MARITAL COUNSELLING RESEARCH PROJECT

Three Studies:

1. A Broad Profile of Distressed Couples.
2. A Typology of Distressed Couples.
3. A Profile of Couples' Psychological Positions.

by

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RESEARCH STUDY 1 of 3:

A BROAD PROFILE OF COUPLES WHO SEEK MARRIAGE COUNSELLING IN IRELAND

INTRODUCTION

From 1990 to the present the Cork Marriage Counselling Centre undertook to maintain detailed records of it's counselling activities. The purpose of such documentation was to enable the agency to monitor its work in order to ensure that the services provided adequately addressed the needs of clients seeking help. We knew that it was absolutely critical that we develop a methodology to critically review service-delivery. This enabled the centre to adapt and develop in accordance with such reviews. We believe that research must play a central role in developing not only the agency, but also the marriage-counselling sector in Ireland. We have needed to know the demographics of our client base, what kinds of problems and concerns they present with, what kind of counselling is being offered, what kind of counselling is being delivered, as well as a host of other more specific queries. While it is difficult to blend the two perspectives when dealing with the realities of human distress and suffering, we believe it wise to espouse a scientist-practitioner model of sector development. That is, that the development of the marriage counselling sector must be equally informed by both the clinical experience of practitioners and the outcomes of reliable and relevant research. It is foolhardy to develop services without including a mechanism to critically evaluate the relevance, effectiveness, and efficiency of these services. It is from these beliefs that this present study emerges. It constitutes one of three studies completed in 1999-2000. The other studies in this trio examined the clinical issues and dynamics of couples presenting for counselling.

This study:

This study presents a sample of demographic and problem-definition statistics drawn from a large database of approximately 2,000 cases accumulated over an eight-year period. All of this material has been recorded on a computer database. Data recorded on the computer was first recorded by counsellors on terminating with a 'case' at the centre. This information was documented in a multiple-choice style questionnaire in which no identifying information for the clients in question were recorded.

The study presents a number of highly relevant statistics that can assist agencies in understanding how best to train and develop counsellors, the kinds of knowledge-base that is needed for agencies, the kinds of problems presented by couples, and the kinds of services that may need to be examined and developed. For the sample of 2,000 cases the following categories were recorded:

Broad demographic categories were: Marital status; age; phase of life; socio-economic level; years in the relationship; number of children; employment.

Problem-focused categories were: Presenting problem; duration of problem; alcohol abuse; domestic violence; barring order prevalence; psychiatric history; sexual abuse victims; suicidal ideation.

Counselling approach categories were: Goal of couple; type of counselling; counselling outcome.

This presentation will go through each category separately and highlight the possible meaning and implications of each finding. Following this, a broad summary will be drawn regarding the overall patterns that have emerged in the statistics. Implications, conclusions, and recommendations will be presented with a view to helping inform the marriage-counselling sector in Ireland.

PART 1:
DEMOGRAPHIC STATISTICS

The broad demographic categories used in this study were: Marital status; age; phase of life; socio-economic level; years in the relationship; number of children; and employment. Each category will be presented and followed by a discussion on the possible meaning and implication of the figures illustrated. (Please note that in most categories the totals do not add up to 100%. The discrepancy is due to situations where the information was unknown or not recorded).

MARITAL STATUS:

Single:	7%
Married:	68%
Separated:	16%
Widowed:	1%

Meaning:

Here we see something of particular relevance – i.e. 32% of people who come to a marriage counselling agency may not be married! There is a high percentage of people who are separated (16%) and of the almost 70% who are married, a considerable percentage of those are contemplating separation. The important learning in this is that the practice and service of an agency may often be considerably different than what is advertised or assumed.

Implication:

We must be aware that a term like "marriage-counselling" may have different meanings for different groups. The general public will likely see marriage-counselling agencies as a place where one can address issues that are related to marriage. Marriage counselling therefore is not seen as only a service for couples wishing to work on their marriage but also as a service for individuals and couples who have left or are leaving a marriage. People who have experienced or are experiencing marital breakdown will more likely seek the help of this service than couples who have a firm commitment to the relationship – obviously because of the different levels of distress experienced.

Recommendation:

Agencies need to consider what kinds of services are available to separated or separating people as much as for married persons. If the ethos or practice of an agency

is to 'support marriage', or to set up a service for married couples, then how does it reconcile this mission with the reality of peoples needs in the area of marital breakdown. Constitutional imperatives that impel the state to support marriage and family life may have to be understood from a more complex perspective. The reality is that supporting marriage must involve the support of separated and separating people. At the level of counselling practice it is clear that agencies and counsellors must attend to and work toward articulating the values and beliefs that underpin their work and to flesh out incongruities that may influence practice. The Cork Marriage Counselling Centre has developed a support and recovery group for separated people and runs an education programme for parents going through separation entitled 'Children of Marital Breakdown' . These are the kinds of creative options available to agencies

AGE:

20's:	18%
30's	38%
40's	23%
50'S+	11%

PHASE OF LIFE:

Courtship:	4%
Childbirth years:	22%
Middle years:	34%
Launching:	10%
Post-parental:	5%

YEARS IN RELATIONSHIP:

1-2:	11%
3-5:	12%
6-10:	14%
11-15:	15%
16-20:	12%
20 +:	16%

NUMBER OF CHILDREN:

None:	10%
One:	11%
Two:	24%
Three:	19%
Four+:	17%

Meaning:

These figures show a predictable spread across the decades. Contrary to popular opinion, couples in later life struggle with marital unhappiness with equal frequency to couples in the early to middle years.

Implication:

It appears that agencies and counsellors need to be informed and trained in issues affecting the developmental life-cycle of individuals and couples. Certainly, from these figures, the age-30 transition and mid-life issues will be affecting a large percentage of clientele. Also, for example, 15% of clients are in either the 'launching of children' or the 'empty nest' stages of family life. Helping families and couples with these issues require sensitivity to how the developmental tasks at this stage in life differ profoundly from other stages.

It is also important for agencies to be able to switch from a marital to a family focus. While individuals or couples may attend for counselling these figures are also a reminder of how many people can be affected by such intervention. We know from our work that children will always be affected directly by the effects of marital distress.

Recommendation:

All training programmes should incorporate components addressing life-cycle issues – i.e. the different stages in adult and family development. It would be worth alerting also to the vulnerability to ageism and the need to be conscious of targeting services toward couples in the latter stages of their life-cycle. Advertising campaigns must not just portray images of young married couples but also of elderly couples who may be lonely, estranged, or forgotten. There is an abundance of material and publications available highlighting these kinds of issues.

SOCIO-ECONOMIC LEVEL:

Poor:	6%
Working Class:	45%
Middle Class:	40%
Upper Class:	2%

EMPLOYMENT:

Him working: At least… 75%
Her working: At least… 45%

Meaning:

These figures are also not too surprising. The clients are drawn equally from different sections of the city. The objective of having quality services available in particular to disadvantaged or less-well off sections of the community is achieved. The setting of the agency and its availability to all sections of a community is extremely important. An agency's connection to a Church body may be of relevance in this context. Though the status of the Church in Irish society has been undergoing a fundamental change in recent times, it is reasonable to assume that, for many, the charitable ethos and non-profit stance of Church agencies contributes substantially to the positive image of a counselling agency – particularly for the less well off. In this context, the traditional notion of pastoral care may have some contemporary relevance.

Implication:

Defining the key pastoral role that different churches can play in providing marriage-counselling services may be important over the coming decade. The positive role that such churches can play should not be underestimated. The blending of civic, pastoral, and therapeutic objectives (as articulated by state, church, and profession) can be rich in both its practice and vision.

It is also worth noting and highlighting the implication of working predominantly with a working-class client base. It has been our experience that there are many ways in which the profession of counselling has been vulnerable to implicitly espousing more middle-class values. Much of the literature and practice of counselling is biased in this way.

Recommendation:

It would seem wise that an agency would articulate its ethos and mission statement. Such statements should probably not be definitive but rather 'works-in-progress' as a means of being vigilant regarding how it's implicit value systems will affect and govern how it delivers it's service. As a subset of such a venture, it might be wise that an agency and its practitioners would seriously consider how class values affect their work. In terms of sector development, the targeting of the more disadvantaged must remain a

priority. Agencies must, however, be conscious of how relationship problems in disadvantaged communities or families may be profoundly different to those with more social advantage. In addition, the counselling needs of disadvantaged or deprived families may also differ.

It is critical also that services and agencies must strive for not just best practice, but also best practice conditions. Just because an agency is a charity or voluntary should not imply that it does not invest in having suitable professional premises. The context within which counselling is delivered communicates to clients the kind of social value placed on the service.

PART 2:
PROBLEM-RELATED CATEGORIES:

First-contact made by:

Man:	14%
Woman:	86%

Type of Counselling:

Individual Female:	51%
Individual Male:	13%
Couple:	28%
Family:	6%

Meaning:

As is evident in clinical practice, in most marital situations the woman carries the responsibility for regulating the emotional satisfaction in the relationship. While the woman may not always be the first to notice a problem in the relationship, it would appear that she is the first to initiate action to change. (Research shows that not only are women the first to seek help for an ailing relationship, they are also more likely to initiate separation). It would also appear that men's sensitivity to issues of status and power mean that they feel more threatened or anxious when faced with the situation of seeking outside help. While woman may see a counselling situation as an opportunity for change, the man will often experience it as a threat to his status or self-sufficiency. Therefore, it will most often be the woman that makes the first contact with the centre. Consequently, our female individual clients are almost four times that of male clients.

Also, what we see is that almost 30% of clients are couples. This is not surprising. However, it is the approach of the CMCC to seek the presence of both partners as the ideal means of addressing marital difficulties. However, for a host of reasons this is not always possible – more often than not the reluctance of the absent partner (more often male) to consider or want help.

Implication:

The implications of these simple 'stats' are quite profound in what it reflects about gender roles in both social and family life. It asks fundamental questions about the emotional health of men and the emotional responsibilities carried by women. Assumptions can be made that the provision of marriage counselling is gender neutral

in its intent and practice, yet we know in reality that gender and related socio-political issues shape how services are delivered, perceived, and received.

Recommendation:

The disproportionate number of female clients compared to male clients is mirrored by an equal disproportion in gender distribution in the profession. In the field of counselling women are being helped by women counsellors. Agencies must continually be aware of the often profound gender dynamics that influence the work. Agencies may need to consider how it can offer services that may address men's needs. The agency may also need to consider it's own gender balance and how that effect's its practice and procedures. Also, in couple counselling, the situation will involve two women in the room with one man. Advanced training needs to heighten a counsellor's awareness of the implications of this situation and to consider how the counsellor's gender biases affect his or her practice.

Agencies do need to consider how men's issues may be appropriately addressed within its service strategy.

DURATION OF PROBLEM

One month:	1%
One year:	19%
1 + years:	71%

Meaning:

As can be seen, in most cases problems are fairly long-standing and often chronic. As with medicine, it would of course be more desirable for couples or individuals to seek early intervention in the development of a problem. It is understandable, however, that people usually seek to exhaust their own remedies before seeking outside intervention. It is a positive fact that more and more people seem now to consider counselling as an acceptable option. However, the reality is that what is presented in the counselling situation is frequently long-standing.

Implication:

An implication of this, and borne out by our clinical experience, is that many people will wait until there is a major crisis before seeking help. This often means that in practice counsellors are dealing with very distressed men and women who are trying to cope with a multi-problem relationship. Very often this is too late for remedial help, as the problems have escalated in severity over many years with the personal wounding that ensues.

Recommendation:

Agencies and counsellor's are obliged to consider the varying ways in which client's seek counselling. An agency must also distinguish between different types of counselling such as crisis-intervention; problem-focused intervention; non-directive listening; psychotherapy; solution-focused counselling; addiction counselling; abuse related counselling, etc. Agencies need to consider the usefulness of different approaches with different kinds of problem-scenario. Also, given the duration of problem cycles it is important that advertising or publicity would encourage couples to seek intervention prior to reaching a point of serious crisis.

GOAL OF COUPLES

Improve satisfying relationship:	3%
Improve relationship with some satisfaction:	19%
Improve relationship with little satisfaction:	36%
Decide whether to continue in relationship:	31%

Meaning:

The level of satisfaction experienced by couples is obviously fairly minimal. Almost a third of couples included at least one partner who needed to decide whether the relationship would continue. This kind of counselling intervention often involves what one might term 'emotional mediation'. This is often needed in situations where it is not possible for a couple to engage in couples counselling as the very future of the relationship is in serious doubt. The skills necessary for such work are quite different from those of marital counselling where there is a shared objective between couple and counsellor.

Implication:

At stated at the outset of this study, the reason that research is so important is because it highlights these kinds of issues – that is that marriage counselling may not be what many clients are seeking. (Marriage counselling is used to here to refer to counselling with couples who wish to work on maintaining and improving their relationship). The implication of this is that the training and orientation of counsellors must mirror the practice of the agency. It may be necessary to develop a speciality in emotional mediation as a precursor to legal mediation – i.e. readying couples for such a process. This is particularly difficult when one partner wants out of the relationship and the other does not. An additional implication may be the need to let the public know that separation-counselling or emotional mediation is an available service.

Recommendation:

It would be worthwhile for agencies to study the profiles of couples seeking help and to seek appropriate agency development and training that would assist counsellors in responding meaningfully to client needs. Counsellors need to have acquired sophisticated psychological sensitivity to the complex of concerns facing couples in these situations. An experientially based knowledge of the dynamics of these concerns must be part of the formation of practising counsellors. In addition, given that many couples are on the brink of break-up, and many individuals seek and need some knowledge of the law, it is important that an agency has access to experts in family law and that counsellors develop a working knowledge of family law procedures.

Alcohol abuse:

Yes:	25%
Men:	21%
Women:	4%

Meaning:

The devastating impact that alcohol abuse can have of marriage and family life cannot be overstated. It is not surprising to find the vast majority of such abuse confined to men. Many of the stories and experiences regarding alcohol abuse in the family are quite harrowing. Drinking problems take many forms however. It can be a chronic issue in a marriage and prevalent to such a degree that both partners have learned to tolerate and accept it as part of the fabric of their lives. In many instances the wife in

these marriages will come to the centre seeking help in trying to cope with a problem-drinking husband. Whatever the scenario, the effect of alcohol can be devastating – in particular for children. Many of our adult clients are 'adult children of alcoholics'. The social ambivalence regarding the abuse of alcohol is something that must be confronted if the emotional lives of children in these homes are going to be of concern.

Our ambivalence about this issue has reached the point where appalling statistics like this are accepted as normative. Yet if the drug of abuse were of another variety there would be social outrage and scandal. The 'emotional bleeding' silently suffered by children in these families is immeasurable because it is of such endemic proportions.

Implication:
Counsellors and agencies need to be able to illustrate a working expertise in this area. The role modelling for children and adolescents given our social ambivalence regarding alcohol abuse is most disturbing. At a social level, the abuse of alcohol is a grave public health issue. The effects of alcohol abuse, as a drug, on all members of a family are often shattering. Unlike visible trauma, like the effects of 'drink driving', the emotional trauma caused by alcohol abuse on countless families across Ireland is endemic.

Recommendation:
We would recommend that there needs to be an inter-departmental and cross-party commitment to putting in place a major public health and public education campaign that seeks to confront this ambivalence. Given the silent abuse of children in many of these homes, for their sakes it is timely that one should call again for extremely strict guidelines regarding the dispensing of alcohol. Is it pointless to recommend that this form of drug abuse should be made illegal? Recent publicity regarding the extent of teenage drinking has highlighted this issue once again. Our social ambivalence is apparent when we find ourselves suggesting that the abuse of this drug is bad for teens but ok for me. Why avoid the reality that it is toxic for everyone?

At an agency level, it is essential that counsellors have developed a working expertise regarding alcohol abuse. This must be a core element in professional training. In addition, it is also vital that agencies set up a working relationship with alcohol and drug-addiction treatment centres as well as other resources such as AA and Al-Anon. Without such resources counselling agencies will be unable to deal adequately with this

most serious problem and will invariably collude at times with the denial and minimisation of the drinker.

DOMESTIC VIOLENCE

Yes:	34%
Male Perpetrator:	18%
Female Victim:	16%
Female Perpetrator:	1%
Male victim only	1%
Mutual violence	3%
Barring order in place:	9%

Meaning:

These kinds of figures were brought to our attention via our internal research in 1991. Having studied the issue for a year the centre deemed it necessary to set up a specialised counselling and treatment 'track' for clients who present with domestic violence as part of their presenting problem. This intervention included treatment programmes for perpetrators of domestic violence and support groups for victims. Men perpetrated the preponderance of this violence. Throughout the nineties we struggled to keep pace with the enormity of the issue and the extent to which it was prevalent. The centre has published extensively on this issue. Somewhat like alcohol abuse, this is an issue that has historically been minimised and gone un-addressed. The extremes of abuse and violence perpetrated in homes are most disturbing and we are pleased that in recent years the issue has received more public attention.

Other research conducted has shown that there are also a percentage of couples that present as 'borderline', which refers to forms of extreme chaos, addiction, mental illness etc which often incorporates incidents of mutual expressive violence. This population comes to approximately 3%

Implication:

The fact that violence is invariable linked with other forms of emotional abuse has shown that this kind of violence is rarely just an incident but rather a pattern of

coercive control that is exerted by the man. The CMCC developed the Cork Domestic Violence Project as a means of responding unambiguously to this issue.

Recommendation:
Our experience is that there should be an obligation on every agency to address this issue as a priority. An agency needs to develop practice procedures and intervention strategies with this issue and should consult with known experts in this area in order to ensure that it responds adequately to this issue.

ABUSE PRESENT IN RELATIONSHIPS:

Yes, at least: 62%

Meaning:
Considering the extent to which violence, alcohol abuse, psychiatric illness, infidelity, borderline personality disorder, and such disturbing conditions appear with couples and individuals who are seeking counselling, this figure should not be surprising at all. The meaning of this is extremely disturbing for it illustrates that most distressed couples are in abusive relationships within which the integrity and rights of at least one partner are being violated in psychological, emotional, or even spiritual ways. Abuse involves various forms of disrespect, ill-treatment, cruelty, neglect, exploitation, etc. Within the home this may involve physical violence, emotional abuse and intimidation, scenes of roaring and shouting around children, sexual abuse, drunken fights, drug abuse, threats of suicide or homicide, psychological control, etc. It is a tragic reality of many families.

Implication:
The effect of this reality impinges most on young children who are proximate to this kind of behaviour. Where this behaviour seems extreme it is often necessary to report or consult with the Health Board. The effect on counsellors and agencies is profound. However, if an agency is not engaged in responsible research and self-critique, these effects can often go undetected, denied, or minimised.

