little time to work with and my own directive style. However, I found that the effort to encourage couples to develop their own tasks had a marked effect on whether or not the task was completed. I also feel that when tasks were not completed that I should have been more agressive in challenging them as to why they were not done. One of the more positive things about task centered therapy is that it imposes work on the couple. I feel that in order for me to allow people to work, I should utilize the two hour session as Mace suggests(62) and once having gained some access to communication patterns and belief systems, impose a firm expectation on the couple to act. It was also suggested by several clients that when the tasks have finally been decided upon, they should be written out and made available to the couple. This would serve as a memory aid between sessions.

After using this model during the practicum, I feel that one of its more attractive features is the amount of structure that it provides. I found that preparation for each session was essential and the model aids that preparation by providing structure; problem delineation by the client; problem classification; task selection; task implementation and review all provided a framework on which to develop treatment strategy. This structure also seemed to give the client a sense of order. When experiencing a period of confusion and disorganization, such a sense of order was seen as desireable. Of course it is necessary to stress that the structure is a

means to an end to provide order and to move things along. However, I also found that it was important to let the client choose the direction of a session if there was something specific they wished to deal with. In this way one retains flexibility while having something to return to if necessary. As part of this I also feel that the therapist must be ready to move into other areas of therapy more quickly. In one instance I feel that it would have been appropriate for me to see the children as well as the couple at least on one or two occasions.

At this point I would like to turn to a point that Reid makes in presenting his model.(63) He points out that the model is probably most effective for clients on the lower end of the income scale. This is so, he states, because such people are more at home with a model that emphasizes action and that deals with obtaining resources that they don't have ready access to. After using this model with clients who were not at the lower end of the income scale, I feel that I would take issue with this point. It appears to me that most clients prefer to have a model that emphasizes action. While they may be more able to use introspection or insight, they also have problems that they wish to resolve.

One important reality that I felt was re-emphasized during the practicum is the tension between design and practical reality. That is to say, what may appear to be effective on paper may not eventuate in practice. This has proven to be particularly true in the area of intake. It is at this crucial point that much was decided: the number of couples; the

type of couple; the time of entering therapy and so forth--all of which can and did have critical influence on the course of the practicum, especially in the second sequence.

Another significant consideration to be expressed while making concluding remarks about design and reality, is the notion that the practitioner must be prepared to be flexible. Apart from all of the issues that make it difficult to execute a practicum design, it is imperative to remember that while the practicum may represent an academic requirement, the therapist is, nonetheless, dealing with persons in difficulty and their needs must take precedence.

A large number of sessions both conjoint and group were taped for audio. This type of intervention has distinct advantages. For example, it was useful to replay the tape to hear the couple's interactions during the session. The use of the tapes also helped the therapist in assessing the impact of the partners on each other. The tapes also provided a reality test for some of the impressions they took away from the sessions. Finally, it was an effective means of assessing the kind of verbal interactions that led to conflict or misunderstanding. After completion of the practicum, I feel that more attention should be given to the use of audio and video. During the sessions that were being taped (audio) several clients asked to hear them. This interest was responded to on a small scale. There were two reasons for this. First, time pressures: In order to listen to the tapes so that significant interaction can be replayed is time consuming both before and during the

sessions. In addition, at least two researchers suggest care in the use of this type of technique.(64) Nonetheless, in the future I feel that I will make greater use of audiotape and, where possible, videotape. It is my opinion that use of this technique should be shared with the clients. It will provide the couples with an objective record of their interactions; it will help them to record agreed upon tasks and it will help them to assess their impact on each other as they work within the session. This would, of course, be particularly true of videotape.

