DEVELOPMENTAL COUPLES THERAPY: A Study of Bader and Pearson's (1988) Diagnostic and Treatment Model

by

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ABSTRACT

The study is an empirical investigation which tests the merits of Bader and Pearson's (1988) developmental model of couples therapy. Bader and Pearson (1988) postulated that developmental couples therapy closely parallels the childhood developmental stages delineated by Mahler, Pine, and Bergman (1975). Not unlike the maternal-infant attachment developmental process, adults progress through a similar separation/individuation couplehood process of developmental stages: symbiosis, differentiating, practicing, and rapprochement. Quantitative measures (e.g., Developmental Couples Therapy Coding System and Developmental Couples Therapy Graph) were developed by the author to test and evaluate the prescribed qualitative diagnostic tools and treatment. The study employed four (n = 8) couples. The findings lend some empirical support in the area of the positively enhancing in each partner a greater developmental sense of self and a greater developmental sense of coupleness. Directions for future research include a deeper understanding (i.e., mutivariate statistical analysis) of the developmental variables as they pertain to respective developmental stages.

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DEDICATION

This thesis paper is dedicated to my mother and father, and my family and friends, all of whom provided unending support and an enduring belief in my personal endeavors. A very special, heartfelt dedication goes out to my father, whose tenacious work ethic and assured sense of achievement helped provide the inspiration and determination leading to the fruition of this thesis. He is remembered always.

CHAPTER I -- INTRODUCTION

Couples therapy has unfolded from conventional relationship therapies such as marriage therapy, family therapy, and divorce therapy. It has emerged from a need for a more contemporary approach to relationship therapy. Recently, Jones (1990) noted that couples therapy offers a more flexible and a more diverse approach to relationship therapy. Couples therapy differs from earlier relationship therapies in that the partners benefit: (1) as a means for dealing with the possible absence of marriage or cohabitation; (2) as an involvement of primary prevention; (3) as a means for conflict resolution, regardless of divorce; and, (4) as a means for continuing therapy, even after divorce.

Ongoing challenges affecting traditional marital relationships has prompted others to envision a growing trend toward relationship equality in the form of peer marriages (Schwartz, 1994) or complementary (Gilbert, 1992; Prosky, 1992) dyadic relationships. With the dynamics of human relationships constantly changing, couples therapy has arrived to facilitate these changing needs. For many, human relationships signify and constitute a vital part in our lives. It seems certain, then, that the function and stability of dyadic relationships will remain an essential feature of our society.

Given the myriad of theories, techniques, approaches and strategies available today on relationship therapy process, it would seem that many analysts and helping professionals are genuinely committed to pursuing research

in the future development of this area. In a survey of current clinical and research trends offered in clinical psychology programs, Sayette and Mayne (1990) discovered that family therapy and marital/couples therapy ranked first and fourth, respectively. Further, it would appear there is an ever increasing demand from society for help in relationships--given the long waiting lists which often exists, the time and energy both couples and professionals are willing to expend on relationship process, and the diversity of services available. It also indicates that many people seek to improve or enhance their interpersonal relationship satisfaction. For many, interpersonal relationships signify an essential and important part of their lives. In today's complex society, it is becoming increasingly more difficult to satisfy personal needs and boundaries, let alone maintain a mutually respected and healthy relationship; still, many people seem to appreciate and are compelled to pursuing a harmonious balance between self and other.

Why Research Therapies?

One of the central tasks for therapists is to provide the best possible service to their clients. However, in order for researchers and helping professionals to successfully fulfill their commitment, it is vital that they be knowledgeable and equipped with tried and true methods and procedures. For instance, one approach to couples therapy offers uniqueness and flexibility in

that it distinctly parallels the groundwork of psychological infant developmental theory. However, in spite of the potential promise some of these innovative approaches to relationship therapy may hold, their empirical merit is somewhat less certain.

Over the years there have been many diverse approaches to relationship therapy. Some of these approaches are now well entrenched and widely practiced among helping professionals. Other approaches, however, are not nearly as well known. The challenges that face the pioneers of a new therapeutic approach are great. First, concepts and theories should be developed from sound and verifiable constructs. Preferably, these should be grounded in some way to an existing, established and relatively accepted theoretical model. Second, a theoretical approach should appeal to both professionals and their clients. Certainly not all approaches can be considered equal, while some approaches may be considered more effective than others or more easily tailored to the specific needs of the client. Third, a theoretical model and its constructs should be testable. A therapeutic model is of little or no use if it cannot be subjected to the rigors of empirical evaluation. Fourth, indeed, the theory itself should be tested. That is, there should exist enough verifiable evidence on the efficacy of its theoretical constructs, its methods, its processes, its instrumentation, and its treatment outcomes. Herein lies a very common

problem found in much of the research literature in social science. When a new or innovative approach is presented to the scientific community, at least initially, it lacks much substantial empirical evidence to overwhelmingly support it. Hence, when a relatively innovative therapeutic approach offers certain appeal to practicing clinicians, he or she may be unwilling or unable to suspend judgement or simply wait for some of the more definitive research questions and answers to come to light.

Statement of the Problem

The fact that supportive empirical research on a theoretical approach often lags behind its implementation and practice has always been problematic. It takes time before theoretical constructs and techniques can be recognized and used with reasonable confidence and assurance. Many earlier therapeutic models have been subjected to rigorous and thorough empirical evaluation and review, and others have not. In general, there exists much literature on traditional approaches to relationship therapy. For instance, techniques in marital therapy alone include, among others, behavioral (e.g., Bargarozzi & Giddings, 1983; Behrens, Sanders, & Halford, 1990; Birchler, 1983; Holtzworth-Munroe, Jacobson, DeKlyen, & Whisman, 1989; Markman, 1991) and cognitive restructuring (e.g., Epstein & Baucom, 1988; Huber, & Milstein, 1985) techniques,

as well as approaches that have integrated both behavior and cognitive restructuring techniques (e.g., Baucom, Sayers, & Sher, 1990; Kendall, 1982).

In some areas the varied approaches to relationship therapy the research literature is quite extensive, indeed. In recent years, however, some therapists and researchers have parted from tradition and incorporated into their arsenal some of the more creative and flexible techniques of couples therapy. For example, humour was found to be effective in facilitating relationships and reducing tensions (Cade, 1986), or when addressing resistant clients (Benningfield, 1990). McKay, Fanning, and Paleg (1994) compiled an recent book on essential couples skills which focuses on action and change rather than theory, providing couples with more control and effecting almost an immediate response to change. In the meantime, however, there remains many current theories and techniques permeating the variety of approaches to relationship therapy upon which little or no research literature has been compiled. The developmental approach to couples therapy is no exception.

The purpose of the thesis is to explore and evaluate the developmental approach to couples therapy as delineated by Dr. Ellyn Bader and Dr. Peter T. Pearson in their 1988 therapeutic handbook, *In Quest of the Mythical Mate: A Developmental Approach to Diagnosis and Treatment in Couples Therapy.* A review of the literature on relationship therapies turned up little on the developmental

model of couples therapy. Let us now take a brief look at the developmental approach to couples therapy.

Couples Therapy: The Developmental Approach

Clinical literature of developmental disorders originated primarily with direct observation of maternal-infant attachment. Originating concepts of object representation pioneered by Klein, Winnicott, Fairbain and, in particular, Mahler helped capture the keen interest of many forthcoming researchers (e.g., Bader & Pearson, 1983, 1988; Cashdan, 1988; Hamilton, 1990; Horner, 1984; Nichols, 1988; Stern, 1985). The earlier plethora of research on object relations therapy spawned Kohut's research on self psychology which continues to be advanced by many others (e.g., Bacal & Newman, 1990; Masterson, 1988, 1993; Ornstein, 1993; Rowe, Jr. & Mac Isaac, 1991). In addition, only recently have paternal influences on childhood development been examined (e.g., Cath, Gurwitt, & Gunsberg, 1989; Scull, 1992), or the impact of absent father figures on masculine identity (Corneau, 1992). Research trends on parent-infant psychotherapy (e.g., Trad, 1993) has produced emerging research on clinical and developmental perspectives and its impact in later life, for example, in the form of attachment disorders (e.g., Karen, 1994; Sperling & Berman, 1994), separation anxiety (e.g., Stevens & Gardner, 1994), and relationship transitions in later life (e.g., Hansson & Carpenter, 1994).

The developmental approach to couples therapy was first formulated by Bader and Pearson in 1983. Based on the highly acclaimed work on separation and individuation in infants originally pioneered by Margaret S. Mahler, among others, Bader and Pearson proposed an innovative and exciting model toward a developmental theory of couplehood. In particular, Bader and Pearson tailored their developmental couples model around the contributions of Mahler, Pine, and Bergman (1975) and Kaplan (1978). In other words, Bader and Pearson (1988) suggested that the developmental stages in which infants advance in childhood are not unlike the developmental stages adult couples progress through in adulthood relationships.

Briefly, the developmental stages of couplehood identified in Bader and Pearson's (1988) couples therapy model consists of the following five developmental stages: *symbiotic* (of which there are two substages, *symbiotic-enmeshed*, and *symbiotic-hostile/dependent*), *differentiating*, *practicing*, *rapprochement*, and *mutual interdependence*. (The developmental theory that envelops the developmental stages of childhood and the developmental stages of couplehood will be discussed in detail in the literature review section.) In short, Bader and Pearson (1988) maintain that all adulthood relationships acquiesce themselves in these developmental stages, for which they have offered various techniques and diagnostic tools to help guide the therapist working with couples. Moreover,

they further suggest that there exists an implicit psychoeducational process in their developmental model to couples therapy, and that the therapeutic process provides the couple with an invaluable set of interpersonal skills upon which they can rely in the future.

Accordingly, then, the therapist's role in developmental couples therapy is to provide the partners with knowledge about each other, their selves, and their relationship. In doing so, the therapist guides them through each stage of couplehood development toward the desirably eminent stage, that is, mutual interdependence. In addition, through successful identification and employment of the developmental couples therapy process, it is hoped that partners will have developed and learned an additional array of useful facilitation techniques of their own.

Given that Bader and Pearson's 1988 therapeutic handbook, *In Quest of the Mythical Mate: A Developmental Approach to Diagnosis and Treatment in Couples Therapy*, was introduced only a few years ago and is made easily available to any practicing clinician, it is undoubtedly being used today in some therapeutic practices and settings. Its theoretical constructs are seemingly well-grounded with other notable research upon which many other researchers have also extended the works of Mahler's developmental stages of childhood (e.g., Alvin, 1989; Gizinski, 1985; Quadrio, 1986; Solomon, 1988). Further, its foundation rests

upon some seemingly very well-developed and well-constructed intervention strategies and techniques. It is not known, however, how many therapists in practice are presently incorporating Bader and Pearson's (1988) developmental approach to couples therapy. Regardless of the extent to which Bader and Pearson's (1988) developmental model of couples therapy has presently gained acceptance by practicing clinicians or within the helping community, some very important research questions and issues remain unanswered.

Research Hypothesis

The research hypothesis (H_1) is stated as follows: Bader and Pearson's (1988) developmental model of couples therapy will promote in each partner of the dyadic relationship a greater developmental sense of self (individuation) and a greater developmental sense of coupleness (relationship satisfaction).

Significance of the Problem and Justification for its Investigation

Regardless of which approach therapists choose to employ in their practice, it should be one in which he or she can believe markedly. Further, therapy should also appear salient to the clients. Because therapy is transitional, that is, the final analysis will rest in the readiness of the client to terminate therapy and get on with life, its success or failure will ultimately rest with the client. Clients' testimonials of the therapy experience are inextricably linked to determining if and to what degree a particular therapy can be considered

successful, though it is only one measure. Nevertheless, the client's perspective remains a fundamental component in the therapy's evaluation process. Clulow (1985) pointed out one of the reasons couples ended their therapy was "...not because all their difficulties had been resolved, but because they had learned sufficient from the therapeutic encounter 'to be able to cope a bit better'" (p. 93). Fortunately, if sufficient empirical data on the efficacy of a particular treatment is lacking, its implementation can be supported further when the methods have been properly replicated with several additional clients and several additional successful outcome cases have been reported. Unfortunately, however, especially when employing a novel yet questionable therapeutic approach, evaluation of treatment outcome can be paradoxical in that sometimes the only means of assessing certain merits of any given treatment is through the self-reports of the clientele.

Therapeutic approaches, techniques and their interventions can be extremely useful if implemented and employed properly. Herein lies the professional ramifications to a significant problem and the justification for its investigation. In theory, at least, Bader and Pearson's (1988) developmental approach to couples therapy may appeal to many therapists. Moreover, some of its appeal may be retained in practice, too. Wide acceptance and usage of a theory, however, do not always guarantee a high degree of its efficacy. Only

when a theory has been thoroughly tested and stands up to the rigors of empirical verification does the potential for a very serious problem diminish. In other words, the ramification of employing anything less than an efficacious therapeutic process is that many therapists and their clients may be negatively subjected to and affected by an ineffectual or, perhaps, even harmful therapeutic approach.

When a therapist evaluates a particular approach as being only moderately successful then, supposedly, he or she should search for a more amenable therapeutic model. Notwithstanding, and sometimes only limited in the options that are available, a therapist may still be convinced that a particular approach holds at least some merit and, thus, may continue using it in practice. Herein lies the reasons a therapist may wish additional study on developmental couples therapy and the justification for its research. In general, counselling techniques and practices should benefit and ultimately lead to an improved sense of "wellness" in the client. Further, any increased insight can best be described and ascertained through continuous and combined assessments by both the therapist and the client(s). Therapists should also have a comprehensive understanding of the therapeutic processes they employ. In addition, they should have at least a moderate trust in the model's theory and its applications. In short, if the techniques and diagnostic instruments delineated by Bader and

Pearson (1988) could be supported by some empirical evidence, then therapists working with couples could employ in practice the developmental model with greater assurance and confidence.

CHAPTER II -- REVIEW OF THE LITERATURE

The ensuing discussion of relationship therapies will review the literature that has imminently led to the development of couples therapy. The traditional relationship therapies presented here include conventional relationship therapies of marital therapy, family therapy, and divorce therapy. Next is a discussion of the theoretical constructs from which the developmental approach to couples therapy has been developed. In so doing, the developmental stages are discussed as they are characterized in childhood attachment theory and, then, in couplehood relationship theory. Lastly, some of the current trends in couples' relationship and current literature on couples therapy will be presented.

Historical Background

Relationship therapies discussed here are marital, family, and divorce therapy. In general, the clinical movement of relationship therapy began in working with couples who were married. Indeed, there is a wealth of research on marriage therapy and married couples. Partly driven by societal attitudes and partly by the impetus of ambitious research, for many years there has been an implicit attempt to salvage nearly any marital contract. Eventually, however, in some cases the determined effort to keep the partners in despondent marriages together were seen as detrimental to the couple and, possibly, to the welfare of the family unit. This reality prompted much needed research in the

area of familial dysfunction, for example, the effects of divorce on children (Hett & Rose, 1991). Whereas the primary focus was on the impasse of the couple, and children were considered secondary in the treatment process, researchers began to examine and therapists turned to treat the family unit as a whole. Nevertheless, in many cases it seemed clear that marital and familial breakup were inevitable.

Now, with divorce a social reality, considerable research has been done on its effects. While some have made despairing predictions about soaring divorce rates, others have predicted continued declining rates of matrimony and a marked desolation of the marital institution. For now at least it would seem that both marriage rates and divorce rates have levelled off and stabilized. It appears, however, that the patterns and dynamics of human relations will continue to be in constant change. From married to cohabitating partners, from nuclear to blended families, from hetero- to homosexual relationships, the changes in contemporary lifestyles and relationships should be met with an adaptable and contemporary style of counselling. In contrast to marital therapy, family therapy, and divorce therapy, many helping professionals have found that traditional approaches to relationship therapy fall short of fulfilling the diverse needs of their clients. Toward this end, the development of couples therapy is gaining momentum in its attempt to observe each relationship as a

unique and dynamic entity. Let us first take a closer look at each of these approaches to relationship therapy.

Marital Therapy

Historically, there have been two basic approaches to marital therapy. Proponents of the first camp, for example, systemic therapy and behavioral marital therapy, believe that change is induced from the outside inward. That is, by manipulating environmental factors people will effectively have a more positive view of themselves and their world. Conversely, proponents of the second camp, for example, psychodynamic therapy, take an inside-out approach and maintain that change depends upon the psychic organization of the individual, marriage, or family group. Nevertheless, the underlying assumption in both of these approaches is that psychological convictions to change are unconscious in nature. In short, for marital therapists there is an interesting meeting point between inner and outer realities (Clulow, 1985). When the outer realities of the wider social world impinge upon the privacy of family life, then, the reality-testing for marriages is to mediate discrepancies between what is and what is believed to be.

Marital therapists recognize marriage for its personal and social development. But given the diversity in marriage patterns, the therapist is also left to distinguish between what is and what is believed to be. Clulow (1985)

illustrated that there are four broad premises in defining the therapeutic aims of marital therapy. First, stress is an integral part of an individual's emotional health, and a person's capacity to manage internal conflict and external stress is important to his or her marital satisfaction. Second, all significant relationships (including attachments between client and therapist) can be used to change past behavior patterns. Third, therapists need to help their clients to become more aware and develop an understanding of unconscious processes. Fourth, because an individual's perception undergoes a re-ordering of self and others, change takes time. These four components are the central features as defined by the Institute of Marital Studies (IMS).

In this regard, marital therapy effectively combines schemes of what is and what is believed to be. Using the principles described by the IMS, the therapist helps individuals relate to both their outer and their inner worlds. During this process, the focus of marital therapy is to help individuals relate to each other. Other researchers have also reported positive outcome results when employing various techniques of marital therapy (e.g., Cline, Jackson, Klein, Mejia, & Turner, 1987; Nugent & Constantine, 1988), and, more specifically, behavioral marital therapy techniques (e.g., Behrens, Sanders, & Halford, 1990).

Toward an integrative approach to marital therapy, Nichols (1988) proposed interrelating the following combination of theoretical approaches to

marital therapy: systems theory, object relations and social learning theory. He purported that these abstractions provide the marital therapist with some guidelines in comprehending object relations and marital interaction. Interestingly, similar to the couples therapy approach proposed by Bader and Pearson (1988), Nichols also heeded the importance of the psychological birth of the human infant based on the work of Mahler (1975) and her associates. [Additional readings of Mahler's extensive works and the separation/individuation process can be found in McDevitt and Settlage (1971)]. In contrast to holding the married couple at the center of therapy, other researchers have instead redirected their focus on family structure and networking.

Family Therapy

Considering the many different approaches to relationship therapy, family therapy is probably the most diverse and comprehensive. The traditions of family therapy stem from a wide array of disciplines such as intergenerational, behavioral and systems theory, as well as having orientations in psychoanalysis and object-relations. Each of these approaches can be further differentiated into subdomains. For instance, falling under the heading of systems theory are: functional, structural and integrative family therapies, as well as the interactional view, strategic approach, and problem-centered systems. To discuss all of these

is beyond the scope of this paper. Instead, because of its broad and all-inclusive features, the integrative family therapy approach was chosen for discussion.

During the mid 1970s, researchers Duhl and Duhl (1981) pioneered the integrative family therapy approach. This team of therapists began their work by helping families to use "cognitive maps." These maps represented a series of connected, interrelated frameworks that allowed the researchers to closely monitor the pulse of the system as well as the individuals inside the system. All the while, the features of this approach also ensured that the therapist not lose sight of the individual for the system nor the system for the individual. Not unlike the information provided in an atlas, these are a collection of overlapping maps, each highlighting one aspect of simultaneous events related to the person, system, or context.

Integrative family therapy models a unified field theory. Integrative family therapy attempts to maintain an awareness that people live in all the levels of systems simultaneously. The central theme promoted in this theory is that of the information-processing styles and stages of individual family members. By allowing for both differentiation and connection, individuals in family systems change their system by changing their actions, attitudes, behaviors, thoughts and feelings. Other researchers have offered to provide Duhls' family therapy model with different labels. For example, some have

called the integrative approach behavioral or structural family therapy because integrative family therapy highlights behaviors and is goal orientated, and because family members are assigned tasks and homework to process and expand new information and familial roles (Duhl & Duhl, 1981). Further, because it attends to past, present, and future images that govern individual behaviors within families and systems, others have been tempted to label integrative family therapy as Gestalt family therapy (Duhl, 1981).

Nevertheless, if the hallmark of family therapy is universality then the tenets of integrative family therapy certainly fulfill this bill. However, at least traditionally, the prelude of a couple's relationship is not immediately complicated by outside family members or complex system levels. Consequently, some professionals have strayed from the all-inclusive approach of family therapy. Instead, some therapists have decided to shift their focus on specific areas of the couple's relationship, for example, toward facilitating an amicable separation and divorce.

Divorce Therapy

A few specialized therapies have been developed to counsel couples on specific matters of marital discord, such as divorce. For instance, Kagan and Zaks (1972) and Markowitz and Kadis (1972) recommended multi-couple therapy for marriages in crisis. Although the researchers differ in their

suggestions for ideal group dynamics (e.g., group size, attendance and duration for a group's existence), they agree that therapy in groups helps individuals gain personal insights into the rooted problems of their dysfunctional marriage. Through their interactions with other couples in crisis group therapy members acquire: (1) a greater understanding of their own personality patterns and needs; (2) heightened sensitivity to their spouse and children; (3) a more realistic picture of how others perceive them and how they interact; and (4) reduced demands of marriage so each spouse can cultivate other friendships and ultimately create space so each partner has a chance to choose to become close again. Viewed not only as a marital intervention method, couple multi-couple therapy acts as a prevention therapy to avoid repetition of the same problems in a possible second marriage (Kagan & Zaks, 1972).

When a couple does seek divorce therapy, Kaslow (1981) along with earlier researchers caution couples about working with a therapist who sees one spouse alone and appears to align with that partner. If this appears the case, it tends to form a coalition in which the other spouse immediately feels outnumbered, threatened, and insignificant. Thus, the potential risk is that one spouse may try to turn the unwanted mate over to the therapist. If this happens, the therapist could become a substitute for the departing spouse for prolonged

periods of time. For optimum results, divorce therapists have suggested conjoint therapy.

Possibly the best single predictor for a successful marriage is the family background of the couple (Kaslow, 1981). If the parents are reasonably well matched and generally content with each other, then they are likely to provide their children with solid role models. Unfortunately, however, far too few people come from such "well-adjusted" families. Tragic occurrences such as child abuse, chaos, rigidity, role stereotyping, substance abuse, continual unresolved tension and conflict, and erratic or mentally ill parent(s) all contribute negatively to the prospective outlook of their children's relations. Kaslow (1981) poignantly pointed out that children are contiguously affected by the processes that led to their parents' divorce as well as after their final decision to divorce. Thus, if the couple was ill-matched or unable to effectively work out their differences in the beginning of their relationship, then it is most unlikely that they will provide stable role models in the future of their children's relations. Compared with females from intact families, females from divorced families may be less differentiated and experience higher levels of chronic anxiety as they experience separation from their family origin in early adulthood (Guentherman & Hampton, 1992).

At the very least, divorce therapists act as a mediator or a pragmatic negotiator for the couple. Their service is often offered as an alternative so that if the couple still chooses to divorce, then it is hoped that their decision will be made more rationally and for sounder reasons. Ideally, it is also hoped that these individuals will be able to make better decisions and selections in future meaningful relationships. In addition, others offer adjustment programs to those parents already divorced (Lee & Hett, 1990).

Summary

In reviewing the relationship therapy approaches discussed thus far, the reader may have observed that within each there are certain inherent assumptions. First, family therapy may not be suitable if the couple does not have children. Moreover, couples simply may not envision their relationship as a complex structure and system levels. Second, the implicit assumption in marital therapy and divorce therapy is that the couple is joined together by a legal agreement. Such assumptions simply may not be germane in the beginning stages of the couple's relationship, nor can they be considered apropos in a changing contemporary lifestyle or relationship. For instance, more recent literature on cohabitation indicates that many of the unions today's couples form can be considered far less traditional from yesteryear's relationships.

Of course, one could argue that it is a moot point if the weakness of past relationship theories rests only on the labels assigned to each; further, that many of these theories could have and have been effectively modified to reflect the changes of society. Conversely, however, it can be argued that any social stigma associated to the name alone (whether justified or not) may be just enough to prevent some couples from ever seeking therapeutic counselling. For instance, cohabitating partners may be quite resistant to seeking relationship therapy from a marital therapist. For reasons such as these, therapists sought to develop a more inclusive relationship therapy appealing to a wider range of clients, for partners of nontraditional relationships. Couples therapy offers both therapists and their clients a more flexible and a more diverse approach to relationship therapy (Jones, 1990). Let us now examine some of the current relationship trends and current literature on couples therapy.

Current Literature on Couples Therapy

In this section some of the current issues, trends and patterns of dyadic relationships will be presented. Presented also will be additional or alternative couples therapy approaches which have been developed and implemented by other researchers. Lastly, a discussion is included on the developmental approach on couples therapy, and an argument for continued research in this area is presented.

Current Trends in Couples' Relationships

Throughout history the focus and emphasis on human relations have endured many changes. Today, the current posture of society seeks to better understand couples who decide to "live together." What does all this suggest for the relationships of the future? In a demographic study conducted in Canada, for instance, it was found that premarital cohabitation had a positive effect on marital stability (White, 1987). The relationship effect was strongest when both length of marriage and age at marriage were controlled. Similarly, another study concluded that premarital relationships, whether they be traditional dating or cohabitation, had no long-term effects on marital adjustment (Watson & DeMeo, 1987).

Teachman and Polonko (1990) conducted a similar study in the United States and concluded somewhat differently. When cohabitants spent more time in union than noncohabitants, the findings indicated that premarital cohabitation was disruptive to marital stability. However, when the total length of couples' unions was taken into account, differences between married couples and couples living together were less apparent. In general, then, findings on cohabitation trends and couples' decisions to cohabitate and their effect on the stability of marriage has been mixed.

In addition, there is some evidence to suggest that cohabitation may lead to higher divorce rates or partners' loss of individuation. In a study on independence and relatedness of nonmarital cohabitation, marriage, and divorce patterns, Newcomb (1987) found discouraging results for couples planning to "move in" together. In a longitudinal study, he originally contacted 739 students in Grades 7-9 and conducted a follow-up investigation nine years later. Of this sample, he reported 24% had married, 34% had cohabitated (including 35% of those who had married), and 13% who had married had divorced within the past four years. Cohabitating males and females showed more deviance, less religiosity, more drug use, and poorer relations with parents. Further, female cohabitators tended to be more insecure, have poorer self-esteem and fewer social relationships, and that they expressed less satisfaction with the overall quality of their lives.

Compared with different forms of relationships, it also appears that cohabitation may provide couples with a "licence to hit." To examine violence among dating, cohabitating, and married couples, Stets and Straus (1989) employed the Conflict Tactics Scale (CTS). Their findings indicated that: (1) the highest rate of assault was among the cohabitating couples; (2) violence was most severe in cohabitating couples; and (3) the most frequent pattern was for both partners to be violent, with the less frequent pattern being male-only violence.

Differences in assault rates were not explained by age, education, and occupation. One reason for these findings may be that a marital agreement commands certain expectations and obligations, and mutual respect is more likely with a legal document. These researchers further suggested that the higher prevalence of violence among cohabitating couples may be the result of family isolation or arguments stemming from issues of autonomy and control.

Moreover, the changing relationship patterns of today, such as cohabitation, are despairingly affecting the children of tomorrow. The Institute for Social Research (Thornton, 1991) conducted a study on the influence that the parents' marital history had on marital and cohabitational experiences of children. Children of mothers whom both married young and were pregnant at marriage were more likely to enter earlier into marital and nonmarital unions. Children exposed to parental dissolution increased children's choice to cohabitate, but had little effect on marriages. Other factors influencing children's attitude toward relationships included status attainment, social control, earlier maturation, parental home environment, and attitudes toward nonmarital sex and cohabitation.

Nevertheless, Spanier (1983) asserted that current trends of cohabitation are likely to continue and even increase. In the United States, for example, between 1970-1980 the number of unmarried couples living together tripled to

approximately 1.6 million. Only one year later this number had increased to 1.8 million. In 1981, this figure represented about four percent of all couples; one or more children were present in about 28% of these households. Considering this survey included only those households with unmarried adults of opposite sexes, it is conceivable that these figures could have been even higher when same-sex relationships are taken into account. Given the considerable discussion and research on the effects of cohabitation, and the growing availability to self-help guides designed specifically to enhance relationship satisfaction among nonmarried dyads (e.g., Bornstein, Wilson, Bornstein, Balleweg, Weisser, Andre, Smith, Woody, Laughna, McLellarn, Kirby, & Hocker, 1985), it is likely that the trends in couples' decisions to live together will remain.

In many countries the current wave of cohabitation arrangements has led to interesting effects on relationship patterns and trends. In Sweden, for instance, many people prefer to think of unmarried cohabitation as a variety of marriage rather than an alternative to it (Lewin, 1982). Compared to any other industrial society, Popenoe (1987) argued that Swedish families have moved farther from the ideal-typical nuclear family form. He also predicted that this changing family form will have far-reaching social and cultural consequences.

In Australia, when unmarried couples live together it is called a "de facto" relationship (Khoo, 1987). Further, it was suggested that particularly young

Australians regard cohabitation as a précis to marriage, but that they would rather feel financially and emotionally ready first. Starting a new job or finishing educational commitments were also important factors. Attitudes toward living together similar to these findings were also reported among graduate student populations (Kotkin, 1983).

Yelsma (1986) reported that age is another significant factor in couples' communication practices and relationship satisfaction between married and cohabitating couples. Couples from each of these groups were administered the Primary Communication Inventory (PCI) and the Dyadic Adjustment Scale (DAS). Results from analysis of variance (ANOVA) indicated that no significant results were found in the areas of nonverbal communication and dyadic satisfaction; however, younger couples from both groups scored higher in the areas of verbal and sexual communication practices. At least in the two latter categories, it seems that age was the major influence rather than preferred lifestyles of cohabitation or marriage.

Decisions to marry or cohabitate aside, some researchers and therapists have noticed and responded to these changing relationship patterns. In doing so, a variety of techniques and approaches have been developed. By actual accounts it would seem that some researchers had foreseen the trend on changing relationship patterns several years ago. For example, in an early study

on couples therapy, Beavers (1982) attempted to focus on the pair's relationship. He found couples therapy to be effective in crisis intervention and superficial adjustment assistance. He concluded that increasingly frequent requests from partners for help are among the simplest indicators that therapy was needed. Accordingly, other indicators that couples therapy is needed included the following: (1) a stalemate in individual therapy; (2) a description of problems in terms of marital difficulty in individual therapy; (3) a evaluation from the family related to a child being defined as mentally ill; (4) acute psychosis; (5) severe depression; and (6) a drug or alcohol problem. The following contraindications for couples therapy included: (1) ambivalence toward the desire for a satisfying relationship; (2) the presence of a highly invested ongoing relationship with a lover by one spouse; and, (3) an overt, persuasive, and disruptive paranoid orientation on the part of one spouse toward the other. In addition to popular modes of psychotherapy, such as individual therapy, administration of psychoactive drugs, marital therapy, family therapy, or group therapy for one or both partners, Beavers (1982) suggested that all of these traditional approaches could be used as an adjunct with innovative models of couples therapy. For the remainder of the section, let us now take a closer look at the evolution of and research on couples therapy for comparison and contrast with the developmental model.

Current Literature on Couples Therapy

Since the early 1980s, several more approaches to couples therapy have begun to emerge. While some therapists prefer to use couples therapy as an adjunct to more traditional relationship therapies, others consider couples therapy an imminent stand-alone approach. For example, Belsey (1990) integrated psychoanalytic and systems viewpoints in an attempt to improve relationship satisfaction among couples in conflict. In a struggling relationship the underlying premise here is that individual issues are functioning and continue to defy the couple from having a satisfying relationship. In this approach the therapist's goal is to help couples differ from each other in ways in which they can respect themselves and each other. Toward this end, therapy is an empathic and compassionate process as the therapist coaches and instructs the couple in a nonjudgemental way.

The psychoanalyst has observed dyadic interplay as an arena for transference and countertransference (Rothstein, 1992). Zeitlin (1991) proposed a Control-Mastery theory of couples therapy, a cognitive psychoanalytic theory which holds that psychopathology is rooted in grim, unconscious "pathogenic beliefs" that arise from traumatic childhood experiences. Brody (1988) presented a psychodynamic model that is aimed at translating and instilling a useful degree of analytic insight in members of marital or family systems. In keeping with the

traditions of psychoanalysis, unconscious hopes and expectations are recommended in conjoint and individual therapy sessions. Additionally, empathy and expression of feelings are impressed upon toward developing a working-level of transference insight. Belsey (1990) discussed psychoanalytic couples treatment by means of integrating family systems viewpoints. In a struggling relationship, conflict and its effect within couples system is sufficiently meaningful to each partner to necessitate and justify repetitive behaviors.

Illustrating the dynamics of feminist theory, Gerber (1986) presented a Relationship Balance Model (RBM) for individual and couples therapy. The basic premise in her model is that the marital relationship is based on sex role stereotypical personality traits. In the feminist approach to couples therapy, a marital relationship is conceptualized in terms of three principles (relationship balances): positivity balance, satisfaction balance, and leadership balance. She argued that the therapist cannot effectively change a client's behavior without considering possible repercussions on the couples relationship. She added that this approach is particularly cogent for female clients who are struggling to change major roles at home and at work but still have been socialized to pay primary attention to the "success" of their marriage.

Contributing to the research on couples therapy, Greenberg, James, and Conry (1988) emphasized what is most important for understanding perceived change process is the clients' attitude toward change. The researchers described that there are five major change processes that take place in emotionally focused couples therapy. These change processes include expression of underlying feelings by one or both of the partners, which leads to change in interpersonal perception, expressing feelings and needs, acquiring understanding, taking responsibility for experience, and receiving validation. Other researchers have directed their attention toward changing the behaviors of the relating partners, for example, systemic couples therapy. It can involve enabling the client's relationship system to regain the ability to function within normal limits rather than directly changing symptomatic behavior therapy (Healey, Kimball, & Smith, 1986), or "systemic couples reversal" which prescribes a way of managing the multiple communications of stability and change (Keeney & Siegel, 1986).

In conducting couples therapy group sessions, Kaslow and Suarez (1988) discussed which structures and operations they considered most important. The researchers recommended that, in group sessions, couples therapists should: (1) promote more adaptive interpersonal behavior between partners; (2) offer support for change, acceptance of, and identification with one another; and (3)

focus on unresolved conflicts and family-of-origin difficulties that impinge on the marital relationship.

Studying autonomy and independence amongst dyads, Solomon (1988) investigated the relationship between the self and marital relations. In particular, Heinz Kohut's (published 1971-1984) notions of self psychology and his theory on early childhood development (also based on reinterpreted works of Mahler, Bergman, & Pine, 1975) provided new insights into the ways these experiences are recreated in adult relationships. It was further asserted that usual problems that arise in interactions between spouses could be understood in the principles of narcissistic vulnerabilities and injuries as they relate to the psychology of the self. Quadrio (1986) reviewed similar works and suggested that the systemic or dyadic basis of Kohutian theory provides a bridge between psychoanalytic models and systems models of marital dynamics. She suggested further that progressive differentiation can be applied developmentally to the mother-infant, husband-wife, or therapist-patient dyad, as can the self-object transference concept. The concepts of selfobject function and empathic interaction is further explicated by Gilhotra (1993) in Kohut's theory of human development.

Combining G. Bateson's systems' constructs with C. R. Rogers's therapeutic constructs, Snyder (1989) described a model of couples therapy that

promotes the "self" of each partner. Specifically, Relationship Enhancement (RE) couples therapy promotes a setting in which unconditional positive regard, empathy, and convergence and integrates these with each individual's self as it is defined and experienced in relationship to others and to the world.