Recommendation:

Agencies must learn to work with issue of abuse in a collective way. A 'private practice' model of counselling seems particularly inept in these instances in that counsellors can be left, or permitted, to carry case-loads of clients within which serious abuse is occurring. Experience shows that counsellors will inadvertently begin to collude with clients who seek to minimise or avoid such behaviour. Collective supervision, support systems, and intervention protocols are necessary to ensure that counsellors are working in a system that holds them accountable for their practice.

At a public health level, the endemic nature of abuse among distressed couples and families suggests that, along with issues of alcohol abuse and domestic violence, public health campaigns aimed at identifying and encouraging alternate emotional health promoting behaviours are warranted. The need for such a campaign and strategy is most serious. Emotional suffering, unlike physical injury, goes unseen and unrecorded. This research puts it on record.

OTHER SERIOUS ISSUES:

Psychiatric history: 11%
Suicidal ideation: 10%
Sexual abuse survivors: 9%

Meaning:

These figures are clustered together to illustrate again the serious nature of the issues emerging within the counselling. As with other identified problems, there are discreet needs experienced and expressed by clients within each of these categories. With regard to psychiatric history, people who have suffered from a major affective disorder (e.g. bi-polar disorder, major depression, anxiety disorders) require a more informed and sensitive form of assistance than other clients. It appears also that a large percentage of those who have suicidal ideation may have had psychiatric treatment, or at least medical treatment, for depression in the past. Many client's seek counselling because of their disillusionment with traditional forms of psychiatric care. In addition, many clients (including both men and woman) attend for counselling with sex abuse issues central to their distress. Other clients disclose sex abuse within the framework of couples or other counselling.

Implication:

The meaning of these figures is that, again, there is a great obligation on agencies to bring considerable expertise to bear when offering to assist people with these kinds of issues. Appropriate referral systems are needed. For an agency to offer a marriage counselling or related service there is a professional responsibility for that agency to be able to show ability to appropriately address and cope with these kinds of issues. An agency must be able to detect psychiatric illness, must know how to liase appropriately with medical professionals, must know the limits of it's own competence, must have specific expertise in responding to disclosures of sex abuse, must have supervisory expertise available, and must know how to respond and handle issues pertaining to suicidal impulses.

Recommendation:

The counselling sector should encourage accountable and professional practice and provide a checklist of resources that are essential structural and procedural requirements for any agency. Counsellors need supervisory assistance in dealing or working with these, and other, kinds of issues given the varied issues at stake. Given that most counsellors do not have the necessary experience or expertise to be able to work with these kinds of issues on a kind of private basis, agencies must develop procedures that ensure that the agency carries overall responsibility for practice.

Counselling Outcome:

Problem Resolved:	15%
Still present but coping:	32%
Problem Unresolved:	25%

Meaning:

These figures are quite sobering. Counsellors believe that in 15% of cases they felt the problems for which the couples sought help were resolved. In a further 32% they felt that the problem had not been eliminated but that the clients had learned to cope with them. In 25% of cases the counsellors felt that the problems experienced by the clients were unresolved. For those of us working in the field, this is not surprising. More

sophisticated outcome studies have shown that the intervention of counselling in peoples lives is, in the preponderance of cases, a helpful experience. However, these figures mirror the seriousness of issues highlighted above and the likelihood that many clients present as multi-problem and a lot of counselling is aimed at assisting people to cope with often unchanging circumstances.

Implication:

An implication here is that agencies must not make assumptions about the effectiveness of their work too readily. Expanding or developing services without also incorporating evaluative systems is foolhardy.

Recommendation:

Agencies must critique their own services on an on-going basis and be prepared to redesign or even terminate certain programmes or counselling strategies if it appears they are ineffective. It may be wise for agencies to develop services that are targeted to specific populations or problems. This enhances evaluative possibilities and guards against complacency.

SOME IMPLICATIONS FOR THE PRACTICE AND DEVELOPMENT OF THE MARRIAGE-COUNSELLING SECTOR IN IRELAND

Demographic issues:

The profiles of clients in terms of age, marital status, and income illustrate the importance of linking sector development to research findings. The uncomplicated demographic statistics illustrate that those who use the services of a marriage counselling agency are varied in terms of age, marital status, income level, and their goal is seeking help. As a voluntary agency a significant proportion of those who use the services will come from the poorer sections of the community. Also, when we think of couples who are experiencing difficulty the image tends to be of a younger couple with small children, however the statistics highlight that older couples with departing young adult children are as likely to seek assistance.

As with other professional services, those who get the education and training necessary to develop and practice tend to come from more middle-class backgrounds. Therefore, one must be cognizant of how such values impinge on how services are developed and delivered to poorer or working class clientele. Counselling, as a profession, does not responsibly attend to the realities of life for families form disadvantaged backgrounds and areas and the kinds of counselling they need. Clearly, because of social disadvantage, many clients present with relationship problems that are set within the sub-culture of the disadvantaged. This study serves to highlight the need to address this issue.

Multi-problem couples in crisis:

The findings in this study highlight an extremely important issue that needs to be emphasised. This is the level of emotional crisis experienced by couples and individuals who seek assistance with relationships. As a supervisor and daily monitor of cases coming into the city centre, the level of distress experienced by clients is quite profound. At times it has felt like the emotional equivalent of a hospital emergency room because of the degree of trauma and wounding suffered by people in families. The crises emerge from issues of attachment, separation, loss, abandonment, abuse, and fear. Our supervision groups reveal the moving stories of people's lives struggling to cope with a host of traumas. This may be an elderly woman who, after 40 years, can no longer cope with her husband's drunken and abusive tirades. It may be a young woman trying to break free of the legacy of her mother's mental illness, neglect and

abuse and her now caught up in a heartless relationship. It may be an adult survivor of child sex abuse struggling to understand the void and emptiness in her life. It may be a married man who has lost his wife and children and is now suicidal, unable to cope with the abandonment. Or it may be a distraught woman trying to come to terms with her husband suddenly leaving their marriage for another woman. The tears and anguish that pours forth in these kinds of life situations are compelling and demanding of counsellors working with these clients.

It is important therefore that those who support these agencies gradually begin to get a feel for the intensity and seriousness of the work that is undertaken. A lay perception may be that the bulk of marriage counselling is about helping couples to learn to communicate and teaching problem-solving skills. Regretfully, cases as straightforward as these are not frequent enough. There are many couples, at the same time, who do not come as multi-problem-couples-in-crisis but these are more the exception than the rule. Given the critical nature of presenting problems this study therefore illustrates the need for advanced and sophisticated service resources.

Violence and Abuse related issues:

The Cork Marriage Counselling centre has sought over many years to develop an adequate response to the issue of abuse and violence in relationships. This study highlights again how prevalent is this issue. Given the consequences for women and children in many of these situations it is incumbent on those who encounter this issue to know how to intervene. *It is a fact that many people may seek counselling when counselling may not be what they need. They seek counselling because they hope that it may be a place of refuge, or a place where they can get information or wise guidance regarding how to handle a serious situation.* Regretfully, many counsellors fail to adequately assess the client's life needs and therefore advise further counselling when it may be inappropriate. Agencies need to know how to assess these kinds of situations and be able to offer more relevant or adequate alternatives. For example, if violence were present it would need to be fully assessed to ensure that the victim of violence is helped in her pursuit of safety. Couple counselling, in most such instances, increases the danger to the victim and set's her up for further disappointment. However, as stated earlier, the extent of these issues demands specialised responses.

Alcohol related issues:

The extent of alcohol abuse in marriage and family life is extremely disturbing with about one quarter of all clients being troubled by a drinking problem. The effects of alcohol abuse on marriage and family life is quite devastating. Alcohol in many cases utterly destroys the fabric of health family life and leaves a legacy of neglect, abuse, chaos, and wounded children to an extent that we as a society do not really want to know. The level of social denial regarding this issue is staggering. At an agency level the need for integration of services with alcohol treatment programmes is essential as is the development of supervisory expertise in this area.

Gender issues:

The fact that counselling is a service provided predominantly by women and is a service used predominantly by women is an issue that must remain at the foreground of how the sector develops. An obvious goal must be how can we get men more open to seeking help. Consideration should be given to how programmes and services can be designed with this fact in mind.

The social institution of marriage

Many people feel trapped in relationships, and this experience can be emotionally demoralising over many years – particularly where it is not possible within the relationship for that person to explore this reality, often out of guilt, fear, or even intimidation. It is my personal view that the social contract for marriage will likely need to be revised in future generations because the 'until death do us part' clause is becoming less substantive. A hundred years ago 'until death do us part' was a reasonable objective, given the high mortality rate of young adults. At least one partner would likely have died before mid-life. It is a little known fact that in the previous century the number of children growing up in single parent households was far greater than it is at present, because of parent mortality. Because we are living 20 years longer than in the previous century, the toll of a loveless marriage weighs enormously on society with ever increasing numbers of broken marriages. The social reality in many western countries is that the breakdown rate is approaching 50%.

Therefore, it is worth considering the emphasis on marriage commitment and the need to measure marital success in terms of respect rather than longevity. The successful marriage being one within which mutual respect for the dignity of each partner is maintained, for however long the marriage lasts, rather than one that stays intact until death. Is it worth considering, therefore, that the marital contract be time-limited

where 'death' is seen not as physical death but psychic and spiritual death. From a religious perspective, is not sacramentality maintained and lived within the context of mutual respect and violated by chronic abuse, violence, or humiliation. Many victims of abuse have realised through horrible trauma, that the spiritual and psychic death of their marriage is what is meant by 'until death us do part'. People could, depending on the presence and needs of children, marry for 'life' rather than 'until death' – where 'life' could be considered in terms of units of ten years.

Though such thinking requires considered debate there are many positive outcomes than can be associated with this form of reorganization. Couples, could then, at key points in their life-cycle, renegotiate a new marriage with each other if so desired. Many couples come to our centre because their 'old' marriage has died and they are faced with this psychic death which forces them to renegotiate a new and more respectful marriage, or chose to go their separate ways. Marriage counselling, in effect, provides couples with a form of renegotiation. However, if the institution of marriage encouraged couples to undertake such stock-taking as a necessary part of the evolution of marriage, rather than as an option chosen only in crisis, it would reflect the social reality of marriage today. Other consequences of this would introduce the element of personal freedom which, when absent, causes huge hardship for many people feeling trapped in loveless marriages; reintroduce the element of choice to marriage; dispel the social stigma and shame that attends the process of marital breakdown and separation for adults and children; would eliminate much of the trauma suffered by families where separation or 'breakdown' occur by normalising what is still socially perceived as a failure; rekindle traditional romance and religious faith in married life; oblige couples to 'work at' their relationship to ensure its survival; prevent couples from turning their frustration on each other and their children; allow an escape hatch for the huge number of women caught in abusive and violent marriages; allow people whose children have grown to leave a marriage with social dignity and respect; and allow a huge element of fresh air to flow into the institution of marriage. In an age of rapid social and cultural change, unless we learn to rethink our assumptions about the nature of marriage, it's integrity as a social institution becomes increasingly damaged.

<u>Agency development, standards, protocols, and values</u>

All of the issues raised above, and revealed in this study, illustrate the enormous responsibility carried by agencies that offer marriage-counselling services. This study

serves to underline some key areas that require special attention. The implications of some of these findings are to raise some important questions:

1. Does the agency have a clearly delineated code of ethics and practice?
2. Does the agency have the necessary professional supervision to ensure good practice?
3. Does the agency have clearly delineated sets of protocols for dealing with a number of very serious situations?
4. Does the agency have expertise available in the areas of family law, alcohol abuse, domestic violence, sexual abuse, and mental illness?
5. Does the agency have a method for assessing appropriately the needs of clients?
6. Does the agency have referral systems in place?
7. Does the agency have methods and protocols in place to facilitate basic research into its work?
8. Does the agency have a mission statement or value-system that both informs its work and sets appropriate priorities?
9. Does the agency have the flexibility to engage with socio-political issues such as domestic violence and sexual abuse?
10. If part of a church setting, does the agency have the flexibility to challenge that church?
11. Does the agency take legal responsibility for the work of its counsellors?
12. Are counsellors working within the agency fully accountable to that agency for their work?
13. Has the agency considered its value systems regarding working with the poor or disadvantaged?
14. Is the agency capable of providing crisis counselling for couples in distress?
15. Is the agency skilled enough to provide emotional mediation and conflict resolution?
16. Is the agency committed to teamwork, as distinct from private-practice models of counselling, as a means of enhancing accountability and quality?
17. Does the agency recognize problem issues that require specific expertise, or has the agency delineated the limits of its competence and services?
18. Is the training provided for agency practitioners commensurate with the levels of distress encountered in practice?
19. Is the method of counsellor selection, accreditation, development, and supervision, sophisticated and adequate enough for practice?

These are but a sample of questions that emerge from this study. Each question is somewhat rhetorical for the response to each must surely be in the affirmative. If not, then there may be a real need for the sector to develop a blueprint of structures, procedures, and resources necessary for development as an agency.

The statistics presented in this study are but a fraction of what is available and can be researched. Hopefully this study will illustrate the key role that basic research can play in developing counselling practice, promoting agency development, and in building a blueprint for the development of the marriage-counselling sector in Ireland.

RESEARCH STUDY 2 of 3:

A TYPOLOGY OF DISTRESSED MARRIAGES

ABSTRACT

A CLASSIFICATION OF DISTRESSED MARRIAGES

This study constituted an exploration of the psychological 'architecture' of distressed marriages by examining the potential for developing a psychological-systemic classification of such marriages. It attempts to be part of an emerging movement within psychology to explore the potential for developing relational, rather then individually focused, classification systems. The overarching question addressed by this study was: Can distressed marriages be reliably classified into types in a manner consistent with interpersonal theories of personality. It looked at marriages as documented in the rich case-note material of 340 couples that presented for marital therapy. This study, when integrated with existing research, contributes to the sparse literature on marital typologies and provides data to further clarify concepts for interpersonal classification and diagnoses. In a cultural context, it represents the first and only comprehensive examination of distressed marriages in Ireland and thus contributes to the development of the fields of marital and family therapy.

Findings and Conclusions:

The research problem being investigated was broken down two separate but related research questions. 'What is the distribution of personality disorders and related personality styles among subjects?' and 'Are spouses with specific personality disorders/styles significantly more likely to be paired together?'

The research found that spouses with particular personality styles, as assessed using a structural analysis of social behaviour, are more likely to be paired together. The primary types that emerged in the study were as follows (with the male type identified first); the abusive/abused relationship; the alcoholic/co-dependent relationship; the passive-aggressive/compulsive relationship, the passive-aggressive/dependent relationship, the borderline/borderline relationship, the compulsive/histrionic relationship, and the narcissistic/dependent relationship. The data therefore showed that couples present in marital therapy with predictable interaction structures that can be clustered according to type consistent with interpersonal and systems theory.

The research also identified the primary personality styles by gender. For men these were: passive-aggressive, abusive, avoidant, borderline, and narcissistic personality

styles. For women, the primary personality styles were dependent, compulsive, abused, borderline, and histrionic.

The research adds data to support the development of systems of classification that may compliment the current individually based nosologies of the Diagnostic and Statistics Manual commonly used in making psychological and psychiatric diagnoses. The findings contribute substantially to the growing need to develop categories that can assist professionals in describing and communicating about couples both within their professions and to couples themselves.

INTRODUCTION

This research constitutes a collaborative venture between the Department of Social Community and Family Affairs and the Cork Marriage Counselling Centre to undertake original research in the area of marriage counselling as a means of helping to inform family policy. The study will contribute toward developing a knowledge base pertinent to the Irish context. In particular, this research will assist in understanding the social and psychological issues affecting marital distress. It will constitute an exploration of the architecture of distressed marriages by examining the potential for developing a psychological-systemic classification of such marriages. The usefulness of the study will lie in determining the degree to which the diversity and variety of marital problems can be reliably classified in a manner consistent with psychological and systemic theory and thus inform clinical practice.

Classification is vital to the development of any science or body of knowledge. To the degree that we are unable to use language to put order on our observations and experience then we are unable to advance our understanding and communicate accurately about that which is being observed. Words are the lens through which we bring blurred complexity into focus. Words, of necessity, classify.

The history of psychology and psychiatry can be understood in terms of the struggle to develop and refine concepts, classification systems, and diagnoses. To date, most of our systems of classification have been in terms of individual psychology and psychopathology. This present study will, however, attempt to be part of an emerging movement within psychology to explore the potential for developing relational, rather then individually focused, classification systems. This movement (Kaslow, 1996) presents a strong case for the need to develop concepts and categories through which one can build a relational diagnostic schema. Practitioners working with couples and families (Fischer & Ransom, 1995) have struggled to advance their knowledge base in the absence of typologies or classification systems to help assess distressed relationships. Clinicians have often had to convert their dynamic formulations of relational difficulties into individual-focused categories in order to remain consistent with DSM-IV (American Psychiatric Association, 1994) categories. Reiss (1996) suggests that there is now a consensus in the field to develop an approach to this classification of relationships. Such a classification could stand as both a

complementary and, if necessary, alternative nosology to individual focused classification systems. Finally, from the perspective of service delivery it will be apparent that developing a schema for appropriately classifying presenting problems by frequency and type will be essential in designing services, training professionals, and funding projects.

This study will contribute to this development by examining distressed marriage relationships, as they have appeared for marital therapy, through an interpersonal and systemically focused lens and thus explore the extent to which such marriages can be classified using such psychological-systemic concepts. It will thus constitute an exploration of both the structural 'architecture' and the dynamic processes of these relationships. It will contribute toward a more sophisticated understanding of the differences between couples, the nature of marital distress, and how relational patterns and dynamics may constitute discreet diagnostic categories. As Kaslow (1996) put it:

> "Relational diagnosis is a concept whose time has come." (pg. vii)

METHODOLOGY

Statement of Problem

The overarching question addressed by this study is: Can distressed marriages be classified into types consistent with interpersonal theories of personality? There are then, in effect, two research questions to be answered. Firstly, what is the distribution of personality disorders/styles among spouses in the sample? And, secondly, are certain personality styles/disorders more likely to be paired together to thus constitute an identifiable marital type?

Research Design

The presence of specific personality types was measured using Benjamin's interpersonal categories and personality disorder checklist (Benjamin, 1996; Appendix 1) as well as the therapist's clinical assessments of personality styles and disorders with reference to DSM-IV criteria. These measures resulted in broad diagnostic impressions of individuals and couples. Therefore the predominant personality style of each spouse was determined. This research question resulted in descriptive statistics that were a measure of the distribution of personality disorders/styles in the sample.