In evaluating my own interventions as I employed this model, I would say that they tended to be too often and too didactic. My basic style is directive and the use of the model tends to encourage a directive style. It will be important for me to monitor this closely in my professional life so that it does not become inappropriate. A major error that has already been mentioned was seeing one member of a couple in an individual session. The disadvantages of such an intervention far outweigh the advantages in my estimation. This experience tends to reinforce my support of conjoint methods. There does seem to be a place for individual session however. At times I felt that it would have been effective to see each partner individually during the time usually set aside for conjoing sessions. This type of manoeuvre would retain the necessary balance and yet would provide an opportunity for the therapist to be more frank with each partner in his assessments or questions without seeming to side with either one. I also used my own personal

experiences in marriage as a source of examples as a linking technique. This was consistent with my growing belief in the fact that the therapist in order to be effective must appear real to the client. It was also used in order to establish mutuality between the therapist and the client; to minimize labelling and to normalize conflict. Finally, such an approach enables the therapist to use the resources of his/her own personality as Rhodes discusses in a recently published article.(65) I now hold the conviction that it is absolutely imperative for the therapist to analyze what happens in each session; either using tapes or notes. The result of this analysis should be brought back to the couple for the next session. In essence then, preparation is crucial in my experience during the practicum. In this regard I felt that a full week between sessions was too long. It seems that the momentum and intensity is lost during this period. Perhaps it would be useful to have a mid-week assessment either by telephone or home visit. This consultation would cover task progress, maintain treatment momentum and intensity, support readiness for change and challenge non-performance. Home visits were also done during the practicum. It was a helpful intervention for the couple as they had an infant for whom babysitting services were not readily available. However, there were disadvantages. During our sessions in the home there were several interruptions caused by the telephone, visitors and so forth. The atmosphere in the home was casual almost to the point, in my estimation, of being dysfunctional. The physical surroundings also presented problems

and were not conducive to a therapeutic milieu.

The measurements that were used were helpful in maintaining our focus on what was achieved. The Dyadic Adjustment Scale did not prove to be totally satisfying (i.e. one couple saw it as ambiguous) but it was helpful as a base for assessment both before and after application of the method. In the future I feel that it would be more effective to share the results of these questionnaires more fully with the client. This sharing would afford the couple an opportunity to discuss their perceptions of the various issues raised on the questionnaire. Often the perceptions of the partners were dramatically opposed (this was true on the Dyadic Adjustment Scale as well as the communications questionnaires) and yet there was a feeling on both sides that their perceptions were shared. To be able to show this as not being the case would be productive in determining areas for discussion and action. The scale was also useful in tracking movement in client's perceptions before and after treatment. I feel then that such measurements are important in developing a sense of the effectiveness of methods of intervention (accountability) and will be an integral part of my work in the future. As part of this, there will be ongoing efforts to obtain more accurate scale as well as to refine whatever we have now. While I am convinced of the necessity for some sort of scale in counselling couples, I also feel that their use should be restricted. During the practicum I noticed a definite resistance on the part of the clients to filling out questionnaires. Such resistance could

make their use counterproductive and hence they should be applied judiciously at key points in the process. Certainly one should be done at the beginning and one should be done at the end. I feel it more appropriate to test approximately three months after the last session. However, this presents its own problems of distribution and retrieval.

In closing, I would say that the intervention model developed for and used in this practicum is one that I am now familiar and comfortable with. It is compatible with my professional style and values and it is open to refinement. In addition, it also provides the practitioner with a handle on the issue of evaluation. It is a model that I feel stresses my own professional accountability both to myself and the client. Working out of such a milieu the environmental demand for effectiveness and efficiency becomes less a threat and more an opportunity.

FOOTNOTES

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APPENDIX 1

COMMUNICATION QUESTIONNAIRES

Preworkshop Questionnaire
Communication in Marriage

Please answer this questionnaire as honestly as possible. It is not meant to assess you or your marriage: it is intended to help us know what the interests and concerns are which you bring with you to this workshop.

What is the biggest problem you and your spouse have in communicating with one another?

What do you hope to get out of the workshop?

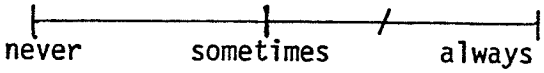
1.

2.

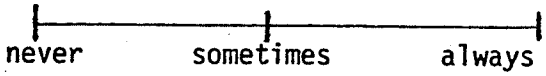
3.

Answer the following questions by putting a slash on the line to indicate your answer.