Other prescriptions for couples therapy have been offered. Emotion, and understanding its role in effecting change, should not be overlooked by therapists (Greenberg & Johnson, 1986). Ellis (1986) applied Rational-Emotive Therapy (RET) as a comprehensive mode of cognitive behavior relationship therapy aimed at helping all the partners in a relationship. In short, the goal of RET is (1) to accept responsibility for their own disturbances and failings and work at correcting these and (2) to understand and work actively at changing the system in which they are relating, and the conditions in the system that are contributing to their practical and emotional problems. Rational-emotive couples therapy has also been recommended for counselling couples with divorce issues (Walen & Bass, 1986). Daniel Stern's concept of RIGS (Representations of Interactions that have been Generalized) has been integrated to generate an integrative model of conjoint therapy (Solomon & Weiss, 1992). Other approaches have integrated techniques of transactional analysis (TA) and systems theory in couples therapy (Massey, 1989a, 1989b); as well, others have

investigated the influence of sex in couples therapy (Metz & Lutz, 1990; Russell, 1990).

Clearly, couples therapy is available to the clinician in a variety of modalities. However, couples therapy in any form is sometimes insufficient by itself. For instance, the extremely common presentation of opposing agendas in couples therapy can lead to the couple blaming the therapist, either overtly or covertly (Goldberg, 1992). Lazarus (1992) recognized the diversity of the couples therapy, and cautioned that it cannot be viewed as a unified form of treatment. By the very nature of dyadic treatment come individual agendas, hidden or otherwise, which undermine the relationship and the therapeutic process. Hence, individual therapy is often essential before the couple can benefit from conjoint therapy. Therapists who insist on working only within dyadic, triadic, or family contexts may fail to achieve desirable goals.

As integrative *and* diverse as the field of couples therapy has become, many additional prospects still need to be addressed. Couples therapy can be conceptualized as a "praxis"--action and reflection--whereby neither the therapist nor the client exclusively has the upper-hand (de Santamaria, 1990). Bennun (1986) argued that the development of couples therapy has primarily focused (1) on refining conceptual models for formulating and intervening with couples and (2) on developing adequate methods of assessment. He maintained

that certain clinical populations have been neglected in couples therapy (e.g., psychiatric patients, individuals who have had radical surgery, the physically and mentally challenged, the elderly). He recommended that the subject of value and ethics should not be secondary to mastering techniques but rather an integral part of training and supervision in couples therapy. Further, Bennun (1993) offered clinicians of marital and relationship therapy a list of several noteworthy books, review papers, methodological approaches and practice techniques.

Summary

As we have seen in the preceding section, many prospects of couples therapy look promising. Couples therapy and much of the research conducted on it thus far indicate that it has indeed sustained it own place along side other more recognized and accepted relationship therapies. In general, it can be said that all relationship therapies share the same common goal. However, compared to earlier approaches of relationship therapy, couples therapy appears to have redirected and strengthened its focus in several areas. First is its apparent emphasis to instill and implement a process that effects change. To effect change in the relationship has always been a notable component in traditional therapies, but couples therapy promotes the responsibility for change equally between partners (interrelational) and the individuals (intrarelational) themselves.

Second, actualization and change in each individual's self are emphasized as important factors to effect the changes that are deemed necessary in the relationship. Each partner's own autonomy, individualization, and process of self-awareness and personal growth are essential to improving and enhancing their "togetherness." Third, couples therapy is less therapist-orientated. Of the new therapeutic styles and techniques, couples therapy places less emphasis on the role of the therapist; more important is educating, empowering and enabling the couple so that relationship enhancement and improvement may continue long after the therapy sessions have ended. Finally, fourth, couples therapy offers a freer, less-restrictive style for both therapists and clients. Clearly, couples therapy offers some very distinct advantages over more traditional approaches to relationship therapy. It is not surprising that couples therapy is gaining growing acceptance, and its allure will no doubt lead to increased usage in the therapeutic community. Not unlike relationship therapies of the past, wider acceptance inevitably will lead to broader usage. Herein lies the importance that related couples therapy models and therapeutic constructs of couples therapy be thoroughly tested and evaluated.

Toward extending the research on couples therapy, the present study is an empirical investigation of Bader and Pearson's (1988) developmental approach to diagnosis and treatment. The developmental model of couples therapy is chosen here to be studied for many reasons. First is its emphasis to dedicating and developing an awareness of self in each individual partner. Second is that the developmental model of couples therapy does not attempt to "patient-identify" the individuals that make up the couple. That is, unlike some medical models, the individuals themselves are not labelled as dysfunctional or impotent; rather, the developmental model of couples therapy emphasizes the dynamics of the relationship type, instead. The third reason is that the developmental approach is a "relationship-orientated" process. That is, the techniques employed by the therapist enable each partner to work through their differences and likenesses toward a better understanding of their relationship, toward a better relationship of "mutual interdependence" of each other. Fourth, through an honest commitment on behalf of both the therapist and the clients, change can occur in a step-by-step or stage-like fashion. The fifth reason is that the developmental approach to couples therapy is, in general, very diverse and very dynamic. The developmental model does not attempt to exemplify an institution, system, or subsystems as do some of the more traditional types of therapies such as marriage, family, and divorce. Couples therapy, in general, and, in particular,

the developmental approach of couples therapy, can be employed with differing individuals in a wide variety of different relationship forms, be they married, separated or divorced, be they living together or apart, be they of opposite or same sexes, or be they intimate lovers or best of friends. Lastly, there is little or no empirical evidence on the developmental model of couples therapy, and it is needed.

With very good reason, therapeutic models should be thoroughly tested and evaluated. Studies on the therapeutic techniques of couples therapy should be conducted and made readily available for others to review. In evaluating the efficacy of the myriad of therapeutic models available today, we are then better able to survey and review outcome research. Presently, outcome research on the process of developmental couples therapy is rather sparse; moreover, even far less process research literature is available on the developmental approach to couples therapy. Toward gathering and expanding clinical research is no small task, indeed. For instance, the many difficulties which impede our ability to gather process research include germane methodological and conceptual problems of evaluation, problems with research instruments, replication, and a sometimes seeming indifference to the investigations done by other researchers.

In summary, then, while certain areas of couples therapy research seem underdeveloped, the future looks promising for couples therapy as it appears to

gaining maturity and recognition in certain methodological and conceptually appropriate directions (Guerney & Maxson, 1990; Piercy & Sprenkle, 1990). Gay and lesbian relations and their context in augmented couples therapy is gaining wider attention (Friedman, 1991; Kirkpatrick, 1991; Sussal, 1993; Ussher, 1991). Other researchers have cautioned that a clearer understanding of the causes and consequences (Glenn, 1990; Moon, Dillon, & Sprenkle, 1990) and how social and technological changes (Berardo, 1990) affect the success of couples' relationships is the challenge set for the 1990s. The following section is dedicated to advancing the discussion of the developmental concepts and research upon which Bader and Pearson (1983, 1988) have based their theory of developmental couples therapy.

Theory Relevant to the Developmental Model

Many cogent theoretical models have been based on and are explicated from the works of earlier researchers. In this section, we will first examine the theoretical constructs developed by Margaret Mahler and her associates on the psychological birth of the human infant. Next we will consider Bader and Pearson's (1983, 1988) developmental theory of couplehood for comparison and contrast with its forerunner theories encapsulated in childhood development. In presenting the highlights of the developmental stages characterized, it is hoped that readers will better understand and appreciate the parallels drawn from

childhood developmental theory leading to the inception of the developmental model of couples therapy.

Developmental Stages of Childhood

Widely acknowledged for her work as a scientist, a psychoanalyst, and a psychoeducational teacher, Margaret Mahler's scientific contributions have indeed inspired a great many. Nowhere has her work been more recognized than in the area of early childhood psychopathology. From an object relations viewpoint, Mahler (1968) postulated that the child's relationship with his or her parents--the first primary objects in the child's life--plays a significant role in depression. An individual's inability to learn to cope psychologically, for example, in the case of clinical depression, may be the result from early developmental failures such as nature or nurturing. Mahler's research showed that the child's absolute emotional and developmental dependence on parents affects his or her psychological capacity to mourn and grieve and recover and, therefore, invariably affects the child's self-esteem and sense of helplessness (Mollica, 1989).

Mahler's (1952) early clinical work on autistic and symbiotic infantile psychosis was prompted by her recognition that psychosis was not confined to adults alone. She believed that the survival instincts of newborns are underdeveloped and unreliable. Further, she believed the neonate "to be an

almost purely biological organism with instinctual responses to stimuli not on a cortical level essentially on a reflex and thalamic level" (Mahler, 1952, p. 286). Because the somatic corollary of ego development is the central nervous system and is in a very immature or rudimentary state at birth, Mahler argued that the undifferentiated ego has to take over the role of adaptation to reality which the id neglects. Critical during this "undifferentiated phase" of development is the psychobiological rapport between nursing mother and baby. Vitally essential to the young infant's survival is the mother's important ministrations (intrauterine process); during the postnatal period, this "parasite-host" relationship must be replaced in the mother's nursing care (extrauterine matrix) to form a kind of *social symbiosis.*

Through direct observation and research on mothers and infants, Mahler delineated the separation-individuation subphases of child development. According to Mahler, the separation-individuation process and its resolve profoundly impacts on adult personality and psychopathology and implications for an analytic treatment process. Mahler's childhood developmental process commences with *symbiosis*.. At the peak of the symbiotic stage begins the separation-individuation process. Gradually, the infant turned toddler moves from need-satisfaction relating to object relationships. Mahler, Pine, and Bergman, (1975) postulated that the psychological birth of the human infant

(separation-individuation process) resides in a set of developmental concepts, which run from about four to five (4-5) months until thirty to about thirty-six (30-36) months. In the separation-individuation process, the child establishes a sense of separation from and relation to the world of reality outside his or her own self. The core of the process consists of securing a sense of separateness of one's own body from the external world as that world is experienced through the infant's experience with its representative, that is, the "mothering" one who serves as the infant's primary love object. Once movement toward symbiosis has begun and the separation-individuation process has crested, it can be further distinguished by the following four subphases: differentiation, practicing, rapprochement, and constancy.

Autistic stage

Prelude to the symbiosis process is normal autism, which takes place from birth to about two (0-2) months. It consists of an objectless phase in which the infant is not aware there is a mothering agent. Satisfaction of the infant's needs is primarily experienced as coming from within his or her own orbit. This early life phase is the first beginning of the symbiotic relationship, which is marked by primary narcissism in the infant. Using predominantly somatopsychic mechanisms, the challenge for the child in this phase is to maintain homeostatic equilibrium outside the womb. Because there exists a

stimulus barrier, the child responds almost totally to internal needs and the infant's physiology is consumed by sleeplike periods of arousal.

Symbiosis

Symbiosis occurs between the ages of three to six (3-6) months. During this phase, the child is described as experiencing a state of undifferentiation. That is, the 'I' is not as yet differentiated from the 'not-I', but gradually the inside and outside perspectives are sensed as being different. Accordingly, symbiosis forms the basic foundation for emotional attachment and relationship. This stage was described as:

> The normal symbiotic phase marks the all-important phylogenic capacity of the human being to invest the mother with a vague dual unity that forms the primal soil from which all subsequent human relations form. (Mahler, Pine, & Bergman, p. 48)

The infant is in a psychological symbiosis in which he or she dimly perceives that satisfaction of needs comes from a need-satisfying object (the mothering one). The object is perceived as a part-object, the source of satisfactions, rather than as a whole object (whole person) (Nichols, 1988). According to Mahler (1968), only when the infant is able to wait for and confidently expect satisfaction is it possible to speak of the beginning of an ego, and of a symbiotic object as well. Gradually, then, learning by conditioning is replaced by learning through experience.

Optimal human symbiosis makes up the vicissitudes for a healthy separation-individuation process (Mahler, 1968). The developmental progression in children's affect, both pleasurable and unpleasurable becomes increasingly differentiated and focalized while the diffuse infant-mother body boundaries give way to awareness and separateness (Pine, 1971). This period of focal separation is inherently an unstable one; stability is achieved when a reliable and remembered object relationship serves to replace the earlier symbiosis and to fill the gap of the separateness felt by the child between himself or herself and the mother.

Differentiation

In the first subphase of childhood development, *differentiation* occurs between six to nine (6-9) months. It is signified by a shift in the child's perception of the self toward the external world, and there is an acknowledgement in the child of the separate existence of another person. The child learns to define his or her own boundaries with an increased awareness of fingers, toes, arms and legs. It is in this stage that the child pulls away from the mother and begins to differentiate the primitive self-image from the wider, outside or external world. The differentiation stage is marked by the infant's "hatching" from the common symbiotic orbit that he or she shares with the mothering one (Nichols, 1988).

Practicing

In the second subphase of the child's development, *practicing* occurs between ten to sixteen (10-16) months. Crawling or walking have characteristically begun when the child reaches the practicing stage. Excited by his or her own newly developed abilities and with the capacity to do things away from mother, the child begins to escape the still-existing symbiotic bond or attachment. Still absorbed in his or her own narcissistic pleasures, the infant begins to busily explore the world around. Thus, the child becomes increasingly aware of his or her separateness from the mothering one, and the need for acceptance and renewed participation in his or her own life. The practicing stage is marked by the extensive emotional "refuelling" actions of the developing infant (Nichols, 1988).

Rapprochement

Rapprochement occurs in the third subphase of childhood development, when the child is between seventeen to thirty-five (17-35) months. This stage is usually the most difficult for the child. Excitement diminishes and an emotional attachment to the mother redevelops, but the child is confused between the wants and needs of having mother emotionally available. The mother often finds this a difficult time, as well. Noticing the state of her child's confusion, she too struggles between wanting to nurture by drawing in the child or to

encourage individuality in her child by withdrawing. Unsuccessful completion of the rapprochement phase is at the core of borderline pathology. Leading to this are two opposed outcome patterns. The first pattern is characterized by complete withdrawal from the mother at the times that the child is moving away. The second pattern occurs when the child needs or simply wants emotional availability from mother, and the mother reciprocates "smotheringly." Thus, the child gets rejected for independence and associates autonomy with abandonment. It is therefore most important during this phase that the mother be emotionally congruent and emotionally available with the child wants and needs, otherwise the child may drain much developmental energy in trying to make her always available.

Nichols (1988) described this stage as time of "rapprochement crisis." Increasingly, the infant is aware that he or she is physically separate from others and that the love objects (mother and now father) are separate individuals. Renewed approach behavior on the part of the toddler toward the love objects is very significant in laying the foundations for subsequent mental health or psychopathology. The toddler avoids intimate bodily contact and engages in "shadowing and darting away patterns." Danger signals here are significant increases in separation anxiety. The kind of acceptance or rejection, availability or nonavailability of predictable and benign love objects establishes patterns of

trust and feelings of reliability, or feelings that love objects are not reliable and trustworthy.

Constancy

Finally, the fourth subphase occurs when the child turns approximately thirty-six (36) months. If successful completion of the rapprochement stage has been achieved, then *constancy* has been attained. Constancy was well described by Kaplan (1978) as:

> ...the enduring inner conviction of being me and nobody else. When constancy prevails, we are able to respect and value the separateness of others. We go on loving them even when they cannot fill us up with a perfect harmony of unconditional love. Through constancy, the perfect is united with the real. Every move into separate selfhood from birth to three years makes a distinctive contribution to constancy and brings with it new potential of love and hate, mastery and fear, trust and suspicion, elation and disappointment. (p. 35)

The formation of mental representations of the mothering one that are physically available to the toddler makes constancy possible. Given such mental representations, the child becomes able to stay away from the mothering one for longer periods of time and still remain able to function independently (Nichols, 1988). Accordingly, then, successful consolidation and completion of each of these developmental phases during our formative years will determine the healthiness of our future conception of self and our relation to others. The developmental theory on childhood born out of Mahler *et al.* (1975) befalls an

innovative model which closely parallels the relationship patterns found in couplehood development.

Developmental Stages of Couplehood

Based on the developmental stages of childhood outlined by Mahler, Pine, and Bergman (1975) and Kaplan (1978), Bader and Pearson (1983) launched their theoretical constructs for the developmental stages of couplehood. The forerunner formulations provided the framework for Bader and Pearson's research, enabling them to provide therapists with the diagnostic tools and treatment interventions offered in their 1988 handbook, *In Quest of the Mythical Mate: A Developmental Approach to Diagnosis and Treatment in Couples Therapy*. The remainder of the section is dedicated to examining the developmental approach to couples therapy. Accordingly, the developmental stages of couplehood discussed here are: symbiosis (enmeshed and hostile/dependent), differentiating, practicing, rapprochement, and mutual interdependence. For a detailed, abridged overview of the developmental model of couples therapy, including a diagnostic description of each developmental stage (developmental task and developmental stalemate) and treatment, see Appendix B.

Symbiosis

Bader and Pearson's (1988) theory on couplehood begins at the second stage of childhood development, that is, *symbiosis*. Accordingly, the symbiotic

relationship is marked by merging lives, personalities, and an intense bonding between two lovers. During this stage of introduction, it is not uncommon for the couple to be amazed at the sameness they share in thoughts, feelings, and behaviors. If both partners are diagnosed to be in the symbiotic stage of couplehood, then their relationship can be further distinguished by the two types: *enmeshed* or *hostile/dependent*. In both types of symbiotic relating, the couple's relationship is 'stuck'. It is marked by a source of personal identity loss (either one or both partners), whereby the relationship is surrounded by feelings of fear or anxiety about the relationship. The individuals are unable or unwilling to manage conflict or disagreement. On the one hand, if the relationship is of the symbiotic-enmeshed type, then it is characterized by a relationship in which there is virtually no conflict, or by conflict-avoidance. In this scenario, the couple goes to great lengths so as not to 'rock the boat', or, 'burst the other's bubble'. On the other hand, if the symbiotic phase is marked by hostile-dependent behaviors, then a type of love-hate relationship develops whereby the individuals can neither live with nor without the other. Characteristic in the symbiotic-hostile/dependent relationship is blame in which often one partner tries to change the other to become more like one's self. In this way, one individual's issue thus becomes a conjoint problem.

An adult symbiotic relationship was well described by Nichols (1988). A symbiotic relationship differs from a "host-parasite" form of attachment in that the former is characterized by one partner providing something the other lacks. Accordingly, the kinds of sharing adult partners seek in their relationship represents a biological-interactional prototype of original mother-child symbiosis. The mother-infant bond functions "as a common psychobiological unit in which the egos of the two are related through highly permeable boundaries" (Nichols, 1988, p. 64). Whereas the child may fantasize about wielding unlimited power over the mother, reality is such that the mother actually possesses the physical and decision-making power. In marital symbiosis, on the other hand, when two adults fuse together it is a temporary relationship condition. When things are working well, neither individual is forced into dependency nor helplessness. Each meets the other's needs without the autonomy of either person being threatened.

Nichols (1988) further identified two types of symbiotic relating: (1) the *character object relationship,* and (2) the *symptom object relationship*. The former not only consists of total involvement between the partners, but it is necessary for the stability of the relationship. The latter consists of only partial involvement whereby, in an effort to maintain their own psychic stability, the partners form attachments to certain facets of the other's personality. For example, an

individual can experience a fear of deep intimacy when attracted to the other's strength, while simultaneously being fearful of getting too close; hence, the individual acts clingingly while remaining emotionally withdrawn toward the partner.

Differentiation

Bader and Pearson's (1988) second stage of couplehood development is called *differentiation*. In the differentiation phase, at least one or both of the individuals begins to view their relationship more objectively. At this point the blended relationship becomes one of individual differentiation. Thus, much to the dismay of the undifferentiated partner, at least one of the individuals begins to challenge former boundaries of the relationship as he or she becomes increasingly aware of different or changing personal feelings. Differentiating individuals begin to sense their individuality and that they are unique from their partner. Many couples may find the differentiating stage very unsettling because it marks the possibility that their relationship could end dramatically and abruptly. However, if the differentiation process is approached with care, the partners can gradually begin to make mental comparisons about their individual differences as well as their similarities, even before these are verbalized. The ability for one or both partners to differentiate from the other allows for movement to the next stage of relatedness.

Practicing

The third phase of couplehood is the *practicing* stage. No longer "empathically attuned" to each other, here the individuals become clearly self-centered, and issues of autonomy and individuation are primary. Of central importance is the partners' feeling of self-efficacy, self-esteem, and individual power, as partners place emphasis on developing the self rather than developing the relationship. As the individuals strive toward feelings of independence, one or both partners may choose to participate in separate activities outside the relationship. Partners may engage in separate activities such as sports, increased time with individual friends, and putting in long hours at work. As conflict intensifies, there is an increasing need for the couple to maintain a healthy process for conflict resolution in order to facilitate their emotional connectedness while developing their own self.

Rapprochement

The fourth stage of development in a couple's relationship is *rapprochement*. Though vulnerability reemerges in each partner, they are more assured about their own individuality. The rapprochement stage is similar to earlier stages when partners seek comfort and assurance in each other, but feelings of anxiety are more relaxed and issues more quickly resolved through alternating periods of increased intimacy and reestablished independence. Both

have a clearer understanding about what it means to be engulfed in the earlier symbiosis, and feel less afraid by its threat. Bader and Pearson (1988) summed up the rapprochement relationship as partners "having developed a clear sense of identity" and "the sensitive balance between `me' and `we'" have "become more firmly established" as a result of "greater resolution of childhood issues interfering with successful coupling" (p. 11).

Mutual interdependence

In the fifth and final phase of couplehood development, *mutual interdependence* can be attained through constancy. Through the encouragement of external contacts and extra-curricular activities, the partners experience both individual and mutual growth. This helps create a deeper bond in the relationship that is further strengthened by the assurance in knowing that one mate is loved by the other. In contrast to earlier stages, the rapprochement phase is marked by an increased awareness in the couple whereby the perfect is reconciled with the real. For the couple which is successful in attaining a relationship of mutual interdependence, it is characterized by "two well-integrated individuals who have found satisfaction in their own lives, have developed a bond that is deep and mutually satisfying, and have built a relationship based on a foundation of growth rather than one of need" (Bader & Pearson, 1988, p. 12).

Summary

In summary, a healthy relationship in the developmental approach to couples therapy is encouraged through fostering in each partner continued growth and maturity. However, one partner may not progress developmentally at the same pace as the other. For instance, Bader and Pearson (1988) illustrated how each individual can coexist at a different stage in couplehood development. That is, if one individual is diagnosed as symbiotic (the first stage), the diagnosis for the other might be differentiating (the second stage). Bader and Pearson (1988) cited the most common relationship types diagnosed are: symbiotic-symbiotic (enmeshed or hostile/dependent), symbiotic-differentiating, differentiating-differentiating, symbiotic-practicing, practicing-practicing, and practicing-rapprochement. Interestingly, Bader and Pearson (1988) report that they have never encountered in practice any couple whereby the partners have been diagnosed more than two stage-levels apart. Reasons for this, they argue, are that the relationship cannot endure or withstand the internal and external strains, and normally the individuals will go their separate ways.

CHAPTER III -- METHODOLOGY

The third section describes the methods that were employed and implemented in order to conduct the present study. Included is a restatement of the research hypothesis and the procedures incorporated in the research design. Presented here for detailed discussion are: methodological rationale and representation, implementation, framework of coding system, treatment implementation, schematic outline of research design, a case example, general characteristics of the study population, location or setting in which the study takes place, calendar of events in carrying out study, sampling design and procedures, instrumentation and tools for measuring variables.

Restatement of the Research Hypothesis

To reiterate, the research hypothesis (H_1) is stated as follows: Bader and Pearson's (1988) developmental model of couples therapy will promote in each partner of the dyadic relationship a greater developmental sense of self (individuation) and a greater developmental sense of coupleness (relationship satisfaction).

Research Design

The developmental model of couples therapy does not lend itself easily to conventional empirical standards of scientific inquiry. Nevertheless, utmost care was taken in setting up the procedures and design to maintain a respectable level

of experimental control. For instance, toward developing a credible research design the following desirable features were considered: (1) that demonstrating a functional relationship between the intervention and behavior does not require withdrawing or temporarily suspending the intervention; (2) the intervention need not first be applied to one behavior and then eventually to others; (3) possible threats to internal validity such as lack of control for history and threat to instrumentation; and (4) possible threats of external validity such as complete control of interaction and testing.

Notwithstanding certain limitations inherent in the design, an all-intensive effort has been made to develop a feasible and sound methodology for testing the developmental couples therapy model. In so doing, the experimental design employed in the study can be classified as a primary-direct, quasi-experimental, single-subject research design. Toward that end, a single-case, changing-criterion design was chosen to be implemented in a time-series fashion.

As delineated by Bader and Pearson (1988), the developmental model of couples therapy is characterized by the individual characteristics and is highlighted in five distinct developmental stages. That the final stage, mutual interdependence, is considered the most desirable in developmental couples therapy. Once attained, theoretically, then, it can be said that the couple has reached a plateau and that their relationship can progress no further toward

another (higher) developmental stage. Thus, the developmental stage of mutual interdependence has not been given considerable treatment in developing the methodology. Rather, of central importance in the study are the diagnostic and treatment measures as they are applicable in the first four developmental stages in couples therapy that includes symbiosis (enmeshed and hostile/dependent), differentiating, practicing, and rapprochement.

One of the most unique features of the developmental couples therapy model is its ability to assess the developmental stages of each partner of the dyadic relationship as well as diagnose the developmental stage of the partners' relationship or relatedness. That is, a diagnostic measurement can be obtained for each partner's own stage of individual development (e.g., symbiotic, differentiating, practicing, rapprochement); further, a diagnostic measurement can also be obtained for the dyadic relationship itself, which can be assessed as a relational dyadic stage of couplehood development (e.g., symbiotic-differentiating, symbiotic-practicing, practicing-practicing). (For an overview of the developmental couples therapy model and its diagnostic and treatment measures, refer to Appendix B). The ensuing methodology presented in the following section has been formulated based on the developmental (separation/individuation process and couples' relatedness) criteria and the diagnostic measures delineated above.

Methodological Rationale and Representation

With regard to the features described earlier in the developmental couples therapy model, the following illustrates the methodological rationale and representation of the diagnostic measures. First is a measure of each partner's individuation or sense of identity. For the purpose of the study, this diagnostic measure is referred to as each partner's *developmental sense of self.* Illustrated graphically in a two-dimensional system, the reader can visualize two real number lines intersecting orthogonally to each other. The horizontal number line (commonly known as the *x*-axis in coordinate geometry) constitutes a measure of each partner's developmental individuation. Second, the vertical number line (commonly known as the y-axis in coordinate geometry) represents for each partner a developmental sense of couplehood. That is, the second line is a measure of each partner's developmental relationship satisfaction. See Appendix N for the Developmental Couples Therapy Graph (DCTG) depicting the scales on Developmental Sense of Self and Developmental Sense of Coupleness.

Each point in the system can be identified by an ordered pair of real numbers (x, y), called coordinates. The origin has coordinates (0, 0). In this system, the origin is the immediate transition point from differentiation toward the practicing stage; that is, the origin represents a neutral (0) sense of self and a

neutral (0) sense of coupleness. The sense of self (x-coordinate) expresses distance to the left (i.e., lesser, if negative) or right (i.e., greater, if positive) of the y-axis. The sense of coupleness (y-coordinate) expresses the distance below (i.e., lesser, if negative) or above (i.e., greater, if positive) the x-axis. The horizontal line and vertical line divide the plane into four regions. Unlike common coordinate geometry, however, there are no conventionally ordered quadrants in this system. Instead, each of the developmental stages is represented in a linear step-like fashion from the lower left (symbiotic) region toward the upper right (rapprochement) region.

Outward from the origin (0, 0) are the coordinates ranging from -20 to 20 on both the sense of self and sense of coupleness axes. First, beginning in the lower left-hand corner is the symbiotic stage that has the coordinate range -20 to -10. Moving upward and right toward the origin is the differentiation stage with coordinates ranging from -10 to 0. Moving again upward and right beyond the origin is the practicing stage with coordinates ranging between 0 and 10. Finally, in the top right-hand corner is the rapprochement stage with coordinates ranging between 10 and 20. In the case whereby a partner's composite developmental score should result lesser than -20 or greater than 20, these shall be illustrated using -20 or 20 as 'ceiling' values.

In addition to these coordinates that represent 'true' regions of developmental assignment, the DCTG has an additional feature. Whereas 'true' developmental regions are represented by nonshaded areas, each developmental stage includes a shaded area to allow for variability in the results. The rationale for this presentation is that, theoretically, at least, without therapeutic intervention couples in the beginning stages of relationship development will have little or no awareness of the therapeutic skills delineated in developmental couples therapy. For instance, the greatest degree of variability can occur in the symbiotic stage, with composite scores deviating from the 'true' symbiotic -20 to -10 (nonshaded) range beyond toward a composite score of 20 on both sense of self and sense of coupleness scales. However, as partners attain greater levels of sense of self and sense of coupleness so should there be an increase in their awareness and effectiveness of skills and, thus, a decrease in the degree of variability in the responses. Consequently, as depicted in the DCTG, the progression toward the more desirable stages of differentiating and practicing also includes a progression of lesser degrees of variability. Finally, as partners are diagnosed to have a heightened awareness of and improved effectiveness in skill implementation, then, increasingly, variability in the partners' responses should diminish as they approach the rapprochement stage.

Diagnosis of the respective developmental stage is dependent on the specific measures observed. On the scale of sense of self, or movement toward individuation, one partner's attributes can be described in the following: low sense of individuality (symbiotic stage, enmeshed); expressed instability in mood and self-image (symbiotic stage, hostile-dependent); developing capacity to tolerate differences in partner (differentiating stage); capacity for empathic response (practicing stage); reemergence of vulnerability (rapprochement stage). On the developmental sense of couplehood scale, or movement toward coupleness, can be described in the following: ability to express own identity or separateness in relationship (symbiotic stage, enmeshed); effort to connect emotionally with partner (symbiotic stage, hostile-dependent); ability to discriminate pertinent problem-solving issues (differentiating stage); relationship viewed as important as individuation process (practicing stage); ability to describe and support partner's growth needs and independence (rapprochement stage). A partner's increased (greater) sense of self or increased (greater) sense of coupleness can be expressed using positive coordinates on sense of self and sense of coupleness, leading toward the practicing and rapprochement developmental stages, respectively. Conversely, a partner's decreased (lesser) sense of self or decreased (lesser) sense of coupleness can be expressed using negative

coordinates leading toward the differentiation and symbiotic developmental stages, respectively.

Observational measures are based on a coding system (to be discussed later in detail) developed by the author. From observational units of couples engaged in a 10-minute problem-solving interaction, both positive and negative measures are combined and recorded. Thus, the two combined coordinates (sense of self and sense of coupleness) provide for each partner one composite developmental score. The composite developmental score is based on, first, a score on developmental sense of self, and, second, a score on developmental sense of coupleness. With the results obtained from the Developmental Couples Therapy Coding System (DCTCS), then, each partner's composite developmental scores can be plotted on the Developmental Couples Therapy Graph (DCTG) indicating their respective developmental stage.

For any given couple, then, a developmental measure for both Partner 1 and Partner 2 can be obtained from observational analysis of one 10-minute problem-solving interaction. For example, the composite developmental score for Partner 1 may be -5 (sense of self) and -9 (sense of coupleness); the composite developmental score for Partner 2 may by -12 (sense of self) and -16 (sense of coupleness). Plotting these on the axes of sense of self and sense of coupleness, Partner 1 falls into the differentiating stage, and Partner 2 falls into the symbiotic

stage. In short, then, the relationship itself is diagnosed and described as being in the symbiotic-differentiating stage of development.

Toward developing an acute method of evaluating the developmental model of couples therapy, there is at least one important salient feature inherent in the real number line coordinate model discussed here. That is, for each of the participating couples included in the study, the coordinate model has the ability to diagnose and track, simultaneously, (1) the developmental sense of self for Partner 1, and the developmental sense of self for Partner 2; (2) the developmental sense of coupleness for Partner 1, and the developmental sense of coupleness for Partner 2, and; (3) the developmental stage of the dyadic relationship itself. The following sections will describe the type and purpose of each of the observational variables, the rationale of the developmental couples therapy coding system, and the observational measures implemented in the coding system.

Methodological Implementation

Systematic measure of couples' developmental progress is acutely dependent on implementing fitting observational measures, or variables, and on a reliable coding system. Following is a discussion of the identification and labelling of the variables. The observational measures were compiled and developed using Bader and Pearson's (1988) overview of developmental couples

therapy model (see Appendix B) as a guide to identifying meaningful behaviors specific to each developmental stage. In the approach to developmental couples therapy, treatment or intervention is distinguished by the whole or ongoing process rather than individual treatments applied to individual developmental stages. That is, treatment or intervention has been identified and classified as one independent variable (IV). Denoting a person's developmental disposition, consistent with the developmental approach to couples therapy, two dependent variables (DVs) have been identified: (1) *sense of self*, and (2) *sense of coupleness*. It is hypothesized, then, that the occupancy or manipulation of the IV (treatment) will cause or effect change in the outcome measurements of either one or both DVs (sense of self, or, sense of coupleness).

Observational measures have been developed and identified for each of the developmental stages: symbiotic (enmeshed, and, hostile-dependent), differentiating, practicing, and rapprochement. For each of the developmental stages identified, two headings (i.e., Sense of Self and Sense of Coupleness) have been assigned and labelled accordingly. Further, within each of these two headings, a set of variables denote either seven positive measures or seven negative measures, coded alphabetically A-G. Under the heading Sense of Self is a set of seven positive variables (A^{+}-G^{+}) and a set of seven negative variables (A^{-}-G^{-}). Positive variables (A^{+}-G^{+}) and negative variables (A^{-}-G^{-}) variables found

under the heading Sense of Coupleness follow a similar coding system that includes a set of seven positive (A^{+}-G^{+}) and a set of seven negative variables (A^{-}-G^{-}).

For each variable (positive or negative) a brief statement of the observable measure has been included. Whereas a negative measure of one variable can be considered a disapproving or unwanted behavior, its corresponding positive measure can be considered an acceptable or desirable behavior. While many of the observational measures are geared toward identified verbal behaviors or responses, many of them can be interpreted as nonverbal, as well.

Following is an example of the observational measures employed for use with the developmental approach to couples therapy. In this example one of the partners has been diagnosed in the differentiating stage of sense of self. For instance, the partner may respond in a negative manner (A^{-}) with statements such as "I feel bad when I want to do things for myself," or, "I want to change, but I'm afraid you won't love me anymore." In other words, the partner is pulled in the direction away from differentiation toward reestablishing a symbiotic bond with the other, thus losing ground in the ability to identify his or her own individuation, or sense of self. On the other hand, the partner may have responded positively (A^{+}) with statements such as "I feel my own time is important to me," or, "I still love you, but I need to do something for myself." In

these latter statements, the partner is quite clear about needing to express his or her own self, is committed to finding a way of self-expression. Thus, the partner recognizes the need for and benefits of self-expression, indicates signs toward this process by acting it out, or practicing (fundamental to the next developmental stage) the behavior. In short, in contrast the earlier stage of symbiosis, the hallmark of in this stage is when one or both partners begin differentiate from the other.

Still using the developmental stage of differentiation as an example, rather than expressions of sense of self, developmental sense of coupleness observational measures are statements or behaviors that focus on the relationship, or on the way the partners interact with each other. Under sense of coupleness, while the partners may have not yet developed a successful fight style (A^-), the desirable behavior or goal is for the partners to make an observable effort toward working out their differences in manner which could be deemed mutually agreeable for both partners (A^+). For instance, one partner may respond toward the other in a negative manner (A^-) with statements such as "Every time I bring this up, you want to fight about it," or, "How can I feel good about myself when you make me feel so lousy?" In other words, the partner is easily led or attempts to lead the other into argumentative bouts, thus pulling the relationship in the direction away from differentiation toward reestablishing a

symbiotic type of relationship or developmental sense of couplehood. On the other hand, one partner may respond toward the other positively (A^{+}) with statements such as "I can understand that my wanting to go out with my friends once in a while makes you feel neglected, but I want you to do the same with your friends, as well," or, "Each of us needs to find a way to work this out, without always fighting about it." In the preceding statements, the partner is able to flag an ensuing fight, and he or she also makes a sincere effort to quickly resolve the issue and advert a fight thus interacting more effectively with his or her partner. The differentiating individual not only accepts that each partner has his or her own differences, but he or she actively searches for ways in which each partner can practice (hallmark of the next stage of development) these self-expressions in a manner that is mutually gratifying. Thus, at this point the concentration of effort is in helping to propel the relationship forward toward a greater sense of coupleness. (For a complete overview of the observational measures for both positive and negative measures of sense of self and sense of coupleness, as each pertains to the specific developmental stages, refer to Appendix C.) Having discussed the implementation of the observational measures, let us now turn to the particulars of the coding system which was designed by the present author to evaluate the developmental couples therapy model.