Method

Selection of Subjects:

The single site chosen for this study is a marital therapy agency in which the phenomenon of marital types was explored. The research was based on documented case files of 400 couples that attended for marital therapy. (Sixty of these cases were eliminated from the study because they did not contain sufficient data.) The site provided documents which were information-rich cases for study-in-depth by using both purposeful and comprehensive sampling.

Materials and procedure

The following constitute the procedure and materials utilized in this study.

1. For each marital therapy case the therapist completed a (1) Intake form (Appendix 2), (2) Problem summary form (Appendix 3); (3) Progress notes sheets (Appendix 4); and (4) A Case-closure form (Appendix 5). These forms were designed for clinical use in summarizing client and case material. The categories employed constituted straightforward demographic categories, problem descriptions, and problem

categories to facilitate data gathering and clinical supervision. The 'Progress notes Sheets' were blank and unstructured allowing the therapist to document clinical impressions in narrative form. All of this material together constituted a case file and presented a rich portrait of the couple in therapy.

2. Based on the material documented in (1) the researcher made a clinical assessment of the predominant personality style or disorder for each spouse using Benjamin's diagnostic criteria (1996). This assessment was made using a comprehensive checklist of core criteria developed by Benjamin (1998) for each personality style/disorder (see Checklists on next page)). The 'Checklist of Core Criteria' for each personality style/disorder is a tool designed by the researcher but adapted directly from Benjamin's formulations of the core diagnostic criteria for each personality disorder. The researcher took Benjamin's categories and recast them with reference to the marital relationship without changing the interpersonal content of any category. This was done to facilitate a more immediate interpretation of Benjamin's categories for therapists. The checklists were designed to summarize the key interactive processes of each individual under five headings:

- Behaviour initiated toward the spouse.
- Behaviour exhibited in response to the spouse.
- Behaviour and attitude toward the self.
- Necessary criteria for the presence of a particular interpersonal style.
- Exclusory criteria, which exclude particular interpersonal styles.

3. A distribution table illustrating the diagnostic categories for each couple was formulated. This table illustrated the frequency with which each diagnostic pair (i.e. the personality style or disorder for each couple - e.g. borderline-narcissistic) was found to exist in the data.

FINDINGS

The data supported the hypothesis that discreet marital types can be found in a population of couples attending a city-based marital therapy agency. The data showed that couples present for marital therapy with predictable interactive structures that can be clustered according to type consistent with interpersonal and systems theory. The results show that certain styles, as assessed using Benjamin's SASB diagnostic criteria, were more likely to be paired together. Figure 1 presents a frequency distribution table of couples classification according to each partner's personality style 'diagnosis'.

Primary Marital Types:

As can be seen from Table 1, a number of discreet marital types emerged from the data. These dyads, in order of frequency, were (with male first and female second) 'Violent Man - Abused Woman'; 'Passive Aggressive Man - Dependent Woman'; 'Passive Aggressive Man - Compulsive Woman'; 'Alcoholic Man - Co-dependent Woman'; 'Borderline Man - Borderline Woman'; 'Narcissistic Man – Dependent Woman; Compulsive Man – Histrionic Woman; and Avoidant Man – Dependent Woman.

Personality Styles by Gender:

The overall frequency distribution of personality styles among couples by gender is presented. As shown, the top five personality styles displayed by men in the therapeutic situation were passive aggressive; violent/abusive; avoidant; borderline; and narcissistic. The top 5 styles displayed by the women were dependent; compulsive; abused; borderline; and histrionic.

Statistics**:**

The data is presented as descriptive statistics with associated frequency distributions. With 196 possible pair cells in Table 1, the expected frequency for any cell should be approximately 2. However, given the personality styles do not appear in the general population with equal frequency, it is not appropriate to use this estimate. Therefore, a simple frequency distribution table of the couple diagnoses will suffice to present and summarize the data. It is self-evident from the table, which pairs appear with significant frequency. So, in terms of the hypotheses it can be concluded that spouses with specific personality styles are significantly more likely to be paired together.

TABLE 1: MATRIX OF COUPLE 'DIAGNOSES'

The number in each cell represents the number of couples receiving this classification where N = 340. For example, cell 'B-B' shows 21 meaning that 21 couples out of the sample of 360 were classified with both partners behaviour being 'borderline'. See Key for Interpersonal Style abbreviations.

HER \ HIM	B	N	H	A	D	C	PA	AV	PN	SZ	ST	AA	V	AB
B	21	1	1		3	1	3	3	1				2	2
N		2	1		7	1	3	1						
H	2	3	2	2	2	14	1	5	2	2	1		1	
A										1				
D	4	16	1	1	2	1	31	11	1	2				2
C	3	2	4		7	1	32	9		1				
PA	1				3	4	2	2						
AV		3	1		1	1	4	2						
PN		1			2		3	1	1	1				
SZ					1					2				
ST					1					1				
CO	1	1										25	1	
V														2
AB													48	1

B = Borderline; N = Narcissistic; H = Histrionic; A = Antisocial; D = Dependent;
C = Compulsive; PA = Passive aggressive; AV = Avoidant; PN = Paranoid; SZ = Schizoid;
ST = Schizotypal; AA = Alcoholic; CO = Co-dependent; V = Violent; AB = Abused.

Note: There is no category of V or AA included in her list, nor CO or AB in his list, in this final diagram in order to reduce it's size. This does not imply that these categories are not legitimate.

The predominant relationship types that emerged, in order of frequency, where N = 360 and where the first part of the pair refers to the man and the second to the woman:

1. Violent/Abusive - Abused (48)

2. Passive Aggressive - Compulsive (32)

3. Passive Aggressive - Dependent (31)

4. Alcoholic - Co-dependent (25)

5. Borderline - Borderline (21)

6. Narcissistic - Dependent (16)

7. Compulsive - Histrionic (14)

8. Avoidant - Dependent (11)

9. Avoidant - Compulsive (9)

10. Dependent - Compulsive (7)
Dependent - Narcissistic (7)

11. Avoidant - Histrionic (5)

12. Borderline - Dependent (4)
Passive Aggressive - Avoidant (4)
Histrionic - Compulsive (4)
Compulsive - Passive Aggressive (4)

13. Dependent - Borderline (3)
Passive - Aggressive - Borderline (3)
Avoidant - Borderline (3)
Passive aggressive - Narcissistic (3)
Narcissistic - Histrionic (3)
Borderline - Compulsive (3)
Dependent - Passive Aggressive (3)
Narcissistic - Avoidant (3)
Passive Aggressive - Paranoid (3)

FIGURE 3
The predominant personality styles as exhibited by sex were as follows:

For Men:

1. Passive Aggressive (80)
2. Violent/Abusive (54)
3. Avoidant (34)
4. Borderline (32)
5. Narcissistic (30)
6. Dependent (29)
7. Alcoholic (25)
8. Compulsive (23)
9. Schizoid (10)
10. Histrionic (10)
11. Abused (5)
12. Paranoid (5)
13. Anti-social (3)
14. Schizotypal (1).

For Women:

1. Dependent (73)
2. Compulsive (59)
3. Abused (49)
4. Borderline (38)
5. Histrionic (37)
6. Co-dependent (28)
7. Passive Aggressive (12)
8. Avoidant (12)
9. Paranoid (9)
10. Schizoid (3)
11. Violent/Abusive (2)
12. Schizotypal (2)
13. Anti-social (1)
14. Alcoholic (1)

The Types

The findings, therefore, show that there are specific identifiable types of couple relationships that present for marital therapy. This section will present a descriptive overview of each of the primary types identified in the study in narrative and diagrammatic form consistent with interpersonal descriptors. Each of these types will be examined in the analysis of findings. The following constitute the primary dyads identified in the study with possible descriptive labels.

1. Husband Violent/Abusive & Wife Abused
2. Husband Passive Aggressive & Wife Compulsive
3. Husband Passive Aggressive & Wife Dependent
4. Husband Alcoholic & Wife Co-dependent:
5. Husband Borderline & Wife Borderline:

The first five types are presented with the aid of both a descriptive and diagrammatic summary. The descriptive summaries are presented in this section. Diagrammatic theoretical summaries of each of the primary types are presented in the accompanying diagrams. These latter summaries are compiled based on integrating personality theory, interpersonal theory, and systemic thinking into an integrated visual portrayal of each type. The narratives represent an integration of Benjamin's interpersonal descriptors and the researchers diagnostic impression as emerged in the case material.

It is worth repeating a few caveats when interpreting this data. Firstly, behaviour has to be understood from a systems perspective. So, for example, instead of talking about a passive-aggressive husband the discussion will talk about passive-aggressive behaviour by a husband in relation to, say, compulsive behaviour by his partner, and vice versa. This systems perspective is central to the interpretation of the data. Secondly, to be consistent with a systemic perspective, this behaviour is understood as being displayed within a particular context (therapy) and at a particular points in time (a session or sequence of sessions). This perspective allows one to consider the meaning of any behaviour when it is placed in a systems context. So the analysis here is confined to the therapeutic situation with a central emphasis on interactive concepts and units where the relationship *between individuals* is given primacy over the dynamics *within individuals*. (A diagrammatic summary of each type is presented in the following pages. A description of each type is then presented in the subsequent sections).

Marital Behaviour Type 1:

The Abusive Man and Abused Woman

Description

The prevalence of violent and abusive behaviour in couple's relationship is a disturbing fact of contemporary life. This study supports previous findings regarding the extent of this problem with thirteen percent of the sample presenting with male abusive behaviour. Detailed research by O'Connor (1998) has illustrated that following detailed assessment, a wide range of violent and abusive behaviours are typically present but undetected in marital therapy. A description and discussion of the details of such behaviour are beyond the scope of this study. Domestic violence is defined "as a pattern of assaultive and coercive behaviours, including physical, sexual, and psychological attacks, as well as economic coercion, that adults use against their intimate partners" (Schecter & Ganley, 1995). A 'diagnosis' of an abusive relationship was afforded in this study when there was evidence of both violence and psychological abuse in the data. The following examples give some illustrations of the kind of data that illustrated these dynamics.

Verbatim from files

"He is very violent….she knows she is being watched, checked up on and has to account for everything she does….we will meet for 4 sessions to identify the cycle of violence…he interrogates her and keeps repeating the same questions over and over…the violence has been going on for about 11 years…she never knows when it will start up….she wouldn't tell anyone because she was afraid he would kill her…"

"He had to leave the house because of his persistent use of violence and his drinking…I asked M to describe the last time he was violent…he gave a detailed account of the days and minutes leading up to his abuse…the reasons he gave for his violence were that he never wanted to be married and is too young to have to cope with all the pressures of a young family…"

"She has left home and has been living at the battered women's shelter….she said she had to leave because she could no longer live in fear…He says he cannot cope with their financial problems…. He became abusive toward me when I didn't give him advice."

"He is expressing his anger toward her through emotional abuse and physical violence…I feel unsure about her safety…he keeps checking up on her…she wants a witness to how he is behaving - his abuse toward her and the children…she told of a recent situation where he assaulted their daughter…the children are terrified of him…at Christmas he was trying to beat her, trying to take off her apron, and the boys (8 & 10) were trying to stop him."

"They came in after a fight involving physical violence…He had assaulted her and she ended up with a beaten face and two black eyes…she is very traumatized but wants to see now if this is the end…she is prepared to leave him because she no longer wants to live in fear of him…He blames the drink on his behaviour…but she has been badly hurt and will take a long time to trust him again…. I have been challenging him to take responsibility for his abuse and violence without blaming the job, the children, the drink, or her."

Comment:
The frequency with which this type of couple was diagnosed remains a chilling reminder of the degree to which domestic violence and abuse is part of the fabric of distressed marital relationships and brings to the forefront the feminist critique of couples therapy and the institutional responses to issues of abuse concerning women (Pence (1988), Walker (1997)) The dynamics of a violent and abusive relationship are profoundly different to that of a relationship without such behaviour. Physical aggression and violence when it involves displays of anger, cruelty, destruction, and hate cannot be addressed or understood within the framework and concepts of couple's therapy. It is clear from many sources (Pence & Paymar, 1987; Ganley, 1993; Walker, 1997; O'Connor, 1998) that relationships which involve recurring male physical violence typically include a variety of tactics of control and abuse that serve to maintain the power and control of the perpetrator. These tactics involve intimidation, isolation, coercion, sexual abuse, economic control, jealousy, stalking, etc. Marital therapy is not an appropriate form of treatment for such behaviour, despite the fact that it appears with such regularity in therapy rooms. There is now a considerable amount of literature that can assists clinicians and agencies in dealing assertively with issues of abuse and violence involving men (O'Connor, 1998).

This marital type reinforces the critique of marital therapy that, differences in power between marital partners often goes unaddressed, and is frequently minimized. Several

of the concepts that have been central to adapting systems thinking to marital therapy have served to render the role of power invisible. The prevalence of abusive and violent behaviour by men within this sample highlights this fact in a most obvious way. For example, the concept of complementarity is central to much systemic thinking but embedded in the notion of complementarity is the premise that all tasks and roles are divided fairly, that both partners are equally free to choose their tasks and roles, and that any differences in status, power, and privilege is offset by actual emotional psychological parity. What holds men and women in particular circular positions are more complex than can be understood by simple terms such as symmetry or complementarity. Similarly, the term 'circular causality' can equally lead therapists to inadequate analyses of how power differences affect the smaller intimacies of married life.

Therefore, there is a serious need for marital and family therapy, as well as the professionals of clinical psychology and psychiatry, to adequately address issues of abuse in family life. The prevalence and emergence of this type as the most common dyad in couples therapy represents substantial evidence for the development of relational diagnoses on a par with DSM-IV classifications. To the degree that issues of abuse and violence go undiagnosed clinically, our professions remain part of a larger pattern of institutional abuse of battered women, and inevitably abused children. The degree to which the primary diagnoses attributed to victims of abuse are DSM-IV Axis I or II disorders should be of ongoing and serious concern to our professions. For example, the typical diagnosis of clinical depression or generalised anxiety for a woman entrapped in an abusive marriage is quite normative in the medical field, with the associated prescription of anti-depressant or anti-anxiety medication.

Marital Behaviour Type 2:

Passive Aggressive Man and Compulsive Woman (See Appendix)

Description

The emergence of this pairing proved most interesting, as it was quite unexpected. However, a preliminary presentation of this type to groups of marital therapists resulted in remarkable agreement regarding the prevalence of this dyad and the dilemmas it presents in therapy. It also resurrects the debate regarding the place of the passive-aggressive personality disorder diagnosis in the DSM. According to Millon (1981), the passive-aggressive personality is characterized by oppositionalism, ambivalence, and irritability while the compulsive personality is characterized by interpersonal control, productivity, perfectionism etc. This type might be referred to as the 'Hide and Seek Relationship' for it is characterized by the woman's attempts to get her partner to 'shape up', assume responsibility, and be accountable and his attempts to avoid her control, minimize responsibility, and maintain disguised opposition. In many ways it appears to be a more accurate caricature of couples then the frequently referred to 'Obsessive-Hysteric' marriage, particular among lower middle-class and working class couples.

Sample verbatim descriptions:

"He has been involved with another woman, which she discovered recently. He did not want to come into the session so sought to meet with me on his own…She feels betrayed and vented a lot of anger and pleaded with him to give it a try…He was cool and said it was over because he now had another woman…. She said the only way she can now find justice is through the courts…He could not see why she would not work with him in mediation…. He seemed to ignore her entitlement to her anger and distress…. She seemed to want to work at it and punish him".

"He did not come for the first session…he said he does not really believe in counselling but he came subsequently…She sees her self as mother/father/wife/parent in the relationship as he did not carry out any responsibilities and showed little love…now that she has decided to possibly leave he now says he loves her but she feels it may be too late…"

"Living with his mother…She worried about children growing up in that house…Husband sees his prime duty toward his mother, who is ailing, and has taken his wife for granted…She is pushing for change and finally has got his agreement for

them to have their own bedroom…He has to be weaned off the mother…She wants him to consider her and the family and feels like the nag….He has been dragging his feet in an irritated way and has acted naïve about the whole business.

"He thinks she is too demanding all the time…she feels he is avoidant and unavailable. He disappears out to the pub but was very irritated at the possibility that he might need to look at that given that they have 4 children. If she gets too angry he threatens her with separation…she stops then. He is very difficult to pin down - he appears to go along with things, including therapy, but makes it all difficult for her…. she's like a dog with a bone! "

"She seems drained…he says he will make an effort but she does not believe him anymore. She says that when they are asked to something he makes her miserable by whining and whinging….She works night duty and he has given up work for depressive reasons….He appears needy but belligerent. .. She appears demanding and wounded."

Comment:
This type has emerged as a most useful descriptor of couples behaviour. It is a type that highlights the gender issues involved in seeking therapy and the likelihood that the man will assume a more oppositional and passive-aggressive stance in therapy (this will be discussed later in the analysis) than the woman's stereotyped pursuit. The passive aggressive/compulsive couple in therapy appeared as the man being there ambivalently, in a manner that was both agreeable and defiant. He is defiant in that he will typically say or do things that will undermine the therapeutic process, express doubts, mild resistance's, etc., all in a manner that make his hostility apparent but done so in a casual way that is hard to pin down. He is likely to say "Listen, I've come for therapy, I would not be here if I didn't want to, what more do you want of me". The message being "I am here and I am suffering". She, on the other hand, presents as the competent, capable woman and appears as an excellent candidate for therapy - cooperative, polite, listens etc. However, her agenda is framed in terms of attempts to get him to change with poor awareness of her own persistent control and pursuit. He may, despite his wife's obvious distress, suggest that the marriage is fine and he does not understand what is wrong with her! She may miss the paradox of this and either feel subconsciously that there is something wrong with her, or start putting various pressures on him to get his compliance.

Gottman's research (1979, 1991) has particular relevance for the passive aggressive - compulsive type couple. His studies show that in distressed relationships, the typical interaction is one of reciprocal aversiveness resulting in both hostility and or withdrawal from the encounter. He has reported that in marital disagreement physiological arousal and negative interactive patterns predicted marital dissatisfaction three years later. Gottman's pattern appears to be one in which the husband becomes intensely physiologically aroused and, possibly because of the males slower recovery rates to physiological arousal, learns to withdraw from the conflict. The wife, in attempting to save face, also becomes physiologically aroused and then blames and complains. This pattern is broadly consistent with the type identified here.