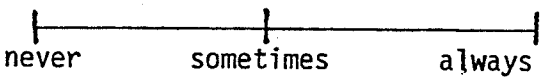
Example: I enjoy watching TV:



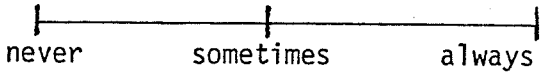
1. When I talk to my spouse, my spouse listens to me:



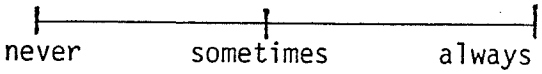
2. When my spouse talks to me, I listen to my spouse:



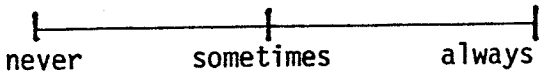
3. When I talk to my spouse, my spouse leaves the room or reads the paper:



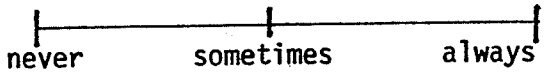
4. When my spouse talks to me, I leave the room or read the paper:



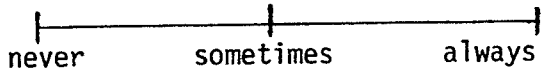
5. When we argue, my spouse is interested in what I have to say:



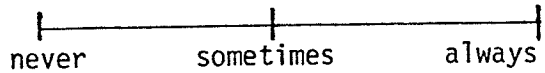
6. When we argue, I show my spouse that I am interested in what he/she has to say:



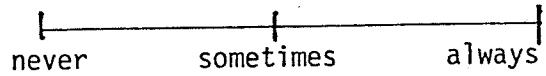
7. When we are discussing something, my spouse shows interest in my viewpoint by asking me to tell more about it:



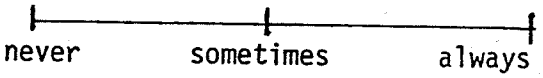
8. When we are discussing something, I show interest in my spouse's viewpoint by asking him/her more about it:



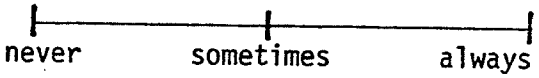
9. My spouse is able to state my position in an argument:



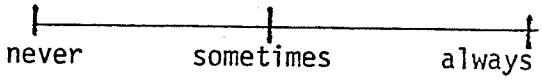
10. I am able to state my spouse's position in an argument:



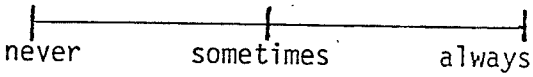
11. My spouse misses the point of what I am trying to say by taking me too literally:



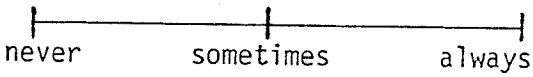
12. I miss the point of what my spouse is trying to say by taking my spouse too literally:



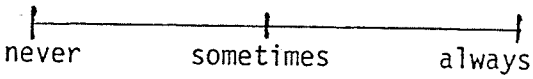
13. We reach some kind of agreement after we argue:



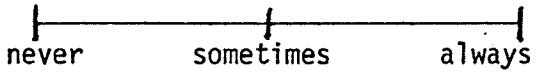
14. When we argue, I know what we are arguing about:



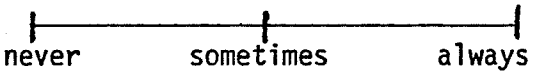
15. When we argue, my spouse knows what we are arguing about:



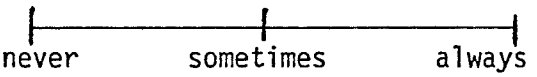
16. We argue about issues we have argued about before:



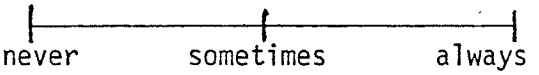
17. The biggest issue in our arguments is who is right and who is wrong:



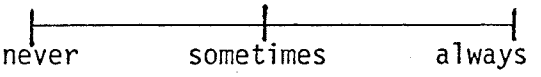
18. Our arguments are not over who is right or wrong but over opinions we have about things:



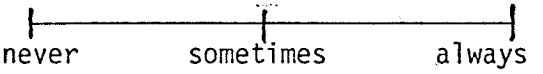
19. My spouse calls me derogatory names:



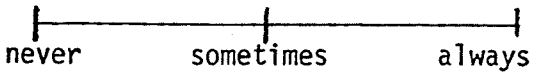
20. I call my spouse derogatory names:



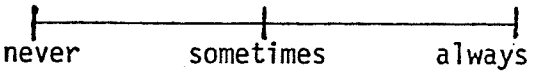
21. My spouse gets out of arguments by refusing to argue:



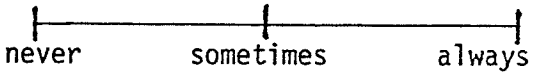
22. I get out of arguments by refusing to argue:



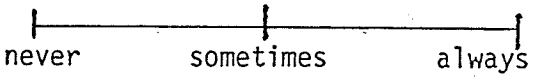
23. My spouse brings up past problems when we argue:



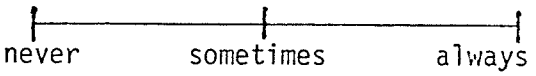
24. I bring up past problems when we argue:



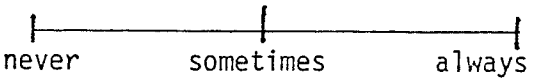
25. My spouse tries to read my mind:



26. My spouse and I see things the same way:



27. My spouse and I communicate in ways other than talking:



APPENDIX 2

THE DYADIC ADJUSTMENT SCALE

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1974 "Theorizing about the family." Pp. 21-30 in Robert F. Winch and Graham B. Spanier (Eds.), Selected Studies in Marriage and the Family. New York:Holt, Rinehart and Winston.

APPENDIX

DYADIC ADJUSTMENT SCALE

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

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation	5	4	3	2	1	0
3. Religious matters	5	4	3	2	1	0
4. Demonstrations of affection	5	4	3	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex relations	5	4	3	2	1	0
7. Conventionality (correct or proper behavior)	5	4	3	2	1	0
8. Philosophy of life	5	4	3	2	1	0
9. Ways of dealing with parents or in-laws	5	4	3	2	1	0
10. Aims, goals, and things believed important	5	4	3	2	1	0
11. Amount of time spent together	5	4	3	2	1	0
12. Making major decisions	5	4	3	2	1	0
13. Household tasks	5	4	3	2	1	0
14. Leisure time interests and activities	5	4	3	2	1	0
15. Career decisions	5	4	3	2	1	0

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your mate leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married? (or lived together)	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22. How often do you and your mate "get on each other's nerves?"	0	1	2	3	4	5

	Every Day	Almost Every Day	Occasionally	Rarely	Never
23. Do you kiss your mate?	4	3	2	1	0
	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	4	3	2	1	0

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

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	0	1	2	3	4	5
26. Laugh together	0	1	2	3	4	5
27. Calmly discuss something	0	1	2	3	4	5
28. Work together on a project	0	1	2	3	4	5

These are some things about which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

	Yes	No	
29.	0	1	Being too tired for sex.
30.	0	1	Not showing love.

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

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

5 I want desperately for my relationship to succeed, and *would go to almost any length* to see that it does.

4 I want very much for my relationship to succeed, and *will do all I can* to see that it does.

3 I want very much for my relationship to succeed, and *will do my fair share* to see that it does.

2 It would be nice if my relationship succeeded, but *I can't do much more than I am doing* now to help it succeed.

1 It would be nice if it succeeded, but I *refuse to do any more than I am doing* now to keep the relationship going.

0 My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

APPENDIX 3

Appendix 3 presents the raw scores produced by the couple in completing the Dyadic Adjustment Scale. The man's score in the first test is presented first; the woman's score is presented next. Areas of concern as represented by this first test can then be highlighted. If a second test was completed the raw scores are delineated in the same manner. Finally, where movement has occurred between the first and second test, it can be highlighted in the final column.