Developmental Couples Therapy Coding System

With observational measures identified and categorized, they can now be coded easily using the Developmental Couples Therapy Coding System (DCTCS), developed and designed by the author for the present study. (See Appendix M for a complete example of the DCTCS form.) One DCTCS form is required for each therapeutic session for each participating couple. For both Partner 1 and Partner 2 the form is divided into two separate headings of observational measures for coding, that is, Developmental Sense of Self, and, Developmental Sense of Coupleness. For both of these two headings is a category for scoring the frequency of the seven positive observational measures (A^{+}-G^{+}) and the seven negative observational measures (A^{-}-G^{-}).

The observational measures scored pertain to the behaviors of the partners during a 10-minute problem-solving unit. In order to obtain an accurate and more reliable frequency count of each partner's behavior and interaction with each other, each problem-solving unit is videotaped. All problem-solving units takes place at the beginning of scheduled sessions, prior to further instruction or treatment implementation. Analysis of each videotaped 10-minute problem-solving unit involves coding the measures observed for each partner on the DCTCS. To enable a more reliable frequency count the 10-minute interval is broken down further into 2-minute intervals.

Preparation for analysis of problem-solving interactions includes two steps. First, the 10-minute videotaped problem-solving interaction is previewed in its entirety. Second, problem-solving interactions are reviewed in segments of 2-minute intervals and variables are scored accordingly. At the end of each 2-minute interval, the videotape is paused to provide the observer an additional opportunity to review and reflect again on the entire list of variables. Frequency counts of the variables are obtained by means of observing the presence of either a positive or a negative measure. Each respective variable, whether it be positive or negative, can be scored once only for each 2-minute interval. However, if in the currently viewed 2-minute segment the respective variable is ambiguous or simply absent in either positive or negative form (i.e., not an issue), then no score shall be recorded. In short , for the duration of each 2-minute interval each respective variable to be identified may be scored positive (+1), negative (-1), both (+1, -1), or neither (0, 0).

Analysis of each 10-minute problem-solving unit, for both Partner 1 and Partner 2, includes frequency counts obtained on both positive and negative observational measures for scales of developmental sense of self and developmental sense of coupleness. Once completed, the observational measures are tallied, and a total for both positive and negative measures is recorded. Following this procedure, both the positive and the negative

observational measures are combined using a right-minus-wrong technique. Scores for positive variables (A^{+}-G^{+}) and negative variables (A^{-}-G^{-}) are combined to arrive at a composite developmental score, (again using a right-minus-wrong technique) for each partner's developmental sense of self and developmental sense of coupleness. A composite developmental score consists of two coordinates representing, first, the partner's sense of self, and, second, the partner's sense of coupleness. Each partner's composite developmental score can then be plotted and illustrated graphically in accordance to the real number line coordinate model described earlier (see Appendix N for the Developmental Couples Therapy Graph).

Treatment

For each couple, treatment or intervention is dependent on the diagnosis determined from the preceding therapeutic session. For instance, if the developmental diagnosis of the couple's relationship is symbiotic-symbiotic (enmeshed type), then the treatment employed is that which is delineated by Bader and Pearson (1988). If the developmental diagnosis of the couple changes, such as differentiating-practicing, then the treatment applied is that which corresponds to each partner's respective developmental stages. A detailed overview of the developmental model and its applied treatment to specific developmental stages is offered in Appendix B. Below is a list of the prescribed

treatments for each of the developmental stages or stages of relatedness.

Symbiotic-Symbiotic (enmeshed)

- Establish initial treatment contract focused on couple's view of the problem
- Establish "no-suicide" and "no-divorce" contracts when indicated
- Build an alliance with couple (family) and then facilitate personal responsibility taking in each partner
- When working with a family, use art or projective technique that elicits each member's perception of the family as a whole
- When appropriate, begin shifting from the family as a whole to the couple's relationship
- Use gestalt or TA techniques for working with each partner's family-of-origin.
- Facilitate differentiation between partners

Symbiotic-Symbiotic (hostile-dependent)

- Diffuse conflict as quickly as possible
- Establish limits and behavioral agreements about fights (see Limits Questionnaire in Appendix G)
- Keep both partners thinking when angry and channel their anger through yourself (as therapist)
- Teach them to complete transactions

- Signal a confrontation
- Predict future fights
- Provide support and positive reinforcement for partners during session
- Help partners learn how to apologize
- Facilitate direct, positive interactions
- Develop consistent, caring behaviors
- Encourage cooperation and joint activities
- Encourage partners to develop outside friendships and activities
- Use humour

Once conflict is contained:

- Help partners develop and maintain a vision of a better future that each will work to create
- Help partners develop an empathic process

Symbiotic-Differentiating

- Help partners resolve the loss of the symbiotic stage
- Help partners identify and express thoughts, feelings, and desires
- Help partners tolerate the anxiety inherent in recognition of differences
- Encourage *differentiating* partner's movements toward self-expression while interrupting *symbiotic* partner's dependency patterns

- Help partners identify their individual contributions to current difficulties
- Establish clear lines of responsibility taking with regard to issues being discussed
- Break down issues into manageable homework assignments
- Generate motivation for change in passive symbiotic partner by stressing personal benefits
- Help partners learn to tolerate anger

Differentiating-Differentiating

- Pace of therapy is determined by degree of differentiation present in each partner
- Use of nonstructured involvement to create therapeutic environment that provides autonomy in the unfolding of partners' differentiation
- Use of questions to help partners identify, understand, and articulate feelings
- Bring pertinent intrapsychic childhood issues into awareness
- Facilitate conflict management via use of the "initiator/responder" format for interaction
- Provide positive role model for partners, as therapist interacts with their demands and outbursts
- Discriminate between problem-solving issues and issues involving more

complex developmental factors

- Provide a larger context for viewing of specific problems
- Facilitate differentiation from family-of-origin
- Identify familial, societal, cultural, or work-related factors that may be inhibiting the differentiation process

Symbiotic-Practicing

- Help partners learn how to manage differentiation and support one another's independence
- Therapist must balance opposing therapeutic goals of partners: Symbiotic partner wants the spouse to "be like he/she used to be"; practicing partner wants to continue self-expression unimpeded
- Initial establishment of discrepant goals is sometimes necessary
- Expose common grief that underlies partners' reactive anger
- Help partners structure time together
- Help practicing partner set self-selected limits that circumscribe the scope of activities
- Help symbiotic partner initiate activities that are self-directed and self-focused
- Use of the "Symbiotic-Practicing Questionnaire" to help partners identify what they want from one another

• Identify and resolve pertinent intrapsychic conflicts from childhood

Practicing-Practicing

• Focus on process rather than content

• Help partners learn ways of protecting separate individualities while resolving conflicts

• Help partners relax boundaries

• Help those couples who have not actively differentiated together to learn how to manage differentiation, while continuing their independence

• Help partners identify and express feelings

• Use of "The Thirty-Day Plan"

• Help partners identify and resolve intrapsychic childhood issues

• Help partners develop a decision-making process that involves giving without anxiety

Practicing-Rapprochement

• Identify temporary incompatibility of respective stages

• Explore each partner's needs with a view toward finding points of intersection and compromise

• Use a future focus to evoke a mutual image of the relationship that combines both sets of needs

• Learn to balance one's own wants and desires with partners

Rapprochement-Rapprochement

• Therapy at this level is primarily facilitative rather than rather than treatment orientated

• Ask partners what most deeply touches them when they are vulnerable

• Focus them on learning to give when it is not convenient

• Use a future focus via developing a relationship purpose, setting goals, or using "The Thirty-Day Plan"

Treatment Implementation

Therapeutic sessions involve working with both partners of the dyadic relationship; only one couple at a time participates in any given therapeutic session. Therapeutic weekly sessions for each of the participating couples consist of 12 consecutive weeks, with treatment introduced and implemented in the final 10 weeks only. A follow-up measure has also been incorporated into the design; that is, the final therapeutic session (week 11) is scheduled two weeks rather than one week from the preceding therapeutic session. Following three pretreatment sessions in which baseline measures are assessed, therapeutic intervention is introduced and continues in the following eight therapeutic sessions. In short, each of the participating couples' involvement in the study is expected to be a total of 11 therapeutic sessions over the duration of 12 weeks.

As mentioned earlier, each session begins with the couple engaging in a videotaped 10-minute problem-solving interaction. However, the first three pretreatment weekly sessions differ somewhat from the following eight therapeutic sessions in that the latter involve the introduction of treatment intervention. The pretreatment phase of the study will primarily be used to introduce the developmental couples therapy model to the couple, and build rapport between the therapist (author) and the couple. The three pretreatment 10-minute problem-solving interactions, Baseline 1 (B1), Baseline 2 (B2), and Baseline 3 (B3) is coded using the DCTCS.

Further, the pretreatment sessions will be used to administer to the couple the required diagnostic instruments. For example, diagnosis involves the administration of the following diagnostic instruments: Question of Attunement (QA), Couples Diagnostic Questionnaire (CDQ), Individual History (IH) (if required), Limits Questionnaire (LQ), Symbiotic-Practicing Questionnaire (SPQ) (if required), Anger Questionnaire (AQ), and, the Paper Exercise (PE). Having the couple return these completed diagnostic instruments in the next session, a diagnosis can be made for each partner's developmental stage and for the developmental stage of their relationship. In subsequent sessions, and provided the couples have achieved the prerequisite developmental stage in their relationship, the Thirty-Day Plan (TDP) will later be introduced.

In the weekly therapeutic sessions that follow, intervention will be introduced by the therapist. Applications of intervention follow Bader and Pearson's (1988) suggestions for treatment as described in their overview of the developmental couples therapy (see Appendix B). As such, they suggest that intervention for each partner be chosen on an individual basis; that is, they offer a list of separate treatment approaches for each of the developmental stages. Thus, therapeutic intervention is specifically tailored to each partner's assessed developmental level in accordance to developmental couples therapy. Further, therapeutic intervention is in accordance with the composite developmental scores obtained from an analysis of the preceding problem-solving units. In other words, if one or both partners' composite developmental scores place him or her in the differentiating quadrant, then treatment implementation consists of those interventions taken from the differentiating treatment classification as suggested by Bader and Pearson (1988).

For example, some of the interventions to be utilized by the therapist for a partner classified as differentiating includes facilitating conflict management via use of "initiator-responder" format for interaction and communication, to provide larger context for viewing specific problems, and to use questions to help partner(s) identify, understand, and articulate feelings. If, perhaps, one or both partners' composite developmental score places him or her in the practicing

quadrant, then treatment is to focus on process rather than content, to help partners learn ways of protecting separate individualities while resolving conflicts, to help partners relax boundaries, to implement the Thirty-Day Plan (TDP), and so forth.

Baseline and therapeutic sessions are coded using a combination of letters and numbers, according to the problem-solving interaction being tested. That is, the initial three baseline sessions are coded B1, B2, and B3, respectively. Treatment implementation begins in the third baseline session (B3), following completion of the couple's third 10-minute problem-solving baseline unit. The coding technique employed for therapeutic sessions includes two sets of letters and numbers: the first indicates the number of treatment sessions (if any) upon which the couple's present 10 minute problem-solving interaction is tested; the second indicates the treatment session number which follows that particular problem-solving interaction. For example, for Week 4 the session is coded T1-T2. This denotes the couple's present problem-solving interaction, coded T1, following only one therapeutic session (which occurred one week prior). Immediately following data collection (via videotape) of the present 10-minute problem-solving interaction, the second treatment session coded T2 begins. Data collected on the second treatment session (T2) is then tested one week later in the session following, and so on.

In short, data collected on any current problem-solving interaction is based on the therapeutic intervention from one week prior (two weeks prior in the case of the followup measure, Week 12). Accordingly, sessions of treatment implementation are coded as follows: Treatment 1 (T1-T2), Treatment 2 (T2-T3), Treatment 3 (T3-T4), Treatment 4 (T4-T5), Treatment 5 (T5-T6), Treatment 6 (T6-T7), and Treatment 7 (T7-T8); the final session (T8F), follows two weeks later (i.e., Week 11 is omitted), and consists of a follow-up investigation and assessment.

At this point, it is considered that each couple has fulfilled their voluntary participation in the study. It is entirely possible, however, that at the time of termination the participants' involvement in the study the couple has been unable to overcome or resolve some particular impasse(s) in their relationship--developmentally related or otherwise--which has prevented or impeded progressive developmental movement. In such cases, the couple is supplied with additional information on related counselling resources and community services. The following schematic outline represents the research design time-line which describes the content and implementation of baseline sessions and treatment sessions for each couple participating in the present study.

Schematic Outline of Research Design

Week Number	Session Number	Description of Session
1	**Baseline 1 (B1)**	• Problem-solving unit (10 minutes, videotaped). • Explanation of study given by researcher. • Couple's questions and/or concerns addressed. • Diagnostic pencil and paper instruments including QA, CDQ, IH (if required), LQ, AQ, and SPQ (if required) are imparted to each couple together with an explanation and requirement for each instrument. • Paper Exercise (PE) (5 minutes, videotaped). • Following completion of baseline measure, diagnosis, analysis, and coding of (baseline unit 1) problem-solving unit begins.
2	**Baseline 2 (B2)**	• Problem-solving unit (10 minutes, videotaped). • Couple submit to the researcher completed diagnostic instruments. • Following completion of baseline measure, diagnosis, analysis, and coding of (baseline unit 2) problem-solving unit continues. • Initial diagnosis established.
3	**Baseline 3 (B3-T1)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple begins (1 hour therapeutic session). • Following completion of baseline measure, diagnosis, analysis, and coding of (baseline unit 3) problem-solving unit continues.
4	**Treatment 1 (T1-T2)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 1) problem-solving unit continues.
5	**Treatment 2 (T2-T3)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 2) problem-solving unit continues.
6	**Treatment 3 (T3-T4)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 3) problem-solving units continues.
7	**Treatment 4 (T4-T5)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 4) problem-solving unit continues.
8	**Treatment 5 (T5-T6)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 5) problem-solving unit continues.
9	**Treatment 6 (T6-T7)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 6) problem-solving unit continues.
10	**Treatment 7 (T7-T8)**	• Problem-solving unit (10 minutes, videotaped). • Treatment with couple continues (1 hour therapeutic session). • Following completion of therapeutic session, diagnosis, analysis, and coding of (treatment unit 7) problem-solving unit continues.
11	**Omitted**	• No therapeutic session scheduled (follow-up measure).
12	**Treatment 8 (T8F)**	• Problem-solving unit (10 minutes, videotaped). • Two-week follow-up investigation. • Treatment with couple is completed and terminated. • Diagnosis, analysis, and coding of (treatment unit 8) problem-solving unit is completed.

General Characteristics of the Study Population

As outlined in the Permission Request Form (see Appendix A), below are the general characteristics of the population sample employed in the study:

1) couples wanting to learn more about themselves and their relationship.

2) couples in which each of the individuals is over the age of 19 years.

3) couples who are married, living together, or involved in an intimate relationship.

4) couples in which *both* individuals are willing and consent to participating.

5) couples who live in the greater Calgary, Alberta area (i.e., within commuting distance).

As mentioned earlier, Bader and Pearson (1988) apprise one of the unique features of their developmental approach to couples therapy is its ability to service diverse populations, for example, hetero- and homosexual relations. However, they note one limitation of their model is that it does not have a direct treatment for substance abuse problems for the individual(s), or within the relationship. In such cases, they suggest that the couple be referred to a specialized substance abuse program. Thus, couples who report problems of substance abuse or addiction were not considered suitable candidates for the study.

Location or Setting in which the Study takes Place

Following the inability to secure continuous lab space at a full-time research centre (e.g., the University of Calgary), the author's residence was the chosen location or setting to conduct the present study.

Calendar of Events in Carrying out Study

Following acquisition of all the necessary approvals (e.g., author's examining committee, University of Victoria Committee on Research and Other Activities Involving Human Subjects, participants' consent forms), implementation and conduct of the present study began in Winter, 1994. Potential volunteers for participation in the study were obtained in early December, 1993. Implementation of baseline measures and therapeutic sessions toward compiling data collection began January, 1994. Data collection was completed and termination of the study for all of the participants involved ended March, 1994.

Sampling Design and Procedures

The present study employed a nonrandom sample. In the study, four (n = 8) couples were considered for participation. The sample cases represented here were dyads in which one or both partners, by their own account or admission, were currently experiencing relationship difficulties. The nature of their concerns or difficulties was of little importance for them to volunteer for the

study. The common characteristic in the unit of study is that the couples in some way expressed dissatisfaction with their present relationship, and that they were actively seeking ways to address the problem(s). The population sample was gathered via the present author's own personal contacts and connections (i.e., word of mouth) and via related community agencies within the greater Calgary area.

Instrumentation, Tools for Measuring Variables

In the developmental model of couples therapy, Bader and Pearson (1988) provide the therapist with an extensive array of instrumentation and diagnostic tools. In addition to these qualitative measures, the author has developed a quantitative approach toward extending and evaluating those diagnostic instruments proposed by Bader and Pearson (1988). (All diagnostic tools relating to the Developmental Couples Therapy model reproduced and employed here for the purpose of conducting the present study were used with the expressed written consent of Ellyn Bader, Ph. D.--a reproduced letter of permission can be found in Appendix N.) Each of these instruments is presented in detail in the Appendices section; however, pertinent information on certain diagnostic instruments is given to provide the reader with a brief description of each. The following is a list of schedules and diagnostic tools which were required for and employed in the present study:

Schedules of Information on Developmental Couples Therapy

Appendix A -- *Couples Relationship Study Form* and *Participants' Permission Form*, as developed by the author, were designed to elicit and disseminate information to persons interested in participating in the present study, as well as obtain informed consent of their participation.

Appendix B -- *Overview of Developmental Couples Therapy (DCT)* is an abridged account of the developmental couples therapy model as developed and delineated by Bader and Pearson (1988).

Appendix C -- *Observational Measures of Developmental Couples Therapy*, developed and delineated by the author, were designed to be incorporated and employed with measures of quantitative instrumentation [i.e., *Developmental Couples Therapy Coding System (DCTCS)* and *Developmental Couples Therapy Graph (DCTG)]*.

Appendix D -- *Observational Approaches to Diagnosis* is a brief summary of additional observational measures (e.g., nonverbal cues, setting) as developed and delineated by Bader and Pearson (1988).

Structured Diagnostic Tools [developed by Bader and Pearson (1988)]

Appendix E -- *Couples Diagnostic Questionnaire (CDQ)* is the most comprehensive (and possibly the most valuable) of the diagnostic questionnaires. The CDQ is designed to elicit the evolutionary history of the couple's

relationship. The questions presented in the CDQ are arranged in developmental sequence in order to pinpoint those phases that have been mastered by each partner and those that signal areas of impasse. The CDQ is presented to each partner individually as a take-home assignment. It is not befitting to discuss in detail partners' answers to all 19 questions of the CDQ; rather, their responses will be discussed to the point at which the developmental impasse has been determined.

Appendix F -- *The Anger Questionnaire (AQ)* is designed to help partners (and the therapist) better understand how early childhood experiences may have impacted the way the partners presently express and manage anger.

Appendix G -- *Limits Questionnaire (LQ)* determines the extent that partners are able to individually define limits of conflict. The responses the partners presented as acceptable and not acceptable limits in conflict management and, when suitable, is a treatment focus during therapeutic sessions.

Appendix H -- *Paper Exercise (PE)* is designed to obtain spontaneous information about how the partners currently interact with each other. The PE is an unstructured tool which allows the therapist to focus on the process of the interaction rather than the content.

Appendix I -- *Individual History (IH) and Intrapsychic Issues* is employed to

help partners reveal how unique experiential and psychodynamic background can lead to current developmental impasses involving unchanging, and self-defeating patterns of interaction.

Appendix J -- *Symbiotic-Practicing Questionnaire (SPQ)* is employed only with those couples in which the diagnostic criteria apply. In this case, a separate questionnaire is administered to each of the partners to elicit additional information about each of their respective stages.

Nonstandardized Instruments [developed by Bader and Pearson (1988)]

Appendix K -- *Question of Attunement (QA)* is employed to elicit a level of differentiation and nurturance between partners.

Appendix L -- *Thirty-Day Plan (TDP)* or Wish List is employed once the differentiation process already occurred and couples had moved into the developmental stage of practicing. The TDP was developed to help partners relax their boundaries toward more openness in a nonthreatening way, and to use the momentum from their own developmental growth process to carry them into new dimensions of positive relatedness.

Nonstandardized Instruments (developed by author)

Appendix M -- *Developmental Couples Therapy Coding System (DCTCS)* is employed in the analysis of the observational measures of the developmental variables with respect to developmental sense of self and developmental sense of

coupleness as these pertain to respective developmental stages.

Appendix N -- *Developmental Couples Therapy Graph (DCTG)* is a graphical representation of couples' intra- and interrelational composite developmental scores based on the developmental scales of sense of self and sense of coupleness.

Standardized Instruments

Appendix O -- *Client Satisfaction Questionnaire (CSQ-8)* was developed by C. C. Attkisson with the second edition of its publication in 1985. The CSQ-8 is an eight-item questionnaire with an ordinal four-point (4 = highest; 1 = lowest) rating system of the clients' levels of satisfaction for the services received. The CSQ-8 has "very good concurrent validity" and "excellent internal consistency" with alphas that ranged from .86 to .94 in a number of studies (Corcoran & Fischer, 1987, p. 120).

Validity and Reliability

Clearly, the present study is highly qualitative in nature and, as such, much relies on accurate attention to and interpretation of the effects that change the indicators or variables. From a methodological design perspective, this consideration is possibly the most problematic. Nevertheless, plans to ensure technical accuracy and empirical adequacy in the study have been maintained through verification and accurate coding of the data (as described earlier in the DCTCS). Data collection and interpretation involved qualitative measures of all

diagnostic instruments employed, as well as laboratory-based observations via videotaped 10-minute problem-solving interactions. Moreover, to further increase reliability review and coding of each 10-minute videotaped problem-solving interaction was (1) segmented into 2-minute intervals; (2) previewed first in its entirety, and; (3) paused at the end of each 2-minute interval to enable the observer to review and reflect again on the entire list of respective observed variables.

Confounding Variables

Not unlike any scientific experiment, a study on developmental couples therapy may encounter factors that influence, relate to, or effect other variables. A few of these variables are presented here to illustrate to the reader that the author is aware of and has considered some of the experimental concerns regarding the present study. For example, a possible major threat to internal validity is attrition. That is, as a result of the therapeutic sessions, couples may become discouraged with their progress or lack thereof and, consequently, they may end their participation in the study. Moreover, in couples therapy one partner's participation is eminently dependent upon the participation of the other; if only one subject chooses to quit, then two subjects are lost to the study. If this is the case, however, the information obtained on the couple thus far can still be of value. That is, because assessment on the developmental model of

couples therapy is a staged process, it is not necessary that the couple attain the final stage of mutual interdependence before termination of therapy or even participate in the study till its full completion. All data collected thus far can still prove of importance and be included in the analysis and results section.

Another possible major threat to internal validity is instrumentation. Because the diagnostic tools which Bader and Pearson (1988) provide in their handbook have not yet been empirically tested, the statistical validity and reliability of the diagnostic instruments are not known. In addition, repeated administration of the measurement scales as well as the standardized instrument employed may also lend to threats of internal validity. Other factors that may threaten the internal validity include, for example, events of history such as children, outside family members, or one partner's feelings of apathy or ambivalence toward the other. Possible maturational threats to internal validity include each individual's age and health.

Further, additional confounding variables include major threats to external validity such as multiple-treatment interference. Invariably, couples therapy involves a dyad, and therapy includes the presence of both partners. That is, during therapy individuals may be introduced to one or more of the prescribed therapeutic interventions. Moreover, by the very nature of conducting a study of couples therapy, it would be virtually impossible to avoid

other major threats to external validity such as reactive assessment and reactive experimental arrangements. Nevertheless, Bader and Pearson's (1988) developmental model with its unique ability to diagnose separately each partners' individual developmental stages as well as the developmental diagnosis of the relationship itself at least moderately provides some inherent controls for some threats to external validity.

Given that the sample employed is nonrandom and is relatively small in nature also contributes to the threat of external validity. This will certainly reduce the study's generalizability to other sample units and to the general population at large. Moreover, the qualitative nature of the relationship problem(s) presented by participating couples, and the degree to which each individual's dissatisfaction has surmounted, also invariably limits the generalizability of the findings. At this time, however, the primary purpose of the study is to provide an empirical spring board for data collection on the developmental model of couples therapy. However, a recurring or dominant theme may appear to present itself through data collection and analysis. In such cases, then perhaps further considerations on these and other confounding variables will provide valuable information for future study on analogous research designs and, hence, allow for greater generalizability of these and future findings.

Definition of the Most Important Terms and Concepts

In the present study, the term relationship therapy is applied to any therapy which addresses either individuals or dyads and their relationships, for example, marital, family, divorce, and couples therapy. Volunteers for the study are referred to as participants, individuals, couples, and partners. The union that two partners form is called a relationship or dyad. The term couplehood is used to refer to the partners' relationship diagnosis and the relating developmental stages as delineated by Bader and Pearson (1988). Mention of the therapist, researcher, or investigator refer to the present author and are used interchangeably.

Protection of Human Subjects

To ensure utmost protection of the participants of the study, careful attention has been taken in devising proper contracts and release forms. For example, special consideration has been given to issues of confidentiality, protection of information obtained, informed consent, as well as the participants' option to voluntary withdrawal from the study at any point or time. See Appendix A for the Participants' Request Form and the Human Subjects Permission Form issued to the participants.

CHAPTER IV -- RESULTS

The following results are described first in terms of qualitative findings and then, second, quantitative findings. Each of the results sections includes a discussion of the data obtained on each of the diagnostic instruments employed. (For a review of each diagnostic instrument and its purpose, the reader is encouraged to refer to the earlier discussion on Structured Diagnostic Tools and Nonstandardized Instruments in the Methodology chapter.) This is then followed by a discussion of the treatment data and related findings obtained from analogous therapeutic sessions.

All of the participants who volunteered for the study fitted to the general characteristics proposed earlier for the study population. Four (n = 8) couples participated in the present study on developmental couples therapy. All dyadic relationships were heterosexual in nature. From hereon "Partner 1" is assigned to represent the male partners, and "Partner 2" is assigned to represent the female partners. Diagnoses of couples' developmental stages (e.g., differentiating-symbiotic) are given first for Partner 1 and second for Partner 2. The age range for male partners was from 24 to 45 years; ages for female partners ranged from 27 to 40 years. Couple 1 and Couple 4 were married and presently living together; Couple 2 and Couple 3 were presently living together in commonlaw. Children were a component in the dyadic relationships for Couple

1, Couple 3, and Couple 4. Therapeutic sessions involved couples only; that is, no sessions involved family therapy. While three couples completed the full requirements of the study (i.e., 12 weeks until termination), Couple 3 had been offered and opted for the opportunity to withdraw following the therapeutic session in Week 5.

Qualitative

Diagnosis and Treatment

The Developmental Couples Therapy model is bundled with a comprehensive set of diagnostic tools. The following is a qualitative account of the data obtained on participants' responses to the prescribed diagnostic instruments. Analyses of the qualitative findings were derived from both written information (questionnaire form) and observed interactions (recorded on videotape). (A complete sample of the diagnostic tools employed can be reviewed in the Appendices.)

Instrumentation

Couples Diagnostic Questionnaire (CDQ). The partners of Couple 1 identified different reasons for entering into therapy. The primary reason for Partner 1 was the veritable fear of and current discussions about an imminent separation. Partner 2, on the other hand, said she was feeling unappreciated and appeared blameful toward her partner. Couple 1 had been living together for about 10 years, of which they were legally married for eight. Both partners were

able to recall a mutually satisfying symbiotic courtship, which led to their decision to live together after about three months of dating. Partner 1 described the most fulfilling part about the relationship was his partner's unconditional ("steadfast") commitment and trust, and also that it felt "right." Partner 2 stated that she found fulfillment in her partner's companionship and the financial security he provides. In the beginning of the relationship, Partner 1 was able to recall "lots of lovemaking, dancing, parties." Partner 2 described it as "extremely lovely, wonderful." Partner 2 was the first to become disillusioned about the relationship after about six months of living together. Her first disillusionment occurred over her partner's lack of contribution to household chores, at which time she "threatened to move." Partner 1 became disillusioned about the separation/individuation was sought by his partner, and persuaded for them to make a move from his partner's hometown after elucidating the "high divorce rates" and "many unwed single mothers" in the area. In their appraisal of the least fulfilling part of the relationship, both partners portrayed themselves as a "Lily-white" victim and consider the other as bad or blameful. For instance, Partner 1 declared he is least fulfilled when he feels inadequate as a financial provider for his family, and when he does not receive the "love and attention" he needs. Least fulfilling moments for Partner 2 are when she feels unappreciated for her (physical) contribution to the relationship. Partner 1 emphasized more

their similarities ("same interests and values"), though he did identify the polarity as a matter of "differing priorities" with some attempt toward understanding and compromise. The similarities Partner 2 identified were that both like to "party" and "make money," and differ in their spending habits; further, her comments indicate both partners have differentiated in that they spend time alone with nonmutual friends. Though separation-anxiety is not pronounced, Partner 1 responded to the following question that he "rarely spends time away" from his partner. Both partners agreed that trust is the hallmark of their relationship, but also that separate activities can lead to conflict and feelings of resentment. However, vulnerability and emotional responsiveness are lacking in the relationship. It is at this point that the developmental impasse emerges and it appears that Couple 1 has reached the differentiation stage. That is, it appears that both partners have entered into a process of separation/individuation, but they lack the mechanisms needed for self-expression, resolve, working out their differences, and managing conflict in a mutually satisfying manner. However, their answers to the final CDQ question contained both symbiotic and differentiating elements. That is, if their relationship was a drama, movie, book, (question 19), Partner 1 would simply call it "The Life and Times of (Partner 1) and (Partner 2)," and it would end "peacefully when our lives ended." Partner 2 entitled their relationship "The

Never Ending Story," which is "about a ride on a spirited horse, not so enjoyable" but "can handle it for the distance."

Couple 2 had been experiencing an increase in conflict that led to their decision to enter into therapy. Partner 2 expressed reasons of ambivalence, "feelings of confinement" and a "lack of freedom." Partner 1 conceded only after seeking help through friends and relatives, and at the suggestion his partner had been making "the past two years." The partners had known each other for about three years. Their relationship evolved from a year-long platonic friendship and, when suggested by Partner 2, they started living together after about three months of dating. The partners were initially attracted to each other because of their mutual interests (e.g., stimulating conversations, enjoyment for the outdoors, sense of humour) and their "competitive" nature. The most fulfilling quality of the relationship both partners identified their mutual affection, genuine caring, and mutually shared interests. The beginning of their relationship was very intense, "playful" and passionate (e.g., "in-depth talks," "dinner and movies," "dancing," "erotic and sensual sex"), and lasted about one year. The first disillusionment for Partner 1 came to light very early in the relationship; it occurred when his partner "insisted" that they live together "because she was so jealous" about his independent lifestyle. Partner 2 first became disillusioned over the fact that her partner did not share a similar

appreciation for enhancing individual and couples growth (i.e., he asked her to "chill out"). Partner 1 very much perceived himself as a "Lily-white" victim (i.e., considers other as bad and blameful) in that he feels least fulfilled in the relationship when his partner "gets boisterous, jealous, belligerent, pig-headed, and can't see through to compromising or accommodating my feelings." For Partner 2, least fulfilling moments are more of an anxiety produced over matters of separation/individuation such as feeling uncertainty about the future, or "feeling unmotivated" and not as "creative or productive" as she would like. Similarities (e.g., "competitiveness," "loud spoken," athletically inclined") between self and other were more the focus for Partner 1, and whereby he considered himself as "more level-headed," his partner "is more likely to react, and then think." Partner 2, on the other hand, gave brief mention to their similarities (e.g., enjoyment for the outdoors, both come from large families) but tended to focus more on her partner's differences, for example, "quieter, more relaxed" and "composed," "less emotional," less health conscious, and less concerned with financial planning. The discernible polarity of the partners' responses here is accentuated by the additional comments that Partner 2 feels pressured or manipulated to change her behavior through her partner's nonverbal expressions (e.g., "facial expressions," "how he breathes"). Partner 1 admitted very little time is spent with individual friends or on individual

activities, sometimes for fear his partner will become "jealous." Partner 2 also agreed that there is little time spent apart from her partner; however, she admitted that only in the last few weeks she has begun to spend time away with nonmutual friends, even though it "feels awkward." Partner 2 expressed further the desire to engage in more independent activities, adding that "maybe we need a little more space." Partner 1, on the other hand, expressed he is not comfortable participating in activities away from his partner, and projected that his partner would "react" by feeling "jealous or mad" or "sad." Neither partner admitted to feeling very comfortable about expressing innermost thoughts and feelings. Partner 1 admitted that he is less likely to make himself vulnerable or ask for support from his partner. Partner 2 said she found it difficult to ask her partner for support, but realized in the past she was not so "nervous" about expressing her thoughts and feelings. Here a developmental impasse for Couple 2 can be pinpointed. That is, it appears Partner 2 has entered into the separation/individuation process and begun to differentiate from her partner, but is ineffective to enact on defining her own identity (self). Partner 1 is less assured about his self-identity and exhibits little ability to differentiate from his partner, thus maintaining a symbiotic pattern of relatedness. These findings are further supported in question 19. That is, if the relationship was a drama, movie, or book, Partner 1 would call it "Scientific Progress goes Boink" and it would

end "continuing on great adventures...laughing and rolling about in the grass." Partner 2 entitled the relationship "Hills, Valleys, and Rough Terrain: The Adventures of (Partner 1) and (Partner 2)," and felt less assured about the ending in that the partners "would go their own ways."