Marital Behaviour Type 3:

Passive Aggressive Man and Dependent Woman (See Appendix)

Description

This couple are not too dissimilar to the preceding couples but are characterized by his passive-aggressive control and her dependent uncertainty. The compulsive woman is characterized more by her extroverted control and his passive-aggressive avoidance. The passive aggressive man will display more oppositionalism with a dependent partner. In the therapeutic context the compulsive partner would drive the course of therapy with her demands. In this couple the dependent partner may drive therapy with her distress but he is a more active and forceful presence.

Sample verbatim transcripts:

"He has had an affair and while he agrees he may have hurt his wife he does not see why the need for counselling…She is very hurt by the affair but still loves him…I am unsure her of his motivation in coming….she has said she hopes for change for him not to be so free with women…she seemed to want security or assurance from him and he seemed indifferent….he takes her for granted….she does not know what she wants"

"He lied about their finances to her in the past and now has done it again…he feels found out…He told her he would go for help and do something…he has not done what he said he would do…She feels distrustful of him…We focused on his habit of lying to her and what it did to her…He always wants to have an answer for people…She saw his lying as his evading responsibility….She comes across as soft spoken, quiet, …She spoke about how she 'allowed' lies to be tolerated for the sake of peace…spoke of co-dependency."

"She is very very tired…working full-time and minding the children…he is very untidy and not helping at all around the house…she feels he is totally inconsiderate…He did not want to be at therapy at all….She is weary of him but wants it to work…he says that she is making too big a deal of things and that he can only do so much…He disappears off to the pub whenever he can, leaving things to her."

"R said he could only stay for a half an hour for the first session but promised he'd be back for the second session …he seems to have been involved with another woman, is impulsive, gambles…He never showed up for the second session…she very

upset…Knows he is not being honest with her, want him to level with her…Yet she doubts herself and does not know how to read him at times…he presents arguments and plays mind-games that leave her confused and uncertain about what she believes…She was aware of his hiding money but did not say anything to him…"

"He has had two affairs…She asked him to leave but then asked him back again…He felt that the children came before him in the relationship but he never spoke about it…She did most of the homecare…She feels he is engrossed in his own needs and desires and becomes irritable if she asks anything of him…She is afraid now, because of the affairs, that he might take her for granted if they get back together…She says she does not want to be a doormat anymore and she depended too much on him in the past….He does not talk about things much…"

Comment:
This type is characterized by her dependency and insecurity in the face of his avoidance. Affairs, deception, lack of truthfulness characterize much of his behaviour which he reframes as a response to her - i.e. seeing himself as suffering mightily yet taking little responsibility and seeing himself as somewhat unique and entitled to serve his own needs. Unlike the narcissist, this man hides, covers up, deceives and acts perplexed at her frustration with him. She, in many instances, has grown weary of his behaviour but likely has tolerated a great deal over time and come into counselling at a point where she can take no more. It is hard for this woman to take herself seriously and in therapy is encouraged to take stock of effects and recognize her own needs and entitlements, which have become lost in her attempts to be continually adapting to his strange behaviour.

Marital Behaviour Type 4:

Alcoholic Man & Co-dependent Woman (See Appendix)

Description

This is a classic pairing of which much has been written in the literature. This deserved a special diagnosis separate from personality style. This was so because of the dynamic around drink that made the alcohol itself a third party in the relationship. While the concept of co-dependency has not received any recognition with DSM classification systems, it has assumed considerable popular significance. Arguing this case is beyond the remit of this study except to state that, in practice, the prevalence of substance abuse in marital relationships is so extensive as to warrant special intervention. To avoid this reality and to describe the relationship solely in terms of personality styles is to ignore this reality. This couple are characterized by the dominance of alcoholism in the relationship and her co-dependent position. Other borderline or abusive relationships had substance abuse involved but did not fit the couple diagnosis afforded here.

Sample verbatim transcripts

"She feels that she can not continue with C's drinking and the worry/shame that it brings to the family…they lived in Dublin up to 6 months ago where he used to go drinking each night (4/5 pints) and at the weekend…on three Saturdays he has started drinking early on Saturday and drove home drunk…she says now with the support of her sisters she cannot put up with another 16 years of drinking."

"This couple's problems are drink based…He has been drinking throughout their 18 years of marriage…He's going to AA and she to Al-anon in recent months…Huge number of issues with associated conflict…."

"She is considering going for separation…the major issues for her has been his drinking…He does not see the drinking as a problem…I referred him to the alcohol treatment centre for assessment…I think he was under the influence of alcohol at the session…He goes to the pub almost daily and has a number of 'drink driving' offences but he still states he does not have a problem…At the same time he came across as argumentative, talkative, clear while she was less articulate, at times passive, tearful and angry…"

"He has an alcohol dependency problem…He has been aggressive, was violent on one occasion and generally creating a lot of distress…He was disturbed that she had told people and sough counselling but has returned to AA…She has grown tired and weary of making allowances for him…He woke the children up when he came home drunk two weeks ago quizzing them about her…The last straw for her."

"She has been confused about the relationship…He has been drinking very heavily for many years….She seems ambivalent about his drinking patterns saying she could tolerate it if only he would show some reliability and commitment…She seemed tearful, naive, and falling for his articulate excuse making.…They own a pub and he drinks every night, she is a part-time nurse….I feel sorry for her yet angry at her tolerance….The children seem part of it all."

Comment:
The inclusion of this type as warranting a separate relational diagnosis proved warranted given the extent to which substance abuse affected the couple's relationship. As has been presented by Bepko & Kristan (1985), the responsibility trap for couples and families in which a member is abusing drink, is relationship defining. From a therapeutic perspective it is generally considered that treating and addressing issues of addiction must take precedence over other responses.

Many researchers (Williams**,** 1996) have suggested that alcohol dependency has its personality patterns that explain and even predict substance abuse behaviour. This perspective describes alcohol dependence as compulsive behaviour that is an effort to escape life's trials. Williams has proposed that certain specific behaviours and attitudes such as impatience, impulsivity, emotional immaturity, narcissism, grandiosity, pseudo-control, etc., are almost universal in alcoholics/addicts.
Regarding the partner of the alcoholic, there is widespread community acceptance of programs such as Al-Anon which have contributed to the development of the term 'co-dependency". Despite it's widespread popularity (Wegscheider-Cruse & Cruse (1990) Schaef, 1986), it has not been accepted as a legitimate DSM-IV psychiatric diagnosis (American Psychiatric Association, 1994). Beattie (1992) defined co-dependency as "one who has let another person's behaviour affect him or her, and who is obsessed with controlling that person's behaviour". In effect, co-dependent behaviour involves the helping of another person when the assistance actually contributes to hurting or disabling him or her and/or oneself. The co-dependent believes in the illusion that they

can stop the pain if they can get the alcoholic to stop drinking. As Beattie points out, being caring of another is not co-dependent behaviour - it is when this behaviour becomes excessive, obsessive, and one-dimensional that they move into the co-dependent behaviour realm. The marriages of alcoholic-co-dependents are characterized, as one might expect, with considerable chaos, crises, and inconsistencies.

Marital Behaviour Type 5:

Borderline Man and Borderline Woman (See Appendix)

Description

This relationship is identifiable by the degree of chaos, intense conflict, patterns of clinging and abandonment, and extremes of rage, self-harm, and confusion. Most of the couples afforded this 'diagnosis' presented with narratives that to many would appear outrageous, intense, and chaotic to an often-extreme degree. At the same time these couples are capable of expressing intense love and rage simultaneously. In typical borderline fashion, these couples's stories were peppered with suicidal gestures, walkouts, in-law wars, histories of abuse, alcohol abuse, affairs, gambling etc. This couple may also be admirable for their resilience, brutal honesty, and tenderness.

Sample verbatim from files (identified by file numbers)

"Fighting and arguing about money…some violence on both sides…Jealousy, barring order suspended…she involved in a prayer group…prays out loud all the time at home…he hit her because of this…separated at present in different houses…he keeps begging her to return…he admits to gambling and goes to a group…. she has had psychiatric treatment - in and out of hospital…both fight like demons….he has threatened to kill himself a number of times….she's very emotional."

"She very unhappy…has been in hospital with nervous breakdown…now on antidepressants…feels he is having an affair…He is drinking a lot and very dependent…She has attempted suicide in past….He was involved in fight with his father - police involved….He crashed the car last week…He was adopted…She has had her mother living with them for a few weeks…Mother alcoholic…"

"They are constantly arguing and fighting…Both of them verbally abusive and get into physical fights…She attacks him physically - he fights back…He is a reformed alcoholic….Had many casual relationships, casual sex - she has had many partners also….this is his first emotional relationship…He admits to being frightened, insecure, and afraid of looking foolish by… fear that she will abandon him….She has a daughter from other relationship - she gives mixed messages telling him she wants to stay and saying she has had enough and wants him out…both say their sex life is great and claim to love each other….the sessions are hectic and hard to contain."

"Both partners abuse drink and he was involved in drugs…She has just come out of treatment…They both made a mess of things…both running up bills, stealing, leaving their children on their own at night…changing home to avoid debts…There both come from abusive families, dysfunction, chaos…They are sheltering a 17 year old nephew who is in trouble…They have no space or time…They have six children…Extremes of tears and fighting in the session…They both say they don't want to lose each other…"

"This couple are at loggerheads…no agreement on anything…they are frequently verbally abusive…She feels he has detached form her and the children and is very bitter…They have been fighting since marriage - frequent incidents of mutual physical abuse…Feelings of bitterness and revenge for both…all of their discussions get out of control to a ridiculous degree…they have no ground rules…he has threatened suicide in the past…he complains about her unpredictability and dramatic mood swings…he has disappeared for weekends at a time…"

Comment:
Slipp (1995) points out that individuals with borderline conditions usually enter marriage with the following problems that they hope the relationship will remedy: "they fear intimacy, are self-preoccupied, have considerable anger, and are acutely sensitive to feeling rejected…they have a profound distrust that others will be responsive to their emotional needs….therefore they need to control and manipulate each other to sustain their self-esteem" (pg. 458). He suggests that there seems to be an attraction between persons suffering from borderline personality disorders.

Solomon (1996), in a discussion on couples with borderline disorders, points out that two people will not form a relationship unless the partnership appears to preserve an internal structure that for each of them recalls experiences that are familiar. Individuals with complementary patterns often marry (Bowen, 1978; Gurman, 1978; Solomon, 1989). In fact, psychodynamic literature operates on the assumption that early bonding failures result in disturbances in relationship patterns in adult life (Masterson, 1985; Scharff & Scharff, 1990). Borderline personalities are difficult to treat because their interactions with each other and a therapist tend to be volatile. They expect much, writes Solomon (1996), are invariably disappointed, and react with anger, negative behaviour, and rapid withdrawals. Following such distancing they typically make efforts to reconnect because of their profound fear of abandonment.

In marital relationships in particular, vulnerable borderlines often feel that they are unable to protect themselves from intrusions. They appear hypersensitive and thin-skinned. They have a high need for an affirming bond with a partner, along with low frustration tolerance and a proneness to shame and guilt. In marriage they may then protect themselves against intolerable internal panic by deadening their emotions or by rageful dumping. The tragedy is that although they need so much from their partner, they are unable to internalise what they receive and often sabotage their relationships when the desired empathy triggers fear rather than comfort. As pointed out by Slipp (1995), these individuals often set up interpersonal situations with their partners to provoke outcomes that confirm their worst fears. They therefore select partners and maintain relationships that are filled with emotional volatility.

DISCUSSION

The results of the research consisted of a number of important findings. These were:

1. Distressed marriages could be clustered according to type consistent with interpersonal theory.
2. The frequency distribution of the 'types' showed a number of surprising findings. These were the prevalence of domestic violence and abusive relationships, the emergence of a passive-aggressive/compulsive and passive aggressive/dependent types in the sample, the prevalence of passive-aggressive behaviour among men, and the prevalence of compulsive behaviour among women.
3. The significance of gender related issues throughout all the findings and types. For men this was apparent in the prevalence of domestic abuse, alcohol abuse, and passive-aggressive behaviour. For women this was apparent in victims of abuse, dependent behaviour, co-dependent behaviour, and controlling or compulsive behaviours.

The finding that distressed marriages could be clustered according to type consistent with interpersonal theory was significant. While there are clear limitations in the methodology of the study (which will be discussed later), the results revealed patterns and types that will warrant further study and description. These findings can have implications for couples assessments, treatment plans, prognosis, etc. They also offer potential for integrating various theories and models of practice.

Gender & Marital Behaviour

The socio-political dimensions that affect gendered behaviour among couples still remain a largely unacknowledged dimension influencing the process and outcome of marital therapy. Jacobson (1997), in his most recent presentation of Integrative Couples Therapy, remarked that we all know that it is the woman in the relationship who initiates therapy. However, while this fact is largely accepted, virtually all of marital therapy techniques and theory ignore this most profound reality (see Jacobson & Gurman, 1996). The methodology of this present study aimed at exploring the nuances of couple self-presentation from a gender perspective in acknowledgment that theory and technique needed also to be largely cognizant of the socio-cultural context in which gender behaviour is determined. The findings of this study are a forceful

reminder of how gender issues profoundly influence how couples present for therapy. It also presents data to assist us in examining the therapeutic, interpersonal, individual, social, and political meaning of the fact that most couples therapy is initiated by women. All of the prevalent types that emerged from the data involved male behaviour that could be classified as reluctant or resistant. The dynamics of each type illustrated how this reluctance, in therapy, was acted out. For example, the narcissistic entitlement of the abusive man, the passive-aggressive avoidance of responsibility, or the alcoholic pattern of under-responsibility all point to fundamental issues that need to be understood from the perspective of gender if therapists are to engage appropriately with couples in therapy. Nowhere in the literature do any of the models of couple's therapy incorporate this reality into its model of practice. The assumption of sameness of the sexes represents a serious gap in the literature and one that this study illustrates compellingly. All feminist-informed approaches carefully attend to the ways in which power differences are manifested in the marital relationship. Counteracting the bias involved in assuming gender equality is difficult because of the overarching myth that marriage in our culture is primarily a relationship of two equal partners.

Geis (1993) presents a social psychological view of gender based on a review of current literature. With reference to marriage her conclusions would be that gendered behaviour and beliefs within marriage can be understood as an overall self-fulfilling prophecy consisting of a cluster of related and mutually reinforcing specific self-fulfilling prophesies. From her perspective, "the masculine or feminine behaviours are primarily results of social expectations and the situational opportunities or constraints of high- versus low-status social roles and power". Applying a social-psychological perspective to the data of the present study we would conclude that the architecture and process of the couple is shaped fundamentally by these influences and overemphasizing interpersonal or intra-personal issues would fail to consider the social dimensions. In addition, the therapeutic situation represents a social situation that presents ambiguities and paradoxes for male and female roles and the resultant reluctance of men to enter that social situation - i.e. that it is not a social situation that will necessarily confirm their social status and power.

Deborah Tannen's (1992) psycholinguistic perspective on women and men in conversation offers insights that are useful in attempting to interpret the findings. Tannen proposes and supports the notion that men and women talk in significantly different ways. While women use language primarily to make connections and reinforce

intimacy, men use it to preserve their independence and negotiate status. The conflict of these different styles and approaches results often in misunderstanding and conflict. Tannen's analysis provides a framework for understanding how men and women experience the therapy situation differently, and how and why men and women will behave differently and how the specific types may have merged in the findings. If we look back at Table 1 and the distribution of personality styles by gender we can see that the more interpersonally avoidant styles are exhibited by men - passive aggressive, abusive, avoidant.

Tannen's thesis would suggest that women will approach therapy as a conversation to enable negotiations for closeness in which each partner would try to seek and give confirmation and support, and to reach consensus. She will try to protect herself from his attempts to push her away. Therapy becomes a struggle to preserve intimacy and avoid isolation. Men, on the other hand, would engage in therapy as individuals in a hierarchical social order in which he is either one-up or one-down. Therapy talk then is seen as a negotiation in which people will try to achieve and maintain the upper hand if they can, and protect themselves from others' attempts to put them down and push them around. Therapy is seen as a contest or a struggle to preserve independence and avoid failure.

Interactive positions

Interactive positions in distressed couples were found to be clearly defined. They created interpersonal structures that contribute toward the development of the repetitive negative interaction, which are typically self-reinforcing in couple relationships. (These are identified as the 'pathogenic hypotheses' presented in the diagrammatic summaries of each type). This inner experience orients one partner to the other and helps to organize their relationship responses. These responses then become the basis of the habitual positions that the partners take with each other, particularly around issues of affiliation-closeness and control-dependence. Therefore, we can suggest that the marital types identified are ones where the interpersonal positions adopted by individuals act to curtail the probable responses of the other. The positions the couple take with each other then create relationship-defining events that in a mutually determining fashion also feed back into the inner experience of each partner.

The Abusive Personality

The frequency distribution of the 'types' showed a number of surprising findings. The prevalence of domestic violence and abusive relationships is a strong reminder of how the field needs to continually re-examine and critique it's position regarding social inequities in terms of status and power that determine marital configurations. Serious questions need to be asked regarding the appropriateness of psychotherapy as a social response to criminal behaviour. The development of treatment programs for batterers in connection with judicial systems seems the way forward in this area (O'Connor, 1998). However, the prevalence of abusive behaviour in intimate family life needs to be continually evaluated. It is a fact that few of the couples presented with domestic violence as the primary problem. This is understandable from the perspective of women, given the degree of fear and threat under which they live. However, the powerful shaping force of gender inequities on the structure and process of marital therapy needs ongoing critique. In fact, the significance of gender related issues are significant throughout all the findings and types. For men this was apparent in the prevalence of domestic abuse, alcohol abuse, and passive-aggressive behaviour. For women this was apparent in female victims of abuse, dependent behaviour, co-dependent behaviour, and controlling or compulsive behaviours.

Passive-Aggressive Behaviour

The emergence of a passive aggressive/compulsive and passive aggressive/dependent types in the sample was most interesting. These types have not emerged as clinical entities in the literature but do have considerable resonance with therapists. Therapists regularly recognise passive-aggressive behaviour by men in marital therapy. It is generally acknowledged that most women initiate couples therapy and most men attend with reluctance. It is most surprising that this reality has received little attention in the literature. This may be connected with the former point regarding the field's reluctance to incorporate gender issues into the centre of its theoretical perspectives. The findings do not necessarily state that men have passive aggressive personalities but rather that they show passive-aggressive behaviour in the therapy situation. However, the researcher's clinical experience suggests that passive-aggressive sums up much male behaviour in distressed marriages. The female prevalence of compulsive or controlling behaviour is consistent with the unpleasant term the 'nagging wife' but the study did show that a lot of the women's behaviour in these distressed relationships was characterized by their attempts to get their husbands to behave or perform adequately - particularly with compulsive and co-dependent

behaviour. It is clear, for example, in the passive aggressive/compulsive relationship that each partner evokes extremes of these kinds of behaviours in one another.