ISSUE - 1 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
Finances	2	1					
Recreation	4	3					
Religion	5	5					
Affection	3	1					
Friends	4	3					
Sex Relations	2	2					
Conventionality	3	3					
Philosophy of Life	3	2					
Parents/In-Laws	2	2					
Aims, goals	4	2					
Time Together	4	3					
Major Decisions	3	3					
Household Tasks	4	4					
Leisure Time	4	3					
Career Decisions	4	3					
Divorce/Separation	3	2					
Fight-Leave	4	3					
Things Going Well	3	2					
Confide In Mate	3	2					
Regrets	3	2					
Frequency of Quarreling	3	2					
Nerves	4	1					
Kissing Mate	4	1					
Outside Interests	2	1					
Exchange of Ideas	3	1					
Laugh Together	4	2					
Calmly Discuss	4	2					
Work Together	1	1					
Sex - Too Tired	1	0					
Not Showing Love	0	0					
Degree of Happiness	1	1					
Relationship	4	2					

ISSUE - 2 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
Finances	4	4		4	5		* +
Recreation	4	3		4	4		* +
Religion	4	5		4	4		* -
Affection	2	4	*	3	3		* +
Friends		4		4	4		
Sex Relations	1	4	*	2	3	*	* +
Conventionality	3	4		3	4		
Philosophy of Life	3	4		2	4	*	* -
Parents/In-Laws	5	5		4	4		* -
Aims, goals	2	4	*	2	4	*	
Time Together	3			3	3		
Major Decisions	3	4		3	4		
Household Tasks	4	5		3	5		* -
Leisure Time	3	4		3	4		
Career Decisions	4	5			5		
Divorce/Separation	4	5		1	4	*	* -
Fight-Leave	3	4		5	4	*	* +
Things Going Well	1	4	*	1	3	*	* -
Confide In Mate	2	3	●	2	4	*	* +
Regrets	4	3		4	3		
Frequency of Quarreling	4	4		4	4		
Nerves	3	3		3	3		
Kissing Mate	2	2	*	3	1	*	* -
Outside Interests	2	2	*	2	2	*	
Exchange of Ideas	2	4	*	1	3	*	* -
Laugh Together	1	5	*	0	4	*	* -
Calmly Discuss	3	5		2	4	*	* -
Work Together	1	3	*	1	2	*	* -
Sex - Too Tired	0	0	*		0	*	
Not Showing Love	0	0	*	0	0	*	
Degree of Happiness	0	1	*	1	1		* +
Relationship	5	7	*	3	3	*	* -

ISSUE - 3 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
Finances	3	4					
Recreation	2	3	*				
Religion	2	3	*				
Affection	4	3					
Friends	3	3					
Sex Relations	2	3	*				
Conventionality	4	3					
Philosophy of Life	2	3	*				
Parents/In-Laws	2	3	*				
Aims, goals	3	4					
Time Together	4	4					
Major Decisions	3	4					
Household Tasks	1	3	*				
Leisure Time	1	2	*				
Career Decisions	3	4					
Divorce/Separation	3	3					
Fight-Leave	0	1	*				
Things Going Well	3	4					
Confide In Mate	4	4					
Regrets	4	4					
Frequency of Quarreling	3	3					
Nerves	3	4					
Kissing Mate	4	4					
Outside Interests	2	1	*				
Exchange of Ideas	3	3					
Laugh Together	4	4					
Calmly Discuss	4	2	*				
Work Together	3	1	*				
Sex - Too Tired	0	0	*				
Not Showing Love	1	0	*				
Degree of Happiness	2	2					
Relationship	3	4					

ISSUE - 4 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
Finances	2	1		4	3		
Recreation	1	0		0	0		
Religion	2	0		3	2		
Affection	1	1		0	2		
Friends	2	1		3	2		
Sex Relations	0	0		0	0		
Conventionality	4	0		4	1		
Philosophy of Life	3	0		3	0		
Parents/In-Laws	3	1		4	2		
Aims, goals	1	0		3	1		
Time Together	0	0		2	1		
Major Decisions	1	0		2	1		
Household Tasks	2	0		4	1		
Leisure Time	0	0		0	1		
Career Decisions	1	0		3	1		
Divorce/Separation	3	2		3	3		
Fight-Leave	4	3		4	3		
Things Going Well	1	1		2	2		
Confide In Mate	1	1		2	3		
Regrets	3	5		4	5		
Frequency of Quarreling	3	2		3	3		
Nerves	3	2		3	3		
Kissing Mate	0	2		1	3		
Outside Interests	1	0		1	2		
Exchange of Ideas	2	1		3	3		
Laugh Together	2	1		2	3		
Calmly Discuss	2	1		3	3		
Work Together	1	0		1	1		
Sex - Too Tired	1	1		1	1		
Not Showing Love	0	0		0	1		
Degree of Happiness	0	1		1	2		
Relationship	2	4		2	4		