Couple 3 was in close agreement when it came to recognize the need for couples therapy. The partners differed, however, in their reasons. While Partner 1 discussed some need to "work out" their differences, the impetus for doing so was more out of self-need in that he was "unable to get her to understand why it is so important for me to do what I do." Partner 2, on the other hand, was more relationship orientated and identified the problem areas as "we" do not "hear" each other and "resentment is building toward each other." Both partners were involved with other persons before they started dating each other. After dating about two to three months, the partners decided to live together and have been doing so for about three years. His lease was about to be terminated and Partner 2 said they decided to live together because "he needed a place" so she "let" him move in. What initially attracted Partner 1 to his partner was her "stunning beauty." Partner 2 was initially attracted to her partner because he "seemed very kind, considerate, and romantic," and "he said all the right things." Partner 1 stated the most fulfilling parts of their relationship are the security in "knowing" his partner will be at home when he arrives and "having somebody" with whom

"to talk." Partner 2 used references to the past to describe the most fulfilling elements about the relationship (e.g., "he gave lots of affection," "he was attentive and thoughtful," and "we had good sex"), but was unable to answer in the present. A "sea of passion" is how Partner 1 described the beginning of their relationship, which lasted about three months. For Partner 2 the beginning of the relationship was "wonderful, everything seemed almost perfect," but ended for her after about four months. Partner 1 first became disillusioned with the realization about his partner's engulfment or "emotional neediness." Partner 2 first became disillusioned when her partner arrived for a date "three hours late," and often arrives late by "an hour or more." Partner 1 expressed he feels betrayed and least fulfilled when his partner does not "support" his need for independence. The least fulfilling moments for Partner 2 are upheld in her partner's consistent inconsiderateness and unreliability, and also his temperament when he starts "swearing and freaking out" or "driving like a lunatic." To the extent that both partners consider the other as bad or blameful, they perceive themselves as "lily-white" victims. Both partners identified their "stubbornness" as a similar quality and, additionally, Partner 1 mentioned similarity in their "passion" and "intelligence." However, the partners were quite exacting in the ways they identified their differences. Partner 1 admitted to being more "outgoing," "realistic," and "business orientated," and perceived his

partner as "idealistic" and "very home orientated." Partner 2 described herself as a "perfectionist," "responsible," "uptight," and "consistent," and described her partner as "impulsive," "irresponsible," "laid back," and "inconsistent." Unfairness was very much the common theme and neither partner identified a single mechanism toward compromising on their differences. Partner 1 stated that in the past he would spend time away from his partner, and recently it has increased to a "majority" of time. Partner 2 admitted she does not "do too much without" her partner, and time together is spent mostly with his friends because he refuses to "see my friends or family." Both partners agreed that incongruent time management creates conflict. Partner 1 confirmed that he is "very comfortable" engaging in activities away from his partner because it relieved him of self-responsibility and responsibility for other (e.g., "I don't have to worry" about "what I say, how I say or how I behave," or "whether or not she is having a good time"). Partner 2 stated she is comfortable engaging in separate activities, though very limited by her opportunities (e.g., does not drive, tends to their newborn baby); however, in terms of feeling secure about her partner's individual activities, she identified it as a lack of trust (e.g., "I also worry he's gone to see strippers or pick up girls"). Though both admitted to making attempts in the past, neither partner currently feels emotionally supported nor is comfortable expressing feelings or innermost thoughts. Past attempts for Partner

1 would end in his partner becoming "very angry and often took it very personally instead of positive criticism." Making herself vulnerable makes Partner 2 feel "uncomfortable" because her partner "misinterprets or misconstrues everything," and "is constantly on the defensive." Couple 3 is far from developing effective mechanisms for managing their differences, and at this point the developmental impasse before them begins to unfold. That is, clearly Partner 1 is secure in his ability to differentiate his sense of self (identity) but, in doing so, he has become over-invested in his own individualization process. On the other hand, Partner 2 reflects some ability to define and make contrasts between self and other, yet, simultaneously, she manifests little differentiation in that her behavior continues on a path of symbiotic relatedness. Once again, these findings are substantiated in the answers the couple provided for question 19. If the relationship was a drama, movie, or book, Partner 1 would call "The Calm Before the Storm," and ends with "allowing each other to fulfill our dreams." Two titles were considered by Partner 2; "The Never-Ending Stress," and "The Lonely Relationship," that would end with either a "break-up" or herself "becoming complacent, submissive, and revolving her life around the identity of the man...like a mail-order bride."

Couple 4 similarly identified their reasons for seeking therapy. Partner 1 discussed the need to tackle "unresolved issues." Partner 2 expressed interest to

become "better at communicating" important issues to her partner. The couple had been involved for about 20 years, at first living together for about three years and then being married. Their decision to live together evolved out of a mutual interest. Initially, Partner 1 was first attracted by his partner's physical attributes and her sense of humour. Partner 2 was initially attracted to her partner's "sensitive, loving nature." Partner 1 considered "good companionship," humour, and his partner's "genuine personality" to be the most fulfilling elements of their relationship. For Partner 2, most fulfilling is the trust and safety, the "team" approach, and the security in knowing that they "will be together always." Partner 1 described the beginning phase of their relationship as mutually satisfying and enjoyable, which lasted about five years. Partner 2 recalled the beginning phase was "exciting, sad," and "tentative," which lasted until about the time they moved in together (i.e., three years). Partner 1 could not recall his first disillusionment. The first disillusionment for Partner 2 occurred with the discovery her partner is a "procrastinator," and usually resolves it by becoming more responsible herself. Partner 1 perceived himself as a "Lily-white" victim, and admitted to feeling least fulfilled in the relationship when "situations are thrust" upon him "without heeding my input, feelings, or thoughts." On the other hand, Partner 1 declared she is least fulfilled when both partners approach issues through conflict-avoidance. Both partners identified

their similarities as mutual enjoyment of the other's company, and as having the "same values and standards." According to Partner 1, they are different in that he is "flexible" and she is "rigid;" Partner 2 differs in that she "worries about what people think" and he does not. Any attempts to compromise are usually not very effective. Partner 1 claimed to engage in separate activities from his partner (e.g., nonmutual friends), but admitted that it creates conflict. Outside their separate work environments Partner 2 did not mention participating in any activities away from her partner, nor did she perceive it an area of conflict. Though he admitted the opportunities are rare, Partner 1 declared he is "very comfortable" with him or his partner engaging in separate activities. However, Partner 2 said she is not "too comfortable" participating in separate activities, and agreed that it does not happen often. With respect to feeling safe about expressing innermost thoughts and feelings, Partner 1 claimed he felt "very safe" in making himself vulnerable to his partner. On the other hand, Partner 2 stated she is "not very" comfortable making herself vulnerable. Partner 1 considered he is emotionally responsive toward his partner's vulnerability. Partner 2 said she is unable to be emotionally responsive because her partner does not adequately "express his needs." It becomes clear at this point that Couple 4 has arrived at a developmental impasse in their relationship. That is, the partners have not established effective mechanisms for which to communicate their

differences or the issues at hand (i.e., entrenched style of conflict-avoidance). Partner 1 recognizes the advantages to differentiate and has initiated the separation/individuation process, albeit minimally. Characterized in a symbiotic pattern of relatedness, Partner 2 finds self-expression anxiety-provoking, resonated in the fact that she far less self-assured about her own identity or about the direction of the relationship. These findings are casually supported by the partners' responses to question 19. Partner 1 entitled their relationship as "Two Idiots Made for Each Other," in which partners "grow old and die together holding hands on the couch." Partner 2 called their relationship "The Life and Times of (Partner 1) and (Partner 2)," and ends "with a comfortable, secure life together.

Anger Questionnaire (AQ). For the partners of Couple 1 it was clear that neither possessed positive expressions or experiences of anger. Partner 1 expressed that anger is "an uncontrollable behavior that makes me resist or change a situation." For Partner 2, anger is "unleashing an emotion to elicit fear which may escalate to physical harm." Moreover, both partners observed poor parental role models for expressions of anger management. While his mother chose a more practical approach to dealing with anger, Partner 1 admitted to emulating his father's behavior that included withdrawal, blame, raising his voice, and finding comfort in drinking alcohol. Partner 2 stated that her learned behavior was reflected in both her parents; that is, they would avoid conflict,

withdraw, and resort to passive-aggressive means of anger management. Both partners said that they were ready and willing to resolve their anger, though Partner 2 was less definite. The behavioral changes Partner 1 was willing to make included to improve listening skills and empathic responses. Partner 2 was vague about the personal behavioral changes she will make; however, she made use of projection techniques in describing the behavioral changes she wants in her partner (e.g., more openness and honesty, no "mind-reading," and no "physical contact or threats").

Couple 2 described their anger as an intense emotional response. Partner 1 expressed that anger is "the built up frustrations a person has over the inability to define or understand a situation deemed intolerable." For Partner 2, anger is "aggressive, loud, hurtful, physical, tearful, talking, listening, thinking about it, then responding." While Partner 2 expressed some degree of optimism in dealing with her anger, the description provided by Partner 1 contained a sense of helplessness. Both partners experienced poor parental role modelling in dealing with expressions of anger. Partner 1 observed both his mother and father resort to a passive-aggressive conflict management style whereby feelings were conveyed through suppression and covert manipulation (e.g., guilt, facial expressions). Both parents of Partner 2 dealt with their anger by raising their voices, threaten each other, become verbally and physically abusive, and her

father usually turned to alcohol. Both partners expressed the need to make personal behavioral changes. Partner 1 identified the need to become more responsible in the areas of self-expression and openness. While Partner 2 identified the need to improve self-expression and not withdraw during conflict situations, she discerningly noted the difficulty encountered to change early childhood patterns of relating.

The partners of Couple 3 defined their anger in different ways. Partner 1 stated that anger is "feelings that haven't been expressed to one's satisfaction." For Partner 2, anger is "the release of feelings (which are valid) over things that happen (which might be fair or unfair)." Whereas Partner 2 confirmed anger as a valid emotion, Partner 1 expressed anger as a collection of pent-up emotions. The partners' parents also expressed their anger in very different ways. As a child, like his parents Partner 1 was told to internalize and suppress (i.e., "ignore") his anger, or like his father until he could "no longer contain it." Partner 2 stated she had "several fathers;" some were "quiet and sullen and tuned-out" until their anger turned outward on the family, and others became "frustrated and psychotic" to the point where they "wreaked the house" and made "death threats on the bed with a hunting knife." Partner 2 declared her mother was "always right," and expressed her anger by suppressing it until "lashing out" and becoming physically and verbally abusive. Through their

childhood experiences the partners learned to suppress their anger out of fear (Partner 2) or until the "breaking point" (Partner 1). Both partners answered "yes" to making behavioral changes in the way they handle anger, but not without conditions. Partner 1 remarked that he would become more open and honest if he received respect from his partner, if his partner did not react defensively as if a "personal criticism." Partner 2 stated that she would attempt to remain calm and refrain from yelling and belittling her partner, but only if her partner would agree to refrain from "lying" and "displacing his anger" onto others.

Couple 4 partners defined anger similarly. Partner 1 expressed that anger is "an emotional outburst, release of frustration." For Partner 2, anger is "an emotion made up of frustration, disappointment, stress." The partners also described that their parents handled anger in a similar fashion. Both parents of Partner 1 suppressed their anger, and the seldom occasions when anger was displayed were handled with techniques of conflict-avoidance and passive-aggression. The parents of Partner 2 also managed their anger by suppression, but only to the point whereby it would "build up until" her father "exploded" and then "sometimes become aggressive and violent." Through their childhood experiences both partners learned to suppress their anger and to avoid conflict. Both partners answered "yes" to being ready and willing to change how they

resolve anger and make behavioral changes. Rather than dealing with issues through conflict-avoidance both partners stated they would become more proactive and direct while still expecting self-responsibility and responsiveness from the other.

Limits Questionnaire (LQ). Couple 1 partners were generally in agreement about their established limits. Both Couple 1 partners stated it was acceptable to elevate voice levels, expect and receive empathic understanding, achieve a mutually satisfying resolution; however, it was not acceptable to resort to physical or verbal abuse, belittle each other, withdraw, or involve children during an argument. Additionally, Partner 2 stated that it is acceptable for her "to have the final word," and for her partner to "be in agreement" with her and "change his ways." Though not an effective means of conflict management, Couple 1 partners were in general agreement about acceptable limits for establishing conflict management.

Couple 2 partners were in agreement on certain items. For instance, they stated it is acceptable to expect and receive empathic understanding, equal opportunities for self-expression, achieve a mutually satisfying resolution; it is not acceptable to intimidate or manipulate, belittle, withdraw, or resort to physical or verbal abuse. Interestingly, an area in which the partners differed was Partner 2 mentioned it was acceptable for her to "yell" or "cry," yet Partner

1 maintained that such behaviors were unacceptable for himself. Further, Partner 2 indicated a higher degree of self-defined personal boundaries in that it was acceptable for either partner to take a break (e.g., "go for a walk") from the intensity of conflict situations.

Couple 3 partners were quite dissimilar in their responses toward establishing limits. For instance, Partner 2 expressed considerable knowledge about conflict management and the nature of effective communication skills. Acceptable behaviors for herself and her partner included honesty and openness, equal opportunities for self-expression and "getting in touch with feelings," reflective listening, ability for give and receive empathic responses, and establish personal boundaries such as time limits to prevent "going in circles" or "attacking each other." On the other hand, the responses provided by Partner 1 contained many conditional statements. For instance, for Partner 1 acceptable limits included the opportunity for self-expression "in almost any manner it may take to do it," and raise voice levels; unacceptable limits included yelling "unless it seems that this may be the only way," or resort to physical or emotional abuse. Given the responses provided by Couple 3 there appeared some very despairing differences between the way each approach conflict.

For Couple 4 partners there was some consensus about permissible limits of conflict management. Both partners agreed that acceptable limits include self-

expression and yelling; limits that were considered not acceptable include withdraw, belittling. In addition, Partner 1 mentioned acceptable limits for his partner and himself includes modes of nonverbal communication (e.g., "hand gestures"). Though in general agreement about acceptable limits, both partners were clearly limited by their choices for establishing an effective means of conflict management.

Paper Exercise (PE). Partner 1 of Couple 1 began the PE exercise with a conscientious effort of self-definition. Partner 2 responded with a low degree of self-definition and was unable to define her personal boundaries. Moreover, so strong was her attempt to avoid conflict that Partner 2 struggled unsuccessfully to hold back her tears. Rather than negotiate Partner 2 simply volunteered to entrust the paper to her partner. In turn, Partner 1 responded graciously in knowing the strength of the trust conveyed by his partner. Rather than accept the paper, Partner 1 expressed that he is secure in giving the paper to his partner. Partner 2 finally accepts and is holding the piece of paper at the end of the exercise (i.e., under 5 minutes).

The exercise for Couple 2 began with both partners seeking to individually define meaning to the piece of paper. Though the partners were unable to effectively express the importance of the paper, Partner 2 contributed more to the discussion. Two solutions discussed by the couple included "Let's

hang it on the wall," and "Let's eat it." The end result was that the couple decided to mutually let go of the paper on the count of three. In doing so, neither partner was in possession of the paper indicating enmeshment and a symbiotic pattern of relatedness. However, Partner 2 appeared to make a greater effort to differentiate and identify boundaries between self and other.

There appeared to be considerable tension between the Couple 3 partners during the PE exercise. Both partners began the interaction passively with little ability for self-definition or individuation. Partner 1 seemed quite frustrated that he was directed earlier *not* to tear the paper in half. Partner 2 seemed only to be angered by the cavalier approach taken by her partner. Through their attempt at negotiation both partners failed to share with each other the importance of the paper. Partner 2 insisted that the paper's meaning could be understood only by himself indicated a strong degree of individuation. Partner 2 was unwilling or unable to define the paper, thus indicating a lack of individuation. Both partners were clearly becoming very frustrated with the negotiation process. Partner 2 finally resolves and ended with the comment, "I'll take the paper only because it doesn't mean anything to you."

Partner 1 of Couple 4 initially desired to establish separate boundaries and define the paper's meaning individually; however, he soon conceded to a mutually defined meaning. Both partners struggled to negotiate and redefine

the paper's meaning, only to again decide that the paper represents their marriage license. Partner 2 later introduced another couple into the discussion that further indicated a low degree of self-definition and poorly established personal boundaries. The couple was unable to negotiate a resolution under the allotted five minutes that left both partners holding the piece of paper at the end of the exercise.

Individual History (IH) and Intrapsychic Issues. Investigations into intrapsychic childhood issues were employed with Couple 1, Couple 2 and Couple 4. (Couple 3 had withdrawn from the study before the IH could be implemented.) The IH was employed with Couple 1 to enable the partners to better understand how their current (ineffective) communication style relates to expressions of anger. That is, both partners described anger as an intense emotion that invariably led to feeling of frustration, helplessness, and loss of control. Intrapsychic childhood issues were presented to reveal the ways in which each partner has adopted many of their parents' patterns of relatedness and mechanisms of conflict resolution.

Couple 2 was considered a good candidate for further investigation into intrapsychic childhood issues because the partners themselves had identified a possible conflict issue being differences in their familial patterns of relating. For instance, one difference highlighted was in the way the two families interact at

mealtime. Whereas the members of one family (Partner 1) were quite reserved and more concerned with proper etiquette and table manners, members of the other family (Partner 2) took advantage of opportune family gatherings to speak out in a direct manner. Investigation into the elements of these diverse communication styles from their past was used to reveal how each partner contributes to their current impasses in communication.

The individual histories of Couple 4 were also investigated due to the partners' highly entrenched means of dealing with issues through conflict-avoidance. For instance, both partners choose a passive-aggressive approach to conflict management (e.g., more desirable to discuss issues via telephone rather than in person) rather than an effective, more direct approach. That is, through the role modelling of both sets of parents the partners have learnt to internalize (i.e., suppress) rather than express their feelings. Having highlighted the ineffectiveness of their past approach of conflict-avoidance in therapeutic sessions, each partner was more willing to take self-responsibility toward developing a more effective communication style.

Symbiotic-Practicing Questionnaire (SPQ). Couple 2 only was diagnosed symbiotic-practicing and, hence, was the only couple administered the Symbiotic-Practicing Questionnaire (SPQ). Partner 1 was diagnosed the practicing partner; Partner 2 was diagnosed symbiotic. Accordingly, the SPQ is employed when (1) a couple had enjoyed a mutually satisfying initial period of

symbiosis; (2) minimal differentiation has occurred and there are with few mechanisms developed to handle conflicting needs, desires, anger, and ambiguity, and; (3) one partner makes increasing demands for independence. As expected, Partner 1 answered the questionnaire with responses that indicated a desire for greater independence and "unconditional support" from his partner. For example, Partner 1 stated that "I need to do what I do" and wanted to alleviate feelings of guilt for pursuing his own independence. Partner 2, on the other hand, made requests that she required from her partner greater understanding, compassion, and emotional support. However, there appeared some mutual goals in that both partners wished they could be more supportive of the other, and Partner 1 made additional comments wanting increased independence for herself.

Question of Attunement (QA). The Question of Attunement (QA) was administered to Couple 1, Couple 2, and Couple 4 and videotaped during the first treatment session (B3-T1). Subsequent weekly QA assignments were issued to the couples as take-home assignments. The responses given by Couple 1 indicated a low degree of differentiation: Partner 1 desired to spend more time together; Partner 2 asked for to continued help with household chores, and to continue building on the prescribed Initiator/Responder communication skills (e.g., feeling checks). Couple 2 seemed at ease when the question was posed, and their responses indicate a high degree of differentiation: Partner 1 asked to

continue building more effective communication skills; Partner 2 requested continued support, as well as for her partner to continue utilizing opportunities for self-expression and direct communication (indicating self-definition and a high degree of individuation). Indicating a low degree of differentiation, Couple 4 had considerable difficulty identifying and expressing personal needs and desires: Partner 1 asked for his lunch to be prepared one day of the week; with much hesitation and reluctance, Partner 2 asked for some flowers.

Thirty-Day Plan (TDP). The TDP or Wish List was employed with Couple 1, Couple 2, and Couple 4. In general, the TDP was effective for all the couples. The results obtained include helping partners relax their personal boundaries, view the relationship as important as individuation, and rejuvenate the emotional connection with their partner. The Wish List Couple 1 created included for Partner 1 continued growth as an individual, better control of personal anger, an increase in time to spend with individual friends, more effective communication, an increase in time to spend with partner, and strengthen relationships with relatives; for Partner 2 the wish list contained better care of individual physical health, increased positive thinking, and more effective communication (e.g., increased "I" statements) to better reflect personal thoughts and feelings. Partner 1 of Couple 2 indicated the desire for an increase in effective communication, an increase in time to spend with friends, the ability to support partner, validation for each other's personal experiences and feelings;

Partner 2 indicated the desire to encourage each other's personal endeavors and experiences, to be more empathic of the other partner's perspective, an increase in positive responses, more "good chuckles" with partner, an increase in time spent with friends. For Couple 4, Partner 1 desired his partner's appreciation and encouragement of his individual interests, an increase in mutual support and empathy, and an increase in quality time to spend with partner; Partner 2 desired more effective self-expression, an increase in mutually fulfilling activities, and more romance.

Diagnosis

The first four diagnostic instruments (CDQ, AQ, LQ, PE) listed above were utilized in combination to arrive at an initial developmental diagnosis for each of the couples. Additional diagnostic tools (IH, SPQ, QA, TDP) were correspondingly employed as treatment measures in subsequent treatment sessions. Treatment intervention (Week 3) was then implemented with respective developmental diagnoses in accordance to the parameters outlined in the Developmental Couples Therapy model. The baseline problem-solving interactions (B1, B2, B3) were not considered as part of the initial qualitative diagnoses.

The initial diagnosis for each couple's developmental stage is given first for Partner 1 and second for Partner 2. It should be noted that throughout the

study at no time were the partners of one couple qualitatively diagnosed to be more than two developmental stages apart. It should also be noted that all partners described the beginning stages of their relationship as an intense emotional connection or bond to the other. This early symbiotic period of enmeshment is a characteristic feature of most any intimate relationship, and is a condition necessary for partners to be considered good candidates for developmental couples therapy (Bader & Pearson, 1989). Based on the interpretative findings of the above combined diagnostic tools, a fitting developmental diagnosis was aptly assessed for each of the participating couples.

Couple 1 partners had similar communication styles. That is, it is their ineffective means of conflict management that often leads to situations arising in ongoing hassles. Moreover, both partners expressed feelings of frustration over not having their partner understand in moments of conflict. An unsuccessful communication style develops out of each partner's attempt to identify individual differences. Each partner competes for the need to define independent thoughts, feelings, and desires. In doing so, feelings of anger and blame culminate. Personal boundaries are not explicitly established. Partners lack self-responsibility. Simultaneously, individual or separate activities are not practiced because partners expressed guilt over identifying differences, all the

while harbouring resentment toward the other for not being more understanding or supportive of their individual expressions of self-identity. In short, the stance of both partners was one of "I'll change if you change." Given the data collected, the initial diagnosis for Couple 1 was *differentiating-differentiating*.

The partners of Couple 2 were diagnosed to be at differing developmental stages. For instance, Partner 1 provided many examples of in which his self-expression and behavior tended to be passive and reactive, rather than self-initiated. There was a marked lack of self-definition in Partner 1, and he expressed feeling uneasy about participating in separate activities. Primarily, the mode of relating for Partner 1 appeared to be ego-syntonic. On the other hand, Partner 2 appeared to be highly individuated from her partner. For instance, there were many examples in which Partner 2 shifted toward internally defining her sense of self with expressions of independent thoughts, feelings, and desires. Partner 2 made some attempts to establish personal boundaries. However, at times Partner 2 would succumb to feelings of guilt for identifying differences, and as a result suppressed practicing them. Oftentimes Partner 2 seemed sincere in her effort to resolve conflict in a mutually satisfying manner, but lacked a workable means of conflict management. Whereas the diagnostic information indicated a "We are one" stance for Partner 1, the expressed stance of Partner 2

was more "I'll change it you change." Thus, Couple 2 was initially diagnosed *symbiotic (enmeshed type)-differentiating*.

Couple 3 partners were also diagnosed to be at differing stages of development and, further, to be more than two developmental stages apart. Partner 1, for instance, provided many examples in which he appeared to be highly individuated and his behavior remained stubborn and self-centered. Moreover, Partner 1 made several demands for increased independence, thus conveying the view that the relationship is secondary. Partner 2, on the other hand, displayed a poorly developed sense of self (i.e., little differentiation) with little ability to perceive the impact of her own behavior. For Partner 2 the primary mode of relating was through conflict and aggression which was used to maintain distance and minimal emotional contact. Together, the partners' communication style most often escalated in conflict with clear expressions of anger, blame, and bitterness. While the stance of Partner 1 is one of "I want to be me!" the stance of Partner 2 can be interpreted as "I can't live with you, and I can't live without you." Couple 3 was initially diagnosed *practicing-symbiotic (hostile-dependent type)*.

The partners of Couple 4 were also diagnosed to be at differing stages in their development. For instance, Partner 1 exhibited some sense of individuation and a developing capacity to negotiate difference; however, to a great extent the

shift toward self-identity and self-expression are suppressed. For Partner 1 personal boundaries were ill-defined, and there were many examples of behavior which lacked self-responsibility. Partner 2 appeared to have a lost sense of individuality, and turned to her partner often for approval or increased emotional bonding. For Partner 2 there was a consuming need to merge with her partner, with many examples that focused on masking their differences. Notwithstanding their developmental differences, both partners appear exceedingly similar in their conflict-avoidant style of communication, that is their inability to discriminate problem-solving issues. In other words, Partner 1 conveyed a stance of "I'll change if you change," and the posture of Partner 2 was one of "We are one." Thus, Couple 4 was diagnosed *differentiating-symbiotic (enmeshed type).*

Therapeutic Sessions

It might be considered a moot point to say that all of the participating individuals could have benefited from most any form of therapy, given the state of their relationships upon beginning the study. Just how well did the partners fare from developmental couples treatment? The following is a qualitative account of the couples' therapeutic sessions. It includes data on the problem-solving interactions and the treatment employed in each session. The qualitative data is compiled from both the videotaped problems solving interactions and

from log entries of couples' interactions written by the author immediately following each therapeutic session. Discussion begins following the third baseline measure, or the session in which treatment had begun (Week 3). Focus is centered on process rather than content. A summary of the therapeutic sessions is presented for each of the four couples. The treatment employed with each of the partners was in accordance with that which was prescribed by Bader and Pearson (1988) and as per the diagnostic criteria for respective developmental stages. (For an overview of the diagnostic criteria and a description of the suggested treatments as they pertain to each developmental stage, refer to Appendix B). Couples' weekly diagnostic assessments and corresponding developmental stages are provided below in Table 1.

Couple 1. Prescribed treatment for Couple 1 began with the initial diagnosis of differentiating-differentiating. During the problem-solving interaction (B3-T1), and just prior to the introduction of treatment, the partners were unable to discriminate or agree on the important problem-solving issues (e.g., "too much spending money" versus "spending too much time with the kids"). Their less than effective communication style contained many examples of defensive presentations, use of projection, and on-going hassling that led to escalating conflict. Toward achieving a more effective communication style, prescribed treatment for each partner included explanation and practice of Initiator/Responder techniques (e.g., feeling checks, reflective listening,

empathic responses, and effective use of 'I' statements).

In the following problem-solving interaction (T1-T2), the partners mutually identified a past week's incident (e.g., "leaving the toaster setting too high") as an unresolved issue that led to the most conflict. They reported that they initially approached this conflicting issue using many of the mechanisms of the past (e.g., defensiveness, blaming, raised voice). However, when one partner initiated the Initiator/Responder skills, both partners reported that it helped them better to resolve the problem-solving issue in a mutually satisfying manner. The IH was employed for the remainder of the session to help both partners examine how their unique experiential and psychodynamic backgrounds can lead to current developmental impasses involving unchanging, and self-defeating patterns of interaction. In addition, some related issues of substance abuse (i.e., excessive drinking) were also explored. (Though substance abuse does not effect the ability for the developmental model to diagnose the developmental stage of the couple, it does have bearing on treatment. Bader and Pearson (1988) recommended a referral be made for treatment of the substance addiction before developmental treatment of the couple continues. At least at this time, it was considered that alcoholism was a mitigating issue only. However, the couple was informed that in future sessions recommendations for treatment of potential substance abuse may be necessary.)

For the next problem-solving interaction (T2-T3) the couple managed to develop a much improved communication style. Moreover, each partner accepted more self-responsibility and was more effective in employing Initiator/Responder skills, which enabled them to reach at least a tentative compromise on their current problem-solving issue (e.g., one partner's wish to smoke occasionally). Couple's differentiation became clearer as each partner developed an increased ability for better self-expression (e.g., defining independent thoughts, feelings, and wants) and redefining personal boundaries. For the remainder of the session the focus turned toward fostering in each partner an increased autonomy and involvement in self-fulfilling interests and activities (i.e., practicing).

Movement toward the practicing stage was a difficult transition for both partners. The problem-solving interaction (T3-T4) predominated the beginning of the session. Moreover, both partners depended partly on familiar, though noneffective, communication styles of the past. Although both partners displayed fewer mechanisms to handle conflicting needs, desires, and emotions, a positive feature of the couple's interaction was their willingness and positive response to reemploy Initiator/Responder skills. The couple was also responsive to relaxing their boundaries (i.e., less competitiveness, unnecessary to "win"). It was believed that each partner's expression of independence resulted

in a mutual impression to view the relationship as secondary. Hence, because of the couple's responsiveness to continue developing the principles of the developmental model and the positive outcome it provided, the TDP was introduced to help the couple focus on the "successes" of their relationship (i.e., facilitate new dimensions of positive relatedness). In addition, the QA was also employed.

The couple displayed a conscientious effort in managing the problem-solving interaction (T4-T5). Both partners effectively employed the Initiator/Responder skills that averted a situation of blame or defensiveness. At one point, however, Partner 1 started to assume (project) his partner's aspirations or career goals. This behavior readily led to a building of frustration in Partner 2. Nevertheless, Partner 1 sensed the negative impact of his behavior and, rather than assume his partner's needs, took affirmative action to pose the question, "What can I do to support you?" This in turn helped Partner 2 relax her boundaries and actually feel "supported." With respect to the TDP and building relationship of positive relatedness, the couple expressed positive experiences but admitted they had not fulfilled all the requirements of the exercise (i.e., once a day instead of the recommended twice a day). The couple was commended on their progress thus far, and also strongly encouraged to meet the demands of each other's Wish Lists (e.g., structure the TDP two times a day).

Interestingly, this problem-solving interaction (T5-T6) incorporated an item from one of the partner's Wish Lists. That is, Partner 2 asked how she could "support" her partner's wish to foster more positive growth in relationships with relatives. The partners were then asked to assess the positive attributes of the problem-solving interaction themselves. The partners identified fewer blame statements and increased ownership (e.g., more 'I' statements). When asked what would have made the interaction more effective, Partner 2 said she would have liked a clearer resolution. Partner 1 mentioned he would have liked a mutual exchange and the opportunity to pose a similar question to his partner, which indicated movement toward more positive relatedness. During the past week the partners structured the TDP twice daily, and both expressed very positive experiences. For example, both partners said they found it easier to implement the TDP and expressed excitement when their personal (future-orientated) wishes become reality (present-based). The remainder of the session focused on how self-growth and individuation need not be incompatible with (i.e., leads to rapprochement) extending the self in a relationship with other, thus fostering a situation of "give and take."

Particular impasses were encountered in the following week's problem-solving interaction (T6-T7). The lack of Initiator/Responder skills may have been at least in part due the emotionally charge and sensitivity evoked by the

issue. That is, when it came to disciplining their children Partner 1 said she felt "undermined" and "not respected." Some attempts toward more effective communication skills were made, but both partners reacted defensively, were blameful of the other, which soon escalated into partners projecting anger and hostility. Partner 2, in particular, found the session very emotional and wept occasionally. The session was used to describe the process of triangulation that commonly occurs between two parents and offspring. Moreover, it was explained how one partner can still offer support and understanding to the other, and still not necessarily be in complete agreement. Nevertheless, the difficulties encountered in this session indicated regressive movement toward a lesser developmental stage.

Last week's issues carried over into this session's problem-solving interaction (T7-T8). Both partners began the interaction with a conscientious effort but then, about the midpoint, they shifted back to using early script partners of relating to each other. That is, what began with the partners using at least some Initiator/Responder skills (e.g., reflective listening, use of 'I' statements) effectively gradually increased into ineffective communication exchanges (e.g., less self-responsibility, self-centeredness, projection and blame). Partner 1 expressed her disappointment in the comment, "Sometimes I feel like we are slipping back into the way we used to communicate." To increase again

the partners' capacity for empathic response, the focus of the session returned to helping partners relax their boundaries. In doing so, partners' were encouraged to share their positive experiences of differentiation and practiced autonomous activities. The satisfaction they experienced in their recent individual achievements provided the partners with the ability to interact with less anxiety. In addition, it was explained how increased efforts toward differentiation of the self are highly compatible with fostering an increase in emotional connectedness with the other. The partners were also asked to project how these skills might fit together six months or a year from now. They said they envisioned their enthusiasm and implementation of the skills "slipping" in their daily lives, and a possible return to their "old ways."

The final problem-solving interaction (T8F) or followup measure occurred two weeks later. Partners were then asked to evaluate their performance. While acknowledging the need for improvement in some areas, they were particularly satisfied with the effectiveness of using 'I' statements and skills of reflective listening. In particular, partners were commended on their increased efforts to 'respond' rather than 'react' to each other's differences (e.g., effective reflective listening). Nevertheless, the partners' seemingly lack of capacity for empathy and lack of emotional connection to each other could not go unnoticed.

Couple 2. Based on the data obtained from the diagnostic instruments, treatment began as prescribed for a symbiotic-differentiating developmental

relationship. In the problem-solving interaction (B3-T1), Couple 2 demonstrated some positive (more advanced) mechanisms of conflict management. Although no homework had yet been assigned, the partners already showed signs that they have been trying to actively work out their differences. For instance, Partner 2 expressed gratitude in her partner's ability to positively support her need for autonomy. That is, the separation/individuation process enabled Partner 2 to become more effective at defining personal needs and desires, and also communicate them to her partner. Considering the possible threat of the issues presented by Partner 2 (e.g., independent travel, prospect of separation due to long-term job opportunity), and compared with earlier problem-solving interactions, the dialogue progressed positively and appeared to provoke only little anxiety for both partners. In short, at the time of the current session both partners appeared to be further differentiated than initially diagnosed (i.e., symbiotic-differentiation). Though the partners appear to have already developed a more effective communication style, the Initiator/Responder skills were explained to the couple in detail.

Toward the end of this week's problem-solving interaction (T1-T2), a shift was observed in the partners' communication. That is, the partners mostly practiced good reflective listening skills, but communication began to break down near the end. Attempts of interruption or projection on behalf of Partner 1

appeared to prompt Partner 2 to withdraw occasionally, and become stubborn and react defensively. The difficulties experienced during the problem-solving interaction were pervasive and intensified during the therapeutic session. It was pointed out that some of the partners' differences may be in direct relation to Partner 1 becoming more self-expressive, and Partner 2 being unaccustomed to her partner's increased efforts to express himself. The remainder of the session focused on increasing the partners' ability to define personal boundaries and rehearsal of the Initiator/Responder skills.

There appeared some tentativeness in the beginning of the next problem-solving interaction (T2-T3). Once an issue for discussion was agreed upon, both partners displayed some effective use of Initiator/Responder skills. Interestingly, both partners also shared feelings about their pursuit and practice of individual activities. However, they expressed feeling somewhat uneasy about spending more time apart. Partner 2 described the separation process as the exciting "rebirth" of a new relationship, and yet it instilled feelings of anxiety over the "death" or loss of the former comfortable and stable relationship. Nevertheless, Partner 2 appeared supportive of her partner's individuation process, and Partner 1 appeared to feel comfortable and secure in developing and expressing his own self-identity. In an unstructured manner, partners were

encouraged to further define individual thoughts, feelings, and desires. In addition, the QA was employed.

This week's problem-solving interaction (T3-T4) progressed well. The couple was observed being more conscientious about employing Initiator/Responder skills. In particular, Partner 2 managed more effective use of 'I' statements, better reflective listening skills, and fewer interruptions that provided allowed partners to become less defensive. However, both partners still had a tendency to assume or project some of their thoughts and feelings. Partner 2 expressed a great deal of pleasure in her partner's increased self-expression, and supported his continued differentiation and practicing individual activities. The session then shifted to focus on the "successes" of their relationship and, as well, the TDP was employed.

Considering the sensitive nature of the next problem-solving issue (T4-T5), the interaction went well. Partner 2 had been struggling to give up her pet (dog) in order to prepare for her travels, and relieve herself and her partner of ownership responsibilities. The couple incorporated many of the Initiator/Responder skills, and did so in a mutually responsible fashion. However, on occasion partners became slightly defensive in presenting their viewpoints, with some energy overinvested in self-expression and development. Immediately following the problem-solving interaction, the couple launched

into another, unrelated issue (i.e., one partner's tendency to procrastinate). The couple's discussion began to escalate, and both partners gradually began to slip into former patterns of relating. The arising conflict provided an opportunity to examine each partner's intrapsychic childhood issues, and techniques of the IH were employed. Having explicated how each partner's early childhood experiences can contribute to an ineffective style of communication, the focus turned again to the successes of their progress. The couple admitted they were not able to fulfill the requirements of the TDP. They were strongly encouraged to make an extra effort to employ the TDP twice daily.

The following problem-solving interaction (T5-T6) focused on one of the diagnostic tools. The topic itself did not impede the partners' ability to effectively employ the Initiator/Responder communication skills. Rather, Partner 2 expressed dissatisfaction with her impression about the nature of the TDP. That is, Partner 2 perceived an incompatibility between partners increasing self-expression and autonomy and the simultaneous intent of the TDP to increase their emotional connectedness. Upon further investigation, it came to light that the partners had become so heavily (perhaps over-) invested in their own self-development (e.g., individuation, practicing autonomy) process that neither had made the time commitments necessary to implement and practice the skills of the TDP. Further explanation was provided to help the couple understand the

nature of the TDP, and its focus to restore the partners' emotional connectedness to each other and the coupleness of the relationship. Again, the couple was strongly encouraged to bring the TDP to fruition (e.g., twice daily), and the directions (i.e., three steps) were handed to them in written form.