The extent to which passive-aggressive behaviour was assessed in the men's behaviour was most surprising and appeared to be evident in a very large proportion of the sample. Passive-aggressive behaviour is characterised essentially by a form of passive defiance – to 'go along' with things yet complain about them. The counselling situation presents many difficulties for men seemingly not experienced by women. Typically, women make about 85% of initial contacts for couple counselling. In many of the cases the man is therefore attending with more reluctance than the woman and typically he would prefer to try and sort things out privately. In the therapy situation the man can be seen to resist or defy either his partner or the counsellor. This is not to be judgemental for the pathogenic origin of this kind of style illustrate that for many passive-aggressive men they will have been exposed to neglectful caregivers or authorities who either demanded too much or quickly withdrew nurturance. The passive-aggressive man has a constant sense of entitlement yet constantly feels deprived and then expresses his neediness in passive or resistant ways. This dynamic is so crucial to the success of couples counselling for without an understanding of the genesis and dynamics of this kind of behaviour it is easy for counsellors to fall into a pattern of accusing men of being difficult or, at the other extreme, bend over backwards in an attempt to please them. Either is doomed to failure if the essential motivations of their behaviour are not brought into awareness. When this kind of propensity is paired with, say, the compulsive or controlling behaviour of a partner it is easy to see how both styles can escalate.

There is, therefore, evidence to support initiatives to develop systems of classification for relationship patterns or disorders. Within this initiative, a compelling case can be presented for the need to develop formal diagnoses for domestically violent and abusive relationships, substance abuse relationships, and passive aggressive/compulsive relationships. There is much clinical and folk wisdom to such an initiative, particularly to therapists working at the coalface of family distress. The reduction of relational dynamics down to individual diagnoses is, in many cases, unethical.

Integrating theories

The findings support the efforts of Kaslow (1996) to develop relational diagnoses and present compelling data to support this thesis. The findings provide data to assist in

the development of concepts and schemas to explore both the structural 'architecture' and the dynamic processes of couple relationships. Therefore, it is feasible to develop discreet diagnostic relational 'diagnoses' with the similar levels of clarity and specificity as the DSM-IV. For example, the passive-aggressive/compulsive dynamic has a definable structure and dynamic. The findings also contribute toward a more sophisticated understanding of the differences between couples and the nature of marital distress. The field of couples therapy has too long neglected the potential in this area and this study presents a bridge between DSM-IV Axis II and interpersonal theory. It is clear from a detailed study of Millon's (1996) latest articulation of the major personality disorders along with other analyses of the same material (Oldham & Morris, 1995; Beck & Freeman, 1990), that the language defining these disorders is littered with relational and interpersonal terms and, contrary to the expectations of many systemic thinkers, DSM-IV Axis II disorders can be seen to be fundamentally disorders of relationship and this study shows the potential for the DSM to be recast in systemic terms.

This study also presents a strong case for moving toward the integration of theoretical systems and models of practice. The potential for integrating personality disorder classifications with interpersonal theory is cleanly illustrated in the study, as is the potential for bridging the gap between family systems theory and individual psychology. Social constructivists and post-modern critiques have illustrated the fallibility of attempting to find of single monolithic theory of individual psychology and psychiatry. This post-modern perspective challenges the fields of inquiry to seek integration based on the simple wisdom that your theoretical constructions will all be dependent on your perspective. Benjamin (1996) has illustrated this in a most sophisticated and elegant way.

An example of this integration is how the findings can be seen as simultaneously supporting object-relations and systems thinking. Slipp (1984) has referred to object relations as the bridge between individual, marital, and family understanding of human behaviour. Projective identification in marriage refers to the process by which an individual can project a part of the self 'into' another person and attempt to deal with it there. Marriage can therefore be described as a mutually gratifying collusive system. Much of the work of couple therapy centres around reducing or eliminating projective phenomena and clarifying the boundaries between spouses. Without such clarity, potentially resolvable internal or *within* conflicts are experienced as irresolvable

conflicts *between* people, and the most frequent person chosen for such chronic displacement is a spouse. This "unholy bargain" could be simplified as follows: "You take one-half of my ambivalence and I'll take the other half of yours. Neither of us will experience an internal conflict and both of our anxiety levels will drop; our self-image will seem clearer. The only unfortunate side-effect is that we will fight like hell for forty years!". Therefore, the unholy bargain of the 'passive-aggressive/compulsive' couple is that he projects his punitiveness and hostility onto her and attacks it in her while she projects her incompetence and helplessness onto him and attacks it there. Therefore, with regard to the types that emerged in this study, one may re-cast them in object-relations terms by attempting to describe the 'unholy' bargain that may have been secured collusively between couples to thus create a relatively stable process of conflict. Again, the findings are consistent with this psychodynamic perspective.

The study also illustrates the potential for 're-languaging' Axis II descriptions into the poetic narrative of people's lives and for developing normal versions of personality disorders. This study did not seek to diagnose personality disorders, but rather to detect the predominant personality styles of partners in the relationship. This makes much of the personality disorder theory more accessible and it is a well-kept secret of Millon's (1996) that this is a valid and theoretically consistent perspective. This potential has been tapped and illustrated by Oldham & Morris (1995). In this way, the objections of postmodernists to classification can be overcome - i.e. by 're-languaging' much of this material into 'narrative' that seeks not to pathologise individuals or couples but rather to introduce metaphors and stories that are accessible to everyone and represent the flesh and bones of everyday existence rather than the troubled lives of the so-called 'disordered' among us.

When applying these findings to the normal population one could borrow Oldham & Morris' terms (1995) to re-label the types. For example, we could term the Passive Aggressive/Compulsive relationship as that of the 'Leisurely/Conscientious couple'. Similarly the normal variant of the Passive-Aggressive/Dependent couple would be the 'Leisurely/Devoted couple'. Therefore, there is potential also to apply the findings to healthy well-functioning couples that have learned to tolerate 'differentness' and achieve interpersonal compatibility.

Implications

The implications of this study for the practice and development of marriage counselling are quite significant. This is the first study of its kind that has sought to detect and classify the various forms of distressed relationships. It is groundbreaking in that it has diagnosed the *relationship* rather than the individuals in that relationship and has therefore taken a step toward advancing psychiatric/psychological diagnoses in such a way as to identify common relationship types. It therefore provides both a theoretical and practical development for couples counselling.

1. The practical implication is immediately evident. These findings and their subsequent refinement shall prove invaluable in the training and development of counsellors and therapists. The results can assist in providing useful theory to assist practitioners in understanding the dynamics and structure of couples relationships and deciding how best to help or intervene. For example, the passive-aggressive/compulsive relationship brings together a great deal of clinical wisdom and experience. Preliminary discussion with practising therapists regarding this kind of couple has already displayed its clinical relevance and usefulness. Counsellors often get 'stuck' when they do not have a framework to help them understand the underlying structure and dynamic of a problem relationship. Counsellor's counter-transference reactions to specific personality types are explained by these couple-models by offering both a theoretical explanation of their pathogenic origins and an explanation of current behaviour within the context of their partner's behaviour. The study, therefore, provides models of couples relationship and a language to describe them. Until now, this has been absent in the literature. The development of concepts in the area of relational diagnoses can be extremely useful in training therapists and developing a language that can identify and describe interpersonal categories and processes. A system of classification can enrich our language and sharpen the focus of our interpretative lenses and can provide both metaphors and concrete categories through which the narrative of couple's unique experience can be represented. It is expected that this study can contribute toward assisting further research in crystallizing interpersonal dynamics. The absence of a common language, of common diagnostic concepts regarding interpersonal behaviour, necessitates this present study and its methodology. This study, when integrated with existing research, contributes to the sparse literature on marital typologies and provides data to further clarify concepts for interpersonal classification and diagnoses.

2. Of enormous importance is that the study shows very clearly that couples-in-crisis or in distress cannot be assumed to be the same. It shows that traditional counsellor training models for working with couples are inadequate to the degree that they operate on an assumption that all couples are structurally and dynamically the same and therefore require the same counselling approach or strategy. It is openly acknowledged (Jacobson, 1997) that there is a dearth of knowledge regarding the relevance of outcome studies for specific categories or diagnoses. That is, while we have accumulated a wealth of data in general about the efficacy of couples therapy and watched the development of a wide array of models of couples therapy, there has been little attention paid to the diversity of relationships that appear for marital therapy and how the identification and understanding of different types of couples is essential to appropriate assessment. Each type in this study shows quite unique behaviours, intentions, motivations, and dynamics. Training and practice must mirror this sophistication. For example a 'borderline' couple, as defined in this study, will present and behave in very different ways to a passive-aggressive/dependent couple. The presentation of therapeutic goals and techniques for each couple can therefore be developed. This study has presented and emphasised the top five couple types. However, there are a number of other types that emerged in the study that deserve mention. The statistical significance of these types is less compelling but the 'Narcissistic man / Dependent Woman' and the 'Compulsive Man / Histrionic Woman' appear with notable significance.

3. It is possible now to consider how this research can be converted in to practical relevance for counselling agencies engaged in couples work. Firstly, the study highlights how couples and couples counselling present a counsellor with profoundly different clinical entities and dynamics than presented in individual counselling. This study encourages agencies to consider specific couple entities and how best to respond to them. It adds further data to support the development of interactive systems of classification that may compliment the current individually-based nosologies of the DSM. It is clear from this study that certain dyadic units and concepts can be identified and described. This study can contribute substantially to the growing need to develop categories that can assist professionals in communications about couples and families.

4. The value of appropriate assessment cannot be overstated. The issues highlighted in this typology illustrate how important it is that an appropriate assessment is made of the couple's situation so that an appropriate therapeutic response can be designed and implemented. The idea that the same kind of counselling is provided for every couple is too simplistic for the complexity of issues that emerge. Clearly each of the types identified require different intervention strategies. In terms of domestic violence, it appears from this study that all couples attending for couples therapy should be assessed, in a detailed way, for the existence of abusive behaviours. It appears that most abuse is not revealed in therapy because therapists are unskilled in addressing such issues and show difficulty in asking the necessary specific and probing questions to elicit this information in a safe way. The protocol for couple assessment needs, therefore, to be considered from this perspective.

5. The development of professional training to enable counsellors identify and work with these kinds of relationships is of critical importance. Agencies must consider the critical value of this kind of advanced professional training. It is all the more imperative given the serious situations that emerge – particularly around abuse, violence, and alcoholism. The need for particular expertise in working with abusive, alcoholic, borderline, and passive-aggressive relationships is evident. In addition to such advanced training, the need for clinical supervision of agency work is paramount, particularly by practitioners who have a depth of experience that allows them to supervise such wide ranging issues as have emerged in this study. Such supervision should also highlight the need for the development of rigorous procedures and protocols within agencies to monitor, supervise, and assess agency practice.

6. The study highlights the need for counsellors and agencies to be aware of the influence of gender on how couples present, behave, and are assessed. Agencies should also be cognizant of how their own gender balance influences practice and professional development and how specific gender-related issues are handled and supervised.
The study presents clear data regarding the influence of gender on couples presentation, dynamic, and problem structure. The prevalent personality styles exhibited by each sex are powerfully illustrative of how gender differences are central to couples therapy. The findings challenge therapists to consider gender related issues in a more sophisticated manner. The presence of passive-aggressive behaviour by men in the therapeutic encounter is most interesting and brings to the fore the un-addressed

issue of the reluctance of men to seek marital therapy. Models of marital therapy consistently ignore this most blatant reality.

7. To date, medical models of mental health and illness (APA, 1992) have determined the approach of health-insurance policies regarding reimbursement, legal assessments of pathology, and primary care. There is a growing need for developing more sophisticated systems of classification to assist both clinician-client dialogue and inter-disciplinary communication. The preponderance of anxiety and depressive disorders in primary health care (Update, 1997) is reflective of this unsophisticated and, in many instances, inappropriate diagnoses. It is an accepted fact that medical, psychological, and psychiatric practitioners tend to consider relational problems as secondary symptoms of more profound individual disorders. However, in many cases it is quite the reverse.

8. In a cultural context, it presents the first and only comprehensive examination of distressed marriages in Ireland and thus may contribute to the development of the fields of marital and family therapy in this country. The study may also contribute to public awareness of marital health issues and dynamics particularly in a time of rapid social change in Ireland following the recent introduction of divorce. Despite the limitations of the study, a valuable contribution can be made to the development of marital therapy and counselling services in Ireland and the growing literature on relational diagnoses.

9. The findings provide a framework for developing a more sophisticated treatment/therapy response to couples that considers gender, personality style, interactive reinforcement, and patterns of complementarity and symmetry. This study contributes to the current debate regarding the validity of including Passive-Aggressive personality disorder within DSM and recommends the development of Benjamin's checklist for diagnostic purposes.

10.. Finally, the clinical usefulness of the work of Benjamin (1996) has been illustrated by this study. This study utilized a sophisticated checklist that has not been used as an assessment instrument. The name of the approach, which permits an operational description of interpersonal patterns and their impact on self-concept, is Structural Analysis of Social Behaviour (SASB). SASB is a rational and empirically tested model of social interactions built on three orthogonal dimensions. It offers

testable, refutable theory for understanding, on a symptom-by-symptom basis, how personality disorders are affected by the individual's specific social learning experiences and current social context. A premise of this thesis is that the groupings described by the DSM-IV represent substantial "folk wisdom". Benjamin translated each DSM diagnostic criterion into the social-interactive terms of the SASB model. Benjamin's hypotheses have been refined and informally confirmed over the past 9 years (Benjamin, 1996). The model therefore represents a theoretical framework that is in formation and in need of ongoing research. However, her model of interpersonal behaviour has received widespread acclaim and acceptability in the field as a sophisticated, elegant, and researchable model and theory. Benjamin herself places her theory at the boundary of art and science (1996). She suggests that the SASB model is specific enough to be tested and validated or refuted but that, for the present, she suggests that the use of the SASB model, in the diagnosis of personality, is presently both art and science. In this regard one has to interpret the present study within that framework. The checklist used in this study represents the intersection between SASB and DSM-IV criteria.

CONCLUSION

This study can be placed within the debate between modern and post-modern approaches to diagnosis and classification and suggests that, within a constructivist perspective, clinicians can be interested in the stories of clients and the degree to which similar stories are being told and expressed. The degree to which certain relational archetypes get replayed in marital relationships can be usefully explored and distilled from the experience of couples and can put descriptive order on these experiences. Millon (1996) agrees that classification is an arbitrary exercise depending entirely on the perspective of the observer and the categories into which classification occurs. Benjamin (1996) describes the diagnosis of personality disorders to be an art! Constructivists need not fear the diagnostic models. There is enormous potential for 're-languaging' modern classification systems into their poetic subscript about the human condition. This study has tried to achieve this - to build a bridge between narrative and clinical approaches; to create categories, concepts and metaphors and assist us in conversations about couples and families; to sharpen our process of assessment; and to get closer to the building blocks of relational distress and how to both understand and influence them. In fact, there is a poetic subscript to much of the clinical descriptions of personality disorders that can appear lost when cast in the lab-coat of psychiatric jargon but comes to life when clothed in interpersonal language and narrative.

Marital and family typologies can usefully organize complex clinical and research data. A typological approach has enormous potential as a means to integrate complex, multidimensional data into broad patterns that have relevance for diagnosis, assessment, and clinical studies of couple and family behaviour. When working with couples, we often think of different kinds of couples. When speaking with colleagues or when reflecting on one's work with particular couples, one seems to simultaneously identify both their unique features and the features they have in common with other like couples. In this way, we frequently use implicit typologies in clinical work, which act as underlying and well-articulated constructs regarding the way people are. We therefore use descriptive typologies implicitly. This study has moved such implicit categorization into explicit analysis and has contributed types, categories, and metaphors to contribute to the development of this area of research and analysis.

Focus on an individually based medical model leads to the loss of vital intersectional data. A relational nosology, typology, or classification system can, with appropriate and ethical use, be of enormous use in accurately evaluating and responding to people's needs and dilemmas. Including relationship data in assessment presents a more realistic and integrative picture of someone's psychological distress. This study does not argue that relational vocabularies must replace individual non-systemic ones; rather it has shown how both languages can be represented in our formal and informal systems of assessment. With regard to marriage, the consequence of this endeavour can only be positive and sensitise us all to the between-people world that often goes unseen, made unremarkable by the absence of the visible human membrane of skin. Were the interaction forces of relationships physically visible, one imagines that our entire understanding of human nature would be of a profoundly different order. A developing typology of relationships will represent one small attempt to put form on a constant process that remains largely invisible.

Typologies have a long and rich history in family research, although they are not much used. In many ways, with the advent of post-modern and constructivist thinking within family therapy, there appears to be a drift away from typological thinking toward more circumspect approaches as, for example, developed initially over the past couple of decades by the Milan group (Boscolo, et al., 1987). However, as has been articulated at the beginning of this chapter, marital and family typologies usefully organize complex clinical and research data. A typological approach has enormous potential as a means to integrate complex, multidimensional data into broad patterns that have relevance for diagnosis, assessment, and clinical studies of couple and family behaviour. The findings of this study support this movement and are allied strongly with the initiatives of Kaslow (1995) to challenge the dominant psychiatric and psychological models, which emphasize individual over interpersonal functioning. This study provides rich evidence for the potential of developing a typology for marital couples in a manner that in integrated with dominant models of classification.

The most important entities in our personal worlds are other people - particularly those with whom we have experienced the intimate life of emotional development and sustenance. As social animals we require transactions with others to satisfy our needs and fulfil our potential. Even when most alone, our minds conjure up images and scenes that keep our imagination centered on our relationships with others. Who we are as people can best be discovered in the patterns of our intimate transactions with

others. Yet, in Western civilization, and more particularly in the dominant medical model of human behaviour, our basic social context gets minimized - our psychiatric nomenclature draws clear boundaries between self and other. While this distinction is necessary to some degree this study reminds us that this very distinction, the uniqueness of our self-hood, was itself moulded from the clay of our interactions with significant others throughout our development. And the template of our individual selves is a template of how to relate to others. What transpires between two people is a moment-by-moment interactive process that attempts to shape and alter each other's reactions in self-confirming directions. The dance and evolution of these interpersonal realities is no more graphically illustrated and experienced than in the relationships of adult intimates - particularly in marriage. The present study has attempted to map some of the landscape and terrain of this unexplored territory and to relocate interpersonal theory at the centre of diagnostic classification.