ISSUE - 5 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
Finances	2	4					
Recreation	2	4					
Religion	3	3					
Affection	2	1					
Friends	2	1					
Sex Relations	4	1					
Conventionality	4	2					
Philosophy of Life	4	1					
Parents/In-Laws	4	0					
Aims, goals	3	4					
Time Together	2	4					
Major Decisions	4	4					
Household Tasks	3	3					
Leisure Time	1	2					
Career Decisions	4	4					
Divorce/Separation	4	2					
Fight-Leave	4	4					
Things Going Well	2	2					
Confide In Mate	3	4					
Regrets	3	5					
Frequency of Quarreling	4	4					
Nerves	3	3					
Kissing Mate	1	2					
Outside Interests	0	1					
Exchange of Ideas	2	3					
Laugh Together	3	3					
Calmly Discuss	3	4					
Work Together	0	0					
Sex - Too Tired	1	1					
Not Showing Love	1	0					
Degree of Happiness	1	3					
Relationship	5	4					

ISSUE - 6 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
Finances	2	2	*	3	3		* +
Recreation	3	3		3	2	*	* -
Religion	3	2	*	3	4		* +
Affection	3	1	*	3	4		* +
Friends	4	4		3	4		* -
Sex Relations	2	2	*	2	4	*	* +
Conventionality	3			4	4		* +
Philosophy of Life	2	0	*	2	3	*	* +
Parents/In-Laws	4	4		4	4		
Aims, goals	2	2	*	3	1	*	* -
Time Together	2	2	*	3	4		* +
Major Decisions	4	4		4	4		
Household Tasks	3	1	*	4	4		* +
Leisure Time	3	1	*	3	2	*	* +
Career Decisions	4	3		4	3		
Divorce/Separation	4	5		5	5		* +
Fight-Leave	3	3		4	5		* +
Things Going Well	2	2	*	4	4		* +
Confide In Mate	3	2	*	3	4		* +
Regrets	4	3		4	3		
Frequency of Quarreling	3	4		3	4		
Nerves	3	2	*	3	3		* +
Kissing Mate	4	4		4	2		* -
Outside Interests	2	2	*	3	2	*	* +
Exchange of Ideas	2	0	*	3	1	*	* +
Laugh Together	3	0	*	4	0	*	* -
Calmly Discuss	4	0	*	4	3		* +
Work Together	3	0	*	4	3		* +
Sex - Too Tired	1	1		1	1		
Not Showing Love	0	1	*	1	1		* +
Degree of Happiness	2	2	*	3	2	*	* +
Relationship	4	5		4	3		* -

ISSUE - 7 -	1	1	Concern	2	2	Concern	Movement
Finances	5	5					
Recreation	5	5					
Religion	5	5					
Affection	3	3					
Friends	3	3					
Sex Relations	5	4					
Conventionality	2	2					
Philosophy of Life	4	4					
Parents/In-Laws	5	5					
Aims, goals	4	4					
Time Together	4	4					
Major Decisions	4	4					
Household Tasks	5	5					
Leisure Time	5	5					
Career Decisions	5	5					
Divorce/Separation	2	1					
Fight-Leave	3	4					
Things Going Well	3	2					
Confide In Mate	4	4					
Regrets	3						
Frequency of Quarreling	3	2					
Nerves	3	4					
Kissing Mate	4	4					
Outside Interests	3	3					
Exchange of Ideas	3	3					
Laugh Together	3	5					
Calmly Discuss	4	4					
Work Together	2	3					
Sex - Too Tired	1	1					
Not Showing Love	0	0					
Degree of Happiness	1	0					
Relationship	4	4					