Considering last week's stalemate, this problem-solving interaction (T6-T7) progressed very well. Rather than concentrate on a particular problem, partners chose to support each other's individual growth and self-definition. Their interaction included a mutual exchange of thoughts and ideas, and many examples of effective Initiator/Responder skills (e.g., reflective listening, empathic response, 'I' statements). In addition, there was a return to playfulness in the interaction not observed since earlier sessions. Further, there appeared a resurgence in each partner's physical affection displayed toward each other. Especially noteworthy was the couple's ability to effectively implement all the requirements of the TDP twice daily, as well as highlight some of its benefits and successes of their relationship. Session was more facilitative rather than treatment orientated. The couple's positive momentum was bolstered by focusing on the successes of the TDP and on their developed effective communication styles. Most impressive was the couple's overwhelming sense of security expressed in self and in supporting each other's practice of autonomous activities, leading them to become physically separated for extended periods of

time (i.e., six months, even a year) in the very near future. Reiterated was the notion how the two components of self-development and coupleness-development can be complementary rather than combative in nature.

Once again, the couple managed to implement very effectively the Initiator/Responder skills in this week's problem-solving interaction (T7-T8). They chose to discuss the way they handled the one (only) incident of conflict from earlier last week. Partners reflected on how they managed the conflict, that is, without feeling threatened, less defensiveness, and neither attributing blame on the other. In short, the partners responded empathically and supported each other in the interaction as they reflected on what "worked" to resolve last week's conflict. Moreover, they noted how each partner had managed a "conscientious effort" toward achieving a mutually satisfactory resolution in "less than 30 minutes." When asked how these skills may fit in six months or a year from now, the partners agreed they have experienced some very positive results in using the skills (e.g., "Hey, this stuff really works!"). The remainder of the session was primarily facilitative-orientated. The couple was assured they could anticipate the future of their relationship to include continued periods alternating between intimacy and efforts to reestablish independence.

The final problem-solving interaction (T8F) or followup measure progressed well, though both partners initiated it tentatively. Before long

partners spoke openly and freely, though, understandably, the emotional intensity of the issue (e.g., immediately following the session, Partner 2 was to depart on extended travels) made it occasionally difficult for them to effectively employ Initiator/Responder skills. Partner 2 has embarked on practicing steps toward marked individuation, and Partner 1 conveyed sincerity and genuineness in supporting his partner's expressions of personal growth. The couple had identified their relationship outcome as "unusual" in that both partners feel "secure enough" to rigorously test the separation boundaries. Each partner accepted the present situation as an opportunity for increased individual growth ultimately leading toward future positive growth of coupleness. In short, the sadness the partners conveyed over their imminent separation was understandable, yet each partner seemed uniquely secure about their future together as a couple.

Couple 3. The initial diagnosis for Couple 3 was practicing-symbiotic. However, previous interactions with the couple were extremely volatile, and included many examples of yelling, hostility, anger, and blame. In other words, it was thought that the relationship as it existed would not endure until formal treatment could be employed. Consequently, though none of specific treatments outlined in the developmental model were employed, the couple had previously been (i.e., in earlier baseline sessions) given some basic homework assignments (e.g., allocate 15 minutes, twice weekly, for togetherness time; develop an idea

for a mutually pleasurable "free time" activity). Treatment in accordance with the developmental model was introduced following the baseline measures.

For the current problem-solving interaction (B3-T1), partners appeared to make a broad attempt to resolve the issues (i.e., time management, shared responsibility in household chores and care of their newborn child). The partners' attempts to express themselves and respond to each other with unrefined listening skills helped decrease defensive statements, thus lending itself to an interaction with less anger and hostility. Still, Partner 1 remained self-centered, aloof, and insincere (e.g., laughing inappropriately) when responding to his partner's needs. Compared with previous (baseline) sessions, Partner 2 appeared less demanding of her partner, and less passive-aggressive toward others. Moreover, it was perceived that the couple not only lacked commitment to each other, but to the study, as well (i.e., they consistently and increasingly arrived late for the sessions; the presence of their newborn baby interrupted the therapeutic process on many occasions). Nevertheless, the session was dedicated toward helping each partner establish personal boundaries. In addition, the Initiator/Responder skills were introduced and practiced.

In the following problem-solving interaction (T1-T2), both partners reverted to many of their past patterns of relating. For instance, their argumentative style, the blaming, the anger, the hostility, the defensiveness, the

unwillingness to compromise, and perhaps even the unwillingness to participate in the session, prevented the partners from reaching even a quasi-resolution to the present issues at hand. Moreover, the issues themselves were quickly lost and buried as one issue compounded the next. During the session, the partners' frustration levels increased as they became more resistant to the other; as well, partners became resistant to any attempts made by the therapist to channel the their anger. Partner 1 persisted on increasing his demands for independence, and was simply unwilling to nurture the relationship (e.g., provided many excuses for not enough time to complete even the 15 minutes/2x weekly homework assignment). Partner 2, in turn, reacted to her partner's historical patterns of relating (e.g., irresponsibility, stubbornness, self-centeredness) with resistance and far less willingness to compromise. In short, it was noted that the couple's ego-syntonic ways of relating must be addressed and diffused before the partners can move forward toward implementing effective communication skills. In addition to reiterating last week's homework assignments (e.g., structure 15 minutes/2x weekly for each other, define personal boundaries, the Initiator/Responder skills), Partner 2 was encouraged toward initiating the process of differentiating from her partner (e.g., structure time and activities for her own self).

The next problem-solving interaction (T2-T3) began with slightly less volatility. Central to the issue (as with previous interactions) for Partner 2 was the frustrations with her partner's persistent pattern of irresponsibility and continual lack of commitment to schedule "togetherness" time. Partner 1 looked to his partner for (unconditional) support and understanding of his need to modify the allotted togetherness time (e.g., starting his own business). Though sounding resentful (e.g., "I don't see why I always have to give in"), Partner 2 agreed to support her partner provided he is "actually working on the club and not sitting in the cafe visiting with friends." The compromise appeared to achieve at least an ephemeral resolution to the conflict. However, about midpoint through the problem-solving interaction, it became obvious that little gains were made toward a successful resolution as the same issue reemerged and both partners became defensive and blameful. Each partner's ability or willingness to respond effectively to the other was impeded by mutually persistent blame, anger, hostility, and lack of self-responsibility. During the session, the stalemate was lessened somewhat when the therapist identified and contrasted each partner's individual needs and differences, thus striking a balance in the therapeutic goals. Some additional attempts were made to present intrapsychic issues, in particular, issues of anger, insecurity, and ego-syntonic ways of relating, though the current tone of the session clearly impeded its

progress. It was also revealed that, with exception to structuring 15 minutes of togetherness time on one occasion only, the couple had not completed or attempted any of the homework that was assigned. The therapist then conveyed to the couple personal commitments (e.g., opportunity for individual sessions) and personal limitations (e.g., can provide the tools to make the changes, but only they can implement the skills), and underscored the fact that for them to successfully benefit from the sessions requires their utmost commitment. The therapist then posed a direct question: "Are you prepared to lose _____ (Partner 1, Partner 2)?" Partner 1 looked surprised by the question, paused, then answered "No." At first, Partner 2 hesitated to answer the question, then answered "Yes," with the additional qualifier that she was unable to see any benefit from continuing. Partner 1 realized the reality of the situation, then said "I'll change within reason." He then added, "I should be able to do anything to get my point across, within reason..." even if it means "restraining" her to "make her understand." It was emphasized again to the couple that the success of these sessions is wholly dependent on their ability structure time and work on the skills. Partner 1 then turned toward his partner and responded, "To be perfectly honest, I would be happy spending less than an hour with you!" The conflict over their separation was raised again, this time with more intensity. Partner 1 insisted he was unable to continue the session because he was too "pissed off."

The session ended late with both partners threatening to separate and end their relationship together. Couple 3 did not return for their session the following week.

Couple 4. Couple 4 was initially diagnosed differentiating-symbiotic. During the problem-solving interaction (B3-T1) the partners made a moderate attempt to define their differences, but still embraced their former style of conflict management (of baseline interactions). That is, a symptomatic pattern of conflict-avoidance persisted throughout the entire interaction, leaving the partners to be less effective toward understanding each other or resolving the issues. Partners displayed some degree of differentiation but lacked the skills for effective self-expression. The session itself was stilted. The therapist was impelled the maintain the energy level and initiate the interactions. Partners appeared tense and withdrawn from each other, both emotionally and physically. During the session the partners chiefly looked to the therapist for direction, guidance, and facilitation. The purpose and mechanics of the Initiator/Responder skills were presented to the couple. To illustrate the skills, partners were asked to conceive of some personal examples but found this task extremely difficult and challenging (i.e., conflict-avoidance). Later, Partner 2 expressed feelings of guilt over identifying differences, and said that "he would have found the exercise easier" to practice and the "concepts easier" to understand "if the issues were not so personal."

In this week's problem-solving interaction (T1-T2) the partners exhibited some of the earlier patterns of relating (e.g., conflict-avoidance, introducing their children to the issue). However, Partner 1 made a better attempt to stay on task and reexamine the central "issue." Moreover, both partners reported being more relaxed and less anxious. The couple admitted that they had not practiced the Initiator/Responder skills, and found it difficult to find the motivation for doing so. They were asked to choose an issue for illustration of the skills. The partners made some effort to practice the skills, but the sensitive nature of the issue (e.g., one partner's smoking) prevented them progressing very far. The different modes of dealing with conflict were then illustrated. That is, two basic, equally unproductive means to managing conflict can be through either 'escalating the situation' or through 'avoidance of the issues'. Using one of the couple's own examples (e.g., they preferred discussing issues over the phone rather than face-to-face), it was illustrated how the partners have developed a customary pattern of conflict-avoidance. The Initiator/Responder skills were reviewed again, and the QA was also assigned as homework.

Considering the sensitive nature (e.g., smoking) of the problem-solving interaction (T2-T3), the couple's interpersonal exchange progressed rather well. Partner 1 initiated the interaction, stayed on task, and made some attempt to effectively use 'I' statements, thus avoiding blame situations. This direct yet

nonthreatening approach, in turn, allowed Partner 2 to respond positively rather than react defensively. More importantly, the couple was able to negotiate a mutually satisfying, even if tentative, compromise or resolution. Partners were then asked to describe how this interaction may have differed from earlier interactions. The couple noticed several differences, not least of which were fewer interruptions and taking more time to listen to each other. Moreover, Partner 2 made the observation that her communication seems to have improved with others as well, and noted that even the children appear to be "less defensive and edgy." The couple was supported for their efforts and their progress. In addition, the separation/individuation process was illustrated to the help the couple understand that personal growth need not be incompatible with supporting the partner's growth. The Initiator/Responder skills were reviewed and, as well, the QA was introduced.

This week's problem-solving interaction (T3-T4) was initiated by Partner 2. The problem-solving interaction resulted in at least an interim resolution (e.g., plan a time to discuss matters further), though it appeared to leave each partner only partially satisfied. Moreover, the couple's effective communication style may have been attributable to each partner's greater effort to employ the Initiator/Responder skills. For instance, Partner 1 stated he was more conscientious about the skills he employed (e.g., 'I' statements, self-

responsibility); however, he expressed some dissatisfaction in not feeling understood (validated) by his partner. Partner 2 agreed and said she could have used more reflective listening skills, for example. The Initiator/Responder skills were once again reviewed. The session then shifted to a discussion about the partners' practiced autonomy. Partner 2 found this process exciting, and that it provided him with a sense of self-fulfillment and self-worth. Partner 1 was asked why he is not actively pursuing some of his personal interests. Partner 1 expressed guilt over differentiating from his partner, though he strongly supported her to develop her own self-interests. Partner 2 said that identifying personal needs, wants, desires, caused her to feel anxious, and described it as a selfish endeavor. Much of the remainder of the session was dedicated to helping Partner 2 develop insight and recognize the benefits of personal growth. Further, the therapist provided a larger context for unfolding the couple's differentiation toward each partner's practiced autonomy.

Partner 2 opened the problem-solving interaction (T4-T5) with how the last session provoked strong feelings in her. That is, Partner 2 said that for several days after last week's session she was feeling anger, resentment, embitterment, and betrayed by the therapist. In short, Partner 2 said she was overwhelmed with the realization that she "had no life." Subsequently thereafter, however, Partner 2 said her projected anger had lessened, and

resolved that she was in dire need of some self-development. During the problem-solving interaction, Partner 1 struggled to respond empathically and reflective listen to his partner's needs. The Initiator/Responder skills that both partners employed were much improved. The interaction was very emotional and ended with no sense of resolution, although there did not seem a need for one. Further into the session, Partner 2 elaborated on her lack of self-identity, and remarked "I've been giving to others so much that they have become the only extensions of my life. I don't have anything left to give to myself." Not only did Partner 2 admit she found it difficult to develop her sense of self, she added that she had no idea where to begin. Therapist supported Partner 2 for her courage in taking a deeper look into self issues, and apologized for own lack of self-responsibility (e.g., more receptive to her vulnerability). The remainder of the session was allowed to become more unstructured. Partner 1 expressed excitement about the self-development (e.g., photography) upon which he has recently embarked. Partner 2 was encouraged to continue her introspective journey, and to visualize herself engaging in an activity that will help her "feel good about herself."

Upon entering there was a noticeable tension between the partners. This week's problem-solving interaction (T5-T6) was initiated by Partner 1. Partner 2 expressed that she felt "violated" by one of their (foster) children. Considering

the emotionally charged issue, the interaction progressed rather well. Both partners reported a positive experience with the problem-solving interaction. Some of the effective skills the couple identified included "feeling supported," "being understood" (empathic responses), "fewer interruptions" (reflective listening), and "ownership of statements" ('I' statements). These skills combined helped to allow the partners better express their feelings, as well as better understand and related to their partner empathically. Following this, Partner 2 reported some very positive experiences in working and succeeding at resolving a past problem-solving issue (i.e., smoking). Partner 2 was then asked to reflect on the self-accomplishment and the positive feelings it evoked. Moreover, Partner 2 expressed additional interest in developing other individual activities (e.g., wood-working). Both partners spoke in ways that supported each other's new found self-interests. The therapist supported the prevailing individuality of both partners, and strongly encouraged them to continue refining and practicing their self-interests. The session wrapped up with the TDP being introduced, and its purpose was explained on how it utilizes the momentum of their own individual developmental growth processes toward a positive sense of coupleness or relatedness.

For the next problem-solving interaction (T6-T7) the partners chose to discuss their impression of the TDP. Though the couple did not appear to be

quite as conscientious of Initiator/Responder skills, their exchanges and communication style were positive and seemingly successful. Both partners expressed positive experiences in the TDP helping them to focus on the "successes" of their relationship. For instance, Partner 2 thanked her partner for supporting her personal endeavors (e.g., foster care treatment); moreover, her advanced thanks for her partner's help with household chores led the completion of certain domestic tasks. Partner 1, on the other hand, said that thanking his partner in advance for supporting his individual interests (e.g., photography) had provided him with more time to actually do so; moreover, he expressed gratitude for his partner's ability to be less "rigid" (i.e., relax her boundaries) which had led to positive changes in familial roles. The therapist then clarified the evolutionary steps leading to the objectives of the TDP. That is, by helping partners effectively communicate and practice their individual self-expression, then relax their personal boundaries, the TDP exercise helps to promote greater emotional connectedness (developmental coupleness) in the partners.

Partner 1 initiated the next problem-solving interaction (T7-T8). Partner 1 stated he thought it unfair that he "always has to take time off work" to attend to family affairs (e.g., children's needs). In discussing the issue, partners made effective use of some Initiator/Responder skills (e.g., reflective listening, 'I'

statements, empathic response). Partner 1 mostly expressed his feelings, Partner 2 mostly listened. Due in part to the inherent constraints of the problem (e.g., differences in each partner's job description), the dialogue ended with no satisfactory resolution to the problem-solving issue. Interestingly, there appeared a predominant shift from previous sessions in that Partner 1 thought it "unfair" that Partner 2 be so "involved" with her own endeavors to the point where she wants to "just run with it." Moreover, both partners to a slightly greater degree appeared defensive, more invested in self-development, and there was some power struggling characterized by 'I' want demands. Perhaps, more important was the couple's ability to discuss such an issue without the outcome leading to anger or escalation. The couple was assured that they can expect times when there may simply be no immediate resolution; rather, most important is that both partners have equal opportunity for self-expression and feel supported and mutually validated in the process. The couple was later asked how the skills learned may fit in their relationship six months or a year from now. The partners reported very positive experiences and planned to implement and practice the skills daily, and continue to use them in their future together. For the remainder of the final treatment session, additional information was provided toward helping the couple achieve relationship goals

toward movement beyond their current stage of development (i.e., toward rapprochement).

Partners began this final problem-solving interaction (T8F) with little conflict-avoidance. That is, Partner 1 was direct about the issue (i.e., frequent phone calls at work from his partner) and expressed that it makes him feel "frustrated." Partner 2 also effectively expressed her reasons (e.g., "I just want you to fix it") and her feelings (e.g., "I was really angry," "I was so frustrated") about the issue. Moreover, the partners were proactive in seeking ways in which they could give to and receive support from the other. An indication of this, for instance, was the expressive nature Partner 1 employed to resolve a (personally) troubling issue, and the way in which it prompted Partner 2 to define herself (e.g., "What I want from you is just affirmation...because you're the only one who can do that for me..."). Partner 1 continued and said he felt "helpless" because the situation was not in his "control." The self-expressions of vulnerability conveyed by her partner prompted Partner 2 to clarify her needs and reasons for the phone calls (e.g., "I need you to just listen to me, that's all. I know you can't do anything. Not to make me feel better, but to understand"). In addition to many effective 'I' statements used, the partners displayed the capacity to empathically respond to each other. Partners reached what appeared to be a mutually satisfying resolution to the problem (e.g., fewer phone calls are

necessary). Though there was a noticeable improvement in the couple's conflict management skills, there appeared some lacking qualities in the partners' relatedness or sense of coupleness (e.g., physical distance in the partners' body postures).

Quantitative

Diagnosis and Treatment

Instrumentation

Developmental Couples Therapy Coding System (DCTCS). The developmental model of couples therapy is highly qualitative in nature and a quantitative interpretation of its features was a formidable task. As is the case with quantifying most any qualitative measure, coding each couple's entire set of videotaped problem-solving interactions was a laborious process. To review, a list of observational measures was compiled for each of the four developmental stages and two symbiotic substages: symbiotic (enmeshed), symbiotic (hostile-dependent), differentiating, practicing, and rapprochement. In general, the Developmental Couples Therapy Coding System (DCTCS) as a quantitative measure retained merit in standardizing the qualitative variables of the Developmental Couples Therapy (DCT) model. For the observational measures characterized for each of the four developmental stages and two symbiotic substages, quantitative measures were successfully converted for the seven positive variables (A^{+}-G^{+}) and seven negative variables (A^{-}-G^{-}) on each scale of

Developmental Sense of Self and Developmental Sense of Coupleness. Little difficulty was encountered with the organization or layout of the coding system. Once coded each partner's composite developmental score (i.e., value for developmental sense of self, and value for developmental sense of coupleness) was easily computed and plotted on the Developmental Couples Therapy Graph (DCTG).

The developmental criteria used for beginning the quantitative coding process was based on each partner's initial developmental diagnosis obtained through qualitative means. That is, through qualitative measures the initial diagnosis (e.g., differentiating-symbiotic) for a couple was determined, then the same developmental criteria for that respective diagnosis was employed to commence the quantitative analysis beginning with the first baseline (B1) measure in Week 1. From thereon, quantitative analyses of subsequent problem-solving interactions and the diagnostic criteria employed were based on the results of previous sessions. In this way, quantitative measures of partners' composite developmental scores were completed for all problem-solving interactions occurring Week 3 through Week 12. If perhaps the outcome of a partner's composite developmental score occurred on the cusp between two developmental stages (e.g., -10, 0, +10), then the diagnostic criteria from the more desirable (upper) developmental stage were employed. Results of partners'

composite developmental scores ranged: on the Developmental Sense of Self scale from -17 to +19; and on the Developmental Sense of Coupleness scale from (below) -20 to +16.

The complete set of observational measures represents a complex array of developmental dimensions. Moreover, not all the observational measures were as easily coded as others. For instance, the Differentiating Stage under Sense of Coupleness contains the positive (C^+) observational measure "sincere effort toward managing ongoing hassles and bickering" and its negative (C^-) counterpart "ongoing hassling." Coding of this variable was very much a discretionary decision left to the observer. That is, if during the 2-minute interval it appeared the partner made some effort toward managing bickering, then a positive measure was scored; if no attempt was made toward negotiating a resolution and hassling was ongoing then a negative measure was scored. In part because within a 2-minute interval there was enough opportunity for the partner to engage in both types of behavior, a partner sometimes received both a positive and a negative score. For each 2-minute interval the negative or positive measure for each observed variable was scored once only. The positive/negative coding conundrum illustrated here for this one variable is just one example upon which other observational variables behaved similarly.

Diagnostic comparisons can be drawn between qualitative diagnostic outcomes and those quantitatively diagnosed. Table 1 below presents the couples' developmental outcomes diagnosed according to the qualitative Developmental Couples Therapy (DCT) method compared with the quantitative Developmental Couples Therapy Coding System (DCTCS). In two instances (Couple 1 and Couple 3), the integrity of the qualitative diagnosis was maintained from the first baseline measure (B1) to the third baseline measure (B3-T1). At the time treatment was initiated (B3-T1), both partners of Couple 2 were quantitatively diagnosed one developmental stage beyond the qualitative equivalent; the same was for also true for Partner 2 of Couple 4. In several instances, on the DCTCS the partners' same developmental stage was diagnosed one session earlier than that diagnosed on the DCT. In addition, for Couple 1 and Couple 2 the integrity of the final diagnosis (Week 12) was upheld in the outcome of both diagnostic methods. It should be noted that throughout the study at no time were the partners of one couple quantitatively diagnosed to be more than two developmental stages apart.

Developmental Couples Therapy Graph (DCTG). The couples' composite developmental scores are presented in the Developmental Couples Therapy Graph (DCTG). Figures 1-4 below present a graphic representation of the outcome of each partner's composite developmental scores, as well as the couples' developmental movement. In general, the DCTG was easy to interpret

and provided a useful stage-by-stage graphic illustration of a couple's developmental diagnoses and movement. However, possibly a consequence of size of the reproduction scale, the pathways tracking each partner's developmental diagnosis from session to session can be difficult to interpret in places. This is a particular problem when many of the outcomes of partners' composite developmental scores are concentrated in the same characteristic area (e.g., practicing stage, Couple 1 and Couple 4), or when both partners obtained the same composite developmental score (e.g., T4, Couple 2).

Each partner's developmental movement was generally progressive in nature (i.e., noticeable movement toward rapprochement stage). The developmental composite scores were mostly concentrated in the 'true' (nonshaded) developmental regions of the DCTG. In some instances, however, the partners' composite developmental scores entered into the shaded areas of the DCTG which indicated some variability from the 'true' measures of the developmental scales. In particular, the composite developmental scores for the partners of Couple 1 and Couple 4 were plotted slightly outside the 'true' developmental region of differentiating. In this case, partners' developmental scores were skewed inside the shaded region, that is, variance toward greater developmental sense of self.

Client Satisfaction Questionnaire (CSQ-8). Following completion of the final therapeutic session (Week 12), participating couples were asked to complete

and return (via postal system) the CSQ-8. (Due to the early withdrawal and the uncertainty of their relationship outcome, no followup contact was made with Couple 3 and their participation in this questionnaire is not made available.) Information about clients' level of satisfaction was obtained from Couple 1, Couple 2, and Couple 4 (n = 6). The means for each of the eight items ranged from 3.00 (question 3 only) to 3.67 (questions 1 and 2). In general, the results indicated that all full-study participants reported a high level of satisfaction from the services they received.

Therapeutic Sessions

In the following, qualitative data from the therapeutic sessions are contrasted with the results of partners' composite developmental scores on the quantitative DCTG. That is, anomalies or variances in partners' developmental movement recorded on the DCTG are compared with conspicuous data found in the qualitative data from the therapeutic sessions presented earlier.

Couple 1. For the entire study both partners of Couple 1 remained closely linked in their developmental stages. For the baseline sessions (B1, B2, B3), both partners plotted within the range of their initial diagnosis, differentiating-differentiating. However, rather than fall within the 'true' region, Partner 2 was plotted mainly within the variance range of differentiating toward greater developmental sense of self. This trend continued for both partners for the ensuing treatment sessions (T1, T2, T3). In general, both partners continued on

the road toward the practicing stage, ending at the rapprochement stage in T5. Most notable was the partners' regressive developmental movement in T6 in which they returned to the lower end of the practicing stage (i.e., nearly inside the differentiating stage). The qualitative data indicated a profound developmental shift in T6; the issue discussed was emotionally charged and a return to the partners' past ineffective communication style was observed. For the remainder of the treatment sessions both partners remained inside the 'true' region of the practicing stage.

Couple 2. The partners of Couple 2 progressed developmentally during the baseline sessions (B1, B2, B3). Couple 2 was initially plotted symbiotic-differentiating, and in the final baseline measure (B3) each partner had progressed toward their succeeding developmental stage, that is, differentiating-practicing. In general, Partner 2 maintained a developmental edge of one developmental stage greater than Partner 1 until T3. In T4 the partners were both plotted within the 'true' region of the practicing stage with equal developmental sense of self and developmental sense of coupleness (i.e., the same point). In T5 Partner 2 was plotted outside the true region of the practicing stage toward greater variance in developmental sense of coupleness. Incidentally, the qualitative data indicated that in this session Partner 2 expressed dissatisfaction with the model's ability to restore positive relatedness within their relationship. In the following session (T6) both partners graduated

toward the rapprochement stage where they generally remained for the duration of the study.

Couple 3. Couple 3 was plotted practicing-symbiotic for the baseline sessions (B1, B2, B3) and remained there for the following two treatment sessions (T1, T2). That is, Partner 1 remained within the 'true' region of the practicing stage (at the lower end) on the cusp of the differentiating stage; Partner 2 oscillated inside the 'true' region of the symbiotic stage. For Couple 3 no further data was collected or plotted beyond session T2.

Couple 4. During the baseline measures (B1, B2, B3), Partner 2 of Couple 4 had advanced one developmental stage from symbiosis into the differentiating stage. In B3 both partners were plotted differentiating-differentiating. While the partners remained in the differentiating stage for the following three treatment sessions (T1, T2, T3), they moved outside the 'true' region of the stage and shifted toward greater developmental sense of self. In the following treatment session (T4), both partners advanced to the practicing stage and remained there for the duration of the study. However, in the final session (T8) Partner 1 stepped outside the 'true' region of the practicing stage marginally toward greater developmental sense of self.

Table 1

*Diagnostic Comparisons of Couples' Developmental Stages using the Qualitative Developmental Couples Therapy (DCT) Method versus the Quantitative Developmental Couples Therapy Coding System (DCTCS) Method**

	Couple No. 1		Couple No. 2		Couple No. 3		Couple No. 4	
Session	**DCT**	**DCTCS**	**DCT**	**DCTCS**	**DCT**	**DCTCS**	**DCT**	**DCTCS**
B1 Week 1	none	differentiating/ differentiating	none	symbiotic/ differentiating	none	practicing/ symbiotic	none	differentiating/ symbiotic
B2 Week 2	none	differentiating/ differentiating	none	differentiating/ differentiating	none	practicing/ symbiotic	none	differentiating/ symbiotic
B3 - T1 Week 3	differentiating/ differentiating	differentiating/ differentiating	symbiotic/ differentiating	differentiating/ practicing	practicing/ symbiotic	practicing/ symbiotic	differentiating/ symbiotic	differentiating/ differentiating
T1 - T2 Week 4	differentiating/ differentiating	differentiating/ differentiating	differentiating/ practicing	differentiating/ practicing	practicing/ symbiotic	practicing/ symbiotic	differentiating/ symbiotic	differentiating/ differentiating
T2 - T3 Week 5	differentiating/ differentiating	differentiating/ differentiating	differentiating/ practicing	practicing/ practicing	practicing/ symbiotic	practicing/ symbiotic	differentiating/ differentiating	differentiating/ differentiating
T3 - T4 Week 6	practicing/ practicing	practicing/ practicing	practicing/ practicing	practicing/ practicing	withdrawn	withdrawn	differentiating/ differentiating	differentiating/ differentiating
T4 - T5 Week 7	practicing/ practicing	practicing/ practicing	practicing/ practicing	practicing/ practicing	withdrawn	withdrawn	practicing/ differentiating	practicing/ practicing
T5 - T6 Week 8	practicing/ practicing	rapprochement/ rapprochement	practicing/ practicing	practicing/ practicing	withdrawn	withdrawn	practicing/ differentiating	practicing/ practicing
T6 - T7 Week 9	rapprochement/ rapprochement	practicing/ practicing	practicing/ rapprochement	rapprochement/ rapprochement	withdrawn	withdrawn	practicing/ practicing	practicing/ practicing
T7 - T8 Week 10	practicing/ practicing	practicing/ practicing	rapprochement/ rapprochement	rapprochement/ rapprochement	withdrawn	withdrawn	practicing/ practicing	practicing/ practicing
Omit Week 11	none	none	none	none	none	none	none	none
T8F Week 12 (Followup)	practicing/ practicing	practicing/ practicing	rapprochement/ rapprochement	rapprochement/ rapprochement	withdrawn	withdrawn	rapprochement/ practicing	practicing/ practicing

* For each therapeutic session the diagnoses of couples' developmental stages are given first for Partner 1 and second for Partner 2

Figure 1. **Developmental Couples Therapy Graph (DCTG) Depicting Scales on Developmental Sense of Self and Developmental Sense of Coupleness Based on Couple 1 Scores Obtained on the Developmental Couples Therapy Coding System (DCTCS)**

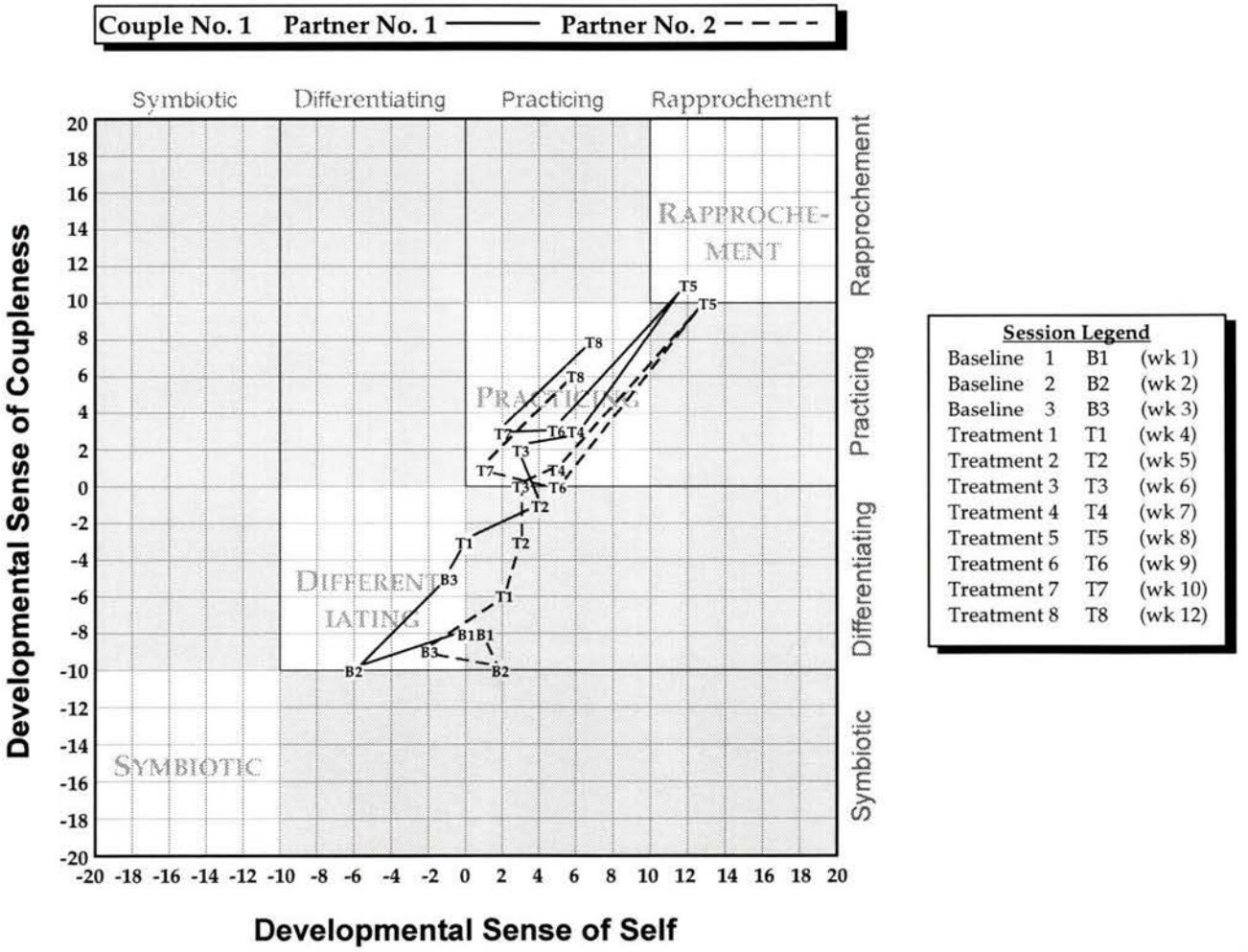


Figure 2. **Developmental Couples Therapy Graph (DCTG) Depicting Scales on Developmental Sense of Self and Developmental Sense of Coupleness Based on Couple 2 Scores Obtained on the Developmental Couples Therapy Coding System (DCTCS)**

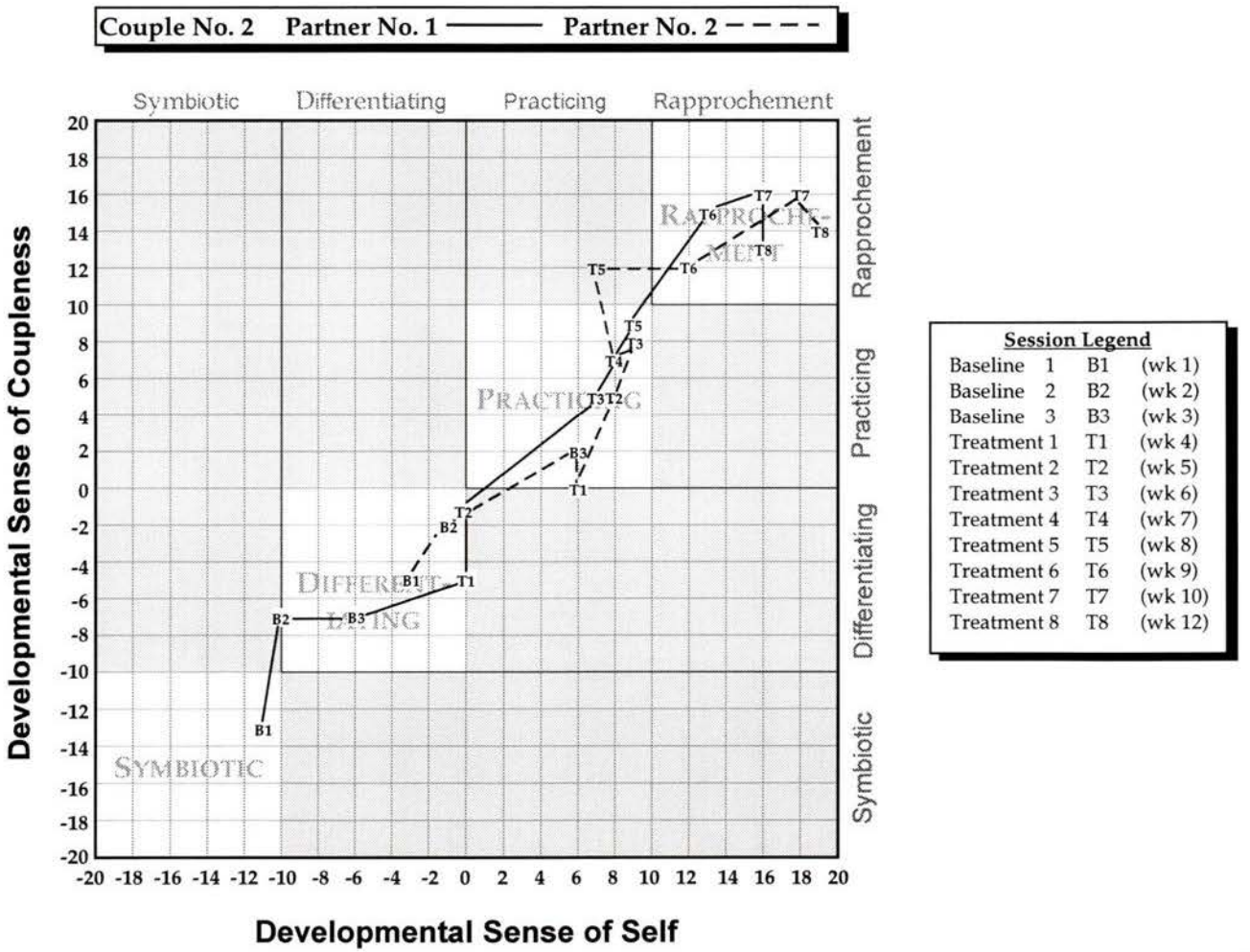


Figure 3. **Developmental Couples Therapy Graph (DCTG) Depicting Scales on Developmental Sense of Self and Developmental Sense of Coupleness Based on Couple 3 Scores Obtained on the Developmental Couples Therapy Coding System (DCTCS)**