RESEARCH STUDY 3 of 3:

A QUALITATIVE ANALYSIS OF DISTRESSED MARRIAGES:

Core themes and metaphors

ABSTRACT

Scope of Study:

This study constituted an exploration of the core themes at issue in distressed marriages. Using a qualitative methodology it looked at marriages as documented in rich case-note material of 400 couples who presented for marital therapy. This study, when integrated with existing research, hopes to be significant in contributing to the sparse literature on marital. In an Irish context, it represents a unique examination of distressed marriages and thus can contribute to the development of the marriage-counselling sector and, in particular, the models used in the marriage-counselling field.

The research sought to identify the key themes, metaphors, and issues that are central to accurately defining individual couples. The methodology identified key concepts through which couples could be compared and contrasted and which were central to relationship definition and the process of therapy. It is clear from this study that certain dyadic units and concepts can be identified and described. The findings contribute substantially to the growing need to develop categories that can assist professionals in describing and communicating about couples both within their professions and to couples themselves.

Findings and Conclusions:

What emerged was that couples could be defined at two different levels (aside from problem-definition). Within these levels the experience and issues at stake for couples could be accurately described. The primary level was termed the *Psychological Position.* This term referred to the psychological and emotional position assumed by a partner toward their relationship and sought to define the unspoken disposition that determined the problem dynamic that was central to the couples struggles. The position therefore referred to the unspoken emotional attitude adopted by the partner. *The Psychological Position* included the following variables: a partners motivation to change, their attitude to the relationship, their 'felt responsibility' for the relationship, their commitment to the relationship, their self-responsibility within the relationship, their beliefs about change, and their interpersonal values.

The second level identified was termed *Emotional Safety and Interpersonal Justice*. This level referred to what appeared to be 'at stake' for couples in distress and included the following variables: independence & freedom, affiliation & belonging, power & control, respect & equality, safety & commitment/stability, safety & trust, emotional distance, and cycles of interaction.

The original finding of this study was that it an accurate assessment of couples relationships in therapy must include assessments of emotional safety, interpersonal justice, and psychological positioning. Without such considerations, couples difficulties remain defined at the basic level of problem-content and the underlying problem structures and dynamics go undetected.

INTRODUCTION AND METHODOLOGY

This research project looks at the differences between couples, the nature of marital distress, and how relational patterns and dynamics may constitute discreet identifiable or even diagnostic categories. The research project looked at marriages as documented in both the rich case-note material and the clinical assessment summaries of 400 couples that presented for marital therapy. Data was examined from the perspective of interpersonal and psychological-systemic theory to determine the potential for developing interpersonally focused diagnostic categories.

The question addressed by this study is: Based on a detailed qualitative analysis of case-note summaries using emergent and predetermined categories, what are the central themes, issues, and dynamics presented by couples and, based on what emerges from this investigation, can couples be clustered into discreet marital types?

Research Design

The qualitative elements employed both ethnographic and analytic designs. The study hoped to develop a descriptive model of relationships by describing and analysing marital process, content, and themes as conveyed in rich and varied case-study documents.

A number of factors were considered in using a qualitative methodology. Firstly, the nature of the raw data, i.e. case-note documents, is most appropriately investigated using a qualitative method. In addition, because of the complete absence of any data on distressed marriages in Ireland, an exploratory research methodology was considered most suitable. The research problem has arisen within the context of a marital therapy agency and the interest of the researcher in analysing the documented case-note records of marital therapy cases over a period of many years. These documents had been accumulated over many years and contain a wealth of information and data regarding the presenting concerns of distressed couples.

Primary assumptions within a qualitative approach which were employed in this study included the following: the data may reveal multiple realities rather than a single objective reality regarding marital dynamics or types; the purpose is to attempt to understand the situation of couples from their perspective as presented in therapy; the research method is flexible; the researcher uses “disciplined subjectivity” (McMillan &

Schumacher, 1997, pg. 17); the researcher becomes immersed in the researcher situation and interacts with the data; and the goal is detailed context-bound (rather than context-free) generalizations.

To enhance validity and minimize researcher bias the study was supplemented by ethnographic methods in that the analytic work was built on the extensive time of the researcher in the site; the ongoing processing that gave shape to the document analysis; the exploratory stance that was assumed with data; on-site observation of couples in therapy; checking preliminary findings in couples workshops and counsellor supervision groups; recorded observations and notes; ethnographic interviews with experienced marital therapists and couples; and the corroboration and checking of emerging themes. While a theoretical and conceptual framework was used in the formulation of questions, categories, and concepts, the study also incorporated a naturalistic discovery approach to the varied meanings conveyed in the documented data.

Consistent with qualitative research, no specific hypothesis was employed - rather a descriptive investigation took place allowing the data to reveal itself in an emergent methodology. The rich case-note material for each couple was studied and the key therapeutic issues, dynamics, themes, and metaphors were identified and explored. The expectation was that central themes, metaphors, and dynamics would emerge in the material.

Selection of Subjects:

The research was based on documented case files of over 400 couples that have attended for marital therapy. The site and documents chosen represent information-rich cases for study in depth by using both purposeful and comprehensive sampling.

Materials and Procedure

The following constitute the material utilized in this study.

1. For each marital therapy case the therapist completes an (1) Intake Form, (2) Problem Summary Form, (2) Progress Notes Sheet and (3) A Case Closure form. All of this material constitutes one case file and are presented in the Appendices. These forms were each designed by the researcher for supervisory. These forms are designed for clinical use in summarizing client and case material. The categories employed constitute straightforward demographic categories, problem

descriptions, and problem categories to facilitate data gathering and clinical supervision. The 'Progress Notes Sheets' are blank and unstructured allowing the therapist to document clinical impressions in narrative form.

2. In studying each case-file, the researcher summarized his impressions of the couple using a 'Qualitative Summary Sheet' designed by the researcher for this study. This sheet allowed for the creation of a holistic picture of the couples relationship (see Appendix 8) while remaining fluid, flexible, and open to emerging themes. In addition the researcher kept additional written notes and comments for each case file.

Coding Topics and Categories.

The objective here was to gradually group couples files into clusters. This was done in two separate ways: Using categories emerging from the data and using predetermined categories. Categories emerging from the data emerged using the following method: Before looking at any files in detail the researcher read through at least 50 files carefully in order to get a feel for the material and to develop a more holistic sense of the data. Following that, the researcher went back and, starting with the first file, asked key questions relevant to the couple such as - What is happening here? What is at stake with this couple? What is the interactive metaphor for this couple? What is each partner seeking or struggling with? Then with these kinds of questions the researcher identified key words and issues using the summary sheet (Appendix 8). Having made a list of issues and themes for each of the first 50 files, couples were to identify major issues, processes, and dynamics between couples.

The investigative process identified above incorporated the use of key predetermined categories to identify themes and topics. For example, categories from the Structural Analysis of Social Behaviour (Benjamin, 1996), adult attachment theory (Greenburg and Johnson, 1994), systems theory, and interpersonal theory (Kiesler, 1983) were employed in the data analysis. When these initial approaches to the initial 50 data files proved fruitful then the approach was continued with the remaining files.

Seeking patterns and identifying marital types.

The overall goal of this study was to be able to make general statements about couples by discovering patterns in the data that may contribute to the creation of a typology of couples. A marital type is understood as a relationship among clusters of couples (categories) that will be building on shared processes (topics). Seeking common

patterns between couples meant examining the data in as many ways as possible - using emergent categories, using predetermined categories, using content focused categories, using process-focused categories, and using concepts borrowed from other typologies. The process of pattern seeking preferred was that of 'crystallization', i.e. one long period of intuition rich immersion with data until patterns crystallize. This involved challenging each major hypothesis, moving back and forth between data, topics, categories, theories, and types. Checking the emerging hunches with key informants, couples, and supervisor consultations protected this approach.

FINDINGS

The qualitative analysis resulted in the identification of key descriptive concepts and variables that are central to accurately defining individual couples. The methodology identified key concepts through which couples could be compared and contrasted and which were central to relationship definition and the process of therapy.

What emerged as the key concept in attempting to describe the data was the *psychological position* of partners relative to each other. This emerged as the pivotal concept or metaphor in summarizing the complex of variables that defined a couple's relationship in interactional terms. By 'psychological position' is meant the complex of behaviours, emotions, and attitudes that, as a whole, can be characterized as a position in relationship to another. These positions were caricatured in a manner that simplified description without compromising the complexity of the cases. The position assumed by each partner was determined by process centred variables - i.e. issues that are not defined by specific content or detail but rather by process, position, or interaction.

<u>How the findings emerged: The method and findings</u>

The qualitative approach meant that I immersed myself in the data - the hundreds of files on couples in therapy. I read through each file to identify key categories, themes, and dynamics. Having identified issues and themes, key process oriented concepts emerged from the data that allowed the material to be interpreted in a meaningful way. These concepts were summarized under the key metaphor - i.e. positioning.

As I explored the potential for developing a typology I found myself increasingly drawn to what were the similarities between couples rather than trying to identify differences - i.e. seeking to understand the common variables through which couples could be compared. I began to seek metaphors or images that might best summarize the relationship as it emerged through the data. In this, I focused more on interactional process - that is how couples interacted, how the problem seemed to be structured, and the interactional 'stuckness' that characterized most of the distressed couples sample - rather than specific content.

<u>STAGE 1 OF QUALITATIVE ANALYSIS: Level 1 Descriptors:</u>

I examined the data closely and was focused initially on case content relating to such issues as addiction, violence, affairs, levels of conflict, communication skill deficits,

extended family issues, life-cycle issues, parenting, separation negotiations, bitterness, conflict resolution, empathic skills, family-of-origin issues, sexual abuse issues, post-trauma issues, poverty and social deprivation, psychiatric and Axis I disorders etc. It was apparent that there were hundreds of unique problem-scenarios. These were content related issues regarding what exactly was the presenting problem and how might one formulate this problem. While detailed and compelling it was apparent to me that such descriptions did not come close to describing fundamental issues. So I asked myself, "What do all of these issues have in common? "What are the issues being negotiated in these conflicts?" This took me to another level of analysis.

STAGE 2 OF QUALITATIVE ANALYSIS: Level 2 Descriptors: Psychological Safety & Social Justice

When I looked at the Level 1 descriptors and the struggles inherent in therapy it was apparent that more fundamental issues than specific content were involved. I became concerned with what was really at issue for the couples in their problem scenarios. So I asked, "What is really at stake in these conflicts?" In asking this question of the data different answers emerged. The answers appeared to exist at the intersection between individual survival and interpersonal needs. The key terms for me in this became *Psychological Safety* and *Social or Interpersonal Justice*. The social reality of these intimate relationships began, therefore, to emerge into the foreground.

Themes and issues involved:

What was at stake for each individual appeared to be, firstly, their own psychological and emotional safety in the relationship and, secondly, their sense of social or interpersonal justice and their associated entitlements. The terms that emerged for me in this regard were for example: 'freedom', 'safety', 'independence', 'rights', 'power', 'control', 'security', 'dependability', etc. Each person seemed to expect and demand that the other would and could ensure his or her safety and entitlements. Rather than struggle about these issues in principle, they seemed to be fought out symbolically through the presenting problems. The following is a presentation of these key issues:

1. Independence & Freedom

   Most couples were struggling with issues of autonomy and the rights or entitlements or appropriateness of levels of freedom within the relationship. Disagreements were regarding what one was supposed to be doing, how one was supposed to behave, etc. In many ways these issues touched on issues of what

is just, fair, responsible, and what one's individual rights, freedoms, and entitlements are in an intimate relationship.

2. Affiliation & Belonging

Most individuals were involved in an intimate relationship because of needs to belong and to be affiliated with another. This basic need for attachment was the glue that kept people involved. The terms or nature of this affiliation appeared to be what much of the struggle was about.

3. Power & Control

This was a key issue involved with most couples and involved various forms of withholding or coercion. In many cases a scenario existed where partner 'A' pursued 'B' to provide a response that 'A' believed 'B' was withholding. Whether 'B' was capable of responding in the manner demanded was avoided. 'A' assumed that 'B' had it to give and 'B' acted as if he/she had it to give. Another scenario existed where 'A' attempted to control 'B's behaviour to inhibit a response that 'A' believed 'B' would show if he did not control 'B' - for example a man's coercive control over the woman's freedom. In these instances the fact that 'B's behaviour was coerced seemed sufficient to 'A'. These struggles were about power, control, and equality and the rights of one to coerce from another what does not come freely. - The interactional movement of couples who were involved in the end-game of their relationship seemed more associated with issues of power and control. Enmeshed couples, who were in considerable distress but some steps removed from a breakdown and disengagement sequence, were more concerned with issues of responsibility, distance, and autonomy.

4. Respect & Equality

The power and control issues were also about equality and the struggles within a relationship by one or both partners to establish an environment of felt and respected equality. How respect for the other was communicated, if at all, was what was at stake. The refrain of " I don't deserve this" being a common one.

5. Safety & Commitment/Stability

The stability of the commitment in the relationship was also a frequent issue in how one partner's sense of psychological safety in the relationship was at stake.

This referred to the level of emotional certainty for both partners that they had a future together. This might also be identified in terms of enmeshment or involvement.

6. Safety & Trust:

The prevalence of abusive and violent behaviour was extensive. This cast a huge shadow over the rest of the relationship and destroyed the marital container within which any issue could be addressed. A lot of couples defined trust as the core issue with dilemmas concerned with how progress could be achieved without trust.

7. Distance

Most couples were engaged in a process of trying to determine the optimal emotional distance permitted between them. This process was evident in a variety of ways but typically in interactions of pursuit, withdrawal, or emotional sidestepping. These movements were concerned with issues of attention, power, responsibility, reassurance etc.

8. Intimacy and Communication

Many couples, having established some degree of distance were struggling with the nature of the intimate contact - i.e. through support, aggression, care, responsibility, etc. The currency through which intimacy was expressed/received and distance regulated was important. For many this was established through intensity, for others through responsibility and children, for others through physical proximity.

9. The cycles of interaction

Regarding all of these issues I could identify basic cycles of interaction as described by the therapists. The cycles identified here are not new in the literature and represent pre-determined categories. However, it is worth naming them here and the issues around which they appeared to be circling. The cycles were complementary, symmetrical, or antithetical and were typically related to issues of affiliation and belonging, distance, responsibility, power, control and the issues identified above. Complementary cycles included Pursue - Distance; Dominate - Submit; Blame - Placate; Abuse - Accommodate; Frighten - Be afraid; Over-responsible - Under-responsible; Parent - Child; Alienate -

Isolate; etc. Symmetrical cycles included Withdraw - Withdraw; Attack - Attack; Surrender - Surrender; Compete - Compete; etc. Antithetical cycles included Intrude - Reject, Accuse - Withdraw, Terrorize - Ignore, Plead - Avoid, Pursue - Avoid etc.

LEVEL 2 ANALYSES RESULTED IN THEMES REGARDING PSYCHOLOGICAL SAFETY AND INTERPERSONAL JUSTICE

1. Independence & Freedom
Most couples were struggling with issues of autonomy and the rights or entitlements or appropriateness of levels of freedom within the relationship.

2. Affiliation & Belonging
Most individuals were involved in an intimate relationship because of needs to belong and to be affiliated with another. This basic need for attachment was the glue that kept people involved and the terms or nature of this affiliation appeared to be what much of the struggle was about.

3. Power & Control
This was a key issue involved with most couples and involved various forms of withholding or coercion. These struggles were about power and control and the rights of one to coerce from another what does not come freely.

4. Respect & Equality
The need or demand for respect and equality also emerged consistently. How respect for the other was communicated, if at all, was what was at stake. The refrain of " I don't deserve this" being a common one. Gender differences were apparent.

5. Safety & Commitment/Stability
The stability of the commitment in the relationship was also a frequent issue in how one partner's sense of psychological safety in the relationship was at stake. This referred to the level of emotional certainty for both partners that they had a future together.

6. Safety & Trust:
The prevalence of abusive and violent behaviour was extensive. This cast a shadow over the rest of the relationship and destroyed the marital container within which any issue could be addressed.

7. Distance
Most couples were engaged in a process of trying to determine the optimal emotional distance permitted between them. This process was evident in a variety of ways but typically in interactions of pursuit, withdrawal, or emotional side-stepping. Many couples, having established some degree of distance were struggling with the nature of the intimate contact - i.e. through support, aggression, care, responsibility, etc.

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The cycles were complementary, symmetrical, or antithetical and were typically related to issues of affiliation and belonging, distance, responsibility, power, control and the issues identified above. Complementary cycles included Pursue - Distance, Dominate - Submit: Blame - Placate, Abuse - Accommodate; Frighten - Be afraid: Over-responsible - Under-responsible; Parent - Child; Alienate - Isolate, etc. Symmetrical cycles included Withdraw - Withdraw; Attack - Attack; Surrender - Surrender: Compete - Compete; etc. Antithetical cycles included Intrude - Reject, Accuse - Withdraw; Terrorize - Ignore, Plead - Avoid; Pursue - Avoid, etc.

STAGE 3 OF QUALITATIVE ANALYSIS:

Level 3 Descriptors: Psychological Positioning

This exploration and the initial findings from stages one and two needed further distillation or crystallization. I was aware that what was being identified were discreet concepts but ones that did not fully capture the essence of the therapeutic struggle. Even more basic realities needed to be accounted for. In essence, examination of the themes showed that they were content rather than process issues - i.e. they were *what* the couples were struggling with or descriptive of *how* the couples interacted around these issues. They answered a 'what?' question - i.e. "What issues are these couples struggling with?" And 'What is at stake for this couple?' or a 'how' question - "How did the couple interact around these issues?" However, content focused themes or descriptions of interactional cycles still seemed to leave more fundamental issues unidentified. The aesthetics of this exploration needed something more because I was not getting a picture of 'How come?' the couples interacted in these ways around these issues.

I therefore took the question to a deeper level and asked 'How come the couple are struggling in this way? - How come this issue is what has come to the foreground for this couple?" or "What approach is each partner taking to therapy that results in the described therapeutic interaction?" This took me to a different level of information which I identified as the *position* assumed by the partner toward the other that, regardless of the issue addressed, would result in an interaction that would still be 'in character' for the couple. Therefore I became concerned with the character of the couple and how that might be described. The metaphor of positioning seemed to allow this character to be described. From an artistic perspective I was imagining the dimensions along which a couples positions might be sculpted. What were the starting positions of the couple regarding any issue that would trigger them into predictable interactional sequences around predictable themes or issues? What emerged, then, were the variables that appeared to describe positions.