ISSUE	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement 103
Finances	4	3					
Recreation	4	4					
Religion	4	5					
Affection	5	5					
Friends	3	4					
Sex Relations	5	3					
Conventionality	3	2					
Philosophy of Life	3	3					
Parents/In-Laws	3	3					
Aims, goals	4	3					
Time Together	4	4					
Major Decisions	3	4					
Household Tasks	4	4					
Leisure Time	4	4					
Career Decisions	5	4					
Divorce/Separation	4	4					
Fight-Leave	5	4					
Things Going Well	4	3					
Confide In Mate	4	5					
Regrets	4	4					
Frequency of Quarreling	3	3					
Nerves	3	4					
Kissing Mate	4	4					
Outside Interests	2	2					
Exchange of Ideas	3	2					
Laugh Together	4	4					
Calmly Discuss	3	3					
Work Together	2	3					
Sex - Too Tired	1	0					
Not Showing Love	1	1					
Degree of Happiness	4	2					
Relationship	4	4					

APPENDIX 4

COMMUNICATIONS QUESTIONNAIRE

Appendix 4 presents the raw scores produced by the couple in completing the Communication Questionnaire. The man's score on the first questionnaire is presented first; the woman's score is presented next. Areas of concern as represented by this first questionnaire can be highlighted. If a second questionnaire was completed the raw scores are delineated in the same manner as are the areas of concern. Finally, where movement has occurred between the first and second test, it can be highlighted in the final column.

ISSUE - 1 -	M 1	W 1	Areas of Concern	M 2	W 2	Areas of Concern	Areas of Movement
My spouse listens to me	70	88		63	85		
I listen to my spouse	56	71		63	80		
My spouse avoids-leaves	12	06		25	70		
I avoid - leave	02	45		04	69		
My spouse is interested	73	95		72	82		
I am interested	70	95		66	82		
Spouse reaches for Info.	44	50		30	72		
I reach for info.	44	75		45	79		
Spouse - my position	27	70		42	80		
Myself - spouse's posit.	46	75		75	-		
Spouse misses point	05	20		50	-		
I miss point	50	20		36	-		
Agreement after arguing	70	78		49	-		
I - Topic of argument	68	49		49	-		
Spouse - Topic of argum.	51	30		50	-		
We argue same issues	87	58		72	30		
Arguments- right/wrong	19	20		26	05		
Arguments - opinions	61	80		66	64		
Spouse - derogatory names	05	10		00	05		
I - derogatory names	09	06		00	05		
Spouse - refuses to argue	45	44		35	70		
I - refuse to argue	69	50		20	59		
Spouse - past problems	23	20		30	20		
I - past problems	66	39		21	38		
Spouse - mind reader	63	40		70	44		
We - see things alike	25	70	*	49	60		*
Communication besides tal	64	55		74	80		

0 = Never

50 = Sometimes

100 = Always

ISSUE	H 1	W 1	Areas of Concern	H 2	W 2	Areas of Concern	Areas of Movement
My spouse listens to me	82	75					
I listen to my spouse	50	78					
My spouse avoids-leaves	08	05					
I avoids - leave	39	05					
My spouse is interested	62	88					
I am interested	32	88					
Spouse reaches for Info.	48	72					
I reach for info.	20	92					
Spouse - my position	68	53					
Myself - spouse's posit.	78	60					
Spouse misses point	15	70					
I miss point	25	70					
Agreement after arguing	49	59					
I - Topic of argument	60	65					
Spouse - Topic of argum.	30	68					
We argue same issues	81	80					
Arguments- right/wrong	85	60					
Arguments - opinions	39	50					
Spouse - derogatory names	15	50					
I - derogatory names	72	50					
Spouse - refuses to argue	10	50					
I - refuse to argue	61	48					
Spouse - past problems	10	50					
I - past problems	85	50					
Spouse - mind reader	41	20					
We - see things alike	61	50					
Communication besides talk	64	80					

0 = Never

50 = Sometimes

100 = Always