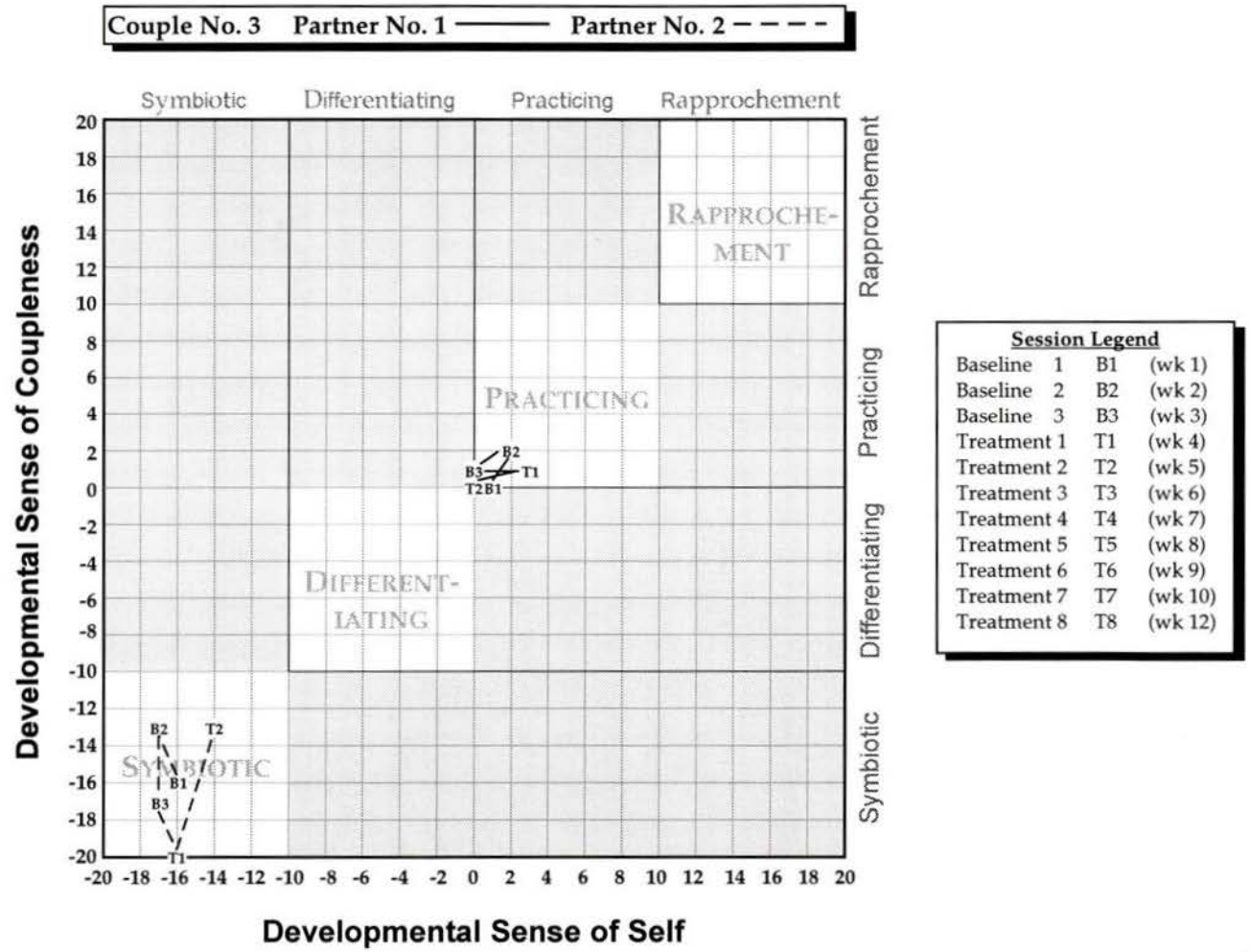
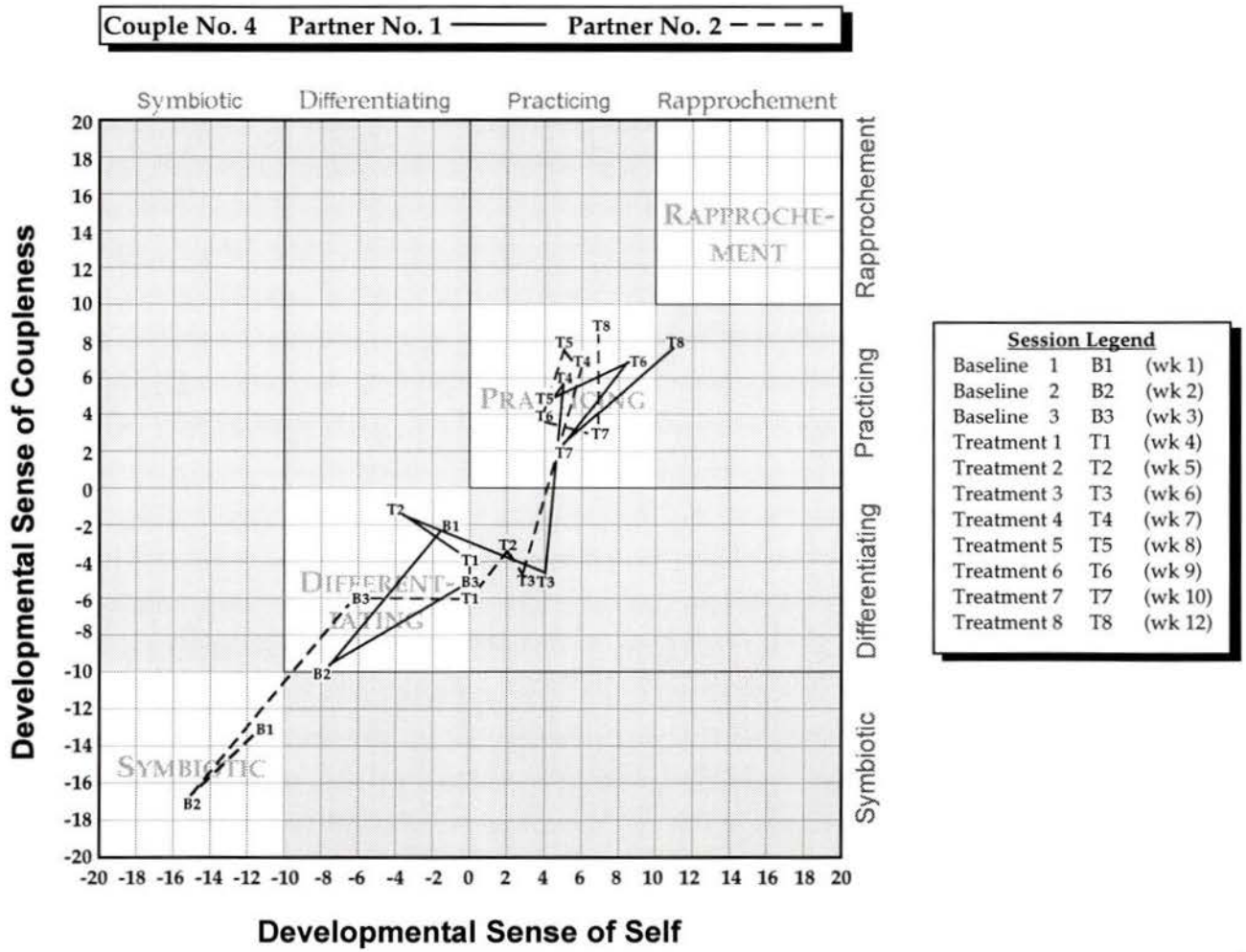


Figure 4. **Developmental Couples Therapy Graph (DCTG) Depicting Scales on Developmental Sense of Self and Developmental Sense of Coupleness Based on Couple 4 Scores Obtained on the Developmental Couples Therapy Coding System (DCTCS)**



CHAPTER V -- DISCUSSION

Before launching into a discussion of the methodological issues encountered or limitations of the present study, certain meaningful observations can be noted from the results. First, it can be said that all four couples reported that they experienced a period of enmeshment or symbiosis at the beginning of their relationship. That is, although the length of time varied from couple to couple, all the couples reported that during the initial stages of their relationship there was an intense period of emotional connectedness, otherwise a 'honeymoon period'. For the couples participating in the study, this typically translated as a rather brief period of dating and soon led to a decision to live together within two to a few months. According to Bader and Pearson (1988), in the developmental couples therapy approach this symbiotic phase is a necessary prerequisite in the treatment of couples. Thus, on this consideration all four couples can be considered good candidates for developmental couples therapy treatment.

Second, the couples' informed consent and acknowledgement of the existence of many meaningful relationship problems also indicated all participants would have benefited in some way from developmental couples therapy. That is, Bader and Pearson (1988) noted that the developmental model's emphasis on "future focus" requires that neither partner uses denial as a primary

defence to examining the relationship problems. If one discomforted partner enacts denial as a primary defence mechanism then "future focus will reinforce this dysfunctional dynamic" and "lead to feelings of craziness on the part of the distressed partner" (p. 226). Analyses of the diagnostic materials indicated that at least initially all of the partners were receptive to treatment and the conditions of the study.

Third, after only two treatment sessions both partners of Couple 3 exhibited increasing signs of distress in their relationship with few effective mechanisms for handling it. As suggested by Bader and Pearson (1988), essential to the treatment of the practicing-symbiotic couple is helping partners to structure time together. The inability or unwillingness to structure the prescribed minimal amount of togetherness time (15 minutes/2x weekly) was remarkably indicative of the initial developmental diagnosis of Couple 3, practicing-symbiotic. Regardless of the diagnosis, any couples' chance of success toward working out their differences is inextricably dependent on their effort and effectiveness to carry out such simple but critical tasks; invariably, it will determine the outcome of most any relationship treatment employing most any therapeutic approach. Practicing-symbiotic partners struggle to reckon with their differences and the constant tension within the relationship takes on a "life-or-death quality" (p. 146). While the practicing partner is primarily focused on

personal growth and independent activity, the symbiotic partner endures emotional poverty. Their dynamic power-struggle "may be blatantly verbal and conflict-laden, or it may occur on a behavioral level where the conflict is acted out..." (p. 147). Consequently, considering the then present status of their relationship and the chance for future momentum it provided, it posed little surprise that Couple 3 had discontinued treatment in the early stages of the study. The outcome of the Couple 3 relationship following the partners' involvement in the study is not known. Though the partners were not legally married, a physical separation was a virtual possibility. Nevertheless, the ultimate outcome of the Couple 3 relationship is not considered a shortcoming of the developmental couples model but rather indicative of their developmental stalemate, and the intense conflict and volatile nature of their relationship.

Fourth, whether evaluated on a qualitative or a quantitative methodological forum, the remaining couples who completed the present study to full term benefited categorically from developmental couples therapy. In general, for Couple 1, Couple 2, and Couple 4, treatment appeared to have a positive effect in the developmental progression or evolution of their relationships. That is, the developmental model of couples therapy enhanced in each partner a greater self and object constancy.

However, such claims or interpretations of the results cannot go

unchallenged. The empirical findings represented in the present study closely resembles those clinical observations dispensed by Bader and Pearson (1988). The authors appear aptly attuned to the therapeutic attributes of their developmental model. They contended that each couple's developmental pattern is unique and complex. Partners rarely evolve at the same rate, progression is not considered linear, and the effects of treatment can include periods of progression and regression. On the process of therapy, they wrote:

> The progression on the part of one partner will create stress in the relationship and frequently serve to mobilize developmental progress in the other partner. Periods of regression can serve to rework parts of earlier phases that were not satisfactorily completed. ... For any individual, growth will not be a smooth, even transition from one stage to the next. Growth often involves the destruction of and building on the past for the creation of the new. The transition from one stage to the next is often an emotional life struggle that spells the doom of part of the past and the emergence of new forms. (pp. 221, 222)

In comparison with quantitative measures the qualitative analyses generally tended to underdiagnosis or render a more conservative diagnosis of the couples' developmental stages. That is, it was the case that for several of the corresponding qualitative/quantitative sessions, the partners' diagnoses on the DCT (qualitative) were determined to be less developmentally advanced when compared to the results of the DCTCS (quantitative). Such findings need not be surprising, however. All qualitative diagnoses were generally founded on the observations and information obtained one week prior. On the other hand, all

quantitative analyses were amassed on the current week's problem-solving interaction, after the couple had opportunities the past week to develop and practice the treatment prescribed earlier by the therapist. Translated results of the DCTCS indicate that when partners were proactive and effective in their implementation of the homework assignments, then their developmental movement tended to be progressive; however, if they were less than earnest in their efforts to complete the assignments, then a stalemate tended to persist, or they regressed to a lower developmental stage. Further, progressive or regressive developmental movement tended to be linked with partners' mutual level of commitment to implement the skills and enhance their relationship.

Any developmental progression of partners' composite developmental scores plotted on the DCTG tended to contain less variability from the 'true' developmental regions. That is, in lesser developmental stages (e.g., symbiosis, differentiating) more composite developmental scores were recorded in the shaded regions indicating greater variance in partners' developmental sense of self or developmental sense of coupleness. However, as partners progressed in their developmental relatedness (e.g., differentiating, practicing, rapprochement), then there was greater tendency for partners' composite developmental scores to be concentrated inside the 'true' regions of the developmental stages.

Variability from the 'true' regions of the developmental stages tended to be skewed toward greater developmental sense of self rather than developmental sense of coupleness. Such results can be expected, however. That is, in the beginning the primary treatment focus is on facilitating differentiation among the partners. In doing so, for each partner the separation/individuation (i.e., sense of self) process becomes paramount and the relationship (i.e., sense of coupleness) is viewed as secondary. Only after one partner has at least moderately differentiated from the other can their emotional connectedness be well developed. Thus, the stability of the partners' relationship is in constant challenge, and the dynamic developmental process can be viewed as one of uncoupling/coupling.

Limitations

Of course, any confidence given to the interpretation of the present findings is tantamount only to its reliability and effectiveness of controlling confounding variables. For instance, the planned nonintervention on the part of the therapist during each videotaped problem-solving interaction may have confounded the ensuing treatment of the therapeutic session. That is, oftentimes the problem-solving interaction began well enough as partners utilized relatively effective communication skills. However, sometimes the problem-solving interactions would go awry. The designed delay of the therapist's intervention

to intentionally refrain from diffusing potential conflict until after the problem-solving interaction may have set a negative tone for the remaining therapeutic session, thus perpetuating the developmental stalemate and impeding the developmental process.

Additional methodological modifications to the present study can also be cited. Discrepancies in the diagnostic modalities could be attributed to several reasons. For instance, the relationship between the implemented coding system and the arrived composite developmental score is tenuous. On the DCTCS there were many instances in which during the course of a single 2-minute interval partners received both a negative and a positive score for several selected variables. The results may have been presented very differently if observational intervals had been divided into, for example, 30 second segments. Thirty second increments have been a preferred method for observation on well established, published coding systems, for example, the Marital Interaction Coding System, Fourth Edition (MICS-IV, 1992). Nevertheless, additional or absent scores of positive or negative observational measures may have directly affected the outcome of partners' composite developmental scores.

Perhaps the foremost methodological regard lies not so much in the coding system itself but rather in the persons doing the coding. Multiple observations of the videotaped problem-solving interactions collected by two or

three independent raters may have greatly enhanced the generalizability and the examining effect of the findings. Additional indices such as the percentage of agreement amongst other raters of the checklist of developmental variables would have been a very useful interobserver reliability measure. Nevertheless, though indices of interrater reliability are informative, they are "conceptually different from reliability estimates and should not be considered substitutes for reliability estimates in describing an observational instrument" (Crocker & Algina, 1986, p. 143).

Additional limitations can be noted in the potentially confounding variables mentioned earlier in the methodology section. With regard to the internal validity of the study, attrition became a considering factor in that Couple 3 terminated involvement prior to completing the full study. Whether the partners became too discouraged by their progress, or whether the current status (i.e., practicing-symbiotic) of their relationship simply impeded developmental progress, or whether it could be attributed to personality conflict with the therapist, or any combination thereof, the partners of Couple 3 decided not to continue developmental couples therapy. Though attrition limits the findings, as addressed earlier in the methodology section, the results amassed on Couple 3 to the point of their withdrawal were considered highly valuable. That is, given the psychodynamics of and diagnostic results based on their relationship, it proved

little surprise that Couple 3 had discontinued treatment before scheduled termination of the study.

No matter the empirical measurement, the complexity and intricacies of developmental couples therapy model ring true. Internal validity was again compromised in the instrumentation. The comprehensive set of diagnostic tools, instrumentation and interventions designed to explore deeply rooted psychodynamic issues are very complex. Incidentally, it is the depth and breath of these diagnostic instruments that also bestows additional merit to the developmental approach to couples therapy. It appears the diagnostic instruments alone helped to serve to enhance the partners' developmental stages, that is, before treatment was introduced. For instance, as indicated by the quantitative analyses of the baseline sessions, both partners of Couple 2 had progressed one developmental stage from symbiotic-differentiating (B1) to differentiating-practicing (B3). There is always the inherent risk that internal validity was compromised by information imparted by the therapist during the baseline sessions. Nevertheless, such results could be interpreted differently, as well; that is, it lends credence to the authors' contention that the developmental model and its diagnostic tools provide the partners with a highly effective psychoeducational tool. In other words, it appears that prior to treatment the questionnaires (e.g., CDQ, LQ, AQ) and diagnostic exercises (e.g., PE) alone may

have served to positively enhance the partners' developmental growth through introspection or perhaps a self-learning process.

An encountered threat to external validity included multiple-treatment interference. To address the treatment needs of partners diagnosed one or more developmental stages apart was often a precarious but vital balance to achieve in the therapeutic sessions. If done effectively, however, it often provided an opportunity for each partner to empathically understand the other and further understand the developmental stalemate of their relationship. Moreover, the very nature of the small sample size employed in the study further contributes to the threat of external validity and limits the generalizability of the findings.

At the very least the methodological approach and empirical findings presented here can be considered as alternative guidelines or as an observance to traditional psychotherapy research practices. In the past, "researchers have often tended to equate intensive analytic research with the uncontrolled case study" (Safran & Muran, 1994, p. 207). Since its inception and Freud's attempt to definitively pioneer psychoanalysis, researchers have grappled with the intricacies and challenges of conducting psychotherapeutic research. Nevertheless, "the challenge is to continue to try to do clinically meaningful research in full awareness of these complexities and ambiguities, using whatever doubts arise to spur us on to greater efforts and to deeper levels of

understanding" (Safran & Muran, 1994, p. 223).

Limitations encountered in cross-cultural boundaries in relation to self and other also lack consideration in Bader and Pearson's (1988) developmental model. For instance, others have argued that the idealistic sense of self is culturally bound. Stepping outside the traditional Western view of the nuclear or individualistic self, some have focused on the cultural or group self. Psychanalytic anthropologists refer to such approaches as political theory. In political psychology, Roland (1988) distinguished among three components of the self: (1) the group-identified, *familial self* (the we-self); (2) the relatively self-contained, *individualized self* (the I-self); and (3) the transcended, *spiritual self*. According to Roland, all three aspects form an all-inclusive self; it is the relative balance and emphasis among them which shifts across cultures, as well as among individuals within cultures.

For instance, in India and Japan, it is the familial, or we-self, which is the dominant component of the self. Roland defined it in terms of the following three categories. First, in relationship-centered cultures, *symbiosis-reciprocity* involves an exchange of emotional connectedness between the individuals whereby their outer ego boundaries are permeable. A highly primitive self is maintained through cultivated high levels of empathy and receptivity to others. Second, *narcissistic configurations of we-self regard* refers to the individual's self-

esteem which is dependent on the reputation and honor of the family and other affiliated groups. Third, a *socially contextual ego-ideal* is characterized by persons and traditions rather than abstract universal values, in which traditionally defined reciprocal responsibilities and obligations are carefully observed. Traditionally, then, in the Western world inner images of the self and other are sharply differentiated and depend less on the achievements and status of the group. On the other hand, the ideal for individuals in Eastern cultures resides somewhere between the we-self and the I-self. In search for the realm of pure being, the spiritual self has no ties to anyone or anything (Alford, 1991).

Roland's reflections of the cultural self echoes Kohut's sentiments in that both contend the self in Western culture is becoming impoverished as achievement in the outer world takes the place of development in the inner world (Alford, 1991). Roland (1988) further argues that to repudiate the entrenched notion in Western psychoanalysis, and Margaret Mahler's work, that individuation is tied closely to the mother-child separation process. He wrote, "These developmental lines in American children are viewed as so intrinsically interrelated that Mahler has hyphenated this process as separation-individuation, and of course has assumed it to be universal" (pp. 100-101). In fact, as Alford (1991) pointed out, no intrinsic connection can be made between the separation-individuation process. For instance, in the I-self, inner and outer

ego boundaries are fused together. In the we-self, on the other hand, the maintained inner self is often coupled with permeable outer ego boundaries filled with real depths of fantasy, sensuality, and spirituality. Accordingly, then, the high value and importance on the development of the I-self is not held universally. Indeed, in some cultures, it is the we-self which is of most importance toward a genuine, real-self.

Achieving the ideal we-self is not easy, however. According to Alford (1991), more so than the I-self, the we-self requires more frequent and constant mirroring, and depends more on the actual presence of responsive others. Conversely, less so than the I-self, the we-self does not internalize others as thoroughly. It is in this latter regard that, according to Alford, Westerners are inclined to consider the we-self as less mature. For Kohut (1977), moreover, autonomy is not possible. But as Alford had argued, the problem is not that we constantly require the presence of responsive selfobjects; rather, of critical importance is whether we use them in an immature (archaic) or a mature fashion. He wrote, "It is the isolated, alienated self, separated from others by the perpetual struggle for existence, who is more likely to depend more upon archaic selfobject relationships, in which fantasies (often unconscious) of total dependence on or total of others predominate. Certainly such fantasies fill the mass media in the United States" (p. 180). He further argued that "if we measure

the self by the richness of its inner life, we may find the we-self more worthy" (p. 180).

The paradox encountered in identifying and treating the psychological self has echoed throughout history. Kierkergaard's (1846; Rubin, 1989) problem, for instance, was one he called of a "levelling" society, or what we would commonly call the problem of nihilism. That is, for example, a person who espouses strong religious or political convictions, but, in fact, is actually void of caring at all and thus creates only an illusion of caring. More recently, Gilligan (1982) made the claim that it is "moral nihilism" which signifies, for women, "a retreat from care to a concern with survival, the ultimate self-protective stance" (p. 126). Because women encounter unyielding refusal and rejection from their partners, they conclude that the strong need not be moral and that only the weak care about relationships, and thus, abortion becomes a woman's test of strength. For Kohut (1977), on the other hand, rather than nihilism the problem is one of narcissism, or what is commonly referred to as narcissistic personality disorders. For this person, it is not a matter of not caring about anything rather than it is a problem that the person lacks self-confidence to pursue that which is cared about in a satisfying and productive manner (Rubin, 1989).

As Rubin (1989) pointed out, in Freud's time, the emotional relationships between parents and children were overly close. Now some one hundred and

thirty years later, she has noted, through Kohut's work, that they have now become overly distant. Thus, problems of contemporary society are results of an "emotional void." She aptly selected the following excerpt from Kohut's writing:

> The environment which used to be experienced as threateningly close, is now more and more as threateningly distant; where children were formerly *over*stimulated by the emotional (including the erotic) life of parents, they are now often *under*stimulated; where formerly the child's eroticism aimed at pleasure gain and led to internal conflict because of parental prohibitions and the rivalries of the oedipal constellation, many children now seek the effect of erotic stimulation in order to relieve loneliness, in order to fill an emotional void. (Kohut, 1977, p. 271)

Clearly, the individualistic self can be intertwined with and yet differentiated from the self of other can be deliberated from different, even opposing, cultural perspectives. For any treatment model--individual, couples, group, or otherwise--to serve as a panacea which encompasses the ideals and values of all far-reaching cultures would be a meritorious in not impossible feat, indeed. Moreover, the outcome ramifications for doing so can also be deemed impracticle and controvertible. That is, any therapist who seeks ultimate universality over cultural boundaries or omnipotence over treatment modalities runs greater risk of being less effective to servicing the needs of the client. For instance, as recognized by Bader and Pearson (1988), the developmental model should not be the treatment of choice for couples in which chemical addiction is diagnosed. In such cases, it is the ethical and professional responsibility of the

therapist to service the primary needs of the client; secondary is employing the specialized modes of treatments known to the therapist. Therapists should always be mindful to servicing the primary needs of clients whether special treatment is needed in, for example, chemical addiction, drug therapy, hypnotherapy, or gender or cultural differences. In other words, therapists themselves should be continually attuned to their own biases or limitations and should practice efficient and effective use of referrals whenever indicated or deemed necessary.

Directions for Future Research

Regardless of the short-comings encountered with any methodological design, certain conditions are necessary in the interest of amassing empirical research. Most often researchers must ultimately discriminate between a robust methodological design that offers the utmost in reliability and validity checks and practicality without compromising its methodological soundness. Notwithstanding these and other methodological issues, future directions and investigations of developmental couples therapy abound. For instance, the MICS-IV (1992) uses a 10-minute problem-solving interaction as a basic unit, and a 70% point for point interobserver agreement criterion. In contrast, however, a practical methodological characteristic of the MICS-IV is that a mere 20% of the total number of sessions is randomly selected for analysis. Laverty (1993) further

enhanced the body of research on the MICS-IV and developed the complementary Marital Interaction Rating System (MICS-S) containing five categories. It is no small consideration that research on the MICS-IV has been ongoing for over 20 years. Clearly, the future of empirical research of developmental couples therapy is exceedingly complex and far-reaching.

Theoretical constructs of developmental couples therapy and its diagnostic instruments may be further enhanced by statistical measures and analysis. A rigorous statistical measure such as factor analysis could be utilised to determine whether there are one or more clusters in the diagnostic tests employed. For instance, to determine a pattern of correlations of meaningful items from those not meaningful factor analysis could be performed between test pairs or traits of developmental sense of self and developmental sense of coupleness. In doing so, it could be determined if the correlations support the hypothesis of the underlying variables for two different developmental traits.

Regression analysis could also be utilized to investigate the relationship between a dependent variable (DV) and several independent variables (IVs). This statistical analysis is useful to determine the strength of the relationship between DV and IVs. For instance, for each developmental trait (developmental sense of self and developmental sense of coupleness) the strength of each positive variable (A^{+}-G^{+}) and each negative variable (A^{-}-G^{-}) could be determined

using multiple regression analysis.

In addition, a multivariate analysis of variance (MANOVA) may shed additional light on the multiple variables underlying the different developmental stages. MANOVA can be used to ask whether a combination of the measures varies as a function of treatment. In doing so, illuminating empirical data could be ascertained by employing MANOVA statistical applications of the several types of developmental treatments on the several developmental stages. For instance, the IVs are the different treatment interventions prescribed for each of the developmental levels. Outcome measures of the treatments on the five developmental levels (symbiotic/enmeshed, symbiotic/hostile-dependent, differentiating, practicing, rapprochement) serve as the DVs.

Directions for future research include those mentioned here and others, for example, longitudinal research. Together they can only serve to raise the awareness of practicing clinicians and enhance our understanding of intrapsychic affects and interrelations. It can be said that the present study has unearthed certain merits of developmental couples therapy. It is also acutely evident that there are many hidden perils to discovering its exacting utility and reliability. Toward developing a definitive relationship therapy, future discussion and debate are certain to be spurred on and influenced by the

attributes arising from a deeper level of understanding developmental couples therapy.

REFERENCES

Alford, C. F. (1991). *The self in social theory.* New Haven: Yale University Press.

Alvin, R. (1989). Sequential differentiation of the individual from two perspectives. *Perspectives in Psychiatric Care, 25*(3), 23-26.

Bacal, H. A., & Newman, K. M. (1990). *Theories of object relations: Bridges to self psychology.* New York, NY: Columbia University Press.

Bader, E., & Pearson, P. T. (1983). The developmental stages of couplehood. *Transactional Analysis Journal, 13*(1), 28-32.

Bader, E., & Pearson, P. T. (1988). *In quest of the mythical mate: A developmental approach to diagnosis and treatment in couples therapy.* New York, NY: Brunner/Mazel, Inc.

Bargarozzi, D. A., & Giddings, C. W. (1983). Behavioral marital therapy: Empirical status, current practices, trends, and future directions. *Clinical Social Work Journal, 11*(3), 263-279.

Bargarozzi, D. A., & Giddings, C. W. (1983). Behavioral marital therapy: Empirical status, current practices, trends, and future directions. *Clinical Social Work Journal, 11*(3), 263-279.

Baucom, D. H., Sayers, S. L., & Sher, T. G. (1990). Supplementing behavioral marital therapy with cognitive structuring and emotional expressiveness training: An outcome study. *Journal of Consulting and Clinical Psychology, 58*(5), 636-645.

Beavers, R. W. (1982). Indications and contraindications for couples therapy. *Psychiatric Clinics of North America, 5*(3), 469-478.

Behrens, B. C., Sanders, M. R., & Halford, W. K. (1990). Behavioral marital therapy: An evaluation of treatment effects across high and low risk settings. *Behavioral Therapy, 21*(4), 423-433.

Belsey, P. (1990). Couples therapy: Integrating the psychoanalytic and systems viewpoints. *Clinical Social Work Journal, 18*(2), 167-174.

Benningfield, M. F. (1990). Addressing resistance stage by stage. *Journal of Family Psychology, 3*(3), 251-253.

Bennun, I. (1993). Marital and relationship counselling. *British Journal of Clinical Psychology, 32*(3), 379-380.

Berardo, F. M. (1990). Trends and directions in family research in the 1980s. *Journal of Marriage and the Family, 52*, 809-817.

Birchler, G. R. (1983). Behavioral systems marital therapy. *Advances in Family Intervention, Assessment and Theory, 3*, 1-40.

Bornstein, P. H., Wilson, G. L., Bornstein, M. T., Balleweg, B. J., Weisser, C. E., Andre, J. C., Smith, M. M., Woody, D. J., Laughna, S. M., McLellarn, R. W., Kirby, K. L., & Hocker, J. (1985). Behavioral cohabitation: Increasing satisfaction among nonmarried dyads? *Journal of Sex & Marital Therapy, 11*(2), 113-120.

Brody, P. R. (1988). Couples psychotherapy: A psychodynamic model. *Psychoanalytic Psychology, 5*(1), 47-70.

Cade, B. (1986). The uses of humour in therapy. *Indirect Approaches to Therapy, 19*, 64-76.

Cashdan, S. (1988). *Object relations therapy: Using the relationship.* New York, NY: W. W. Norton & Company.

Cath, S. H., Gurwitt, A., & Gunsberg, L. (Eds.). (1989). *Fathers and families.* Hillsdale, NJ: The Analytic Press.

Cline, V. B., Jackson, S. L., Klein, N., Mejia, J., Turner, C. (1987). Marital therapy outcome measured by the therapist, client, and behavioral change. *Family Process, 26*(2), 255-267.

Clulow, C. F. (1985). *Marital Therapy: An Inside View.* Great Britain: The Aberdeen University Press.

Corcoran, K., & Fischer, J. (1987). *Measures for clinical practice: A sourcebook.* New York, NY: The Free Press.

Crocker, L., & Algina, J. (1986). *Introduction to classical and modern test theory.* New York, NY: Holt, Rinehart and Winston.

Corneau, G. (1991). *Absent fathers, lost sons: The search for masculine identity.* Boston, MA: Shambhala Publications, Inc.

de Santamaria, M. (1990). Couples therapy: Analysis of a "praxis" with a Freirian perspective. *Family Process, 29*(2), 119-129.

Duhl, B. S., & Duhl, F. J. (1981). Integrative family therapy. In A. S. Gruman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 483-513). New York, NY: Brunner/Mazel, Inc.

Ellis, A. (1986). Rational-emotive therapy applied to relationship therapy. Special Issue: Rational-emotive couples therapy. *Journal of Rational Emotive Therapy, 4*(1), 4-21.

Epstein, N., & Baucom, D. H. (1988). Outcome research on cognitive-behavioral marital therapy: Conceptual and methodological issues. *Journal of Family Psychology, 1*(4), 378-384.

Friedman, R. C. (1991). Couples therapy with gay couples. *Psychiatric Annals, 21*(8), 485-490.

Gerber, G. L. (1986). The Relationship Balance Model and its implications for individual and couples therapy. Special Issue: The dynamics of feminist therapy. *Women and Therapy, 5*(2-3), 19-27.

Gilbert, R. M. (1992). *Extraordinary relationships: A new way of thinking about human interactions.* Minneapolis, MN: Chronimed Publishing.

Gilhotra, J. (1993). The concepts of selfobject function and empathy in couples therapy. *Australian and New Zealand Journal of Psychiatry, 27*(2), 294-297.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Gizinski, M. N. (1985). The effects of marital depression on children. *Clinical Social Work Journal, 13*(2), 103-116.

Glenn, N. D. (1990). Quantitative research on marital quality in the 1980s: A critical review. *Journal of Marriage and the Family, 52*, 818-831.

Goldberg, M. (1992). The impasse in couples therapy. *Psychiatric Annals, 22*(10), 520-525.

Greenberg, L. S., & Johnson, S. M. (1986). When to evoke emotion and why: Process diagnosis in couples therapy. *Journal of Marital and Family Therapy, 12*(1), 19-23.

Greenberg, L. S., James, P. S., & Conry, R. F. (1988). Perceived change processes in emotionally focused couples therapy. *Journal of Family Psychology, 2*(1), 5-23.

Guerney, B. G., Jr., & Maxson, P. (1990). Marital and family enrichment research: A decade review and look ahead. *Journal of Marriage and the Family,* 5(2), 1127-1135.

Hamilton, N. G. (1990). *Self and others: Object relations theory in practice.* Northvale, NJ: Jason Aronson Inc.

Hansson, R. O., & Carpenter, B. N. (1994). *Relationships in old age: Coping with the challenge of transition.* New York, NY: The Guilford Press.

Healey, J. C., Kimball, K. E., & Smith, D. A. (1986). The double paradoxical prescription: The beginning of systemic couples therapy. *International Journal of Family Psychiatry, 7*(2). 157-165.

Hett, G. G., & Rose, C. D. (1991). Counselling children of divorce: A divorce lifeline program. *Canadian Journal of Counselling, 25*(1), 38-49.