When couples entered therapy it was very clear that beneath the problem narratives and the content of couples disclosures, there were anxieties, power struggles, and responsibility struggles latent in the sessions around which the interactional process was essentially defined. It could be stated, that couples were indirectly negotiating with both the therapist and themselves what positions were going to be acceptable within the

therapeutic system. So I asked myself basic process centered questions about files I was reading - how come this man is approaching and/or responding to this woman in this way. What position has he assumed relative to her that defines the character of their relationship. This led me to identifying fundamental character defining issues. These meta-positions appeared to be in relation to motivation, attitude, responsibility, commitment, ambivalence, self-focus, change beliefs, interpersonal values, and paradox.

Meta-Positions: A descriptions of variables.

1. Motivation to Change.
   Non-verbal Psychological Positions under this included 'I am highly motivated to change'; 'I am not motivated because I do not need to change but will help my partner'; 'I am not going to change under pressure'; 'I will not change'; 'I am determined to change him/her'; etc.

2. Attitude to Relationship / Marriage
   'I care a great deal about sustaining this marriage. I value what we have'. 'I am indifferent'. 'I care but I will not show it'. 'I could not care less - but I will not show it'. 'I do not care'. 'I care about me more'.

3. Felt Responsibility for relationship
   The level of responsibility they were each willing to assume regarding both the origins and nature of the problems, the solution to their difficulties, and the process of therapy itself.

4. Commitment to Relationship
   The degree of commitment that each partner felt toward the other, the relationship, and the process of therapy.

5. Self-responsibility
   The degree to which each partner was willing and able to take responsibility for their own behaviour and effect change without demanding quid pro quos. This refers to levels of ego-strength and maturity where a person shows the courage to

take responsibility for their own behaviour and is able to accept partner criticism openly and with minimal defensiveness.

6. Change Beliefs

This represents a person's beliefs regarding whether change is possible, whether change is necessary, whether change is easy or difficult, can be immediate or not, whether one can change on one's own or not, whose responsibility is change, etc. These are all crucial issues that represent the core position that one approaches the process of therapy. Examining these attitudinal positions would be considered central to the early stages of therapy. For example, a therapist may work over a long period of time with a couple regarding conflict management when both partners may feel or believe that change is not possible and, if it to occur, it can only be a very difficult process. These attitudes need to be addressed prior to attempting conflict resolution.

7. Interpersonal Values

People carry certain values regarding what is important in a relationship. These values go unarticulated but represent the ground rules and boundaries regarding their and other people's behaviour. Values conversations are rare in therapy but crucial - i.e. what are and are not acceptable ways to treat or be treated, what constitutes breaches of relationship vows, what are 'bottom-lines' in terms of what is or is not endured, etc.

8. Paradox & Ambivalence

This refers to the manner in which the couple simultaneously assert and deny the positions they have assumed with each other. For example 'A' who was stating that she could no longer trust 'B' yet was in therapy that demanded degrees of trust. 'B's demand that he be trusted thus demanding that 'A' not trust her suspicions. Conflict emerged, therefore, when couples were struggling at different levels simultaneously - i.e. while a wife was trying to secure and negotiate issues of control the husband was trying to deal with intimacy.

Having identified and explored these issues I realized how fundamental they were and also how ignored they seem to be in the field. For example, the change beliefs of any individual in couples work tends to be seen as symptomatic of the relationship rather

then relationship-defining. For example an individual or couples answer to the question “Do you believe that change is possible” is a fundamental question. As is “Do you believe you need to change?” as is “Do you feel you have a responsibility to change?” As is “Do you want to have a future together” etc.

LEVEL 3 DESCRIPTORS: META PSYCHOLOGICAL POSITIONS

The following issues emerged as being key constituents of any spouse's psychological position relative to the other. It was determined that the psychological positions of the spouse mutually determined interpersonal behaviour. This study proposes that a model of couples therapy can be developed that is process-oriented rather than content oriented and focused on these key elements. To the degree that these relationship-defining issues go un-addressed, couples therapy fails to assess and respond to the foundations and structural architecture of the relationship.

1. Motivation to Change
Non-verbal Psychological Positions under this heading included 'I am highly motivated to change'; 'I am not motivated because I do not need to change but will help my partner'; 'I am not going to change under pressure'; 'I will not change'; 'I am determined to change him/her'; etc.

2. Attitude to Relationship / Marriage
'I care a great deal about sustaining this marriage. I value what we have'. 'I am indifferent'. 'I care but I will not show it'. 'I could not care less - but I will not show it'. 'I do not care'. 'I care about me more'.

3. Felt Responsibility for relationship
The level of responsibility they were each willing to assume regarding both the origins and nature of the problems, the solution to their difficulties, and the process of therapy itself.

4. Commitment to Relationship
The degree of commitment that each partner felt toward the other, the relationship, and the process of therapy.

5. Self-responsibility
The degree to which each partner was willing and able to take responsibility for their own behaviour and effect change without demanding quid pro quo's.

6. Change Beliefs
The beliefs that each partner had about change - i.e. the degree to which they felt it was possible, the level of control they assumed for change,

7. Interpersonal Values
The degree to which they are affected by the other (in terms of empathy and sympathy) and an appreciation of the effects of their behaviour.

8. Paradox & Ambivalence
The manner in which the couple simultaneously assert and deny the positions they have assumed with each other.

SUMMARY OF FINDINGS

What emerged was that couples could be defined at two different levels (aside from problem-definition). Within these levels the experience and issues at stake for couples could be accurately described. The primary level was termed the *Psychological Position.* This term referred to the psychological and emotional position assumed by a partner toward their relationship and sought to define the unspoken disposition that determined the problem dynamic that was central to the couple's struggles. The position therefore referred to the unspoken emotional attitude adopted by the partner. *The Psychological Position* included the following variables: a partners motivation to change, their attitude to the relationship, their 'felt responsibility' for the relationship, their commitment to the relationship, their self-responsibility within the relationship, their beliefs about change, and their interpersonal values.

The second level identified was termed *Emotional Safety and Interpersonal Justice.* This level referred to what appeared to be 'at stake' for couples in distress and included the following variables: independence & freedom, affiliation & belonging, power & control, respect & equality, safety & commitment/stability, safety & trust, emotional distance, and cycles of interaction.

The original finding of this study was that an accurate assessment of couple's relationships in therapy must include assessments of emotional safety, interpersonal justice, and psychological positioning. Without such considerations, couples difficulties remain defined at the basic level of problem-content and the underlying problem structures and dynamics go undetected.

LEVEL 1 DESCRIPTORS	LEVEL 2 DESCRIPTORS	LEVEL 3 DESCRIPTORS
(What's involved) The Bricks	**(What's at stake)** The Mortar	**(How it's approached)** The Architecture
Sample content focused issues	**Emotional Safety & Interpersonal Justice**	**Psychological Positions**
addiction violence affairs levels of conflict communication skill deficits life-cycle issues separation negotiations historical bitterness conflict resolution family-of-origin issues post-trauma issues poverty and social deprivation Axis I disorders	Independence & Freedom Affiliation & Belonging Power & Control Respect & Equality Safety & Commitment/Stability Safety & Trust: Distance Cycles of interaction	Motivation to Change Attitude to Relationship / Marriage Felt Responsibility for relationship Commitment to Relationship Self-responsibility Change Beliefs Interpersonal Values Paradox & Ambivalence

DISCUSSION

This study has revealed a number of findings regarding the potential for classification. The findings present interesting and useful categories within which one can describe and understand couple behaviour. The primary result is the presentation of a new structure for describing couples behaviour in therapy.

The findings of this research question represent a description of the issues that shape couple's interaction. This investigation presents qualitative material that should be particularly useful in describing and assessing couples in therapy. The nature of the material in the results is essentially descriptive and conceptual. It provides a conceptual framework within which the narrative of couples experience and their self-presentation in therapy can be described and understood. What has emerged from the data has not been quantitative facts or findings but rather a more literary, descriptive, conceptual summary of material that uncovers concepts or issues that have received occasional attention in the mainstream of models of couples therapy but hithertofore have not emerged as central concepts. The findings of this exploration suggest that the following issues are so central to couples interaction as to be relationship defining: psychological and emotional safety; social and interpersonal justice; attitudes to change; interpersonal responsibility; interpersonal values; and commitment. As was shown, these issues emerged at different levels of investigation.

<u>The Level 3 Descriptors: The psychological positioning of the spouses:</u>

The terms that emerged at the third level of analysis, summarized as the psychological position, constitute a new dimension in the area of the assessment of couples. In the search for systems concepts, and a devotion to interactional terms, family therapy appears to have lost a hold on some of the more obvious intrapsychic issues that give shape to interactional therapy. In analysing the data it was apparent to the researcher that most of the couples work was content focused, historically focused, interactionally focused, or incident focused in a manner that, while it was compelling and substantive, it did not seem to examine the emotional scaffolding that appeared to hold these various issues in place. The research investigation suggested that attitude to change and change beliefs, responsibility for self and the relationship, motivation, commitment, attitude toward the relationship, interpersonal values, and ambivalence were issues that, while mentioned, were rarely engaged with directly and continuously in therapy. This is understandable when you examine basic couples models - behavioural,

psychodynamic, problem-centered, experiential and systems models all scan the terrain of couples interaction for specific kinds of material that makes it difficult for therapists to step back from the therapeutic process itself and consider the container in which it is all set. Therefore, this study will suggests that pre-therapy investigation and exploration might focus less on presenting problems, psychodynamic formulations, family-of-origin assessments and look directly with couples at such issues as what are your beliefs about change? Is change possible? Do you need to change? Who should change? Who is responsible? What is your motivation to work on your relationship? Do you feel responsible for your relationship? What are your values about relating - what does your partner deserve from you, what can you promise, what do you prize at the end of the day? Etc. Questions like this do not go for content, or stories, or incidents but are rather guided toward beliefs, values, and responsibility. An object relations investigation may present a formulation that would help a therapist understand how and where some of these beliefs or attitudes emerged but, as a primary intervention, this study would suggest that an exploration of couples psychological positions regarding these issues, should be central.

The notion of a position is not a new one in the field of family therapy. It would be associated particularly with strategic family therapy. The strategic analysis of family problems was to suggest that the position that one took to a problem and it's solution was what was at the heart of problem-formation.

The results can be understood as an initial draft of the architecture of a couples relationship in terms of therapy and issues of change. The therapy situation places couples in a unique situation within which attitudes toward change immediately move to the foreground of couples presentation. The level 3 descriptors of the couples psychological positions constitutes an important addition to the field in that there is a remarkable absence of commentary in the couples therapy literature regarding couples psychological position toward change and therapy. What is compelling about the variables that contribute to defining psychological position is that while they may appear somewhat obvious, they are almost entirely neglected in the models of couples therapy.

The primary variables of motivation to change, attitude to the relationship, responsibility for relationship, commitment to the relationship, self-responsibility, change beliefs, interpersonal values, and paradox have all emerged separately in the

field but have not been unified into a coherent identifying whole. Each of these concepts, as they emerged in the study, are located in the individual rather than between the individuals. However, this analysis will hope to show that it is interactional process that initiates, reinforces, and maintains these positions. The most obvious illustration of this in the data was how the stage in the life of the couples relationship strongly influenced the positions held. For example, couples engaged in what might be termed the end-game in their relationship will show different psychological positions than couples in the early years. However, typically in the data the discrepancy between individuals' positions was what created the unique character of their relationship. In addition, marked gender differences on positional variables seem likely.

It is worth pointing out that there are a host of secondary factors that affect and influence the nature of the psychological position assumed. These would be issues of flexibility; resilience; ambivalence; chronicity; accessibility; characterological or skill deficit; reactivity; developmental maturity; etc.

The variables affecting the psychological position

Issues regarding *motivation* for change have been addressed indirectly in object relations therapy and primary defence mechanisms (Slipp, 1986) and more directly in the work of the MRI group. Motivation in this context refers also to the degree to which both or either partner feels that change is necessary and inevitable. The discrepancy between partners is what can create the conflict and, of course, ambivalence can disguise motivation. For this reason, we can understand why most couples only come in for marital therapy when change has become urgent, necessary, unavoidable, or difficult to initiate - for one or both partners. The discrepancy between partners' positions regarding this motivation has to be understood to accurately respond to a couple.

A couple's attitude toward their relationship also emerged as defining. It may appear to be a rather obvious variable but nonetheless affects the process of therapy. By attitude is meant the degree to which the relationship is prized, valued, or cherished by the individual partners as distinct from attitudes of despair, cynicism, or disregard. A paradoxical element in therapy will often be the cynical participant who sought help for a relationship he needs to value if things are to change.

Responsibility for the relationship is another key variable. As pointed out before, nowhere in the literature is the fact that women carry much of the responsibility for seeking outside intervention for the relationship - making 85% of the first contacts with outside providers - considered as a fundamental framing element in understanding the meaning of the therapeutic situation for the couple and the relationship. This study suggests that it needs to be considered as a primary defining element. Responsibility is less an issue in individual therapy with adult patients but in couples work it immediately becomes the primary dynamic influencing couples behaviour in therapy. Feminist writers have long since raised these gender related issues yet it is remarkable how little of their analysis has filtered down into the theory and models of couples therapy. This is particular marked, for example, with regard to issues of responsibility for change and how this responsibility is assumed and acted out in the couples therapy context. Responsibility, in this study, is presented as a defining positional variable that determines the structure and process of couples interaction in therapy.

Commitment is an old-fashioned term yet powerfully meaningful in the lives of couples yet, like many of these variables, one that receives little attention. It is crucial to the process of therapy, particularly with the sample involved because if therapy is to be a successful venture a degree of psychological safety has to be established if couples are to take risks. Such safety cannot be provided unless there is some sense of a couple having a future together. If a commitment to a future, even if it's just a matter of months, can be established then a context and climate can be created within therapy to facilitate a therapeutic exploration. It is ironic, and again paradoxical, that many individuals in the process of marital separation seek to create a psychological process in therapy that demands emotional approaching. This, of course, creates emotional conflict and confusion and if un-addressed creates more harm than good.

The issue of self-responsibility is emphasized by Gestalt Therapists (Zinker, 1994). It is also a key concept in Bowen therapy (Bowen, 1971). In the present study, it was identified as a necessary ground rule to effective therapeutic interaction. The data showed that many couples were caught in cycles of conflict that involved much blaming, projective blaming, projective identification, etc. Gestalt therapists will often set down self-responsibility as a condition for therapy. This is less the case with family systems thinkers because it is a concept that appears to fly in the face of traditional systems thinking. But Bowen, gestalt family therapists, and post-modern thinkers are now reinventing this basic concept. In many of the cases in the study, a considerable

amount of blaming was addressed at the level of content - i.e. trying to help a couple negotiate conflict or determine the 'real' facts. Such an approach often leaves the issue of self-responsibility un-addressed. Like other variables that define positioning in this study, it is too obvious to ignore.

Another obvious variable are the *beliefs about change* that are held by each party. How these beliefs interact create unique relational structures. For example, a borderline individual will believe that change is inevitable and uncontrollable. A compulsive's belief will be that change should be minimized and managed. A passive-aggressive's beliefs will be that change is likely but will be initiated by others. A narcissistic perspective will be that change should not happen except when initiated by the self. Couples get into difficulties regarding change. One has to understand if partners feel that change is essential and necessary, whether it is possible, whether it can happen immediately, whether it takes one or two to change, whether one needs help to change, etc. All these notions are crucial to psychological positioning. Symmetrical or complementary positions can be anticipated. The compulsive woman pushing for change, which is resisted by the passive-aggressive partner. The avoidant who fears change and the histrionic who creates change. The paranoid who is terrified of change and the dependent that wants change but does not know how to initiate change.

The concept of values is another obvious element that has received no attention but is so central and obvious. It was clear to the researcher that different individuals values different elements and dimensions of a relationship. Individuals place different value strengths on things such as loyalty, commitment, family, sympathy, empathy, individual freedom, devotion, dependency, faithfulness, parenting, separateness, etc. These values are typically forged through generations and family of origin experiences yet they frequently go unseen and un-addressed. This touches also on issues of ethnicity, class, and gender. Poor or working class families will have different value systems than middle-class therapists. For one individual or couple loyalty to one another may supersede all other values - even to the point of emotional death. While for another couple, individual freedom may be prized to the degree of inevitable separation. Conversations about such things should really be part of the therapeutic process because they often touch the 'heart' or 'soul' of an individuals life narrative in a way that problem-exploration never will.

Finally, we turn to the presence of *paradox*. The other variables identified in the study did not quite capture the complexity of couple behaviour that had at times blatant and at other times subtle paradoxical double-bind characteristics. A sculpture of the psychological positions needed to capture the inherent ambivalence and conflicted tension of the position where each partner was simultaneously stating and denying needs, pursuing and distancing, engaging and withdrawing, saying yes and no. Strategic marital therapy suggests that power in a marital relationship is balanced through what Madanes (1981) termed 'incongruous hierarchies'. She sees many marital problems as a consequence of attempts to balance power, incorporating control and responsibility, in the relationship. Distress or symptoms in one spouse are seen to develop as an attempt to change the hierarchical arrangement and balance the division of power in the couple. She uses the following example to illustrate her case and uses the metaphor of positioning to do this. She suggests that if, for example, we describe the husband as symptomatic - e.g. depressed and withdrawn, he is in an inferior position to his wife who tries to change him; yet he is also in a superior position because he refuses to be helped or change. While requesting support and help from his partner, he also refuses to be influenced. In this way the strategic approach emphasizes how two incongruous hierarchies are defined in the couple. In one, he is in an inferior position because he is in need of help, and his wife is in the superior position of helper. In the other, he will not be influenced or helped, which puts him in a superior position to his wife, who tries unsuccessfully to change him. If the man abandons his symptoms, he loses his superior position in relation to his wife, who will no longer be engaged in trying to change him. If she, on the other hand, is successful in getting him to change, she then loses the superior position of being the 'healthy' one in the relationship.

The concept of a position that is simultaneously inferior and superior is important in strategically focused therapy. Spouses may be in a superior or inferior position in relation to each other alternately and in different areas. Sometime, however, the division of power is unsatisfactory to one of the spouses, and the couple do not find a way of balancing power that is satisfactory to both. It is then that symptomatic behaviour may appear. But this is an unfortunate solution because instead of balancing power in the relationship, it produces a hierarchical incongruity in the marriage. The couple become restricted to a situation where one's behaviour defines simultaneously an inferior and superior position of each spouse in relation to the other spouse.

Level 2 Descriptors:

Psychological Safety & Interpersonal Justice embedded in interactional cycles

The notion of *interpersonal justice* emerged as a key issue affecting couples. This concept appears to be a most useful one as it has meaning at the level of socio-political analyses of couples relationships and marriage as well as psychodynamic and object-relations perspectives. The feminist critique of couples therapy still appears to be a marginal perspective. This investigation suggests that issues of justice are central to every couples struggle for relational harmony. Notions of justice in heterosexual relationships often actually seem to be avoided by therapists. Issues concerning values, ethics, and justice at times seem a step removed from the remit of couples therapy. However, this study suggests that it is at the heart of the work and, more particularly, what couples are seeking. A couples therapist will typically distance him/herself from issues saying to couples "I know you are looking for someone to be a judge or referee over what is happening in your relationship, but that is not what I will do with you". This of course is an appropriate response by a therapist, but to the degree that he/she wishes to avoid the heart of a couples struggle then he she seems to miss a most crucial element. Interpersonal justice, in the context of this study appears in issues of loyalty, abuse, extra-marital affairs, violence, past hurts, pain, forgiveness, punishment, making amends, guilt or non-guilt, Etc. In fact, one could describe a great deal of couples struggles in justice-related terms and everyone's desire to receive justice, and to be just themselves. This refers to a basic unspoken morality that connects also with values (which also emerged as a key concept). Words such as these typically scare therapists because the associations to them are often negative. This study would suggest that basic terms and issues in this arena can be recast in terms that are emotionally accessible and real. From the perspective of gender, there is a real need for couples therapy to grapple with this in a way that can assist women and men to enter couples therapy meaningfully.

This connects meaningfully to the concept of psychological safety. This term has resonance in object-relations theory where issues of emotional security and safety remain constant throughout adult life. The term psychological safety has resonance with couples when a therapist talks about safety, both in therapy and in the relationship. Couples appear quick to recognize the emotional relevance of this. As will be discussed later, this term has a footing in attachment theory and object-relations.

Systems theory partially explains these patterns but does not address the issue of motivation and dynamics internal to the individual. Attachment theory, as already illustrated, suggests that it is the innate need for security and protection and the concomitant vulnerability to rejection by or loss of the attachment figure, which underlies the habitual responses. Marital distress may generally be considered as the failure of an attachment relationship to provide a secure base for one or both partners. Attachment theory, in addition, emphasizes that emotional experience and expression are of primary importance in close relationships and organize proximity-seeking behaviours.

Therefore, to understand the stability inherent in the distressed relationships identified in this study, one has to appreciate the power of attachment and connection and how the possibility of losing connection with those we love terrifies us in a primordial way. When our very survival appears to be at stake it arouses the deepest fear, rage, and grief that most of us will ever know. If one partner's cruelty is really a frantic protest against the loss of attachment, the other's withdrawal expresses the equally primordial urge to protect oneself when one's intimate partner looks like a predator. In understanding the couple behaviour identified in this study one must be finely tuned to the process of approach, avoidance, pursuit, and withdrawal highlighted by attachment theory.

The function of attachment behaviour in adults is analogous to those in infants: proximity seeking, separation protest, having a secure base and safe haven.

The study is also consistent with placing affiliation and control as central to describing interpersonal behaviour, as outlined by Benjamin (1998) and Leary (1957). Their work touches, indirectly, on issues of interpersonal justice. Human interpersonal behaviour represents varying blends of two basic motivations: the need for control and the need for affiliation. Wiggins (1994) broadened this view to society at large and renamed control as the need for agency; and re-named affiliation as the need for communion. He saw the meeting of these needs as essential ingredients for a harmonious society.

Finally we look at interaction cycles. From the perspective of emotion-focused couples therapy, we can suggest that positions adopted by individuals act to curtail the probable responses of the other. The positions the couple take with each other then create relationship-defining events that in a mutually determining fashion also feed

back into the inner experience of each partner. These events may create, maintain, or modify each partner's experience of the relationship. In a distressed relationship, inner and outer realities, context and experience, mesh into a tight negative system that becomes an absorbing state and precludes the evolution of new patterns or responses. The marital therapist has to then modify the inner experience of both partners, the positions they take in the relationship dance, and the relationship events that define the quality of attachment.

Distress in marriage can be described in terms of the level of reactivity, the rigidity of the interaction patterns, and the quality of affective responses. Patterns can be delineated in terms of pursuit and withdrawal or blaming and placating. The central problems in distressed relationships can be seen as (1) the inability to respond to the other, (2) inaccessibility, and (3) resulting lack of engagement and contact. The patterns that are the most prominent in distressed couples seem to be attack-withdraw or pursue-distance , which eventually evolve into attack-attack or withdraw-withdraw patterns. All of these are consistent with the findings of this part of the research study.

IMPLICATIONS

This chapter will present an outline of the implications, and recommendations of this study. It will conclude with a brief summary. This study resulted in detailed descriptive outlines of distressed couples classified using both quantitative and qualitative methods. While there are considerable limitations to this study, there are a range of useful implications and recommendations that can be drawn from the data. The methodological limitations are presented in the Appendices.

Implications

The development of concepts in the area of relational diagnoses can be extremely useful in training therapists and developing a language that can identify and describe interpersonal categories and processes. A system of classification can enrich our language and sharpen the focus of our interpretative lenses and can provide both metaphors and concrete categories through which the narrative of couples unique experience can be represented.

It adds further data to support the development of interactional systems of classification that may compliment the current individually-based diagnostic systems. It is clear from this study that certain dyadic units and concepts can be identified and described. This study can contribute substantially to the growing need to develop categories that can assist professionals in communications about couples and families.

In addition, it is expected that this study can contribute toward assisting further research in crystallizing interpersonal dynamics. The absence of a common language, of common diagnostic concepts regarding interpersonal behaviour, necessitates this present study and its methodology. This study, when integrated with existing research, contributes to the sparse literature on marital typologies and provides data to further clarify concepts for interpersonal classification and diagnoses.

The findings have immediate application in the area of marital assessments. A number of the categories would appear to be of immediate use. Specific personality types, and personality-based relationship types can be examined in terms of issues of psychological safety, interpersonal justice, and psychological positioning. Also, the gender related issues that emerged here are significant. Issues of justice, responsibility, and safety have marked gender related dimensions that need examination. An advantage inherent in the concepts that have emerged here is that

they challenge the assessor to immediately consider how gender issues affect positioning, responsibility, and safety.

The research resurrects basic concepts such as attitude, values, and commitment and challenges investigators and therapists to consider how issues of justice, fairness, equality, freedom and such like can be reintegrated into the narrative of couples therapy. A presentation of the ideas emerging from this study to therapists resulted in immediate recognition and acceptance of the relevance of the concepts involved.

There is therefore considerable potential for the development of a process-oriented therapy that would, at least initially, sideline content related issues by working with couples at the level of position, safety, and justice before exploring historical or problem-focused issues.

The concepts and terms that emerged appear to have an existential and experiential dimension that often goes un-addressed in the systemic formulations of people and problems. Existential issues are concerned with issues of meaning, life and death, survival, suffering, forgiveness, etc. The concepts that emerged in this study were concerned with these issues through such terms as responsibility, safety, freedom, justice, values, etc. It is timely that couples therapy would reawaken such issues in its formulations and models for intervention.

APPENDICES

APPENDIX 1
Intake Form

APPENDIX 2
First Session Form

APPENDIX 3
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APPENDIX 4
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The SASB Simplified Cluster Models - all three surfaces.

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APPENDIX 1: Intake Form

INITIAL CONTACT INFORMATION SHEET

Counsellor Surname _____ Counsellor First Name_____
Surname _____ Client No. _____
First Name _____
Spouse _____ Gender _____
Address _____ Client phone 1 _____
_____ Client phone 2 _____
_____

Area 1 _____
Area 2 _____

Appointment given _____Date Appt _____ Date First _____
Time First _____
Made Appt
Appt use 24 hr clock e.g. 22.30

Source of Referral _____ Name _____
Marital Status _____
Age, Male _____ Age, Female _____
Years married _____
No of children _____
Working, Him _____Working, Her _____

Kind of Counselling _____
Previous Counselling _____

Availability times_____

Comments _____

APPENDIX 2: First Session Form

Marital/Couples Counselling

Confidential - Clients names not to be written in this Form

Client no. _____ Counsellor: _____

Date _____ Couple: Married _____ Unmarried _____

Couple Seen: Conjointly _____ Separately _____

Ages: Him _____ Her _____

Occupations: Him _____Her _____

Brief outline of presenting problem (use clients initials):

_____
_____
_____

Problem Information - Factors involved:
(indicate only what has been disclosed in initial session with Yes, No, Undetermined

Verbal Conflicts
Drinking
Physical Abuse
Sexual Difficulty
Parenting
Family Problems
Indicate goal of couple:
Improve an already satisfying relationship
Improve a relationship that now offers only some satisfaction
Improve a relationship that now offers little/no satisfaction
Decide whether to continue in this relationship
Other _____

Please outline the outcome of the session:

_____
_____
_____

Current Plan:

Additional appointment made _____ Not made _____
To be arranged_____ Other
_____

APPENDIX 3: Case Notes Form

CASE-NOTES SHEET:
Please complete after each session:

Confidential: Please use first name initial when referring to clients

Appt No. Date Case Notes

APPENDIX 4: Case-closure Form.

CASE CLOSURE SHEET CATEGORIES

Type of Counselling _____ Client No._____

Counsellor Surname _____ Counsellor First Name_____

Total Number of Sessions _____
Sessions with one _____
Number of cancellations _____
Sessions with both _____
Number of No Shows _____
Phase of life _____
Working, Him _____
Socio-economic level _____
Working, Her _____
Presenting problem _____
Goal of couple _____
Duration of problem _____
Behaviour _____
Communication _____
At the end _____
Agreement _____
Psychiatric Problems _____

Drink Problem _____
Infidelity_____
Physical Abuse Problem _____
Extended Families_____
Physical Abuse Victim _____
Sexual Difficulties_____
Sexual Abuse Victim _____
Parenting_____
Suicide _____
Financial _____
Barring Order _____
Stressors_____

Closing notes
_____
_____

APPENDIX 5.

Summary of SASB Perspective of Diagnostic and Differential Indicators of Personality Disorders and Styles.

The thesis of the SASB Model is that personality disorders and styles can be described well by three underlying orthogonal dimensions:

(1) How one behaves toward another,
(2) How one reacts to another, and
(3) How one treats oneself.

Under each of these headings eight primary interpersonal positions or SASB labels are possible for a person. The constellation of positions exhibited by someone determines the dominant interpersonal style.

The checklists used in this study illustrate this in more detail. If a clinician uses these dimensions in assessing a client's behaviour toward themselves and their partner, he or she will be able to identify the respective disorders or styles. In this study, each partner was assessed along each of these three dimensions using a detailed checklist.

The SASB model, built on the three dimensions, has provided the language for interpersonal descriptions used in this study. The characteristic baseline positions for the respective disorders/styles are presented identified in the checklists. These positions are based on the cluster version of the SASB Model.

APPENDIX 6:

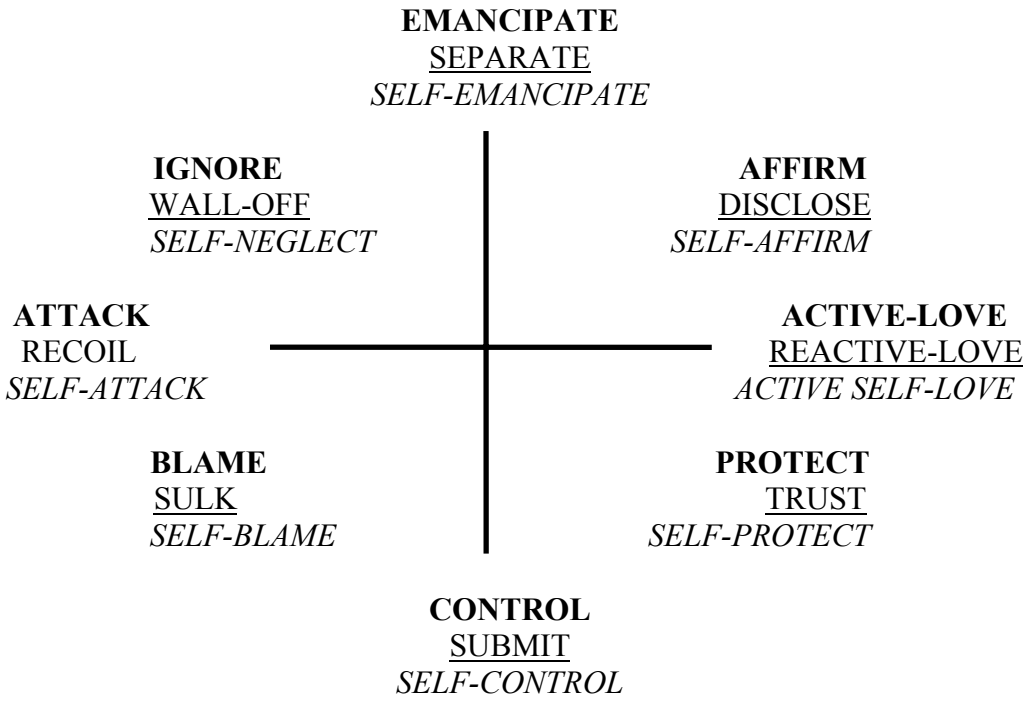
The SASB Simplified Cluster Models - all three surfaces placed on the Affiliation-Control Axes (X-Y axes).

The X axis indicates affiliation (i.e. from hate to love) and the Y axis indicates interdependence or control (from dominance to autonomy-granting).

The focus-on-other dimension is indicated in **BOLD** from **EMANCIPATE** around to **IGNORE** and describes behaviour directed at the partner.

The focus-on-self dimension is indicated by UNDERLINED words from SEPARATE around to WALL-OFF and describes reactions to the partners perceived initiations.

The internalized introject dimension is indicated by *ITALICS* from *SELF-EMANCIPATE* around to *SELF-NEGLECT* and describes a persons attitude to self.



APPENDIX 7

Methodological Limitation

Methodological Limitations of Research Study 2: A Typology of Distressed Marriage.

1. The findings of this study are situation specific in that they apply to a population of couples attending for marital therapy in an inner-city constituency. Therefore, the conclusions are not applicable to the general population. In addition, the findings cannot be generalised to all distressed couples as the sample is from a specific inner city agency with it's own ethos, policy, and procedures.

2. The cognitive approach (Cross & Markus, 1993) sees gender as a primary category by which we simplify a complex interpersonal world. This leads to a natural process of stereotyping. This perspective would raise the issue that the researcher may have unconsciously been engaging in such a process and possibly categorizing male and female behaviour differently. This is a critique that deserves mention because no observer is essentially free of social bias.

3. The bias of the researcher is a limitation to this study in that a considerable amount of interpreting undertaken by the researcher was not objectively ratified. This is an inherent subjective element that represents a notable limitation. However, as an exploratory broad ranging exploration the data is still substantive.

4. The profiles of the sample were obtained by using specific diagnostic criteria, which represent a translation of DSM criteria into SASB terms. As such, these criteria are representative of theories (SASB) and models (DSM-IV) that, while in widespread clinical usage, remain empirically unproved.

5. The findings of this study have low validity in that the checklists used are not a standardized test. In this regard they are utilized in a manner consistent with DSM diagnostic criteria. The interpretation of data was not done using objective measures but was based on the researchers interpretation of the data using the SASB criteria. This method was obviously subject to error. Therefore, additional research needs to be undertaken to assess further the objectivity and clinical usefulness of SASB criteria.

6. The raw data itself is limited. Firstly, as the documented material were not verbatim transcripts of sessions there was an inevitable loss of accuracy in the data. However, this is controlled to a considerable degree by the large database employed, thus minimizing idiosyncratic therapist variables that might undermine the validity of a smaller sample. Secondly, there was no record of non-verbal behavior, which represents a huge class of behavior eliminated from the study. Thirdly, the data employed in this study, i.e. clinical case-note files, are third party accounts of marital interaction and, as such, are one step removed from direct accounts, and a further step still removed from direct 'live' observation. The data, therefore, is clearly limited and thus represented an analysis of the therapists' and researchers inferences regarding marital behavior.

7. Finally, in examining interpersonal marital behaviour some theoretically derived clinical disorders by definition avoid seeking help from others and, as a result, would show up infrequently in clinical treatment settings.

Methodological Limitations of Qualitative Research Study 3

1. The findings of this study are situation specific in that they apply to a population of couples attending for marital therapy in an inner-city constituency. While some reasonable hypotheses can ensue from these findings, they are not directly applicable to the general population. In addition, there is limited ability to generalise to all distressed couples as the sample is from a specific inner city agency.

2. The bias of the researcher is a limitation to this study in that a considerable amount of interpreting, which was not objectively ratified, was undertaken by the researcher. The methodologies of both the primary research questions demanded that the researcher interpret the data as a primary step. This is an inherent subjective element that represents a notable limitation. However, as an exploratory broad ranging exploration, the tentativeness of the conclusions and the appropriate use of qualitative methodology (which recognizes the experience of the researcher) suggest that the data is still substantive.

3. The raw data itself is limited. Firstly, because the documented material was a not verbatim transcript of sessions there was an inevitable loss of accuracy in the data. However, this is controlled, to a considerable degree by the large database

employed thus minimizing idiosyncratic therapist variables that might undermine the validity of a smaller sample.

4. The data employed in this study, i.e. clinical case-note files, are third party accounts of marital interaction and, as such, are one step removed from direct accounts, and a further step still removed from direct 'live' observation. The data, therefore, is clearly limited and thus represented an analysis of the therapists' and researchers inferences regarding marital behaviour.

5. In examining interpersonal marital behaviour some theoretically derived clinical disorders by definition avoid seeking help from others and, as a result, would show up infrequently in clinical treatment settings.

6. The investigation of this research question is not replicable. There are a host of variables that are idiosyncratic to the context and method - e.g. the agency setting, the experience and involvement of the researcher, the sample, the descriptive method, etc. However, this was understood at the outset and it is hoped that the concepts and ideas that have resulted from this investigation will have applicability within the field and prompt further analyses of its emergent concepts and categories.

7. The investigation resulted in a narrative and literary description of the data. The concepts that emerged from the interaction of the researcher with the data were influenced by the researchers experience and pre-determined dispositions. This is both the value and limitation of the study.

8. As the investigation moved more from specifics to general themes and descriptions the findings represented theoretical formulations as much as behavioural accounts. As such, the study could be understood as a conceptual analysis with its findings presented in terms of concepts considered useful in classifying couples issues and concerns.

In conclusion, the limitations of the study are apparent. The value of the research project, in contrast, will be seen in terms of its general applicability, implications, and the recommendations that ensue.

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