Holtzworth-Munroe, A., Jacobson, N. S., DeKlyen, M., & Whisman, M. A. (1989). Relationship between behavioral marital therapy outcome and process variables. *Journal of Consulting and Clinical Psychology, 57*(5), 658-662.

Horner, A. J. (1984). *Object relations and the developing ego in therapy.* Northvale, NJ: Jason Aronson Inc.

Huber, C. H., & Milstein, B. (1985). Cognitive restructuring and a collaborative set in couples' work. *American Journal of Family Therapy, 13*(2), 17-27.

Jones, S. L. (1990). Family, marital, and couples therapy: A comparison. *Archives of Psychiatric Nursing, 4*(3), 145-146.

Kagan, E., & Zaks, M. S. (1972). Couple multicouple therapy for marriages in crisis. *Psychotherapy: Theory, Research, and Practice, 9*, 332-336.

Kaplan, L. (1978). *Oneness and separateness: From infant to individual.* New York, NY: Simon and Shuster.

Kaslow, F. W. (1981). Divorce and divorce therapy. In A. S. Gruman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 662-696). New York, NY: Brunner/Mazel, Inc.

Kaslow, N. J., & Suarez, A. F. (1988). Treating couples in group therapy. In J. C. Hansen & F. W. Kaslow (Eds.), *The family therapy collections. Couples therapy in a family context: Perspective and retrospective* (pp. 3-14). Rockville, ML: An Aspen Publication.

Karen, R. (1994). *Becoming attached: Unfolding the mystery of the infant-mother bond and its impact on later life.* New York, NY: Warner Books.

Keeney, B. P., & Siegel, S. (1986). The use of multiple communication in systemic couples therapy. Special Issue: Philosophical and pragmatic issues in systems therapy. *American Journal of Family Therapy, 14*(1), 69-79.

Kendall, P. C. (1982). Cognitive processes and procedures in behavior therapy. *Annual Review of Behavior Therapy Theory and Practice, 8*, 120-155.

Khoo, S. (1987). Living together as married: A profile of de facto couples in Australia. *Journal of Marriage and the Family, 49*(1), 185-191.

Kirkpatrick, M. (1991). Lesbian couples in therapy. *Psychiatric Annals, 21*(8), 491-496.

Kohut, H. (1977). *The restoration of the self.* New York, NY: International Universities Press, Inc.

Kotkin, M. (1983). Sex roles among married and unmarried couples. *Sex Role, 9*(9), 975-985.

Lazarus, A. A. (1992). When is couples therapy necessary and sufficient? *Psychological Reports, 70*(3, Pt 1), 787-790.

Laverty, R. A. (1983). *Marital Interaction Rating System (MICS-S) containing five categories*. Version 1.0. Eugene, OR: University of Oregon Marital Studies Program.

Lee, J. M., & Hett, G. G. (1990). Post-divorce adjustment: An assessment of a group intervention. *Canadian Journal of Counselling, 24*(3), 199-209.

Lewin, B. (1982). Unmarried cohabitation: A marriage form in a changing society. *Journal of Marriage and the Family, 44*(3), 763-773.

Mahler, M. (1952). On child psychosis and schizophrenia. *Psychoanalytic Study of the Child, 7*, 286-335.

Mahler, M. (1968). *On human symbiosis and the vicissitudes of individuation, 1.* New York, NY: International Universities Press, Inc.

Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York, NY: Basic Books.

Marital Interaction Coding System, Fourth Edition (MICS-IV). (1992). Training and reference manual for coders. Version 5.01. Eugene, OR: University of Oregon Marital Studies Program.

Markman, H. J. (1991). Backwards into the future of couples therapy and couples therapy research: A comment on Jacobson. *Journal of Family Psychology, 4*(4), 416-425.

Markowitz, M., & Kadis, A. (1972). Short term analytical treatment of married couples in a group be therapist couple. In C. J. Sager & H. S. Kaplan (Eds.), *Progress in group and family therapy*. New York, NY: Brunner/Mazel.

Massey, R. F. (1989a). Integrating systems theory and TA in couples therapy. *Transactional Analysis Journal, 19*(3), 128-136.

Massey, R. F. (1989b). Techniques for integrating TA and systems theory in couples therapy. *Transactional Analysis Journal, 19*(3), 148-158.

Masterson, J. F. (1988). *The search for the real self: Unmasking the personality disorders of our age.* New York, NY: The Free Press.

Masterson, J. F. (1993). *The emerging self: A developmental, self, and object relations approach to the treatment of the closet narcissistic disorder of the self.* New York, NY: Brunner/Mazel, Inc.

McDevitt, J. B., & Settlage, C. F. (Eds.). (1971). *Separation-individuation: Essays in honor of Margaret S. Mahler.* New York, NY: International Universities Press, Inc.

McKay, M., Fanning, P., & Paleg, K. (1994). *Couples skills: Making your relationship work.* Oakland, CA: New Harbinger Publications, Inc.

Metz, M. E., & Lutz, G. (1990). Dyadic playfulness differences between sexual and marital therapy couples. *Journal of Psychology and Human Sexuality, 3*(1), 169-182.

Mollica, R. F. (1989). Mood (affective) disorders. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry/V* (pp. 859-951) (vol. 1) (4th ed.). Baltimore: Williams & Wilkins.

Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1990). Family therapy and qualitative research. *Journal of Marital and Family Therapy, 16*(4), 357-373.

Newcomb, M. D. (1987). Cohabitation and marriage: A quest for independence and relatedness. *Applied Social Psychology Annual, 7*, 128-156.

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

Nugent, M. D., & Constantine, L. L. (1988). Marital paradigms: Compatibility, treatment, and outcome in marital therapy. *Journal of Marital and Family Therapy, 14*(4), 351-369.

Ornstein, R. (1993). *The roots of the self.* New York, NY: HarperCollins Publishers.

Piercy, F. P., & Sprenkle, D. H. (1990). Marriage and family therapy: A decade review. *Journal of Marriage and the Family, 52*, 1116-1126.

Pine, F. (1971). On the separation process: Universal trends and individual differences. In J. B. McDevitt & C. F. Settlage (Eds.), *Separation-individuation: Essays in honor of Margaret S. Mahler* (pp. 113-130). New York, NY: International Universities Press, Inc.

Popenoe, D. (1987). Beyond the nuclear family: A statistical portrait of the changing family in Sweden. *Journal of Marriage and the Family, 49*(1), 173-183.

Prosky, P. S. (1992). Complimentary and symmetrical couples. *Family Therapy, 19*(3)215-221.

Quadrio, C. (1986). Analysis and system: A marriage. *Australian and New Zealand Journal of Psychiatry, 20*(2), 219-224.

Roland, A. (1988). *In search of the self in India and Japan.* Princeton, N. J.: Princeton University Press.

Rothstein, A. (1992). Observations on the utility of couples therapy conducted by a psychoanalyst: Transference and countertransference in resistance to analysis. *Psychoanalytic Quarterly, 61*(4), 519-541.

Rowe, Jr., C. E., & Mac Isaac, D. S. (1991). *Empathic Attunement: The "technique" of psychoanalytic self psychology.* Northvale, NJ: Jason Aronson Inc.

Rubin, J. (1989). Narcissism and Nihilism: Kohut and Kierkergaard on the Modern Self. In D. W. Detrick & S. P. Detrick (Eds.), *Self psychology: Comparisons and contrasts* (pp. 131-150). Hillsdale, NJ: The Analytic Press.

Russell, L. (1990). Sex and couples therapy: A method of treatment to enhance physical and emotional intimacy. *Journal of Sex and Marital Therapy, 16*(2), 111-120.

Safran, J. D., & Muran, J. C. (1994). Toward a working alliance between research and practice. In P. F. Talley, H. H. Strupp, & S. F. Butler (Eds.), *Psychotherapy research and practice: Bridging the gap* (pp. 206-226). New York, NY: Basic Books.

Sayette, M. A.. & Mayne, T. J. (1990). Survey of current clinical and research trends in clinical psychology. *American Psychologist, 45*(11), 1263-1266.

Schwartz, P. (1994). *Peer marriage: How love between equals really works.* New York, NY: The Free Press.

Scull, C. (Ed.). (1992). *Fathers, sons, and daughters: Exploring fatherhood, renewing the bond.* Los Angeles, CA: Jeremy P. Tarcher, Inc.

Snyder, M. (1989). The Relationship Enhancement model of couple therapy: An integration of Rogers and Bateson. Special Issue: Person-centered approaches with families. *Person Centered Review, 4*(3), 358-383.

Solomon, M. F. (1988). Self psychology and marital relationships. *International Journal of Family Psychiatry, 9*(3), 211-226.

Solomon, M. F., & Weiss, Nancy. (1992). Integration of Daniel Stern's developmental theory into a model of couples therapy. *Clinical Social Work Journal, 20*(4), 377-393.

Spanier, G. B. (1983). Married and unmarried cohabitation in the United States. *Journal of Marriage and the Family, 45*(2), 277-288.

Sperling, M. B., & Berman, W. H. (Eds.). (1994). *Attachment in adults: Clinical and developmental perspective.* New York, NY: The Guildford Press.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* New York, NY: Basic Books.

Stets, J. E., & Straus, M. A. (1989). The marriage as a hitting license: A comparison of assaults in dating, cohabitating, and married couples. *Journal of Family Violence, 4*(2), 161-180.

Stevens, G., & Gardner, S. (1994). *Separation anxiety and the dread of abandonment in adult males.* Westport, CT: Praeger.

Sussal, C. M. (1993). Object relations couples therapy with lesbians. Special Issue: Lesbians and lesbian families: Multiple reflections. *Smith College Studies in Social Work, 63*(3), 301-316.

Teachman, J. D., & Polonko, K. A. (1990). Cohabitation and marital stability in the United States. *Social Forces, 69*(1), 207-220.

Thornton, A. (1991). Influence of the marital history of parents on the marital and cohabitation experiences of children. *American Journal of Sociology, 96*(4), 868-894.

Trad, P. V. (1993). *Short-term parent-infant psychotherapy.* New York, NY: Basic Books.

Ussher, J. M. (1991). Family and couples therapy with gay and lesbian clients: Acknowledging the forgotten minority. *Journal of Family Therapy, 13*(2), 131-148.

Walen, S. R., & Bass, B. A. (1986). Rational divorce counselling. Special Issue: Rational-emotive couples therapy. *Journal of Rational Emotive Therapy, 4* (1), 95-109.

Watson, R. E., & DeMeo, P. W. (1987). Premarital cohabitation vs. traditional courtship and subsequent marital adjustment: A replication and follow-up. *Family Relations Journal of Applied Family and Child Studies, 36*(2), 193-197.

White, J. M. (1987). Premarital cohabitation and marital stability in Canada. *Journal of Marriage and the Family, 49*(3), 641-647.

Wile, D. B. (1988). In search of the curative principle in couples therapy. *Journal of Family Psychology, 2*(1), 24-27.

Yelsma, P. (1986). Marriage vs. cohabitation: Couples' communication practices and satisfaction. *Journal of Communication, 36*(4), 94-107.

Zeitlin, D. J. (1991). Control Mastery Theory in couples therapy. *Family Therapy, 18*(3), 201-230.

BIBLIOGRAPHY

Behling, J. H. (1983). *Guidelines for preparing the research proposal.* (rev. ed.). Lanham, MD: University Press of America, Inc.

Blatt, S. J., & Lerner, H. (1991). Psychodynamic perspectives on personality theory. In M. Hersen, A. E. Kazdin, & A. S. Bellack (Eds.), *The clinical psychology handbook* (pp. 147-169). (2nd. ed.). New York, NY: Pergamon Press.

Bowen, M. (1982). *Family therapy in clinical practice.* New York, NY: Jason Aronson.

Bouson, J. B. (1989). *The empathic reader: A study of the narcissistic character and the drama of the self.* Amherst: The University of Massachusetts Press.

Butler, S. F., & Strupp, H. H. (1991). Psychodynamic psychotherapy. In M. Hersen, A. E. Kazdin, & A. S. Bellack (Eds.), *The clinical psychology handbook* (pp. 519-533). (2nd. ed.). New York, NY: Pergamon Press.

Corsini, R. J., & Wedding, D. (1989). *Current psychotherapies.* (4th ed.). Itasca, IL: F. E. Peacock Publishers, Inc.

Duke, M. P., & Nowicki, Jr., S. (1989). Theories of personality and psychopathology: Schools derived from psychology and philosophy. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry/V* (pp. 432-448). (5th ed.). Baltimore: Williams & Wilkins.

Elkind, S. N. (1992). *Resolving impasses in therapeutic relationships.* New York, NY: The Guilford Press.

Fincham, F. D., & Bradbury, T. N. (Eds.). (1990). *The psychology of marriage: Basic issues & applications.* New York, NY: The Guilford Press.

Freedman, N., & Sherman, R. (1987). *Handbook of measurements for marriage & family therapy.* New York, NY: Bunner/Mazel, Publishers.

Fromm, M. G. (1989). Winnicott's work in relation to classical psychoanalysis and ego psychology. In M. G. Fromm & B. L. Smith (Eds.), *The facilitating environment: Clinical applications of Winnicott's theory* (pp. 3-26). Madison, CT: International Universities Press, Inc.

Griffin, B. P., & Grunes, J. M. (1990). A developmental approach to psychoanalytic psychotherapy with the aged. In R. A. Nemiroff & C. A. Colarusso (Eds.), *New dimensions in adult development* (pp. 267-287). New York, NY: Basic Books, Inc.

Guerney, B. G., Jr. (1977) *Relationship enhancement.* San Francisco, CA: Jossey-Bass Inc.

Hersen, M., Kazdin, A. E., & Bellack, A. S. (1991). *The clinical psychology handbook.* (2nd ed.). New York, NY: Pergamon Press, Inc.

Hughes, J. M. (1989). *Reshaping the psychanalytic domain: The work of Melanie Klein, W. R. D. Fairbairn, & D. W. Winnicott.* Berkeley, CA: University of California Press.

Jacob, T. (Ed.). (1987). *Family interaction and psychopathology: Theories, methods, and findings.* New York, NY: Plenum Press.

Kahn, E. (1989). Carl Rogers and Heinz Kohut on the importance of valuing the self. In D. W. Detrick & S. P. Detrick (Eds.), *Self psychology: Comparisons and contrasts* (pp. 213-228). Hillsdale, NJ: The Analytic Press.

Kazdin, A. E. (1982). *Single-case research designs: Methods for clinical and applied settings.* New York, NY: Oxford University Press.

Klein, M. (1950). *Contributions to psychoanalysis: 1912-1945.* (2nd ed.). London: The Hogarth Press, Ltd.

Kohut, H. (1971). *The analysis of the self.* New York, NY: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* A. Goldberg & P. E. Stepansky (Eds.). Chicago, IL: University of Chicago Press.

Kohut, H. (1987). In M. Elson (Ed.), *The Kohut seminars on self psychology and psychotherapy with adolescents and young adults.* New York, NY: W. W. Norton & Company.

Locke, L. F., Spirduso, W. W., & Silverman, S. J. (1987). *Proposals that work: A guide for planning dissertations and grant proposals.* (2nd ed.). London: Sage Publications.

Nagler, S. H. (1972). Melanie Klein. In A. M. Freeman & H. I. Kaplan (Eds.), *Interpreting personality: A survey of Twentieth-Century views* (pp. 335-346). New York, NY: Atheneum.

Nemiroff, R. A., & Colarusso, C. A. (1990). Frontiers of adult development in theory and practice. In R. A. Nemiroff & C. A. Colarusso (Eds.), *New dimensions in adult development* (pp. 97-124). New York, NY: Basic Books, Inc.

Sayers, J. (1989). Melanie Klein and mothering: A feminist perspective. *International Review of Psycho-Analysis, 16,* 363-376.

Smith, B. L. (1989a). Winnicott and the British Schools. In M. G. Fromm & B. L. Smith (Eds.), *The facilitating environment: Clinical applications of Winnicott's theory* (pp. 27-51). Madison, CT: International Universities Press, Inc.

Smith, B. L. (1989b). Winnicott and self psychology. In M. G. Fromm & B. L. Smith (Eds.), *The facilitating environment: Clinical applications of Winnicott's theory* (pp. 52-87). Madison, CT: International Universities Press, Inc.

Sproull, N. L. (1988). *Handbook of research methods: A guide for practitioners and students in the social sciences.* Metuchen, NJ.: The Scarecrow Press, Inc.

Stevens-Long, J. (1990). Adult development: Theories past and future. In R. A. Nemiroff & C. A. Colarusso (Eds.), *New dimensions in adult development* (pp. 125-169). New York, NY: Basic Books, Inc.

Tannen, D. (1990). *You just don't understand: Women and men in conversation.* New York, NY: Ballentine Books.

Weeks, G. R. (Ed.). (1989). Treating couples: The Intersystem Model of the Marriage Council of Philadelphia. New York, NY: Brunner/Mazel Publishers.

Winnicott, C., Sheppard, R., & Davis, M. (Eds.). (1989). *Psycho-analytic explorations: D. W. Winnicott.* Cambridge, MA: Harvard University Press.

Winnicott, D. W. (1957). *The child and the outside world.* London: Tavistock Publications.

Wong, N. (1989). Theories of personality and psychopathology. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry/V.* (vol. 1). (4th ed.). (pp. 356-403). Baltimore: Williams & Wilkins.

APPENDICES

Appendix A -- Human Subjects Permission Forms

Couples Relationship Study

Winter, 1993/1994

To: Anyone interested in participating in the 1993 Couples Relationship Study

I would appreciate your help in a research study. Through the course of any relationship, there are times when one individual or, oftentimes, both individuals feel that the relationship could be better. Given the abundant professional and self-help choices available, it seems many people seek to enhance or improve their relationship. If you are involved in a relationship, if you AND your partner are wanting to learn more about your relationship and each other, then please read on. Similar to marriage and family therapy, couples therapy is one of the many varied approaches which is being used by therapists in helping relationships. In particular, couples therapy is used to help couples who wish only to enhance their relationship or who are experiencing certain relationship difficulties.

If interested, participants should fit the following relationship description:

1) couples wanting to learn more about themselves and their relationship.
2) couples in which each of the individuals is over the age of 19 years.
3) couples who are married, living together, or involved in an intimate relationship.
4) couples in which *both* individuals are willing and consent to participate.
5) couples who live in the greater Calgary area.

The term "couple" can apply to any two people who are involved in a relationship. For the purpose of the study, a couple is defined as two people who are committed to each other in one or many ways, for example, emotionally, physically, or sexually. In the relationship that they form, called a dyad, there exists a certain kind of personal investment in that each partner wishes to maintain the ongoing relationship with his or her partner.

Aside from volunteering your time (12 weekly 1-hour sessions), there will be no additional cost to you. Participation in the study will include many of the components recognized as accepted methods of measurement in couples therapy (e.g., complete questionnaires, participate in videotaped problem-solving interactions). However, PARTICIPATION IS STRICTLY VOLUNTARY and you may withdraw from the study at any time. PARTICIPATION IN THE STUDY WILL BE IN STRICT CONFIDENCE AND ALL INFORMATION WILL BE USED ONLY TO SECURE KNOWLEDGE about couples' relationships.

Presently, having completed my course work, I am researching for my Masters Thesis on the subject area of couples therapy. If you any further questions, I can be reached at (403) 228-0382. If you AND your partner are interested in participating in the study, please complete the Participants' Permission Form (attached) and return it to the addressed heading. Your interest and/or participation in this study is greatly appreciated.

Sincerely,

Kenneth J. Barabash, B.A., M.A. (cand.)

Participants' Permission Form

Winter, 1993/1994

We, as partners in a relationship, understand and meet the requirements outlined in the Couples Relationship Study request form, and we wish to participate in the study. Our consent to participate is with full understanding that ALL INFORMATION WILL BE IN STRICT CONFIDENCE AND WILL BE USED ONLY TO SECURE KNOWLEDGE about couples' relationships. Though full participation in the study will require 12 weekly 1-hour (approximate) sessions to complete, we understand that OUR PARTICIPATION IN THE STUDY IS STRICTLY VOLUNTARY, AND WE RESERVE THE RIGHT TO WITHDRAW FROM IT AT ANY TIME. For those referred by a counselling agency, participation or nonparticipation in the project will have no effect on current counselling.

We understand, further, that the nature of the study involves that each weekly session begin with our participation in a 10-minute problem-solving interaction, for which we grant permission to be videotaped. It is our understanding that the videotapes will remain anonymous (i.e., no names will be used), remain strictly confidential (i.e., kept in under lock and key), and destroyed (i.e., erased) following their utility to the study.

_____ _____

(Signature of Partner #1) (Date)

_____ _____

(Signature of Partner #2) (Date)

We (I) _____ may be contacted at _____

(Home No.)

Please complete the above information and return it to:

Kenneth J. Barabash, B.A., M.A. (cand.)
#102, 1827 16A Street S.W.
Calgary, Alberta T2T 4J8
(403) 228-0382 phone
(403) 228-0218 fax

To be completed later, upon consultation with researcher and participants:

Participation start date: _____ Participation termination date: _____

Weekly sessions to take place on_____ at_____
(Weekday & Time) (Location)

Appendix B -- Overview of Developmental Couples Therapy

Stage	Description Of Stage		Diagnosis	Treatment
	Developmental Task	**Developmental Stalemate**		
Symbiotic-Symbiotic (Enmeshed) "We are one"	·Bonding ·Falling in love ·Emphasis on similarities ·Nurturing ·Establishing "coupleness"	·Consuming need to merge; inseparable ·Dependency ·Loss of trust ·Loss of individuality ·Fear of abandonment ·Behavior becomes passive and reactive rather than self-initiated ·Interactions focused on masking differences ·Ego-syntonic ways of relating	·Nonverbal manipulative communication designed to mask or obscure differences ·Use of *we* and *us* rather than *I* in therapeutic sessions ·Severely symptomatic child, or severe symptoms in one partner who is the identified patient ·*Paper Exercise:* Swiftly evokes clear pattern of enmeshed interaction; marked lack of self-definition with excessive efforts to obscure conflict ·*Diagnostic Questionnaire:* Provides a historical overview of the emergence of the enmeshment over time	·Establish initial treatment contract focused on couple's view of the problem ·Establish "no-suicide" and "no-divorce" contracts when indicated ·Build an alliance with couple (family) and then facilitate personal responsibility taking each partner ·When working with a family, use projective art techniques that elicits each member's perception of the family as a whole ·When appropriate, begin shifting from the family as a whole to the couple's relationship ·Use gestalt or TA techniques for working with each partner's family-of-origin ·Facilitate differentiation between partners

OVERVIEW OF DEVELOPMENTAL COUPLES THERAPY

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Symbiotic-Symbiotic (Hostile/Dependent) "I can't live with you, and I can't live without you"	·Bonding ·Nurturing ·Establishing "coupleness"	·Conflict and aggression used to maintain distance and emotional contact ·Poorly developed sense of self; little differentiation ·Emerges when symbiotic fantasy begins to crumble ·Common pattern in borderline and narcissistic personalities ·Open & ongoing expressions of anger, bitterness, & blame ·Competitive, escalating interactions often ending in violence ·Unable to negotiate ·Unable to perceive impact of their own behavior on partner ·Strong projection of feelings and assumptions onto partner ·*Paradoxical patterns of interaction:* Demands nurturance yet rejects it when offered ·Simultaneous fear of abandonment & engulfment ·Pronounced separation anxiety adamantly denied ·Positive responses of partner often interpreted as manipulative or rejected	·In therapeutic sessions, extremely difficult for partners to identify and articulate what each wants, thinks, and feels ×Rapid escalation into regressive behavior ·*Paper Exercise:* Competitive, angry, escalating transactions without any negotiation or give-and-take ·*Question of Attunement:* Expect mind reading, so requests are vague, generalized demands for nurturance leading to failed responses; since there is very limited capacity for autonomous interaction, as soon as one errs the other will punish or withhold	·Diffuse conflict ·Establish limits & behavioral agreement about fights (see *Limits Questionnaire*) ·Keep both partners thinking when angry and channel their anger through yourself ·Teach them to complete transactions ·Signal a confrontation ·Predict future fights ·Provide support and positive reinforcement for partners during sessions ·Help partners learn how to apologize ·Facilitate direct, positive interactions ·Develop consistent, caring behaviors ·Encourage cooperation and joint activities ·Encourage partners to develop outside friendships and activities ·Use humor ·*Once conflict is contained:* Help partners develop and maintain a vision of a better future ·Help couple develop an empathic process

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Symbiotic-Differentiating "Don't betray me"	*Symbiotic* (see above) *Differentiating* ·Learning to express self clearly and openly ·Shift toward internally defining sense of self with independent thoughts, feelings, and wants ·Reestablishment of boundaries ·Developing the capacity to tolerate differences ·Learning to risk expressing one's differences ·Defining clear areas of responsibility and authority	·System becomes unbalanced for the first time ·*Symbiotic Partner:* Feels threatened and betrayed ·Attempts to tighten the symbiosis via "clinging" behavior ·May be characterologically passive ·Little empathy for partner's needs ·*Differentiating Partner:* Feelings of guilt ·Anger at denial of differences ·Increased efforts to define identity	·Look for anger, grief, or despair at disillusionment of romantic fantasy ·*Diagnostic Interview:* Symbiotic partner will focus more on similarities and highlights of initial bonding, while differentiating partner will focus on differences and disillusionment ·*Personal History Exercise:* Use this exercise to diagnose origin of impasse in the symbiotic partner, such as "I'll never go out alone again" ·*Paper Exercise:* Symbiotic partner does not define what the paper is and tends to relinquish it rapidly to the differentiating partner, who defines it	·Help partners resolve the loss of the symbiotic stage ·Help partners identify and express thoughts, feelings, and desires ·Help partners tolerate the anxiety inherent in recognition of differences ·Encourage *differentiating* partner's movements toward self-expression while interrupting symbiotic partner's dependency patterns ·Help partners identify their individual contributions to current difficulties ·Establish clear lines of responsibility taking with regard to issues being discussed ·Break down issues into manageable homework assignments ·Generate motivation for change in passive symbiotic partner by stressing personal benefits ·Help partners learn to tolerate anger

OVERVIEW OF DEVELOPMENTAL COUPLES THERAPY

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Differentiating-Differentiating "I'll change if you change"	·(See above), actively working out how to manage the differences that do exist in personality styles, goals, desires	·Successful fight style not yet developed ·Use of projection and manipulation to push partner toward change ·Ongoing hassling	·Discover how couple has managed conflict thus far in relationship ·Discover if couple has developed a workable fight style ·Discover if partners have begun to reestablish their boundaries via separate activities, friendships, etc. ·*Paper Exercise:* Effort spent in examining the *process* of how partners are going to decide who gets the paper ·*Question of Attunement:* The level of differentiation in each individual will determine how clearly the request is made and how accurately they assess their own capacity to respond	·Pace of therapy determined by degree of differentiation present in each partner ·Use of nonstructured involvement to create therapeutic environment that provides autonomy in the unfolding of partners' differentiation ·Use questions to help partners identify, understand, and articulate feelings ·Bring pertinent intrapsychic childhood issues into awareness ·Facilitate conflict management via use of the "initiator/responder" format ·Provide positive role model for partners ·Discriminate btwn problem-solving issues & issues involving complex developmental factors ·Provide larger context for viewing specific problems ·Facilitate differentiation from family-of-origin ·Identify familial, societal, cultural, or work-related factors that may be inhibiting the differentiation process

OVERVIEW OF DEVELOPMENTAL COUPLES THERAPY

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Symbiotic-Practicing "Don't leave me"/"Leave me alone"	*Symbiotic* (See above) *Practicing* ·Attention directed to external world, independent activities and relationships ·Rediscovery of self as individual ·Consolidation of self-esteem and individual power ·Development of healthy fight style ·Blossoming of individuation process whereby the individual learns to express him/herself creatively in the world	·*Symbiotic Partner:* Feelings of betrayal and abandonment ·Attempts to intensify enmeshment ·Fear of loss of relationship escalates into angry and demanding behavior	·Previous history of mutually satisfying symbiosis ·Minimal differentiation between partners; few mechanisms to handle conflicting needs, desires, or emotions ·An unexpected developmental shift in one partner resulting in increased demands for independence ·*Diagnostic Interview:* Reveals historical evolution from an intense symbiotic phase, to a phase in which active differentiation did not occur between the partners, to the stage in which one partner shifts to intense individual self-preoccupation ·*Personal History Exercise:* This exercise often reveals parallels between current practicing behavior and how the individual separated from the family-of-origin	·Help partners learn how to manage differentiation and support one another's independence ·Therapist must balance opposing therapeutic goals of partners: Symbiotic partner wants the spouse to "be like he/she used to be"; practicing partner wants to continue self-expansion unimpeded ·Initial establishment of discrepant goals is sometimes necessary ·Expose common grief that underlies partners' reactive anger ·Help partners structure time together ·Help practicing partner set self-selected limits that circumscribe the scope of activities ·Help symbiotic partner initiate activities that are self-directed & self-focused ·Use "Symbiotic-Practicing Questionnaire" to help partners identify what they want from one another ·Identify and resolve pertinent intrapsychic conflicts from childhood

OVERVIEW OF DEVELOPMENTAL COUPLES THERAPY

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Practicing-Practicing "I want to be me!"	(See above)	·Energy overinvested in self-development and expression ·Relationship viewed as secondary ·Staunch defence of boundaries ·Fear that greater intimacy will lead to loss of self ·Power struggle characterized by "*I*-want" demands ·Use of projections and transference under emotionally charged circumstances ·Repetition of early script decisions ·All of the above are greatly intensified when the couple does not have a foundation of positive bonding and active differentiation	·Marked lack of emotional connectedness throughout session ·Defensive presentation of each partner's side, and polarized views ·Competitive dialogue leading to impasses in problem solving ·Practicing-practicing couples who have differentiated together will still have power struggles, but with decreased intensity ·*Paper Exercise:* Both partners are well defined about what the paper represents, but often are unable to give to the other or compromise; often the exercise is not completed in the five minutes allotted ·*Diagnostic Interview:* Reveals no anxiety for either partner in having separate activities of friendships	·Focus on process rather than content ·Help partners learn ways of protecting separate individualities while resolving conflicts ·Help partners relax boundaries ·Help those couples who have not actively differentiated together to learn how to manage differentiation, while continuing their independence ·Help partners identify and express feelings ·Use of "The Thirty-Day Plan" ·Help partners identify and resolve intrapsychic childhood issues ·Help partners develop a decision-making process that involves giving without anxiety

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Practicing-Rapprochement "One foot in, one foot out"	*Practicing* (see above) *Rapprochement* ·Return shift toward relationship for intimacy and emotional sustenance ·Reemergence of vulnerability ·Greater ease in negotiating ·Balance between "I" and "us" becomes more firmly established ·Ongoing utilization of skills learned in previous stages ·Capacity to respond with consistency ·Capacity to give to partner even when inconvenient to do so ·Further resolution of remaining childhood impasses that interfere with successful coupling	·*Practicing Partner:* Fearful of "putting myself second" ·Equating *intimacy* with *sacrifice* ·Overcompromising; reduction of options ·Conflict over empathizing with partner's intimacy needs versus responding to personal needs for growth and individuation ·*Rapprochement Partner:* Alternates between periods of intimacy and efforts to reestablish independence ·Conflict over supporting partner's growth and independence versus seeking to gratify personal needs for greater intimacy	·*Diagnostic Interview:* Elicits the characteristics described under the developmental stalemate	·Identify temporary incompatibility of respective stages ·Explore each partner's needs with a view toward finding points of intersection and compromise ·Use of future focus to evoke a mutual image of the relationship that combines both sets of needs ·Learn to balance one's own wants and desires with partner's

OVERVIEW OF DEVELOPMENTAL COUPLES THERAPY

	Description Of Stage			
Stage	**Developmental Task**	**Developmental Stalemate**	**Diagnosis**	**Treatment**
Rapprochement-Rapprochement "Homeward bound"	(See above)	·At this advanced stage of development, stressors to the relationship usually come from external sources such as a job promotion, a potential move, an ailing relative; intra- and interpersonal processes are generally highly developed and integrated	·Diagnosis at this level occurs primarily through the elicitation and observation of what is *right* in the relationship: all the strengths and abilities that are present and operative in the relationship	·Therapy at this level is primarily facilitative rather than treatment-orientated ·Ask partners what most deeply touches them when they are vulnerable ·Focus on them learning to give when it is not convenient ·Use a future focus via developing a relationship purpose, setting goals, or using "The Thirty-Day Plan"

Appendix C -- Observational Measures of Developmental Couples Therapy

OBSERVATIONAL MEASURES OF DEVELOPMENTAL COUPLES THERAPY

Stage	Sense of Self		Sense of Coupleness	
	Positive	**Negative**	**Positive**	**Negative**
Symbiotic (Enmeshed) "We are one"	**A**$^{+}$·Sense of individuality	**A**$^{-}$·Loss of individuality	**A**$^{+}$·Expresses own identity in relationship; separateness	**A**$^{-}$·Consuming need to merge; inseparable
	B^{+}·Secure in possibility of separation	**B**$^{-}$·Fear of abandonment	**B**$^{+}$·Trusting of partner	**B**$^{-}$·Loss of trust
	C^{+}·Capacity to see advantages in becoming self-reliant	**C**$^{-}$·Dependency on others; bonding	**C**$^{+}$·Nonverbal communication highlights differences	**C**$^{-}$·Nonverbal manipulative communication designed to mask or obscure differences
	D^{+}·Behavior is self-initiated and nonreactive	**D**$^{-}$·Behavior becomes passive and reactive rather than self-initiated	**D**$^{+}$·Interacts openly, able to identify differences	**D**$^{-}$·Interactions focused on masking differences
	E^{+}·Personal responsibility taking	**E**$^{-}$·Severely symptomatic child, or severe symptoms in one partner who is the identified patient	**E**$^{+}$·Relates empathically toward partner	**E**$^{-}$·Ego-syntonic ways of relating
	F^{+}·Initiates self-expression	**F**$^{-}$·Marked lack of self-definition	**F**$^{+}$·Makes use of '*I*' statements rather than *we* and *us*	**F**$^{-}$·Use of *we* and *us* rather than *I* in therapeutic sessions
	G^{+}·Independent thought and behavior	**G**$^{-}$·Intense need for approval from others	**G**$^{+}$·Identifies partner as separate individual	**G**$^{-}$·Ephasis on similarities between partner

OBSERVATIONAL MEASURES OF DEVELOPMENTAL COUPLES THERAPY

Stage	Sense of Self		Sense of Coupleness	
	Positive	Negative	Positive	Negative
Symbiotic (Hostile/Dependent) "I can't live with you, and I can't live without you"	**A**$^{+}$·Well-defined sense of self; identified differentiation	**A**$^{-}$·Poorly developed sense of self; little differentiation	**A**$^{+}$·Makes an effort to connect emotionally with partner	**A**$^{-}$·Conflict and aggression used to maintain distance and emotional contact
	B^{+}·Differentiation is maintained, even in light of reality	**B**$^{-}$·Emerges when symbiotic fantasy begins to crumble as reality sets	**B**$^{+}$·Interacts with partner in nonthreatening manner	**B**$^{-}$·Competitive, escalating interactions often ending in violence
	C^{+}·Expresses stability in mood and self-image	**C**$^{-}$·Common pattern in borderline and narcissistic personalities	**C**$^{+}$·Ability to negotiate	**C**$^{-}$·Unable to negotiate
	D^{+}·Open expressions of thoughtfulness, personal responsibility, understanding	**D**$^{-}$·Open expressions of anger, bitterness, and blame	**D**$^{+}$·Able to perceive impact of own behavior on partner	**D**$^{-}$·Unable to perceive impact of his or her own behavior on partner
	E^{+}·Makes effort toward intimacy, while still maintaining differentiation	**E**$^{-}$·Simultaneous fear of abandonment and engulfment	**E**$^{+}$·Makes use of '*I*' statements rather than assume partner's feelings	**E**$^{-}$·Strong projection of feelings and assumptions onto partner
	F^{+}·Acknowledges and is secure in possibility of separation	**F**$^{-}$·Pronounced separation anxiety that is adamantly denied	**F**$^{+}$·Unconditionally accepts positive responses offered by partner	**F**$^{-}$·Demands nurturance yet rejects it when offered
	G^{+}·Behavior remains composed and stable	**G**$^{-}$·Rapid escalation into regressive behavior	**G**$^{+}$·Able to clearly define and articulate what partner wants, thinks, and feels	**G**$^{-}$·Extremely difficult to identify and articulate what each wants, thinks, and feels

OBSERVATIONAL MEASURES OF DEVELOPMENTAL COUPLES THERAPY

Stage	Sense of Self		Sense of Coupleness	
	Positive	Negative	Positive	Negative
Differentiating "I'll change if you change"	**A**$^{+}$ Learning to express self clearly and openly	**A**$^{-}$ Feelings of guilt over identifying differences	**A**$^{+}$ Attempt to resolve conflict in mutually satisfying manner	**A**$^{-}$ Successful fight style not yet developed
	B^{+} Shift toward internally defining sense of self with independent thoughts, feelings, and wants	**B**$^{-}$ Anger, grief, or despair at disillusionment of romantic fantasy	**B**$^{+}$ Respectful in allowing partner to change at own pace	**B**$^{-}$ Use of projection and manipulation to push partner toward change
	C^{+} Reestablishment of boundaries	**C**$^{-}$ Ill-defined personal boundaries	**C**$^{+}$ Sincere effort toward better managing ongoing hassles and bickering	**C**$^{-}$ Ongoing hassling
	D^{+} Developing the capacity to tolerate differences	**D**$^{-}$ Anger at denial of differences	**D**$^{+}$ Reflective in learning how partners have managed conflict thus far in the relationship	**D**$^{-}$ Unable to reflect on how partners have managed conflict thus far in the relationship
	E^{+} Learning to risk expressing one's differences	**E**$^{-}$ Inability to express or suppression of differences	**E**$^{+}$ Able to define personal boundaries toward a workable means of conflict management	**E**$^{-}$ Unable to identify the principles of a workable fight style
	F^{+} Able to define clearly areas of responsibility and authority	**F**$^{-}$ Avoids responsibility and authority	**F**$^{+}$ Differentiation begins thru establishing individual and separate activities	**F**$^{-}$ Inability to reestablish boundaries via separate activities, friendships, etc.
	G^{+} Increased efforts to define identity	**G**$^{-}$ Aviodance or reluctance to define identity	**G**$^{+}$ Able to discriminate problem-solving issues	**G**$^{-}$ Important problem-solving issues not clearly defined

OBSERVATIONAL MEASURES OF DEVELOPMENTAL COUPLES THERAPY

Stage	Sense of Self		Sense of Coupleness	
	Positive	**Negative**	**Positive**	**Negative**
Practicing "I want to be me!"	**A**$^{+}$·Open to situations requiring personal give and take	**A**$^{-}$·Stance of stubbornness and self-centeredness	**A**$^{+}$·Degree of emotional connection with partner; engaging	**A**$^{-}$·Lack of emotional connection to the partner; withdrawal
	B^{+}·Capacity for empathic response	**B**$^{-}$·Loss of capacity for empathic response	**B**$^{+}$·Relationship viewed as important as individuation	**B**$^{-}$·Relationship viewed as secondary
	C^{+}·Considerate balance between self-expression and personal development	**C**$^{-}$·Energy overinvested in self-development and expression	**C**$^{+}$·Not threatened by partner's need for intimacy	**C**$^{-}$·Feels betrayed by partner's engulfment
	D^{+}·Openly defined personal boundaries	**D**$^{-}$·Staunch defence of boundaries	**D**$^{+}$·Differentiated couples tend still to have power struggles, but with decreased intensity	**D**$^{-}$·Power struggle characterized by "*I*-want" demands
	E^{+}·Affirms ideal that greater intimacy need not be incompatible with individuation process	**E**$^{-}$·Fear that greater intimacy will lead to loss of self	**E**$^{+}$·Proactive rather than reactive in emotionally charged situations	**E**$^{-}$·Use of projections and transference under emotionally charged circumstances
	F^{+}·Able to construct and define mechanisms to better handle conflicting needs, desires, or emotions	**F**$^{-}$·Few mechanisms to handle conflicting needs, desires, or emotions	**F**$^{+}$·Encourages positive bonding and active differentiation	**F**$^{-}$·Defensive presentation of each partner's side, and polarized views
	G^{+}·Satisfaction in level of independence attained	**G**$^{-}$·Increased demands for independence	**G**$^{+}$·Effective dialogue leading to successful problem-solving	**G**$^{-}$·Competitive dialogue leading to impasses in problem solving

OBSERVATIONAL MEASURES OF DEVELOPMENTAL COUPLES THERAPY

	Sense of Self		Sense of Coupleness	
Stage	**Positive**	**Negative**	**Positive**	**Negative**
Rapprochement "Homeward bound"	**A**$^{+}$ Clearly defined in shifting between needs for intimacy and needs for individuation	**A**$^{-}$ Alternates between periods of intimacy and efforts to reestablish independence	**A**$^{+}$ Ability to describe and support partner's growth needs and independence	**A**$^{-}$ Conflict over supporting partner's growth and independence
	B^{+} Reemergence of vulnerability	**B**$^{-}$ Protective of personal growth	**B**$^{+}$ Self-assured that greater intimacy and each partner's personal growth are compatible and desirable	**B**$^{-}$ Fear that seeking greater intimacy may conflict with gratification of personal needs
	C^{+} Balance between *I* and *us* becomes more firmly established	**C**$^{-}$ Use of *I* statements predominant over *us* statements	**C**$^{+}$ Interpersonal processes are generally highly developed and integrated	**C**$^{-}$ Slight ambiguity in defining and demonstrating interpersonal skills
	D^{+} Intrapersonal processes are generally highly developed and integrated	**D**$^{-}$ Slight ambiguity in defining and demonstrating intrapersonal skills	**D**$^{+}$ Ability to distinguish conflict in the relationship due to internal vs. external source	**D**$^{-}$ Conflict over stressors to the relationship usually come from external sources
	E^{+} Further resolution of remaining childhood impasses propel successful coupling	**E**$^{-}$ Tentativeness in exploring deeper possible childhood issues	**E**$^{+}$ Capacity to respond to partner with consistency	**E**$^{-}$ Responds to partner inconsistently
	F^{+} Ongoing utilization of skills learned in previous stages (e.g. differentiation)	**F**$^{-}$ Regression toward behaviors highlighted in earlier stages	**F**$^{+}$ Capacity to give to partner even when inconvenient	**F**$^{-}$ Gives to partner conditionally, or with reluctance
	G^{+} Use of future focus	**G**$^{-}$ Tendency toward past areas of conflict	**G**$^{+}$ Greater ease in negotiating	**G**$^{-}$ Attempts of negotiation not successfully resolved

Appendix D -- Observational Approaches to Diagnosis

Observational Approaches to Diagnosis

In addition to the structured diagnostic tools, *observation* serves as an essential focus of any diagnosis. Sometimes these observations are made in response to the couple's undirected interactions, and sometimes in response to structured interventions. The following offers only a brief acknowledgement to the richness of information which can be obtained through observational techniques.

Climate

By focusing on the interaction of the couple, the *climate* within a relationship can be characterized by the following: Is the relationship loving and growth-promoting for each partner? Does it exhibit signs of aggression and continual eroding of each partner's self-esteem? Is intimacy allowed, or is any depth sacrificed for "looking good?" Is one partner used to promote growth in the other? Does the relationship require on partner to squelch himself or herself, thus inhibiting individual growth, in order to build up the other and ensure the relationship continues? Are the partners trying to find themselves through one another?

Body Language

The couple's interactional climate is further revealed in their *body language*. It is important for that the therapist closely observe how the couple interact as individuals between themselves, and also how they interact with the therapist. For example, the absence of eye contact, or minimal eye contact between the partners, may be an important indicator of *symbiosis*, as well as of the level of difficulty that might ensue in working with the couple. That is, the individuals may be operating from an *undifferentiated* position in which their early experience as a child is projected onto the partner. Instead of "taking in" here and now cues from seeing what the partner is saying, the internal past experience dominates. One of the results of minimal eye contact between partners is that they generally have to guess or invent their own version of how the partner is responding to them. Other individuals may look at their partners but continue to talk about them in the third person as though they were still talking to the therapist. Another immediate source of diagnostic data from the couple's body language is their chosen sitting positions. (Sometimes the latter is dictated by the type of furniture available in the room.)

Elements of body language, such as these, indicate the fluidity of the couple's boundaries and how difficult it is to maintain self in the face of even a positive emotional exchange with the partner. Indeed, there is a range of behaviors that couples exhibit in their initial session, as they shift from talking to the therapist about their problem to talking to one another. It is of critical importance, however, that the therapist be sensitive to cultural differences of body language such as, for example, eye contact. For instance, while majority of North Americans may emphasize the importance of eye contact, First Nations people downplay its importance or avert eye contact almost entirely.

Behavioral responses can serve as an indication of how fast the couple's system of interaction is going to be changed and how readily the couple will allow the therapist to exert an influence. If couples are completely unable to receive empathically from one another (i.e., do not let the partner in emotionally in a positive way), then the chances are high that they are not going to let the therapist in emotionally in a positive way unless it is to create an ally.

Appendix E -- Couples Diagnostic Questionnaire (CDQ)

Couples Diagnostic Questionnaire (CDQ)

The purpose of the *Diagnostic Interview* (or questionnaire) is to elicit the evolutionary history of the couple's relationship. The questions may be presented to each partner either verbally in a live interview (CDI), or as a take-home questionnaire (CDQ). The questions are arranged in a *developmental sequence* in order to pinpoint those phases that have been mastered by each partner and those that signal areas of impasse. Together with a brief commentary about what the questions are intended to elicit, the following is a list of questions:

1. *What is the problem that led you to decide to come to therapy?*

How each partner initially defines the problem gives an immediate sense about whether the couple is *symbiotic* or whether emerging and unresolved differences are creating the problem. That is, each partner may not recognize their own responsibility in creating it. Suggesting a strong symbiotic pattern in an individual, for example, would be if there was a history of hastily moving in and out of relationships; a relationship engaged in practicing struggles would be manifested in partners' differences and desires of independence.

2. *How long have you and your partner been together? In what form (i.e., married, dating, living together)?*

How long the couple has been together usually signifies their developmental stage; somewhere between six months and two years, a couple is able to define their relationship as relatively stable and typically begin to evolve out of the symbiotic stage. When movement toward *differentiation* does not occur, the evolution of the relationship is defined as an *enmeshed* or *hostile-dependent symbiotic* relationship.

3. *What initially attracted you to each other? How did you decide to get married or live together?*

Responses to the original attractions evokes both the real and the fantasy illusions that were part of the couple's initial bonding experience. Such information provides clues to aspects of the problem the couple remain unaware of or are unable to resolve between themselves. How the decision was made about living together or getting married reveals the degree of the couple's orientation toward either a *symbiotic* or an independent style of relationship.

4. *What do you find most fulfilling about your relationship?*

Answers to this question reveals whether the relationship is based on dependency and *symbiotic* elements or on growth-enhancing ones. For example, contrast a relationship in which a child provides the only fulfilling element in a relationship with one in which openness, willingness to talk, and flexible roles are emphasized.

5. *What was the very beginning of your relationship like? How long did this phase last?*

This question examines the intensity and duration of the early phase, strength of the early bond, how long the couple maintained it, if the couple allow themselves time for ecstasy, if falling in love was a delight or a chore, did they acknowledge themselves as a couple, and if the early relationship was shrouded with so much ambivalence about coupling that they never established a solid base of feeling and commitment to sustain them through the disillusionment of the *differentiation* stage. A *symbiotic* relationship, for example, may include statements such as "The first two years were intense, sexually passionate, and filled with emotional and financial dependency. We are as thick as thieves and very close." In contrast, a *practicing-practicing* couple may report difficulty with their early attachment, with statements such as "We were both so afraid of losing ourselves in each other that we did silly things....I think we missed out on something."

6. *What was your first disillusionment? What happened and how did you resolve it?*

Considered one of the most important questions in that the first disillusionment usually propels partners into a phase of *separation/individuation*. If disillusionment is not resolved by the couple, it may lead to the emerging of a *hostile-dependent symbiotic* relationship. The disillusionment represents the loss of the initial fantasy. It is important that the therapist note if the loss is minimal or substantial, and when it occurred. Contrast, for example, the lack of resolution for a woman who says "My first disillusionment came after 16 years of marriage when my husband told me that he wasn't in love with me anymore; since that moment he has hardly spoken to me," with a woman who says "After we had been together for a year, I discovered that my boyfriend wasn't a travel buff like I am. Since we had done so much travelling early in our relationship, I had assumed he loved being away from home as much as I did."

7. *When do you feel least fulfilled in your relationship?*

Answers to this question will pinpoint areas of conflict in a relationship as well as identify those partners who view themselves as "lily-white" victims, while considering the other as bad and blameful. For example, "I rarely feel fulfilled. I never get positive feedback. I am excluded from her thoughts and repulsed whenever I approach her."

8. *In what significant ways are the two of you similar? different? What methods have you worked out to accommodate or compromise on your differences?*

The polarity of the partners' responses to these questions will show whether their focus is on sameness or on difference. The *differences* may be a source of threat to one partner, whereas the *similarities* may aggravate the other. The therapist looks at what mechanisms the couple has developed for managing their differences. If the couple has not found any positive ways to work with the differences, then the therapist knows they have reached an impasse in their *differentiation* stage.

9. *Do you spend time in activities away from your partner? If so, how often? Do you spend time alone with people who are not mutual friends? Does this create conflict in your relationship?*

Here some of the highlights of the *practicing* stage are explored; both questions 9 and 10 are intended to elicit responses that illuminate both sides of the *practicing* stage. For instance, the partners' ability to manage their own independence, ability to manage the other's independence, role of independent activities and friendships in the relationship, if the roles are perceived as threatening and if they lead to repetitive fights, and if *separation anxiety* occurs when either goes off on his or her own.

10. *How comfortable are you doing activities away from your partner? How comfortable are you with your partner doing things away from you?*

(Refer to Question 9)

11. *How safe do you feel expressing your innermost thoughts and feelings to your partner? How do you ask for emotional support from your partner when you are feeling vulnerable? Do you expect to get it?*

(Refer to Question 13)

12. *Would your partner say that you are emotionally responsive to his/her vulnerability? Explain?*

(Refer to Question 13)

13. *Do you take an active, energetic role in nourishing the relationship? Does your partner do the same? How?*

Questions 11, 12, and 13 elicit information that will help pinpoint where the partners are in relation to the *rapprochement* stage. That is, the stage in which the adult enjoys engaging in activities away from the partner, but also enjoys returning to the relationship to express more vulnerability and to give and receive nurturance. At this stage, however, there is still a regressive element in the nurturance, as earlier issues are in the final stages of resolution. In reference to Question 11, contrast one individual who answer it by saying "I don't feel safe. I feel humiliated whenever I open my mouth and a feeling comes out," with the woman who says "I feel fine expressing *very* personal things. Sometimes I hold back when I'm confused and wait until I'm sure what I'm feeling, but once I know, I feel safe sharing with him. Usually, he responds very caringly." With respect to Question 13, note the difference between a woman in the *symbiotic* stage who answered by saying, "This is a hard question. I never thought about it before, but I think, no. Mostly I expected my husband to nurture and protect me," with a more differentiated man who responded, "Yes, we both do. I do special things for holidays and birthdays. I want her to know our relationship is special. I also bring up new ideas to discuss or do."

14. *Do you support your partner's development as an individual? How (give example)? Do you support his/her growth as an individual even when you don't agree? How (give example)?*

Many people respond negatively to both variations of this question, but partners who are able to support the other in spite of disagreement are manifesting a high level of *differentiation*. The emotional valence of a person's response to these questions can help identify his or her specific developmental level. For example, a symbiotic partner will tend to respond with fear and anxiety, whereas a *practicing* partner might evidence a subtle tone of resentment. Contrast the following responses of individuals in three very different stage:

Symbiotic Hostile-Dependent: "I am constantly made aware by my husband that I do not support him as an individual, so I live with the feeling of guilt of not being able to do anything for him."
Differentiation: "I try to support his development, but if I don't agree with his direction, I don't support it. In fact, that's when the fighting begins."
Rapprochement: "Yes, I have recently been supporting her education and development both financially and emotionally."

15. *Do you believe that your partner is giving at least 50% to the relationship?*

Very few partners believe the partnership involves an equal give-and-take. With the major exception found in couples who have been together for only a short time, usually such equality does not evolve until the *rapprochement* or *mutually interdependent* stage. One woman in a *practicing* relationship responded, "My husband has never given such a high percentage to our relationship. Soon after we got married, he started medical school, next it was law school, and then on to his career as a travelling consultant." A man in a *practicing-rapprochement* relationship responded, "Absolutely, she gives much more than 50%. I'm still learning how to give." Another man in a *mutually interdependent* relationship expressed, "Our therapy has really paid off. It shows now since we are in the process of starting our own business. It's a time of high financial and emotional stress and we keep supporting each other."

16. *Do the two of you have joint commitments to projects, work activities, or social causes? If so, what?* (Refer to Question 17)

17. *Did you deliberately decide to create something together in one of these areas?*

Couples who have successfully passed through all the previous stages begin to feel a desire to do something together. In the earlier stages this desire more often reflects a *symbiotic* movement rather than an outreach toward creating an experience of mutual creativity and sharing. It is usually obvious which vantage point a response is reflecting. For example, note the difference between the couple who described their joint commitment to the husband's church, and the couple who worked together in Southeast Asia after the Vietnam War.

In the first situation, the wife's commitment took the form of bringing lunch to her husband at church each day. The *symbiotic* overtones are made quite clear in when she becomes upset her husband want to have lunch once a week without her. On the other hand, the latter couple had deliberately decided to go to Southeast Asia together to aid in restoration work in Vietnam and Laos. They

are able to describe how their commitment to their work strengthened the bond between them.

18. *Does this project seem to add or detract from the bond between you?*

It is in the latter stages that a joint project will add deeply to the bond between the partners. Prior to this, joint activities may be enjoyable and satisfying but may also serve to tighten a *symbiotic* connection, to obscure differences, or to detract from the unfolding *individuation* of either partner in *practicing* stage.

19. *If your marriage were a drama, movie, or book, what would it be titled? How would it end?*

This question is intended to give the therapist the most salient feeling-tone of the relationship in a few words that draw a crystal-clear picture. The following represent some examples:

- Two partners in a *hostile-dependent* relationship called their marriage "The Tidal Wave" and "Two Prisoners in One Cell."
- A *symbiotically enmeshed* partner labelled his marriage "The Perfect Match" and another "A Marriage Made in Heaven."
- A *differentiating* partner said, "A Life Without Problems Is No Life At All."
- A *practicing* partner called his marriage "The Lone Ranger," while another entitled it "Drifting Along," or "900 Miles Away."

Appendix F -- Anger Questionnaire (AQ)

Anger Questionnaire (AQ)

This questionnaire is designed to help you understand what you learned about anger as a child. It will also help you describe how you utilize anger now and then facilitate you to define clearly how you want to express angry feeling.

1. Anger is_____.

2. When you were growing up, what did your mother do with her anger? Your anger?

3. When you were growing up, what did your father do with his anger? Your anger?

4. As a child, what did you decide about expressing your angry feelings?

5. In the present, what do you do when you are angry at your partner?

6. Are you satisfied with how you resolve your anger with your partner?

7. What do you want to change so you will feel good about how you resolve anger with your partner?

8. Take a few moments to fantasize an ideal fight between you and your partner. Describe it in detail. Include setting, tone of voice, actual words said.

9. Are you ready and willing to change how you resolve your anger?

10. Describe behaviorally the changes you will make.

11. Describe behaviorally the changes you want your partner to make.

Appendix G -- Limits Questionnaire (LQ)

Limits Questionnaire (LQ)

In every couples relationship, it is important to define the limits of what is and what is not acceptable behavior in a fight. Below, please define these limits for yourself in clear, specific terms. Also, define the limits you would like your partner to have. Be sure to cover such areas as physical behavior, voice tone, ending a fight, and what you don't want said. On the back, list what you negotiate as agreeable to both of you.

1. For me, it is acceptable to do the following during a fight:

2. For me, it is not acceptable to do the following:

3. For you, it is acceptable during a fight to do the following:

4. For you, it is not acceptable to do the following:

Appendix H -- Paper Exercise (PE)

Paper Exercise (PE)

The *Paper Exercise* was adapted from a technique developed by Susan Campell (1980). The purpose of the *Paper Exercise* is the provide spontaneous information about how the partners currently interact with each other. It provides the therapist with a diagnostic tool and is useful to help couples engage in their own process of evaluation. The verbal directions given to the couple reads as follows:

> *This piece of paper represents something important to you* [looking at one member of the couple], *and something important to you* [looking directly at the other member of the couple]. *I want you to hold this paper between you, and you will have up to five minutes to decide who gets the paper without ripping or tearing it. You can do it verbally or nonverbally. You can do it any way you choose, and you will have up to five minutes to decide who gets the paper.*

With exception of a one-minute warning to signal the end of time is drawing near, no additional information is provided to the couple, even if questions are asked. The *Paper Exercise* is designed as a projective tool, and is therefore unstructured. Focusing in on how the couple manages their time, the therapist focuses in on the following area:

1. Capacity for self-definition
2. Management of boundaries between self and other
3. Recognition of the separate wholeness of the partner
4. Capacity to handle conflict
5. Ability to negotiate
6. Capacity to give and receive

Less important is the content of the exercise rather than the way the couple handles the process. By observing the process in the context of the six categories listed above, the therapist is able to determine the skills that an individual and couple must develop in order to evolve beyond the current impasse.

Appendix I -- Individual History (IH) and Intrapsychic Issues

Individual History (IH) and Intrapsychic Issues

The purpose of the *Individual History* interview is to reveal each partner's unique experiential and psychodynamic background. Its intent is to uncover those feelings out of each person's past history that are being displaced or projected onto the spouse. These lead to rigid, unchanging, and self-defeating patterns of interaction. The central feature of the exercise is to enable the therapist to identify quickly particular childhood issues that contribute to the current developmental impasse, rather than examine all elements of an individual's early history.

The interview was adapted from work of the Gouldings (1979) on identifying chronic negative feeling underlying the presenting problem. That is, they illustrated that, through combined TA and Gestalt techniques, the current impasse could be resolved by tracing current chronic negative feelings back to the original childhood traumas that spawned them. Adapted from their work, "the short script" was designed to uncover each individual's intrapsychic impasse in the context of couples therapy. The instructions the therapist reads to each individual are as follows:

> *Close your eyes and allow yourself to go back to a time when you were a young child growing up in your own family. And as you go back, allow yourself to remember the time when either your mother or your father treated you the worst or meanest you can remember. And as you're back in that scene, allow yourself to see what is happening, to know what you are feeling, and to see what you are deciding about how to cope with the situation. Also, let yourself know what demand you would like to have made of either of your parents. Then, after you have discovered answer to these questions, slowly grow yourself up and come back into the room, once again being your own age now.*

Appendix J -- Symbiotic-Practicing Questionnaire (SPQ)

Symbiotic-Practicing Questionnaire (SPQ-P) -- Practicing Form

The following is to filled out by the practicing partner: *(please use point form)*

1. What I want from _____ (partner's name) when I'm taking my independence is:

2. What I want from myself when I'm taking my independence is:

3. What I want to do for _____ (partner's name) when he/she is scared is:

4. What I want to do to support _____ (partner's name) independence is:

Symbiotic-Practicing Questionnaire (SPQ-S) -- Symbiotic Form

The following is to filled out by the symbiotic partner: *(please use point form)*

1. What I want from _____ (partner's name) when I'm scared is:

2. What I expect from myself when I'm scared is:

3. What I want to do to become more independent is:

4. What I want from _____ (partner's name) to help me become more independent:

5. What I expect myself to do to support _____ (partner's name) independence:

Appendix K -- Question of Attunement (QA)

Question of Attunement (QA)

The purpose of the *Question of Attunement* is to elicit the level of differentiation and nurturance between partners. It is meant to complement the Paper Exercise in that it elicits clear, behavioral indices of the partners' abilities to both differentiate from and nurture each other. The couple's developmental status depends on each partner's ability and willingness to identify and express important wants, and, their capacity to respond to one another in an empathic, differentiated manner. In order to determine the extent of differentiation, one partner is asked direct the attunement question to their partner, and the other partner is asked respond. The specific question is as follows:

> *What can I do this coming week to make your week go a little bit better or make you feel more loved, valued, and appreciated?*

Once completed by one partner, then the opportunities are reversed. By engaging the couple in both a therapeutic and self-information process, how the question is answered indicates their capacity for self-definition. In addition, the partners' response to the question--both verbally in the session and behaviorally throughout the following week--also serves as a simultaneous intervention. The couple's verbal and behavioral response provide the therapist with information to questions such as:

> Is there sufficient self-awareness and trust to express meaningful desires?
> Can partners respond to the question in a clear, understandable way?
> Can they allow themselves to be given to in a comfortable way?
> How well do they react and what do they say when they receive a negative response to their request?

Moreover, how partners respond to the request made of them indicates their ability to view their partner as separate selves. For instance:

> Can they appreciate the significance of the request to their partner, even if it is unimportant to them?
> Can they agree to the request without a quid pro quo agreement?
> Can they agree to the request even if it requires effort on their part?
> Do they ask clarifying questions that enhance the meaningfulness of the request?
> Can they say no to a request that exceeds their ability or desire to fulfill?

Other than repeating the question to the partners, or perhaps intervening to operationalize an agreement that seems too vague (e.g., "I want more attention"), the therapist allows them to complete the process from start to finish, without interruption or doing anything to facilitate the negotiation. Observing their interaction provides the therapist with data about their level of differentiation and their capacity for empathy. The exercise is not intended to be set up as a quid pro agreement; rather, it is intended as a means of initiating each partner into the process of taking responsibility for making autonomous, self-directed (differentiated) changes.

Appendix L -- Thirty-Day Plan (TDP)

Thirty-Day Plan (TDP)

In working with *practicing-practicing* couples, *The Thirty-Day Plan: Creating a Wish List*, was developed to help them use the momentum from their own developmental growth process to carry them into new dimensions of positive relatedness. This method will help partners relax their boundaries in a nonthreatening way and thereby shift their interaction from those of distancing and rigidity to actively positive exchanges. The plan serves the function of either supporting the movement of the couple toward more openness and looser boundaries, or of identifying the impasse that is preventing each individual from moving beyond the developmental "stuck point." The plan is most effective when it is used early in treatment with *practicing-practicing* couples with whom *differentiation* has already occurred. (*Hostile-dependent symbiotic* couples have also profited from the plan, but usually on a short-term basis often unable to sustain for an extended period of time the level of communication necessary to use the plan in a way that creates a growthful impact on the relationship. When used with such couples, the plan is effective in catalyzing previously unrecognized psychodynamic impasses.)

The therapeutic implementation of the plan requires a high level of structure, activity, and firmness of the part of the therapist. When successful, the plan leads the couple out of the isolation and self-absorption of the practicing stage and back into a more mutually creative relational and developmental experience. For example, the *Thirty-Day Plan* can be effective in helping elicit the couple's unresolved intrapsychic issues that were impeding their *differentiation*, and to interrupt the couple's power struggles and provide a supportive milieu in which they could begin to resolve their specific issues.

To participate in the process, a couple must make a minimum four-week commitment to spending 15-20 minutes each day at home carrying out specific instructions. In beginning the process, the partners are asked to describe their *ideal relationship* by listing the aspects that currently go well, and, in addition, by describing what they want "more of" in the future. In effect, the couple is requested to imagine a "Wish List" for their relationship that will include everything they would like it to be. They are cautioned, however, that these items are intended to reflect what they *want* rather than what they think they *should* have. It is also suggested that they be general rather than overly detailed in formulating items on the Wish List, because asking for details at this point often leads to arguments. Further, they are told to avoid using the words *don't* and *stop*; for example, to avoid listing the negative request to "stop nagging and

criticizing," and instead list the positive desire for "more appreciation of my efforts at doing the household chores."

After partners have compiled their lists, the therapist asks the couple to describe--as explicitly and specifically as possible--the kind of support they would most like to receive from one another in order to enhance their individual growth. Next, the therapist helps both partners to identify the areas of needed change, explain as follows:

> *In order to change your relationship in a manner that reflects the above list, you will probably need to change something about yourself. At this point, think of the personality trait or characteristic that you will have to give up, as well as the trait or characteristic that you will have to increase or acquire in order to assist you in creating the relationship described in your list.*

At this point the partners are asked if they believe it is possible to accomplish the list. If there is any item that seems totally impossible, it is removed from the list. Next, the therapist instructs the couple as follows, noting that this exercise is to continued at home.

> *Talk to each other twice a day about the items on your Wish List as if they were already occurring or already have occurred. Give acknowledgement to each other about these items in the present tense, even if you have not yet convincingly demonstrated them. For example, you might say to your partner: "I appreciate your keeping the house neater," or "I feel your support much more now," or "Thank you for listening to me without giving advice or trying to make me feel better."*
>
> *At this point do not worry about the "truth" of your conversation. This is future talking. Keep in mind that the talk is about* who you want to be, *not who you are today.*
>
> *These gentle reminders of how you want to be will act like a magnet in pulling you forward and taking the stress of blaming off your relationship. If you are struggling with a future decision about where to live or buy a house, give yourselves a general reinforcement such as, "I'm glad we're making the decision about where to live."*
>
> *I have found it easier for couples to solve difficult problems when they are approached from a positive position of trust and support. Doing this exercise builds in the expectation that the relationship is going to flourish.*
>
> *These daily conversations may last anywhere from one to five minutes. The important thing is to do them twice a day.*
>
> *The next part of the exercise has to do with the characteristics you have identified as the ones you are going to give up and those you are going to develop.*

For example, if you want to give up being jealous and develop more trust, then every day this week, as soon as you begin to feel jealous, create an opposing fantasy in which you imagine yourself being supported by your partner, and recall the trusting elements in your relationship.

In other words, every time you begin to think, feel, or act out the trait you want to give up, actively replace it with the trait you want to acquire.

In the final part of the exercise, you are to fantasize, reflect, and think about the future two times a day, for a few minutes. Imagine yourselves six months or three years from now--whatever time period you prefer--and create scenes in which you have made your list happen. Imagine what your relationship is like in great detail, when you have created all the elements on your lists.

After the couple have completed the assignment, and the therapist has answered any questions, they are told that their next session will begin with talking about *their successes* in executing their Wish List exercise.

When the couple returns for subsequent sessions, it is important that the therapist follow through with a positive, forward-moving direction initiated in the plan. For example, a good question would be "What did each of you do to be effective with the Wish List?" Often the couple will exert pressure to return to negative patterns of complaining and blame, and to engage the therapist as referee. For the duration of the plan (four weeks), however, the therapist refuses to engage in this negative pattern and instead uses the time in the office to help the couple create what they want to have happening in the home.

After giving the assignment, two main results are commonly encountered: either the partners will be successful and have an unusually good week, or a core problem (script issue) that remains from childhood will surface.

Appendix M -- Developmental Couples Therapy Coding System (DCTCS)

DEVELOPMENTAL COUPLES THERAPY CODING SYSTEM (DCTCS)

Couple No.: _____	Session: _____	Week No.: _____	Date: _____

Partner No. 1 (/)
Stage: _____

Problem-Solving Interaction (10 minutes)	Developmental Sense of Self														Developmental Sense of Coupleness											
	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-
0 - 2 minutes																												
2 - 4 minutes																												
4 - 6 minutes																												
6 - 8 minutes																												
8 - 10 minutes																												
Positive/Negative Measures																												
Combined Pos./Neg. Scores																												
Composite Dev. Score (plot)																												

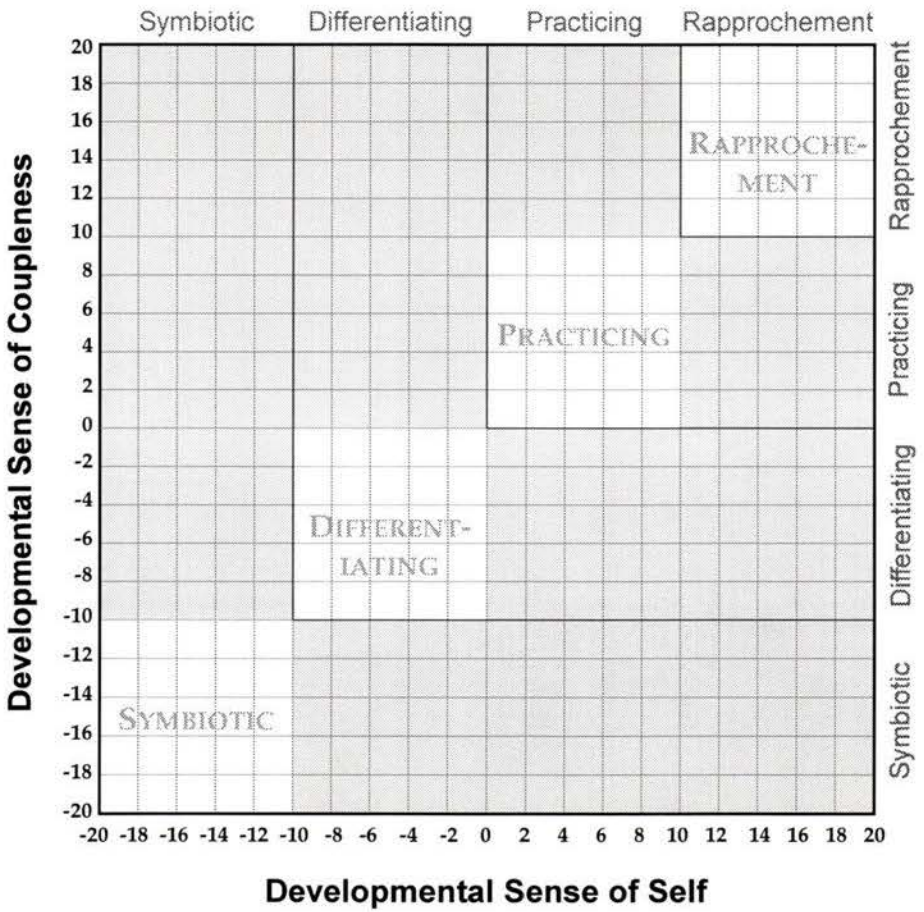
Partner No. 2 (/)
Stage: _____

Problem-Solving Interaction (10 minutes)	Developmental Sense of Self														Developmental Sense of Coupleness											
	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-
0 - 2 minutes																												
2 - 4 minutes																												
4 - 6 minutes																												
6 - 8 minutes																												
8 - 10 minutes																												
Positive/Negative Measures																												
Combined Pos./Neg. Scores																												
Composite Dev. Score (plot)																												

Appendix N -- Developmental Couples Therapy Graph (DCTG)

DEVELOPMENTAL COUPLES THERAPY GRAPH (DCTG)

Couple No. 1 Partner No. 1 ——— Partner No. 2 – – – –



Session Legend

Baseline	1	B1	(wk 1)
Baseline	2	B2	(wk 2)
Baseline	3	B3	(wk 3)
Treatment	1	T1	(wk 4)
Treatment	2	T2	(wk 5)
Treatment	3	T3	(wk 6)
Treatment	4	T4	(wk 7)
Treatment	5	T5	(wk 8)
Treatment	6	T6	(wk 9)
Treatment	7	T7	(wk 10)
Treatment	8	T8	(wk 12)

Appendix O -- Client Satisfaction Questionnaire (CSQ-8)

Client Satisfaction Questionnaire (CSQ-8)

Please help me improve my program by answering some questions you have received. I am interested in your opinion, whether they are positive or negative. *Please answer all the questions.* I also welcome your comments and suggestions (which can be written on back). Thank you, I really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

3. To what extent has the program met you needs?

4	3	2	1
Almost all my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend the program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you received?

4	3	2	1
Quite dissatisfied	Indifferent, or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent, or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to the program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

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October 25, 1995

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Author: [redacted]

Kenneth John Barabash
April 18, 1995